



APPLICATION FOR ONE-TIME DDP TRAINING GRANT
Fiscal Year 2027
Send completed application to Cindy Dallas: 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 Montana 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:

By signing below, I acknowledge I have read and agreed to the grant guidelines. I further acknowledge invoices with proof of payment are due within 30 days of the completion of each training.

Signature:

Date: