Red Lake Chemical Health Programs

PO Box 114

Red Lake, MN 56671

Phone: (218) 679-3321 Fax: (218) 679-2727

Assessment Request Form

Date of Request: _____ **DOB:** _____

Full Name: _____
Last First M.I

Address: _____
PO Box City State Zip Code

Address: _____
Physical

Home Phone: _____ **Cell Phone:** _____

Work Phone: _____ **Message Phone:** _____

Social Security #: _____ **Are You Employed:** (Yes) (NO)

House Hold Size: _____ **Annual Income:** _____

Are you an IV user: (YES) (NO) **Are you pregnant? (# of weeks):** _____

What is your method of use?: _____

Please select one: (Voluntary) (Court Ordered) (Involuntary Commitment)

Office Use

PMI #: _____ (PMAP) (PrimeWest) (Blue Plus)

Other Insurance: _____ **Procentive Number:** _____

CHEMICAL HEALTH PROGRAMS

PO Box 114
Red Lake, MN 56671

Phone: (218) 679-3321
FAX: (218) 679-2727

RED LAKE BAND OF CHIPPEWA INDIANS
RED LAKE CHEMICAL HEALTH PROGRAMS
RED LAKE, MINNESOTA 56671
(218) 679-3392

>>

CLIENTS BILL OF RIGHTS

As a client you have these rights:

1. Every client shall have the right to considerate and respectful care.
2. Every client can reasonably expect to obtain from his/her counselor of the facility complete and current information concerning his diagnosis, treatment and prognosis in terms and a language the client can reasonably be expected to understand. In cases in which it is not medically advisable to give the information to the client. The information may be available to the appropriate person in his/her behalf.
3. Every client shall have the right to know by name and specialty, if any, the counselor responsible for coordination of his/her care.
4. Every client shall have the right to every consideration of his/her privacy and individually as it related to his /her social, religious, and psychological wellbeing.
5. Every client has a right to respectfulness and privacy as it relates to his/her treatment program. Case discussions, consultation, examination, and treatment are confidential and should be conducted discreetly.
6. Every client shall have the right to obtain information as to any relationship of the facility to other health care and related institutions; in so far his/her care is concerned.
7. Every client shall have the right to expect reasonable continuity of care that shall include but not be limited to what appointment time counselors are available.
8. Every client shall be fully informed prior to or at the time of admission to the program, what services are available in the facility and so related changes including any charges for services not covered under Medicare, Medicaid or not covered under the facilities basic rate.
9. Every client should be afforded the opportunity to participate in the planning of his/her treatment and refuse to participate in experimental research.
10. No client shall be arbitrarily transferred or discharged but may be transferred or discharged only for therapy reasons, for his/her or to her clients welfare, or for nonpayment for stay unless prohibited by the welfare program paying for the care of the client as documented in the case file. Reasonable advance notice of any transfer or discharge must be given to a client prior to transfer or discharge.
11. Every client may manage his/her personal financial affairs, or shall be given at least a quarterly accounting of financial transactions on his/her behalf if he/she delegated this responsibility in accordance with the laws of Minnesota to the facility for any period of time.

(TURN PAGE OVER)

12. Every client shall be encouraged and assisted throughout his/her period in the program to understand and exercise his/her rights as a client and a citizen to this and, he/she may voice grievances and recommend changes in policies and services to facility staff and outside representative of his/her choice, free from restraint, interference, coercion, discrimination or reprisal.
13. Every client should be free from mental and physical abuse, free from chemical and physical restraints except in emergencies, or as authorized in writing by his/her physician for a specified and limited period of time and only when necessary to protect the resident from injury to himself/ herself or others.
14. Every client should be assured confidential treatment of his/her personal and medical records and may approve or refuse their release to any individual outside facility except as otherwise provided by law or third party payment.
15. No client shall be required to perform services for the facility that are not included for therapeutic purposes in his/her plan of care.
16. Every client may associate and communicate privately with persons of his/her choice.
17. Every client may meet with representative in activities of commercial, religions, and community groups at his/her discretions provided however that the activities shall not infringe up the right of privacy of other clients.
18. Every client shall be fully informed prior to or at the time of admission and during his/her stay in the program of the rights and responsibilities set forth in this section and of all rules governing client conduct and responsibilities.

Minnesota Statues 1974, Section 144,651 as amended; Complaints and/or grievances related to right expressed in the Patient's Bill of Rights or to any other patient rights may be resolved within this facility to be contracting.

X _____
*Client Signature

X _____
*Date

_____
Red Lake Chemical Health Program Staff

_____
Date

CHEMICAL HEALTH PROGRAMS

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Red Lake, MN 56671

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FAX: (218) 679-2727

CLIENT TRANSPORTATION POLICY

Client attending outside treatment facilities will only be transported by Red Lake Chemical Health Programs to and from the facility, at the successful completion of treatment. After being transported to outside treatment the client must follow that facility's transportation policy.

Clients who leave a treatment facility on their own, or who are asked to leave, must find their own transportation home. Red Lake Chemical Health Programs will not transport clients who have not completed treatment. Parents, guardians, or referring agencies, i.e., Social Services, will be responsible for juveniles.

I have read and agree with the Red Lake Chemical Health Programs transportation policy.

X _____
*CLIENT'S SIGNATURE

X _____
*DATE

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MANDATED REPORTER POLICY

The Red Lake Chemical Health Programs Rule 25 Assessors are Mandated Reporters, which means they are obligated by Tribal and Federal guidelines to report the following:

1. Sexual, Physical and Emotional abuse, and neglect.
2. If you threaten to harm others, and
3. In certain circumstances, If you are in danger of harming yourself.

