APPLICATION FOR ONE-TIME DDP TRAINING GRANT
For Calendar Year 2026
Send completed application to Cindy Dallas at: cdallas2@mt.gov

Agency Name:

Agency Contact:

Name:

Title:

Phone:

E-Mail:

☐**General Training** ☐**Behavioral Training Total**

Amount Requested:

Note:Reimbursement for lodging, mileage & food will be paid at the standard state rate.

Presenter Name and Brief Description of Qualifications:

Anticipated Date of Training:

Topic of Proposed Training: (Specifically describe the information to be presented by the training.)

Training Rationale: (Specifically describe how the training will benefit the agency and members served.)

Relation of training to services currently provided under Montana DDP- administered Medicaid Waivers:

For DDP to Complete:

☐Approve ☐Return for Additional Information ☐Denied

Comments:

Signature: _____ **Date:** _____

Agency Post Training Benefit

Please provide confirmation that the training was conducted and how it benefits the agency/ member(s) within 30 days of completion of training

Submitted By: _____ **Date:** _____