



CHISAGO COUNTY HEALTH & HUMAN SERVICES

313 North Main Street, Room 239
Center City, MN 55012-9665

General Information	651-213-5600
Administrative	651-213-5609
Child Support	651-213-5647
Financial Assistance	651-213-5640
North Branch	651-213-5200
FAX	651-213-5685
Public Health	651-213-5200

Rule 24 Eligibility Application for Direct Access OO Span

Name: _____

DOB: _____ SSN: _____

Address: _____

**** You must provide verification of your address (i.e. a copy of a lease or recent utility bill with your name on it, a piece of mail addressed to you at this address, or a signed statement from the homeowner you live with).**

Phone #: _____ Cell Phone #: _____

Gender: Male Female Hispanic: Yes No

Race: American Indian/Alaskan Native Asian Black/African American
 White Pacific Islander

Marital Status: Never Married Married living with spouse Separated
 Divorced Widowed

Insurance Status:

Do you have private health insurance? Yes No

If yes, please provide a copy (front and back) of your insurance card.

Number of persons living in household (include yourself, your spouse and any minor children ONLY): _____

Income Status: The following items are considered income. Please enter the **monthly amount** you (and your spouse, if married) receive each month.

\$ _____ Wages/Salary, including cash payments	\$ _____ Veteran Benefits
\$ _____ Self Employment, including cash payments	\$ _____ Military Family Allotments
\$ _____ General Assistance (GA), SSI, SSI Disability	\$ _____ Unemployment
\$ _____ Social Security/Social Security Disability	\$ _____ Union Funds
\$ _____ Railroad Retirement Benefits	\$ _____ Royalties
\$ _____ Private or Government Pensions	\$ _____ Insurance
\$ _____ Rent received from rental properties	\$ _____ Interest (when withdrawn monthly)
\$ _____ Annuities	\$ _____ Child support, received
\$ _____ Alimony, received	

****Please provide written proof of any income indicated above for the past 30 days****

Are you paying court-ordered child support? Yes (monthly amount: _____) No

Chisago County is An Equal Opportunity Employer

Declarations

Why the County needs this information: The information that you give us will be used to decide what kind of help you need and if we can pay for it. Unless the law says we can, or unless you tell us we can, your information will not be shared with anyone else. You have the right to see any information that we have about you. If you do not tell us the information that we need to know, we may not be able to help you.

Rule 25 applicant: By my signature below, I attest that the information provided in this application is true and correct. I also understand that providing information that is inaccurate or untrue is fraudulent and may be investigated.

I also understand that this application cannot be processed until ALL verifications requested are provided.

Client Signature _____
Date

**Completed form can be faxed to 651-213-5701 or can be mailed/dropped off in person at either Chisago County Health and Human Services location:

313 North Main Street, Room 230
Center City, MN 55012

6133 402nd Street
North Branch, MN 55056

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FOR OFFICE USE ONLY

Date application received: _____ PMI: _____

Current social services client: Yes No

If yes, County: _____ Worker: _____ Phone: _____

Confirmed receipt and/or verbal acknowledgement of privacy notice: Yes No

Eligibility status:

Eligible PMAP active/referred to: _____

Not eligible/Reason: _____

Notified not eligible (date and method) _____

Alternate options/resources provided: _____

Assessment date/time/location: _____

Intake completed/detail documented: Yes No

Staff signature: _____ Date: _____