I have discussed, read, and agree with the Red Lake Chemical Health Program's Mandated Reporter Policy.

X _____
*CLIENT'S SIGNATURE

X _____
*DATE

_____
PARENT/GUARDIAN SIGNATURE

_____
DATE

_____
RULE 25 ASSESSOR SIGNATURE

_____
DATE

CHEMICAL HEALTH PROGRAMS

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Red Lake, MN 56671

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CLIENT'S RIGHT TO APPEAL

A CLIENT HAS THE RIGHT TO A FAIR HEARING UNDER MINNESOTA STATUES, SECTION 256.045, IF THE CLIENT:

A. Is denied an assessment under part 9430.6615
B. Is denies a second assessment under subpart 1;
C. Is denied placement;
D. Disagrees before services begin with the level of chemical dependency care of the length of placement that the tribe, county or prepaid health plan proposes to authorize;
E. Is receiving authorized services and is denied additional services that would extend the length of the current placement beyond the end date specified in the placement authorization.
F. Is denied a placement that is appropriate to client's race, color, creed, disability, national origin, religious preference, marital status, sexual orientation, or sex, or
G. Objects under part 9530.6622, subpart 11 to a religious placement and is not given an alternate referral

For more services during the appeal of additional services and consideration in granting, or denying additional services, please refer to 9530.665 subparts 3 and 4. For clients who wish to use it, a form to request Appeal, approved by the Commission of Human Services, is available from the Assessment Coordinator or from your assessor.

A CLIENT assessed under Part 9530.6615 who disagrees with the treatment planning decision HAS A RIGHT TO A SECOND ASSESSMENT IF:

A. The second assessment is requested within five days of the time the results of the first assessment are communicated to the client.
B. The second assessment is requested in writing, and
C. The client has not begun to receive services under the first assessment, prior to completing the second assessment.

The program has five days after receipt of a valid, written request for a second assessment to make that second assessment available. If the client agrees with the outcome of the second assessment, the placing authority shall place the client in accordance with (part 9530.6622 and) the second assessment. If the client disagrees, the placing authority must place the client according to the assessment that is most consistent with the client's collateral information.

AS A CLIENT OF THE RED LAKE CHEMICAL HEALTH PROGRAMS, I HAVE READ AND I FULLY UNDERSTAND THE STATEMENTS MADE ABOVE.

X_____
*CLIENT'S SIGNATURE

X_____
*DATE

_____
RED LAKE CHEMICAL HEALTH STAFF

_____
DATE

CONSENT FOR FOLLOW UP

Red Lake Chemical Health Programs is participating in the Minnesota Continuum of Care Pilot. The purpose of this project is to facilitate the flow of services as needed. The project gives us the resources to do some things we have not previously done.

We would also like your confidential feedback on how we are doing.

I agree to participate in the pilot. I agree to participate in a confidential Client Satisfaction survey.

X_____
*Initials or Signature

If you do participate in treatment, one thing we would like to do is have follow up contact with you after you finish treatment to continue to keep you in touch with resources as you need them. by authorizing this we can provide peer support or assistance accessing resources when you want, even when you are no longer in treatment.

I agree to provide Red Lake Chemical Health Programs with the best possible contact information for me and to update that information before I leave treatment. If there is any specific manner to best contact me, I agree to inform Red Lake Chemical Health Programs, care coordinators, or peer support staff or volunteers to use this information to contact me after I leave treatment to discuss how I am doing and my additional needs for the purpose of aftercare. These calls will not occur on an exact frequency, but will be more frequent immediately after treatment and will decrease with the passing of time, unless I request more frequent calls.

I understand that I can also call Red Lake Chemical Health Programs after my treatment completion.

X_____
*Typed or Printed Name

X_____
*SIGNATURE

X_____
*DATE

This permission expires two years after the signature date.

I understand that I can revoke this consent at any time, except to the extent that aftercare is included in my Court ordered Recommendation and I have agreed to this order to comply with my Court Order.

Acknowledgement of receipt of Chemical Health Programs

Notice of Privacy – Practices

I hereby acknowledge receipt of the Chemical Health Programs (CHP) Notice of Privacy Practices at:

CHEMICAL HEALTH PROGRAMS
RED LAKE, MN 56671

X _____
*SIGNATURE OF CLIENT

X _____
*DATE

_____
SIGNATURE OF CLIENT REPRESENTATIVE
State Relationship to client or witness
(IF signature is by thumb print or mark)

_____
DATE

_____
SIGNATURE AND TITLE OF CHP EMPLOYEE

_____
DATE

****

For Clients unable to Acknowledge receipt

I hereby certify that the client was unable to acknowledge receipt of the CHP Notice of Privacy Practice because:

