

State of Montana
DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES

MONTANA MENTAL HEALTH SERVICES PLAN
Non-Medicaid Enrollment Application

Please complete this form with information specific to the applicant seeking services.

<input type="checkbox"/> New Enrollment
<input type="checkbox"/> Re-enrollment
<input type="checkbox"/> New Information

Full Name of Applicant: _____
Last
First
MI
Maiden

Social Security Number: _____

Mailing/Residence Address: _____

City, State, Zip: _____

Current County of Residence: _____ Education Level: _____

Home Phone #: _____ Work/Message Phone #: _____

Applicant Date of Birth:	Marital Status:	Gender:	Race:	Tribal Affiliation:
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LIST EVERYONE WHO LIVES WITH APPLICANT.
(Attach additional sheet if more than five people live with applicant.)

Last Name, First, Middle Initial	How is this person related to applicant?	Gender	Birth Date	Social Security Number
1.				
2.				
3.				
4.				
5.				

INCOME:**SUBMIT VERIFICATION OF ALL INCOME**

List all income and benefits you, your spouse, dependents, or other household members receive from any source

(i.e., employment, Social Security, SSI, Pensions, VA, Child Support, BIA, etc.)

Name	Source	Gross Amount of Income	How Often Received

Do you anticipate this income to change in the next two months? Yes No

If yes, what is the expected change:

Number of Family Members Dependent on Family Income? _____

RESOURCES:

How much to the members of your household have in liquid resources such as cash, checking, savings, Stocks, or bonds: \$ _____

Excluding the home you live in, do you own/co-own any real-property? Yes No

If yes, what is the value of your property? \$ _____

Please list all vehicles, including recreational vehicles you own or own with others and the value of each vehicle:

Vehicle: _____ Value \$ _____

Vehicle: _____ Value \$ _____

Vehicle: _____ Value \$ _____

DO YOU HAVE HEALTH INSURANCE COVERAGE? Yes No

(If yes, please complete the following for all insurance coverage including Medicare.)

ATTACH COPY OF CARDS

Name of Insured: _____

Relationship to Applicant: _____ Insured's SSN: _____

Policy # _____ Group # _____

Insurance Carrier Name: _____

Insurance Carrier Address: _____

Start Date: _____ End Date: _____

ARE YOU RECEIVING MEDICARE?..... Yes No

Please attach copy of Medicare card

PLEASE LIST THE MENTAL HEALTH CARE PROVIDERS AUTHORIZED TO RECEIVE COPIES OF MHSP CORRESPONDENCE:

Name: _____

Agency: _____

Address: _____

Phone #: _____

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Name: _____

Agency: _____

Address: _____

Phone #: _____

I hereby declare that all statements and answers to the above questions are complete and true to the best of my knowledge and belief. I agree that they shall form a part of the insurance contract for which I am applying. I hereby authorize any licensed physician, medical practitioner, hospital, clinic, organization, institution or person that has any records or knowledge of my health to disclose to Department of Public Health and Human Services (DPHHS) or its designee any such information. A photographic copy of this authorization shall be as valid as the original. I may revoke this authorization at any time except to the extent that the person or entity making the disclosure has already taken action in reliance on it. If not previously revoked, this consent will terminate one year from the date that I sign.

I agree to notify DPHHS at of any changes of income, family size or other insurance coverage within 30 days of the change.

Signature of Applicant: _____

Date: _____

This application is considered complete only when income documentation has been attached. Please mail to:

**Benefit Management Team
Addictive & Mental Disorders Division
PO Box 202905
Helena MT 59620-2905**