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.

☐ New Enrollment
☐ Re-enrollment
☐ 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:

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 #: _________________________________

. . . .

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