

**State of Montana**  
**DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES**  
**Addictive & Mental Disorders Division**  
**Clinical Eligibility Form**  
**Mental Health Services Plan (MHSP) and Waiver for Additional Populations (WASP)**  
***NOTE: This form needs to be submitted with the Medicaid Enrollment Application***

<b>APPLICANT INFORMATION</b>		
Date of intake appointment:	Referred by:	
Applicant ID/SSN:	DOB:	Gender:
Applicant Name: Last:	First:	Middle:
Mailing Address:	City:	State:
County:	Zip:	Telephone #:
Applicant's stated reason for seeking services:		
<b>PROVIDER AGENCY INFORMATION</b>		
Name:	Clinician email address:	
Address:	City:	State:
Zip:	Telephone #:	Fax #:
<b>CLINICAL INFORMATION</b>		
<b>CURRENT DSM5/ICD-10 DIAGNOSES:</b> Please list both code and narrative, including substance use disorders.		
Primary Diagnosis:	Specifiers Required:	
Other (requiring treatment):		
Medical Conditions (specify):		
*List signs / symptoms to substantiate the qualifying SDMI primary diagnosis:		
Name of Medication:	Dose / Frequency:	Prescriber:

<b>Applicant Name: Last:</b> _____ <b>First:</b> _____	
If no current medications, has a medical professional with prescriptive authority determined that medication is necessary to control the symptoms of the mental illness? <input type="checkbox"/> Yes <input type="checkbox"/> No Name and title of medical professional: _____	
History of adult outpatient mental health treatment: <input type="checkbox"/> Yes <input type="checkbox"/> No Please list any services in which the individual has participated, <b>including</b> individual and/or family therapy: _____	
History of Inpatient Adult Mental Health (NOT CD) Treatment: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Number of Acute Psychiatric Admissions: _____ Date of most recent admission: _____	
Number of Montana State Hospital Commitments: _____ Date of most recent commitment: _____	
Reason for most recent admission: _____	
Is the individual unable to work/school full time <b>due to mental illness</b> ? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, briefly describe: _____	
Is the individual unable to live independently <b>due to mental illness</b> ? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, briefly describe: _____	
Is the individual unable to care for themselves <b>due to mental illness</b> ? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, briefly describe: _____	
Is the individual homeless or at risk of homelessness <b>due to mental illness</b> ? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, briefly describe: _____	
Current Risk Factors (e.g. suicidal ideation/plan, danger to others, history of abuse impacting current functioning): _____ _____	
Proposed Treatment Plan (identify services, i.e. medications, CM, OPT, etc.): _____ _____	

“I certify I am the person who performed face-to face clinical assessment and the above statements are true and correct.”

Provider Signature: \_\_\_\_\_ Title: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_

Supervisors Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please Mail or fax the Checklist, Application and Clinical Eligibility Form to:

Addictive & Mental Disorder Division  
Mental Health Services Bureau  
PO Box 202905, Helena, MT 59602-2905

Please send through a secure method (such as ePass) to:  
HHSAMDDMHSPWaiver@mt.gov

Fax: 1-406-444-7391 or 1-406-444-4435

Questions? Call 1-406-444-3964