_____

_____
Signature of CHP STAFF

_____
DATE

Questions: Contact HIPAA Coordinator at (218) 679-3995

MINNESOTA DEPARTMENT of HUMAN SERVICES

CLIENT PLACEMENT AUTHORIZATION (CPA) - CCDTF

DHS-2730-ENG 6-11

1. AGREEMENT START DATE	2. AGREEMENT END DATE	3. PMI# (RECIP ID)	4. CLIENT NAME (LAST NAME, FIRST, MI)	
5. CLIENT ALIAS, IF any		6. DOB (MM/DD/YYYY)	7. CO/TRIBE OF SERVICE DELIVERY	8. COUNTY OF RESIDENCE
			A8	004
9. CO/TRIBE OF FINANCIAL RESPONSIBILITY				
A8				
10. DATE OF SIGNATURE	11. AUTHORIZED COUNTY/TRIBAL SIGNATURE	12. SOCIAL SECURITY #	13. LANGUAGE	14. HISPANIC? Y = Yes N = No
			09	
15. MARITAL STATUS M = Married U = Unknown D = Divorced N = Never Married W = Widowed L = Legally Separated S = Living Apart		16. GENDER M = Male F = Female	17. A NOTIFICATION LETTER IS AUTOMATICALLY SENT TO THE CLIENT. CHECK THE BOX IF CLIENT DOESN'T WANT A LETTER SENT.	18. SERVICE AGREEMENT #

Placement & Financial

19. CLIENT ADDRESS (ADDRESS, CITY, STATE, ZIP)		20. RACE 1 = White 2 = Black 4 = American Indian 5 = Asian/Pacific Islander 8 = Other 9 = Unknown
21. FINANCIALLY RESPONSIBLE PERSON (LAST, FIRST, MI)	22. FINANCIALLY RESPONSIBLE PERSONS ADDRESS (ADDRESS, CITY, STATE, ZIP) (if different than the client)	
	SAME AS #19	

23. RULE 25 ASSESSMENT DATE	24. ASSESSMENT SEVERITY RATINGS (0-4) I II III IV V VI	25. LIMITED ELIGIBILITY M = Minor P = Pregnant A = Adult with Minor O = Other	26.

27. HAVE CLIENT INITIAL BOX IF CLIENT IS A MINOR AND APPROVES NOTIFICATION LETTERS BEING SENT TO THE FINANCIALLY RESPONSIBLE PERSON	28. PLACEMENT EXCEPTION 01 = Distance 02 = Special Populations 04 = Civil Commitment 08 = Adolescent 99 = None	29. ANNUAL INCOME $	30. HOUSEHOLD SIZE

Service Line 1

31. PROCEDURE CODE (if applicable)	32. MODIFIER(S)	33. REVENUE CODE	34. DRUG CODE (if applicable) M = Methadone A = Antabuse N = Naltrexone B = Buphenorphine	35. SERVICE START DATE	36. SERVICE END DATE	37. SERVICE RATE
H001	SE					$ 519.00

38. TOTAL # UNITS	39. TOTAL AMOUNT	40. NPI #	41. PROVIDER NAME
	$	1881802411	RED LAKE OUTPATIENT ASSESSMENT

42. PROVIDER ADDRESS & TAXONOMY/CONTRACT ID (if necessary)	43. RESERVE FUND ELIGIBILITY E = Tier I/Entitled V = Voucher O = Other (Must choose "Y" in box 43)	44. COUNTY PAY 100% Y = County Will Pay 100% N = County will Not Pay 100%
PO BOX 114 RED LAKE, MN 56671	E	N

Service Line 2

31. PROCEDURE CODE (if applicable)	32. MODIFIER(S)	33. REVENUE CODE	34. DRUG CODE (if applicable) M = Methadone A = Antabuse N = Naltrexone B = Buphenorphine	35. SERVICE START DATE	36. SERVICE END DATE	37. SERVICE RATE
T1016	U8 / HN			/ /	/ /	$ 519.00

38. TOTAL # UNITS	39. TOTAL AMOUNT	40. NPI #	41. PROVIDER NAME
	$	1881802411	RED LAKE OUTPATIENT CARE COORDINATION

42. PROVIDER ADDRESS & TAXONOMY/CONTRACT ID (if necessary)	43. RESERVE FUND ELIGIBILITY E = Tier I/Entitled V = Voucher O = Other (Must choose "Y" in box 43)	44. COUNTY PAY 100% Y = County Will Pay 100% N = County will Not Pay 100%
PO BOX 114 RED LAKE, MN 56671	E	N

Service Line 3

31. PROCEDURE CODE (if applicable)	32. MODIFIER(S)	33. REVENUE CODE	34. DRUG CODE (if applicable) M = Methadone A = Antabuse N = Naltrexone B = Buphenorphine	35. SERVICE START DATE	36. SERVICE END DATE	37. SERVICE RATE
H0038	U8			/ /	/ /	$ 519.00

38. TOTAL # UNITS	39. TOTAL AMOUNT	40. NPI #	41. PROVIDER NAME
	$	1881802411	RED LAKE OUTPATIENT PEER SUPPORT

42. PROVIDER ADDRESS & TAXONOMY/CONTRACT ID (if necessary)	43. RESERVE FUND ELIGIBILITY E = Tier I/Entitled V = Voucher O = Other (Must choose "Y" in box 43)	44. COUNTY PAY 100% Y = County Will Pay 100% N = County will Not Pay 100%
	E	N

Private Ins.

45. EMPLOYER NAME AND ADDRESS		46. MEDICARE CLAIM #
47. HEALTH INSURANCE COMPANY NAME AND ADDRESS	48. CERTIFICATE/POLICY #	49. GROUP NAME # / 50. PRE-CERTIFICATION #
51. POLICYHOLDER NAME AND ADDRESS (if not the client)	52. EMPLOYER OR POLICYHOLDER	53. RELATIONSHIP TO CLIENT

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 determine health care and/or Medica. benefits payable for chemical dependency 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 extent that actions have taken in advance of my revocation. If I revoke this authorization, I may be responsible for the total cost of treatment.

