State of Montana
DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES
Addictive & Mental Disorders Division
Clinical Eligibility Form
Mental Health Services Plan (MHSP) and Waiver for Additional Populations (WASP)

NOTE: This form needs to be submitted with the Medicaid Enrollment Application

APPLICANT INFORMATION		
Date of intake appointment:	Referred by:	
Applicant ID/SSN:	DOB:	Gender:
Applicant Name: Last:	First:	Middle:
Mailing Address:	City:	State:
County:	Zip:	Telephone #:
Applicant's stated reason for seeking services:		
PROVIDER AGENCY INFORMATION		
Name:	Clinician email address:	
Address:	City:	State:
Zip:	Telephone #:	Fax #:
CLINICAL INFORMATION		
CURRENT DSM5/ICD-10 DIAGNOSES: Please list both code and narrative, including substance use disorders.		
Primary Diagnosis:	Specifiers Required:	
Other (requiring treatment):		
Medical Conditions (specify):		
*List signs / symptoms to substantiate the qualifying SDMI primary diagnosis:		

Name of Medication:	Dose / Frequency:	Prescriber:

Applicant Name: Last:_____ **First:**_____
If no current medications, has a medical professional with prescriptive authority determined that medication is necessary to control the symptoms of the mental illness? ___Yes ___No Name and title of medical professional:
History of adult outpatient mental health treatment: ____Yes ___ No Please list any services in which the individual has participated, including individual and/or family therapy:
History of Inpatient Adult Mental Health (NOT CD) Treatment: ___ Yes ___ No
Number of Acute Psychiatric Admissions: Date of most recent admission:
Number of Montana State Hospital Commitments: Date of most recent commitment:
Reason for most recent admission:
Is the individual unable to work/school full time due to mental illness? __ Yes __ No If yes, briefly describe:
Is the individual unable to live independently due to mental illness? __ Yes __No If yes, briefly describe:
Is the individual unable to care for themselves due to mental illness? __ Yes __No If yes, briefly describe:
Is the individual homeless or at risk of homelessness due to mental illness? __ Yes __ No If yes, briefly describe:
Current Risk Factors (e.g. suicidal ideation/plan, danger to others, history of abuse impacting current functioning):
Proposed Treatment Plan (identify services, i.e. medications, CM, OPT, etc.):

"I certify I am the person who performed face-to face clinical assessment and the above statements are true and correct."

Provider Signature:_____ Title: _____

Printed Name:_____ Date: _____

Supervisor Signature:_____ Date: _____
(if applicable)

Please mail or fax the Checklist, Application and Clinical Eligibility Form to:

Addictive & Mental Disorders Division
Mental Health Services Bureau
PO Box 202905, Helena MT 59620-2905

Secure Email: HHSAMDDMHSPWaiver@mt.gov

Fax: 1-406-444-7391 or 1-406-444-4435

Questions? Call 1-406-444-3964