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

Substance Use Services Application

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

<u>Service you are seeking</u> (check all that apply)**:**

___ Funding – Direct Access funding to obtain an assessment and/or treatment from any provider.
___ Assessment – You have MA, Blue Plus or Direct Access funding and need an assessment.
___ Assessment and Funding – You would like to obtain funding and an assessment from our agency.
___ Care Coordination – Assistance with referrals, housing resources, social services, etc.

<u>Insurance Status:</u>

Do you have private health insurance? ___ Yes ___ No
If yes, please provide a copy (front and back) of your insurance card.

Do you have Medical Assistance or Minnesota Care? ___ Yes ___ No
If yes, are you enrolled in a health plan (Ucare, Medica, HealthPartners, Blue Plus)? ___ Yes ___ No
If yes, this is a covered benefit – please contact your health care plan and ask for a substance use assessment. Blue Plus members can obtain an assessment from our agency.
If no, please continue.

Do you have veteran's medical benefits available to you? ___ Yes ___ No
If yes, you must access VA services first.

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

Are you currently pregnant? ___ Yes ___ No ___ N/A

Are you currently an IV drug user? ___ Yes (date of last use: __________) ___ No

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Referred by: ________________________ Assessment Court ordered? ___ Yes ___ No

Have you had a chemical use assessment in the last 6 months? ___ Yes ___ No
If yes, where?____

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$________ Interest (when withdrawn monthly)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

How would you like to receive notice of your eligibility?
___ Phone #: __________ May we leave a voice mail message at this number? ___ Yes ___ No
___ Mail Address: ____

By selecting and providing the contact information requested above, you are authorizing Chisago County Human Services to contact you with private information via any of the options marked.

Declarations

I certify that to the best of my knowledge and belief, the information provided above is complete and correct. I understand that if the information provided is false or incomplete, I may be responsible for the total cost of treatment provided. I authorize access to medical information needed to determined health care and/or Medicare benefits payable for the substance use services, I authorize payment of any third-party benefits directly to the Department of Human Services, this authorization expires one year from the date services were rendered, I understand that I may revoke this authorization at any time except to the that actions have taken in advance of my revocation. If I revoke this authorization, I may be responsible for the total cost of treatment.

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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