Client Signature (Parent/Guardian if Client is a minor): X _____ Date: X _____

Financially Responsible Person Signature (and/or Policyholder if not the Client) _____ Date: _____

Green Copy - County, Tribe or Managed Care Organization

White Copy - Client

MINNESOTA DEPARTMENT of HUMAN SERVICES

CLIENT PLACEMENT AUTHORIZATION (CPA) - CCDTF

DHS-2780-ENG 6-11

1. AGREEMENT START DATE	2. AGREEMENT END DATE	3. PMI# (RECIP ID)	4. CLIENT NAME (LAST NAME, FIRST, MI)	
5. CLIENT ALIAS, if any		6. DOB (MM/DD/YYYY)	7. CO/TRIBE OF SERVICE DELIVERY: A8	8. COUNTY OF RESIDENCE: 004	9. CO/TRIBE OF FINANCIAL RESPONSIBILITY: A8
10. DATE OF SIGNATURE	11. AUTHORIZED COUNTY/TRIBAL SIGNATURE	12. SOCIAL SECURITY #	13. LANGUAGE: 09	14. HISPANIC? Y = Yes, N = No
15. MARITAL STATUS: D = Divorced, L = Legally Separated, M = Married, N = Never Married, S = Living Apart, U = Unknown, W = Widowed	16. GENDER: M = Male, F = Female	17. A NOTIFICATION LETTER IS AUTOMATICALLY SENT TO THE CLIENT. CHECK THE BOX IF CLIENT DOESN'T WANT A LETTER SENT.	18. SERVICE AGREEMENT #	

Placement & Financial

19. CLIENT ADDRESS (ADDRESS, CITY, STATE, ZIP)	20. RACE: 1 = White, 2 = Black, 4 = American Indian, 5 = Asian/Pacific Islander, 8 = Other, 9 = Unknown
21. FINANCIALLY RESPONSIBLE PERSON (LAST, FIRST, MI)	22. FINANCIALLY RESPONSIBLE PERSONS ADDRESS (ADDRESS, CITY, STATE, ZIP) (if different than the client): SAME AS #19
23. RULE 25 ASSESSMENT DATE	24. ASSESSMENT SEVERITY RATINGS (0-4): I, II, III, IV, V, VI
25. LIMITED ELIGIBILITY: M = Minor, P = Pregnant, A = Adult with Minor, O = Other	26.
27. HAVE CLIENT INITIAL BOX IF CLIENT IS A MINOR AND APPROVES NOTIFICATION LETTERS BEING SENT TO THE FINANCIALLY RESPONSIBLE PERSON	28. PLACEMENT EXCEPTION: 01 = Distance, 02 = Special Populations, 04 = Civil Commitment, 08 = Adolescent, 99 = None
29. ANNUAL INCOME: $	30. HOUSEHOLD SIZE

Service Line 1

31. PROCEDURE CODE (if applicable)	32. MODIFIER(S)	33. REVENUE CODE	34. DRUG CODE (if applicable): M = Methadone, A = Antabuse, N = Naltrexone, B = Buphenorphine	35. SERVICE START DATE	36. SERVICE END DATE	37. SERVICE RATE
H001	SE					$ 162.24
38. TOTAL # UNITS	39. TOTAL AMOUNT	40. NPI #	41. PROVIDER NAME			
	$	1881802411	RED LAKE OUTPATIENT ASSESSMENT			
42. PROVIDER ADDRESS & TAXONOMY/CONTRACT ID (if necessary)			43. RESERVE FUND ELIGIBILITY: E = Tier I/Entitled, V = Voucher, O = Other (Must choose "Y" in box 43)		44. COUNTY PAY 100%: Y = County Will Pay 100%, N = County will Not Pay 100%	
PO BOX 114 RED LAKE, MN 56671			E		N	

Service Line 2

31. PROCEDURE CODE (if applicable)	32. MODIFIER(S)	33. REVENUE CODE	34. DRUG CODE (if applicable): M = Methadone, A = Antabuse, N = Naltrexone, B = Buphenorphine	35. SERVICE START DATE	36. SERVICE END DATE	37. SERVICE RATE
T1016	U8 / HN					$ 11.71
38. TOTAL # UNITS	39. TOTAL AMOUNT	40. NPI #	41. PROVIDER NAME			
	$	1881802411	RED LAKE OUTPATIENT CARE COORDINATION			
42. PROVIDER ADDRESS & TAXONOMY/CONTRACT ID (if necessary)			43. RESERVE FUND ELIGIBILITY: E = Tier I/Entitled, V = Voucher, O = Other (Must choose "Y" in box 43)		44. COUNTY PAY 100%: Y = County Will Pay 100%, N = County will Not Pay 100%	
PO BOX 114 RED LAKE, MN 56671			E		N	

Service Line 3

31. PROCEDURE CODE (if applicable)	32. MODIFIER(S)	33. REVENUE CODE	34. DRUG CODE (if applicable): M = Methadone, A = Antabuse, N = Naltrexone, B = Buphenorphine	35. SERVICE START DATE	36. SERVICE END DATE	37. SERVICE RATE
H0038	U8					$ 15.02
38. TOTAL # UNITS	39. TOTAL AMOUNT	40. NPI #	41. PROVIDER NAME			
	$	1881802411	RED LAKE OUTPATIENT PEER SUPPORT			
42. PROVIDER ADDRESS & TAXONOMY/CONTRACT ID (if necessary)			43. RESERVE FUND ELIGIBILITY: E = Tier I/Entitled, V = Voucher, O = Other (Must choose "Y" in box 43)		44. COUNTY PAY 100%: Y = County Will Pay 100%, N = County will Not Pay 100%	
			E		N	

Private Ins.

