



# Anoka County MINNESOTA

Respectful, Innovative, Fiscally Responsible

## COMMUNITY SOCIAL SERVICES & BEHAVIORAL HEALTH DEPARTMENT

Phone: 763-324-1270

Fax: 763-324-1044

### SUD Assistance Eligibility Application

(Must be completed in full for Anoka County to process your application)

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

DOB: \_\_\_\_\_ Do you have a SSN: Yes No If yes, SSN: \_\_\_\_\_

If no, reason: \_\_\_\_\_

Are you an Anoka County resident? Yes No

If yes, attach a piece of mail with your name and current address on it or a statement from your landlord or homeowner from the last 30 days.

**Your application may pend until proof received.**

Are you homeless? Yes No If Yes, what city did you stay in last night: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Gender: Male Female

Race: Hispanic Caucasian Black or African American  
Asian Pacific Islander American Indian/Alaskan Native

Other: \_\_\_\_\_

Do you need an interpreter? Yes No If yes, what language: \_\_\_\_\_

Marital Status: Single Married Separated Widowed Divorced

Have you had a previous Chemical Health Assessment? Yes No

If yes, Date: \_\_\_\_\_ Location: \_\_\_\_\_

Are you currently working with a SUD Provider? Yes No If yes,

Name of Provider: \_\_\_\_\_

Admission Date: \_\_\_\_\_ Date of Assessment: \_\_\_\_\_

#### INSURANCE

Do you have Medical Assistance (MA, PMAP, MNSure)? Yes No

If yes, MA#: \_\_\_\_\_

Do you have private insurance or HMO Coverage (Medica, HealthPartners, etc.)? Yes No

Benefits for SUD Treatment? Yes No

If yes, please provide a copy of your insurance card.

**Your application may pend until proof received.**

Insurance Company Name: \_\_\_\_\_

Insurance Company Phone Number: \_\_\_\_\_

**HOUSEHOLD SIZE**

**Who do you live with?**

(Parents (if minor), spouse, dependent minor children) Please do not include unmarried partners or their children.

**INCOME (please provide last two most recent proofs of income, ex: pay stubs, self-employment records, tax forms, verification by employer)**

- Do you **and/or** your spouse **receive**:
 

Earned income? (income from employment, including self-employment)	Yes	No
How much: _____		How often?
Unearned income? (Social Security, SSI, Retirement or other unearned income)	Yes	No
How much: _____		How often:
Child Support?	Yes	No
How much: _____		How often:
- Do you **and/or** your spouse **pay** Child Support?
 

	Yes	No
How much: _____		How often:

**Your application will pend until proof of income is received.**

Comments about income:

**How would you like to receive notice of your eligibility for a Substance Use Disorder Assessment?**

- Phone      Phone #: \_\_\_\_\_
- May we leave a voice message at this number?    Yes    No
- Email      Email Address: \_\_\_\_\_
- Mail      Address: \_\_\_\_\_

**DECLARATIONS**

Applicant: By my signature below I attest that the information provided in this application is true and correct. 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 understand that the information received will only be used for the purpose of assisting in the determination of eligibility/treatment coordination.

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's stated above. I understand that if I refuse to release information, the information will not be released unless the law otherwise allows its release. My consent will expire one year from the date of my signature. A photocopy of this consent will be treated in the manner as the original. I may cancel this consent by written request to Anoka County.

Print Full Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Applicants Signature: \_\_\_\_\_