State of Montana
DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES
Behavioral Health and Developmental Disabilities Division
Clinical Eligibility Form
Waiver for Additional Populations (WASP)

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:

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

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 work/school full time **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: _____

Date: _____

Printed Name: _____

Date: _____

Supervisors Signature: _____

Please Mail or Fax the Checklist, Application and Clinical Eligibility Form to:
Behavioral Health and Developmental Disabilities Division Mental Health Services Bureau
PO Box 202905, Helena, MT 59602-2905
Fax: 1-406-444-7391 or 1-406-444-4435

Please send through a secure method:
Montana File Transfer Service to:
HHSAMDDMHSPWaiver@mt.gov

Questions? Call 1-406-444-3187 • Email: Tracey.Palmerton@mt.gov

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