45. EMPLOYER NAME AND ADDRESS	46. MEDICARE CLAIM #
47. HEALTH INSURANCE COMPANY NAME AND ADDRESS	48. CERTIFICATE/POLICY # / 49. GROUP NAME # / 50. PRE-CERTIFICATION #
51. POLICYHOLDER NAME AND ADDRESS (if not the client)	52. EMPLOYER OR POLICYHOLDER / 53. RELATIONSHIP TO CLIENT

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 determine health care and/or Medicare benefits payable for chemical dependency 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 extent that actions have taken in advance of my revocation. If I revoke this authorization, I may be responsible for the total cost of treatment.

Client Signature (Parent/Guardian if Client is a minor): X _____ Date: X _____

Financially Responsible Person Signature (and/or Policyholder if not the Client) _____ Date: _____

Green Copy - County, Tribe or Managed Care Organization

White Copy - Client

MINNESOTA DEPARTMENT of HUMAN SERVICES

CLIENT PLACEMENT AUTHORIZATION (CPA) - CCDTF

DHS-2780-ENG 6-11

1. AGREEMENT START DATE	2. AGREEMENT END DATE	3. PMI# (RECIP ID)	4. CLIENT NAME (LAST NAME, FIRST, MI)	
5. CLIENT ALIAS, if any		6. DOB (MM/DD/YYYY)	7. CO/TRIBE OF SERVICE DELIVERY	8. COUNTY OF RESIDENCE
9. CO/TRIBE OF FINANCIAL RESPONSIBILITY				
10. DATE OF SIGNATURE	11. AUTHORIZED COUNTY/TRIBAL SIGNATURE	12. SOCIAL SECURITY #	13. LANGUAGE	14. HISPANIC? Y = Yes N = No
15. MARITAL STATUS D = Divorced L = Legally Separated M = Married N = Never Married S = Living Apart U = Unknown W = Widowed		16. GENDER M = Male F = Female	17. A NOTIFICATION LETTER IS AUTOMATICALLY SENT TO THE CLIENT. CHECK THE BOX IF CLIENT DOESN'T WANT A LETTER SENT.	18. SERVICE AGREEMENT #

Placement & Financial

19. CLIENT ADDRESS (ADDRESS, CITY, STATE, ZIP)		20. RACE 1 = White 2 = Black 4 = American Indian 5 = Asian/Pacific Islander 8 = Other 9 = Unknown
21. FINANCIALLY RESPONSIBLE PERSON (LAST, FIRST, MI)	22. FINANCIALLY RESPONSIBLE PERSONS ADDRESS (ADDRESS, CITY, STATE, ZIP) (if different than the client)	
23. RULE 25 ASSESSMENT DATE	24. ASSESSMENT SEVERITY RATINGS (0-4) I II III IV V VI	25. LIMITED ELIGIBILITY M = Minor P = Pregnant A = Adult with Minor O = Other
26.		
27. HAVE CLIENT INITIAL BOX IF CLIENT IS A MINOR AND APPROVES NOTIFICATION LETTERS BEING SENT TO THE FINANCIALLY RESPONSIBLE PERSON	28. PLACEMENT EXCEPTION 01 = Distance 02 = Special Populations 04 = Civil Commitment 08 = Adolescent 99 = None	29. ANNUAL INCOME $
30. HOUSEHOLD SIZE		

Service Line 1

31. PROCEDURE CODE (if applicable)	32. MODIFIER(S)	33. REVENUE CODE	34. DRUG CODE (if applicable) M = Methadone A = Antabuse N = Naltrexone B = Buphenorphine	35. SERVICE START DATE	36. SERVICE END DATE	37. SERVICE RATE
38. TOTAL # UNITS	39. TOTAL AMOUNT $	40. NPI #	41. PROVIDER NAME			
42. PROVIDER ADDRESS & TAXONOMY/CONTRACT ID (if necessary)			43. RESERVE FUND ELIGIBILITY E = Tier I/Entitled O = Other (Must choose "Y" in box 43) V = Voucher	44. COUNTY PAY 100% Y = County Will Pay 100% N = County will Not Pay 100%		

Service Line 2

31. PROCEDURE CODE (if applicable)	32. MODIFIER(S)	33. REVENUE CODE	34. DRUG CODE (if applicable) M = Methadone A = Antabuse N = Naltrexone B = Buphenorphine	35. SERVICE START DATE	36. SERVICE END DATE	37. SERVICE RATE
38. TOTAL # UNITS	39. TOTAL AMOUNT $	40. NPI #	41. PROVIDER NAME			
42. PROVIDER ADDRESS & TAXONOMY/CONTRACT ID (if necessary)			43. RESERVE FUND ELIGIBILITY E = Tier I/Entitled O = Other (Must choose "Y" in box 43) V = Voucher	44. COUNTY PAY 100% Y = County Will Pay 100% N = County will Not Pay 100%		

Service Line 3

31. PROCEDURE CODE (if applicable)	32. MODIFIER(S)	33. REVENUE CODE	34. DRUG CODE (if applicable) M = Methadone A = Antabuse N = Naltrexone B = Buphenorphine	35. SERVICE START DATE	36. SERVICE END DATE	37. SERVICE RATE
38. TOTAL # UNITS	39. TOTAL AMOUNT $	40. NPI #	41. PROVIDER NAME			
42. PROVIDER ADDRESS & TAXONOMY/CONTRACT ID (if necessary)			43. RESERVE FUND ELIGIBILITY E = Tier I/Entitled O = Other (Must choose "Y" in box 43) V = Voucher	44. COUNTY PAY 100% Y = County Will Pay 100% N = County will Not Pay 100%		

Private Ins.

