If you have a Managed Care plan through Medical Assistance (such as Health Partners or UCare), 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 (763) 324-1270.

Rule 25 is state paid chemical dependency treatment funding. If you are eligible, the State of Minnesota 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 experiencing a Mental Health Crisis, contact CANVAS HEALTH at (763) 755-3801 or Mercy Hospital Crisis unit at (763) 236-7911 or Unity 763-236-5949

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

Fax to: (763) 422-6984 Attention: Rule 25

Mail or bring to:

Anoka County Government Center
Rule 25--5th Floor
2100 Third Avenue
Anoka, MN 55303

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 mailed in your application and you have not received a response, please call (763) 324-1270.

If you have any further questions about this application or the Rule 25 program, please call 763-324-1270.

Community Social Services & Behavioral Health
Government Center ▲ 2100 Third Avenue N, STE 500 ▲ Anoka, MN 55303-5049
PHONE: 763-422-7000 ▲ FAX: 763-422-6987

Rule 25 Consolidated Fund Application

Office Use Only

Application Date: _____ Expiration Date: _____

Intake Worker: _____ Approval Date: _____
(Valid 45 days)

Client Information

1. _____
(Last, first, middle name)

2. _____

_____

_____
(Street / Apt # / City / State / Zip code)

PROVIDE VERIFICATION OF YOUR ADDRESS. EXAMPLE: COPY OF A PIECE OF RECENT MAIL SENT TO YOU WITH THE ABOVE NAME AND ADDRESS ON IT, COPY OF LEASE, SIGNED STATEMENT FROM HOMEOWNER/RENTER

3. Phone #: Home:_____ Work:_____ Cell: _____
4. Birth date: _____
5. Social Security #: _____
6. Gender: ___ Male ___ Female
7. Marital Status: _____
8. Race: _____
9. Hispanic Ethnicity: ___Yes ___ No
10. Are you a veteran? ___ Yes ___ No
11. If yes, type of discharge: _____
12. Do you have veteran's medical benefits available to you (self or as dependent coverage)? ___ Yes ___ No

Family Information

13. Number of persons living in household and/or dependents: _____
14. Client:

Names of Members of Family Unit	Birthdate	Gender	Relationship to You

15. Are you pregnant: ____Yes ____No ___N/A

Insurance Information

16. Are you receiving Medical Assistance or Minnesota Care benefits?: ___Yes ____ No

    Comments: _____

17. If yes, are you enrolled in a health care plan such as Health Partners or Medica?
    ___Yes ____ No

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

18. Do you have any private health insurance or HMO coverage? ___Yes ____No

    If yes, please provide the following information OR a copy (front & back) of your insurance card.
    If no, please skip to line 28.

19. Company Name:
20. Company Address:
21. Policy Number:
22. Policy Holder Name:
23. Policy Holder Address:
24. Group Name / Number:
25. Contact Person Name/Tel#
26. Coverage Type Limitations/Co-payments

    Outpatient

    Inpatient

    Comments:

27. Other: _____

    NOTE:
    If you do not have any medical insurance apply online at WWW.MNSURE.ORG.
    Adults with no children can call 763-422-7200 (Government Center, 4th Floor).
    Adults with children or minors can call 763-717-7700 (Blaine Human Services Center, 4th Floor).

Income Information - Applicant

28. Are you currently employed or have unemployment income? ___Yes ___ No
29. If yes, what is your average **weekly** amount: $_____ Employer: _____

    (If yes, please provide copies of your 2 most recent pay stubs or self-employment records or copies of your most recent tax returns or a statement of employment & income signed by your employer)

30. If you are not currently employed, what was your last date of employment: _____

    (If your job ended less than 3 months ago, please provide a statement from the former employer showing your last date of work or COBRA statement or termination notice).

Income Information – Spouse

31. If married, is your spouse employed: _____Yes ____ No, ____N/A
32. If yes, spouse's average **weekly** amount: $_____. Employer: _____

    (If spouse is working please provide copies of their 2 most recent pay stubs, self-employment records or copies of your most recent tax returns or a statement of employment & income signed by spouse's employer)
33. If your spouse is not currently employed, what was their last date of employment: _____

    (If spouse's job ended less than 3 months ago, please provide a statement from the former employer showing spouse's last date of work or COBRA statement or termination notice).

Financial Information - Other

34. Do you have any unearned income? ___Yes ___ No

    (i.e., interest, dividends, insurance payments, SSI, pensions, VA benefits, alimony, worker's comp, unemployment, social security, Veteran's pensions, etc)
35. If yes, what are the total income amounts & sources: $_____. Source/s: _____

    (Please provide written verification of income, for example, monthly statements, pay stubs,award letters, bank deposits etc.)
36. Do you receive child support: ___Yes ___ No
37. If yes, how much: $ _____/month ***(Please provide a copy of your last month's payment received)***
38. Do you pay court ordered child support? ___Yes ___ No
39. If yes, how much do you pay each month: $_____

    (Please provide a copy of your last month's payment or current paystub showing payment.)

Referral, Legal and Social Service Information

40. Have you had a chemical use assessment in the past 6 months? _____Yes ____ No
41. If yes – where? _____
43. Are you currently in Chemical Dependency Treatment? _____ Yes _____ No
44. If so, which type of program? ___ Outpatient(where)_____
    ___ Inpatient(where)_____
    ___Methadone(where)_____

45. Are you currently on probation or have a parole officer? ___Yes ___ No

    If yes: Name: _____Phone:_____
    County: _____
46. Are you currently working with a county social worker? ___Yes ___ No

    If yes: Name: _____Phone:_____
    County: _____

47. Are you serving or do you expect to serve any jail sentence / workhouse time? ___Yes ___ No

If yes: County: _____

Start Date: _____

48. Do you have any warrants? ___Yes ___ No

County: _____

If yes, please be aware that any active warrants will be served at the time of your appointment.

49. Do you currently use Heroin, Yes _____ No _____

IV Yes _____ No _____

Opiates Yes _____ No _____

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, we will not give anyone else any information about you. 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 help you.

Rule 25 Applicant: By my signature below I attest that the information provided in this application is true and correct. I know that I may have to pay a fee based upon my income. I agree to pay the fee, if any. I acknowledge that I may have to pay the full cost of these services if I do not tell the truth in this application.

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

_____ _____

(Client name – print) (Date)

_____

(Client signature)

AUTHORIZATION TO RELEASE INFORMATION

I,_____ give my consent for Anoka County Rule 25 staff to
(APPLICANT)

speak with _____ _____
(RELATIONSHIP TO APPLICANT)

To obtain information in order to complete my Rule 25 eligibility determination for funding.

I understand that the information received will only be used for the purpose of assisting in the determination of Rule 25 funding in reference to my Rule 25 application.

This includes: -Appointment dates
-Verification requests
-Application status

I understand that the Minnesota Government Data Practices Act and other laws require that this data remain private. This data cannot be released without my consent except as provided by law. I understand why I am being asked for this information. With my consent, this information could be shared with only the person stated above. I understand that if I refuse to release information the information will not be released unless the law otherwise allows its release. If I consent, this information will be used in the determination of eligibility for Rule 25 funding. My consent will expire one year from the date of my signature. A photo copy of this consent my be treated in the manner as the original. I may cancel this consent by written request to anoka County Rule 25 staff.

_____ _____
(PRINT FULL NAME) (APPLICANTS SIGNATURE)

_____
(TODAY'S DATE)