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

If you have a Managed Care plan through Medical Assistance (such as Ucare, Medica, Health Partners, or Blue Plus), please contact your health insurance provider for coverage information and appointments.

If you wish to apply for Rule 25 funding, please complete the attached application and provide all requested verifications. If you are pregnant or using intravenous drugs, or need help completing this application, please call 651-213-5600 and ask for Rule 25 intake staff.

Rule 25 is state paid chemical dependency treatment funding. If you are eligible, the state of MN will pay for you to have a chemical dependency evaluation and assessor recommended treatment. Rule 25 is non-emergency funds. If you feel that you are having a mental health crisis, please contact East Central Crisis Services at 1-800-523-3333.

Completed applications and verifications can be submitted in one of the following ways:

Fax to: 651-213-5701 Attention Rule 25

Mail or bring to:

Chisago County Health and Human Services
313 N. Main Street, Room 239 -or- 6133 402nd Street
Center City, MN 55012 North Branch, MN 55056

Once your complete application and verifications are received, you will be contacted by phone or mail. If you have been determined to be eligible for funding, an appointment for an evaluation will be scheduled for you. You will meet with an assessor to discuss your alcohol and/or drug use. The assessor will determine if you need help for alcohol and/or drug use and where you will go to receive treatment. If it has been longer than two weeks since you turned in your application and you have not received a response, please call 651-213-5600 and ask for Rule 25 intake staff.

If you have any further questions about this application or the Rule 25 program, please call 651-213-5600 and ask for Rule 25 intake staff.

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Rule 25 Eligibility 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, any piece of mail addressed to you at this address, or a signed statement from the homeowner you currently 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: Please note if you do not have any medical insurance , we will help you apply for MNSure during your assessment. Alternatively, you can apply online at www.mnsure.org

Do you have Medical Assistance or Minnesota Care? ___ Yes ___ No

If yes, are you enrolled in a health care plan (Ucare, Medica, HP, Blue Plus)? ___ Yes ___ No

If yes, this is a covered benefit – contact your health care plan and ask for a chemical dependency assessment. If no, please continue.

Do you have private health insurance? ___ Yes ___ No

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

Do you have veteran's medical benefits available to you? ___ Yes ___ No

If yes, you must access VA services first.

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

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

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

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

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

Referral, Legal, and Social Service Information:

Who referred you for a Rule 25 assessment? _____

Have you had a chemical use assessment in the past 6 months? ___ Yes ___ No

If yes, where? _____

Is this a court ordered assessment? ___ Yes ___ No

If yes, which court ordered it? _____

Are you currently in chemical dependency treatment? ___ Yes ___ No

If yes, which type of program? ___ Outpatient (where) _____
___ Inpatient (where) _____
___ Methadone (where) _____

Are you currently on probation or parole? ___ Yes ___ No

If yes, PO's name: _____ Phone: _____

Agency: _____

Are you currently working with a county social worker? ___ Yes ___ No

If yes, Name: _____ Phone: _____

Agency: _____

How would you like to receive notice of your eligibility for a Rule 25 assessment:

___ 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

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

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: _____