45. EMPLOYER NAME AND ADDRESS		46. MEDICARE CLAIM #
47. HEALTH INSURANCE COMPANY NAME AND ADDRESS	48. CERTIFICATE/POLICY #	49. GROUP NAME # / 50. PRE-CERTIFICATION #
51. POLICYHOLDER NAME AND ADDRESS (if not the client)	52. EMPLOYER OR POLICYHOLDER	53. RELATIONSHIP TO CLIENT

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 determine health care and/or Medicare benefits payable for chemical dependency 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 extent that actions have taken in advance of my revocation. If I revoke this authorization, I may be responsible for the total cost of treatment.

Client Signature (Parent/Guardian if Client is a minor): X _____ Date: X _____

Financially Responsible Person Signature (and/or Policyholder if not the Client) _____ Date: _____

Green Copy - County, Tribe or Managed Care Organization

White Copy - Client

CHEMICAL HEALTH PROGRAMS

PO Box 114

Red Lake, MN 56671

Phone: (218) 679-3321

FAX: (218) 679-2727

RULE 25 CHEMICAL USE ASSESSMENT RESULTS AND RECOMMENDATIONS

Date: X_____

To: _____
_____
_____
_____

FROM: RED LAKE CHEMICAL HEALTH
BOX 114
RED LAKE, MN 56671
FAX # (218) 679- 2727

This is to verify that _____ completed a Rule 25 Chemical Use Assessment on _____. Additional Information about this client was gathered from _____collateral contacts.

According to Minnesota's Rule 25 Assessment Guidelines, I find that _____ has the following planning needs:

_____ Dimension 1 CURRENT INTOXICATION OR WITHDRAWAL
_____ Dimension 2 PHYSICAL HEALTH
_____ Dimension 3 MENTAL, EMOTIONAL, OR BEHAVIORAL
_____ Dimension 4 TREATMENT ACCEPTANC E
_____ Dimension 5 RELASPE POTENTIAL
_____ Dimension 6 RECOVERY ENVIRONMENT

and meets DSM IV TR criteria for _____ Substance Use Disorder

My treatment recommendations are:

_____ NO TREATMENT NEEDED
_____ DWI CLINIC
_____ TREATMENT AT:_____for a suggested initial period of _____.
_____ BOARD & LODGING AT: _____for a suggested initial period of _____.
_____ TRANSITIONAL /HALFWAY HOUSE PROGRAM AT:_____
_____ OTHER RECOMMENDATION_____

This client ___ is ____ is not financially eligible for the State Consolidate Fund to pay for their treatment.

Comments:_____
_____
_____

ASSESSOR:_____ CLIENT: X_____
PARENT'S SIGNATURE(IF UNDER 16)_____

CHEMICAL HEALTH PROGRAMS

PO Box 114
Red Lake, MN 56671

Phone: (218) 679-3321
FAX: (218) 679-2727

AUTHORIZATION FOR DISCLOSURE OF CLIENT INFORMATION >>COLLATERAL<<

(1)

I _____ REQUEST THAT THE RED LAKE
X *(Client's Name)

CHEMICAL HEALTH PROGRAMS RELEASE: participation in Rule 25 Assessment and receive information about my chemical use and functioning in all life areas
(TYPE OF INFORMATION/DOCUMENT)

TO and FROM

_____
*(COLLATERAL CONTACT'S NAME & PHONE NUMBER)

FOR THE PURPOSE OF: collateral contact (obtaining this person's perspective on my use)
(REASON OR PURPOSE)

A willfully false statement or representation is a criminal offense punishable by maximum fine of $10,000, or minimum imprisonment of 5 years, or both.
(U.S. Code, title 18, section 1001, formerly section 80)

X _____
*SIGNATURE OF APPLICANT (Patient, next of kin, administration of estate, etc.)
IF OTHER THAN PATIENT INDICATED RELATIONSHIP OR AUTHORITY.

_____
*CONTACT PHONE OR ADDRESS OF APPLICANT

X *DATE

This consent is subject to revocation at any time except to the extent that Chemical Health Programs has already taken action in reliance on it. However, if this consent was granted to show satisfaction of a legal or court order, then this permission cannot be revoked until that order has been satisfied.

TO EXPIRE ONE YEAR FROM DATE MENTIONED ABOVE.

NOTE: Public Health Service Act 42. U.S.C Section 290dd-2, previously recognized as 42 C.F.R, Part 2, protects the confidentiality of all individual, client data. Any disclosure of information, which is not authorized by those regulations, is subject to a fine of not more than $500 in the case of a first offense and not more than $5,000 in the case of each subsequent offense.

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Red Lake, MN 56671

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FAX: (218) 679-2727

AUTHORIZATION FOR DISCLOSURE OF CLIENT INFORMATION >>COLLATERAL<<

(2)

I _____ REQUEST THAT THE RED LAKE
X *(Client's Name)

CHEMICAL HEALTH PROGRAMS RELEASE: participation in Rule 25 Assessment and receive information about my chemical use and functioning in all life areas
(TYPE OF INFORMATION/DOCUMENT)

TO and FROM

_____
*(COLLATERAL CONTACT'S NAME & PHONE NUMBER)

FOR THE PURPOSE OF: collateral contact (obtaining this person's perspective on my use)
(REASON OR PURPOSE)

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(U.S. Code, title 18, section 1001, formerly section 80)

X _____
*SIGNATURE OF APPLICANT (Patient, next of kin, administration of estate, etc.)
IF OTHER THAN PATIENT INDICATED RELATIONSHIP OR AUTHORITY.

