

**APPLICATION FOR ONE-TIME DDP TRAINING GRANT
For Calendar Year 2025
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: _____