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

Note: This checklist needs to be submitted with the Application and Clinical Eligibility Form

Applicant Name:_____ Referring Provider: _____

Applicant ID/SSN: _____ Date of Birth: _____ Date Received: _____

Please include items below in application packet.

1. MHSP/WASP Application – **Required** ☐Yes ☐No
2. Clinical Eligibility Form/Assessment – **Required** ☐Yes ☐No
3. Does Client Have Current MHSP Eligibility? ☐Yes ☐No
4. Applied for Medicaid- (if yes date) ☐Yes ☐No Date _____
5. Does Client Currently Receive SNAP Benefits? ☐Yes ☐No
6. Medicare Card ☐Yes ☐No
7. Current Paystubs for 2 Months - **Required** ☐Yes ☐No
8. Insurance Card (other insurance) ☐Yes ☐No

Date of Clinical Assessment (cannot be older than 2 years): _____

****Eligible SDMI diagnoses with severity specified of moderate or severe are listed below (NOS does not qualify). Please provide the primary diagnosis indicated in the Clinical Eligibility Form.**

Primary Diagnosis _____

Agency Name:_____ Date: _____

Mailing Address: _____

Phone #:_____ Fax #: _____

Email: _____

Signature: _____

By signing your name electronically, you agree that this form has been completed accurately to the best of your knowledge.

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

Please send through a secure method (such as ePass) to:
HHSAMDDMHSPWaiver@mt.gov

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

Questions? Call 1-406-444-3964

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