_____
*CONTACT PHONE OR ADDRESS OF APPLICANT X *DATE

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TO EXPIRE ONE YEAR FROM DATE MENTIONED ABOVE.

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CHEMICAL HEALTH PROGRAMS

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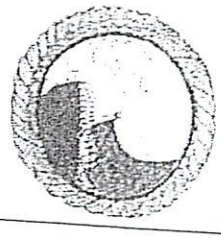
Red Lake, MN 56671

Phone: (218) 679-3321
FAX: (218) 679-2727



AUTHORIZATION FOR DISCLOSURE OF CLIENT INFORMATION >>COLLATERAL<< (3)

I _____ REQUEST THAT THE RED LAKE
X *(Client's Name)

CHEMICAL HEALTH PROGRAMS RELEASE: participation in Rule 25 Assessment and receive information about my chemical use and functioning in all life areas
(TYPE OF INFORMATION/DOCUMENT)

TO and FROM

_____
*(COLLATERAL CONTACT'S NAME & PHONE NUMBER)

FOR THE PURPOSE OF: collateral contact (obtaining this person's perspective on my use)
(REASON OR PURPOSE)

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(U.S. Code, title 18, section 1001, formerly section 80)

X _____
*SIGNATURE OF APPLICANT (Patient, next of kin, administration of estate, etc.)
IF OTHER THAN PATIENT INDICATED RELATIONSHIP OR AUTHORITY.

_____
*CONTACT PHONE OR ADDRESS OF APPLICANT X *DATE

This consent is subject to revocation at any time except to the extent that Chemical Health Programs has already taken action in reliance on it. However, if this consent was granted to show satisfaction of a legal or court order, then this permission cannot be revoked until that order has been satisfied.

TO EXPIRE ONE YEAR FROM DATE MENTIONED ABOVE.

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CHEMICAL HEALTH PROGRAMS

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AUTHORIZATION FOR DISCLOSURE OF CLIENT INFORMATION >>GENERIC<<

(1)

I _____ REQUEST THAT THE RED LAKE
X *(Client's Name)

CHEMICAL HEALTH PROGRAMS RELEASE: _____

_____
(TYPE OF INFORMATION/DOCUMENT)

TO _____
*(AGENCY OR INDIVIDUAL'S NAME & PHONE NUMBER)

FOR THE PURPOSE OF: _____
(REASON OR PURPOSE)

A willfully false statement or representation is a criminal offense punishable by maximum fine of $10,000, or minimum imprisonment of 5 years, or both.
(U.S. Code, title 18, section 1001, formerly section 80)

X _____
*SIGNATURE OF APPLICANT (Patient, next of kin, administration of estate, etc.)
IF OTHER THAN PATIENT INDICATED RELATIONSHIP OR AUTHORITY.

_____
*CONTACT PHONE OR ADDRESS OF APPLICANT

X *DATE

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TO EXPIRE ONE YEAR FROM DATE MENTIONED ABOVE.

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CHEMICAL HEALTH PROGRAMS

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AUTHORIZATION FOR DISCLOSURE OF CLIENT INFORMATION >>GENERIC<< (2)

I _____ REQUEST THAT THE RED LAKE
X *(Client's Name)

CHEMICAL HEALTH PROGRAMS RELEASE: _____

_____
(TYPE OF INFORMATION/DOCUMENT)

TO _____
*(AGENCY OR INDIVIDUAL'S NAME & PHONE NUMBER)

FOR THE PURPOSE OF: _____
(REASON OR PURPOSE)

A willfully false statement or representation is a criminal offense punishable by maximum fine of $10,000, or minimum imprisonment of 5 years, or both.
(U.S. Code, title 18, section 1001, formerly section 80)

X _____
*SIGNATURE OF APPLICANT (Patient, next of kin, administration of estate, etc.)
IF OTHER THAN PATIENT INDICATED RELATIONSHIP OR AUTHORITY.

_____
*CONTACT PHONE OR ADDRESS OF APPLICANT X *DATE

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TO EXPIRE ONE YEAR FROM DATE MENTIONED ABOVE.

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AUTHORIZATION FOR DISCLOSURE OF CLIENT INFORMATION >>GENERIC<<

(3)

I _____ REQUEST THAT THE RED LAKE
X *(Client's Name)

CHEMICAL HEALTH PROGRAMS RELEASE: _____

_____
(TYPE OF INFORMATION/DOCUMENT)

TO _____
*(AGENCY OR INDIVIDUAL'S NAME & PHONE NUMBER)

FOR THE PURPOSE OF: _____
(REASON OR PURPOSE)

A willfully false statement or representation is a criminal offense punishable by maximum fine of $10,000, or minimum imprisonment of 5 years, or both.
(U.S. Code, title 18, section 1001, formerly section 80)

X _____
*SIGNATURE OF APPLICANT (Patient, next of kin, administration of estate, etc.)
IF OTHER THAN PATIENT INDICATED RELATIONSHIP OR AUTHORITY.

