

**AGENCY APPLICATION FOR ONE-TIME DDP TRAINING GRANT  
- FY2021 -**

Agency Name: \_\_\_\_\_

Agency Contact Name: \_\_\_\_\_

Title: \_\_\_\_\_

Phone: \_\_\_\_\_

E-Mail: \_\_\_\_\_

General Training    Behavioral Training

Total amount requested: \_\_\_\_\_

Presenter name and brief description of qualifications:

Anticipated date of training: \_\_\_\_\_

Topic of proposed training: (Specifically describe the information to be presented by the training.)

Training Rationale: (Specifically describe how the training will benefit the agency and members served.)

Relation of Training to Services Currently Provided Under Montana DDP-Administered Medicaid Waivers:

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FOR DDP TO COMPLETE:

Approve    Return for Additional Information    Denied

Comments:

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

## **AGENCY POST TRAINING BENEFIT**

Please provide confirmation that the training was conducted and how it benefits the agency/member(s) within 30 days of completion of training.

Agency Name: \_\_\_\_\_

Benefit:

Submitted By: \_\_\_\_\_ Date: \_\_\_\_\_