Anoka County
HUMAN SERVICES DIVISION
Community Social Services and Behavioral Health

Rule 25 funding (also known as the Consolidated Chemical Dependency Treatment Fund) is non emergency public funding for substance use disorder treatment. If you are found to be eligible, this funding will pay for a substance use disorder needs assessment and recommended treatment.
If you feel that you are experiencing a Mental Health Crisis, contact Anoka County Mobile Crisis Response at (763) 755-3801(Canvas Health) or Mercy Hospital Crisis unit at (763) 236-7911.

If you have Medical Assistance (Medicaid) or MN Care, coverage for chemical dependency treatment is available to you. For a list of providers who can help, click here https://findtreatment.gov/ **to find a provider**.

If you have a Managed Care plan through Medical Assistance or MN Care, (such as Health Partners, Blue Plus or UCare), please contact your Managed Care Provider for coverage information and appointments.

To apply for Medical Assistance (Medicaid) or MN Care, please visit www.mnsure.org or call EZ Info line at 763-422-7200. If you would like help applying, feel free to call 763-324-1270.

If you **DO NOT** have Medical Assistance or MN Care or have insurance with limited Substance Use Disorder coverage and are of low income, you can apply for Rule 25 funding to cover the cost of an assessment and recommended treatment. Please complete the attached application and provide all requested verifications. If you would prefer to apply by phone, are pregnant or using intravenous drugs, please call (763) 324-1270.

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

Fax to: (763) 324-1044 Attention: Rule 25

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

Bring to: Anoka County Government Center Drop Box
2100 Third Avenue
Anoka, MN

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, you can:

1) Choose a provider enrolled with Minnesota Health Care Programs to arrange an assessment at https://findtreatment.gov/
2) Schedule an appointment for an assessment with an Anoka County Substance Use Disorder Assessor by calling 763-324-1270.

If it has been longer than one week since you mailed in your application and you have not received a response, or you have any further questions, please call (763) 324-1270.

Community Social Services & Behavioral Health
Government Center ▲ 2100 Third Avenue N, STE 500 ▲ Anoka, MN 55303-5049
PHONE: 763-324-1400 ▲ FAX: 763-324-1110

Rule 25 Consolidated Fund Application

NOTE: IF YOU HAVE MEDICAL ASSISTANCE OR MNCARE OR A PRE-PAID MEDICAL PLAN (i.e Ucare, Blue Plus, Health Partners, etc.), THEN YOU HAVE COVERAGE FOR CHEMICAL DEPENDENCY SERVICES. PLEASE CONTACT YOUR HEALTH CARE PROVIDER.

If no, you need to apply online at WWW.MNSURE.ORG or call EZ Info line at 763-422-7200 and continue completing the Rule 25 Consolidated Fund Application.

1. _____
   (Last, First, Middle Names)

   _____
   (Street, Apt #/ City/State/Zip Code)

Provide verification of your Address, Example: copy of a piece of recent mail sent to you at the above Name and Address on it, copy of a lease or signed Statement from Homeowner/Renter.

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

	Names of Members of Family Unit	Age	Relationship to you
CLIENT			

13. Are you pregnant: ☐ Yes ☐ No ☐ Not Applicable

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14. 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 25.

15. Company Name: _____
16. Company Address: _____
17. Policy Number: _____
18. Policy Holder Name: _____
19. Policy Holder Address: _____
20. Group Name/Number: _____
21. Contact Person Name/Tel#: _____
22. Benefits available for Chemical Dependency: _____

If unsure, contact your insurance provider for information & complete

23. Are you currently employed or have unemployment income? ☐ Yes ☐ No
24. 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)

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

(If your job ended less than 1 month ago, please provide a statement from the former employer showing your last date of work or COBRA statement or termination notice).

26. If married, is your spouse employed: ☐ Yes ☐ No
27. 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)

28. If your spouse is not currently employed, what was their last date of employment?_____
29. Do you and/or spouse have any unearned income? ☐ Yes ☐ No

(i.e. interest, dividends, insurance payments, SSI, pensions, VA benefits, Alimony, Workers Comp, Unemployment, RSDI, Veteran's pensions etc.)

30. 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.)

31. Do you receive child support: ☐ Yes ☐ No
32. If yes, how much: $_____/month ***(Please provide a copy of your last month's payment received)***
33. Do you pay court ordered child support? ☐ Yes ☐ No
34. If yes, how much do you pay each month: $_____

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

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35. Have you had a chemical use assessment in the past 6 months? ☐ Yes ☐ No

36. If yes, Where? _____ When? _____

37. Are you currently in Chemical Dependency Treatment? ☐ Yes ☐ No

If yes, Where? _____

38. Are you currently on probation or have a parole officer? ☐ Yes ☐ No

If yes: Name: _____ Phone: _____
County: _____

39. Are you currently working with a county social worker? ☐ Yes ☐ No

If yes: Name: _____ Phone: _____
County: _____

40. Within the last 3 – 4 months have you used Heroin? ☐ Yes ☐ No

IV? ☐ Yes ☐ No

Opiates? ☐ Yes ☐ No

YOU ARE ENCOURAGED TO CLEAR ANY WARRANT(S) PRIOR TO YOUR ASSESSMENT.

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 signature) (Today's Date)

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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 photocopy of this consent will 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)

******Once you have Completed the Application, please PRINT, then Sign and Date where required. Then Fax or Mail.******

FAX: ***PSU Fax Line - 763-324-1044*** ***OR*** ***MAIL:*** ***Anoka County Human Services***
CSSBH - Rule 25
2100 3rd Avenue, 5th Floor
Anoka, MN 55303-9945