_____
*CONTACT PHONE OR ADDRESS OF APPLICANT X *DATE

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CHEMICAL HEALTH PROGRAMS

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AUTHORIZATION FOR DISCLOSURE OF CLIENT INFORMATION >>TREATMENT and CARE COORDINATION<<

I _____ REQUEST THAT THE RED LAKE
X *(Client's Name)

CHEMICAL HEALTH PROGRAMS RELEASE: Rule 25 Recommendation and Statewide Uniform Assessment Packet, as well as care coordination information.
(TYPE OF INFORMATION/DOCUMENT)

TO _____
*(AGENCY OR INDIVIDUAL'S NAME & PHONE NUMBER)

FOR THE PURPOSE OF: Treatment planning and Care Coordination
(REASON OR PURPOSE)

I also REQUEST THAT _____
*(AGENCY OR INDIVIDUAL'S NAME)

Release to RED LAKE CHEMICAL HEALTH PROGRAMS weekly treatment progress reports and treatment plan revisions, attendance and status in treatment, case management information, any other information relevant to the coordination of various aspects of my care, and termination summary for the purpose of case management.

A willfully false statement or representation is a criminal offense punishable by maximum fine of $10,000, or minimum imprisonment of 5 years, or both.
(U.S. Code, title 18, section 1001, formerly section 80)

X _____
*SIGNATURE OF APPLICANT (Patient, next of kin, administration of estate, etc.)
IF OTHER THAN PATIENT INDICATED RELATIONSHIP OR AUTHORITY.

_____
*CONTACT PHONE OR ADDRESS OF APPLICANT X *DATE

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TO EXPIRE ONE YEAR FROM DATE MENTIONED ABOVE.

NOTE: Public Health Service Act 42. U.S.C Section 290dd-2, previously recognized as 42 C.F.R, Part 2, protects the confidentiality of all individual, client data. Any disclosure of information, which is not authorized by those regulations, is subject to a fine of not more than $500 in the case of a first offense and not more than $5,000 in the case of each subsequent offense.

CHEMICAL HEALTH PROGRAMS

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AUTHORIZATION FOR DISCLOSURE OF CLIENT INFORMATION
>>RED LAKE FAMILY & CHILDREN SERVICES (OMBIMINDWAA)<<

I _____ REQUEST THAT THE RED LAKE
X *(Client's Name)

CHEMICAL HEALTH PROGRAMS exchange:
Information on legal history and child welfare investigations including complaints, nature of abuse or neglect reported, charges and court orders and
Rule 25 Recommendation. Compliance with Results. and any Treatment Dates.
(TYPE OF INFORMATION/DOCUMENT)

TO: RED LAKE FAMILY & CHILDREN SERVICE (OMBIMINDWAA) AND RED LAKE NATION COURTS
*(AGENCY OR INDIVIDUAL'S NAME & PHONE NUMBER)

FOR THE PURPOSE OF: Understand the nature of referral for assessment. develop a full assessment picture. and demonstrate Compliance with Court Orders
(REASON OR PURPOSE)

A willfully false statement or representation is a criminal offense punishable by maximum fine of $10,000, or minimum imprisonment of 5 years, or both.
(U.S. Code, title 18, section 1001, formerly section 80)

X _____
*SIGNATURE OF APPLICANT (Patient, next of kin, administration of estate, etc.)
IF OTHER THAN PATIENT INDICATED RELATIONSHIP OR AUTHORITY.

*CONTACT PHONE OR ADDRESS OF APPLICANT X *DATE

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TO EXPIRE ONE YEAR FROM DATE MENTIONED ABOVE.

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Red Lake, MN 56671

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FAX: (218) 679-2727

AUTHORIZATION FOR DISCLOSURE OF CLIENT INFORMATION >>RED LAKE NATION COURTS<<

I _____ REQUEST THAT THE RED LAKE
X *(Client's Name)

CHEMICAL HEALTH PROGRAMS RELEASE:

Rule 25 Recommendation. Compliance with Results. and any Treatment Dates.
(TYPE OF INFORMATION/DOCUMENT)

TO: RED LAKE NATION COURTS
*(AGENCY OR INDIVIDUAL'S NAME & PHONE NUMBER)

FOR THE PURPOSE OF: Demonstrate Compliance with Court Orders
(REASON OR PURPOSE)

A willfully false statement or representation is a criminal offense punishable by maximum fine of $10,000, or minimum imprisonment of 5 years, or both.
(U.S. Code, title 18, section 1001, formerly section 80)

X _____
*SIGNATURE OF APPLICANT (Patient, next of kin, administration of estate, etc.)
IF OTHER THAN PATIENT INDICATED RELATIONSHIP OR AUTHORITY.

*CONTACT PHONE OR ADDRESS OF APPLICANT X *DATE

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AUTHORIZATION FOR DISCLOSURE OF CLIENT INFORMATION >>OTHER COURTS<<

I _____ REQUEST THAT THE RED LAKE
X *(Client's Name)

CHEMICAL HEALTH PROGRAMS RELEASE:

Rule 25 Recommendation, Compliance with Results, and any Treatment Dates.
(TYPE OF INFORMATION/DOCUMENT)

TO: _____
*(AGENCY OR INDIVIDUAL'S NAME & PHONE NUMBER)

FOR THE PURPOSE OF: Demonstrate Compliance with Court Orders
(REASON OR PURPOSE)

A willfully false statement or representation is a criminal offense punishable by maximum fine of $10,000, or minimum imprisonment of 5 years, or both.
(U.S. Code, title 18, section 1001, formerly section 80)

X _____
*SIGNATURE OF APPLICANT (Patient, next of kin, administration of estate, etc.)
IF OTHER THAN PATIENT INDICATED RELATIONSHIP OR AUTHORITY.

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