SELF DIRECT APPLICATION FOR ONE-TIME DDP TRAINING GRANT
Calendar Year 2024
Send completed application to Cindy Dallas at: cdallas2@mt.gov

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:

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

Submitted By: _____ Date:_____