Instructions to Complete RULE 25 Applications

Rule 25 Application: Fill out completely.

Statement of Income and Health Care Benefits: Only fill out if the applicant has no income AND no insurance; if one of the statements is true then the form does not need to be completed.

Residency Verification: Only needs to be filled out if the applicant does not have their own proof of residence. If this form is used the person signing off on residence verification would need to provide a copy of their mail, utility bill, lease, etc.

Consent for Release of Information: Check the box next to all service areas which the applicant is receiving services in, and then sign and date.

Notice of Privacy Practices- Your copy to keep.

Please remember to include the following proofs:

- Residence (a copy of mail, lease, utility bill, or hospital face sheet if currently hospitalized)
- Income for applicant, and if applicable, applicant's spouse's income (last months' worth of paystubs, benefits statement, or child support documentation)
- If there is private insurance: include a copy of the front and back of the insurance card, explanation of benefits statement including the section referencing payment for CD treatment, and denial letter from insurance denying for chemical health.

Once completed fax back to 507-437-9721, email to dhsrecep@co.mower.mn.us or drop off at Mower County Health and Human Services.

Thanks,
CD Intake

Mower County Health and Human Services is located at:
201 1st Street NE, Suite 18
Austin, MN 55912

MOWER COUNTY

Health & Human Services
201 1st Street NE, Suite 18
Austin, Minnesota 55912
Phone: 507-437-9701 Fax: 507-437-9721

Application Date: _____ Authorization #: _____

Chemical Health Services

Rule 25 Assessment Application

Name: _____
(Last, First, Middle Initial)

DOB: _____ SS #: _____

MOWER COUNTY RESIDENT: Yes ☐ No ☐
If yes, bring residency verification. (Anything with your name and address such as a copy of a lease, an electric bill, credit card bill, or a copy of mail from the person you live with and a signed statement from that person verifying how long you have lived at your current address.)
If you are homeless please give your last permanent address with the dates you resided at that address.

Address: _____

_____

Phone #: _____ Cell #: _____

Gender: M ☐ F ☐

Race: _____ 1-White 2-Black 4-American Indian 5-Asian/Pacific Islander 8-Other 9-Unknown

Non-Reservation American Indian: Yes ☐ No ☐

Hispanic: Yes ☐ No ☐

Marital Status (check one): Single ☐ Married ☐ Widowed ☐
Separated ☐ Divorced ☐ Never Married ☐

DWI: Yes ☐ No ☐ Date: _____

COURT ORDERED ASSESSMENT: Yes ☐ No ☐ What County: _____

What was the charge: _____

Probation Officer/Social Worker: _____ Phone #: _____

Medical Assistance (MA), General Assistance Medical Care (GAMC), or Minnesota Care:
Yes ☐ No ☐ (If checked yes, MA #: _____)

PRIVATE INSURANCE or HMO Coverage: Yes ☐ No ☐
(If yes, please complete the following or send a copy of your insurance card.)

Insurance Company Name: _____

Insurance Company Address: _____

Employer Name: _____

Employer Address: _____

Policy Name/Number: _____ Group Name/Number: _____

Contact Person/Phone Number: _____

Coverage Type: _____

Any Limitation/Co-Pay: _____

EMPLOYED: Yes ☐ No ☐ **What does count as income is listed below, please fill in amounts as specified and attach documentation of recent payment. If married, include spouse's income.**
(Based on current month's income.)

$ _____ Cash for Wages or Salary
(Please attach last two pay stubs)

$ _____ GA, SSI Disability

$ _____ Social Security

$ _____ Railroad Retirement

$ _____ Unemployment Compensation

$ _____ Royalties

$ _____ Rental received from rental owned properties

$ _____ Veterans Benefits

$ _____ Child Support (received)

$ _____ Military Family Allotments

$ _____ Private or Government Pensions

$ _____ Insurance

$ _____ Annuities

$ _____ Interest

HOUSEHOLD SIZE: _____ (Adult - include self, spouse & minor children)
(Minor Child – include self, parents and minor aged siblings)

INCOME: _____ **(Total based on above check list)**

Minus – _____ **(Court Ordered Child Support Payment - Include Verification)**

TOTAL INCOME: $ _____

Client Signature _____

(*Mower County reserves the right to terminate treatment immediately if any of the above information is found to be fraudulent.*)

MOWER COUNTY

Health & Human Services
201 1st Street NE, Suite 18
Austin, Minnesota 55912
Phone: 507-437-9701 Fax: 507-437-9721

Chemical Health Services

Statement of Income and Health Care Benefits

I, _____, confirm that on this date _____

I do not have a source of financial income through employment or other sources. I, also, do not have health insurance coverage of any kind and am in need of Rule 25 assistance to complete an appropriate treatment placement.

Client Signature:_____ DOB:_____ Date:_____

Note: Providing information that is inaccurate or untrue is fraudulent and may be investigated.

MOWER COUNTY

Health & Human Services
201 1st Street NE, Suite 18
Austin, Minnesota 55912
Phone: 507-437-9701 Fax: 507-437-9721

Residency Verification

CCDTF

To be completed by Owner, Manager, or Caretaker Only

Tenant's Name:				
ATTENTION: HOMEOWNER, MANAGER, AND CARETAKER: *Please submit address verification such as a current utility bill before this request can be processed. This information can be attached or faxed to: Attn: 507-437-9721				
Please legibly print the information requested below:				
Owner, Manager, or Caretaker's Name:		**Address:**		**Apt. #:**
City	**County**	**State**	**ZIP**	**Phone/Cell #:** ***(circle)***
Length of time you have resided at this address:		**Length of time tenant has resided at this address:**		
Relationship to Tenant:				
Owner, Manager, or Caretaker's Signature:				**Date:**

Note: Providing information that is inaccurate or untrue is fraudulent and may be investigated.

MOWER COUNTY

Health & Human Services
201 1st Street NE, Suite 18
Austin, Minnesota 55912
Phone: 507-437-9701 Fax: 507-437-9721

RELEASE OF INFORMATION

Client Name:_____	Date of Birth:_____	Social Sec #:_____
Previous/Maiden Name:_____		Phone:_____
Address:_____		

I give Mower County permission to share information about myself with and receive information from:

(Name and address of individual(s), or entities to receive or release the information)

Send To: Mower County Health & Human Services **Attention:** _____

Information to be Disclosed:

- ☐ Child Protection Assessment Summary
- ☐ IEP/School Assessment
- ☐ Billing Statements/Financial Data
- ☐ Psychiatric Assessments
- ☐ Diagnostic Assessment
- ☐ Psychological Testing or Evaluation
- ☐ Case Management Summary
- ☐ Discharge or Closing Summary
- ☐ School Records, IEP, Assessments
- ☐ Social Service Records
- ☐ Social History
- ☐ Birth Records
- ☐ Progress Reports
- ☐ Vocational Reports
- ☐ Court Records
- ☐ Treatment Records
- ☐ Other (specify):_____

Medical Information:
- ☐ Clinic Records
- ☐ Hospital Records
- ☐ Chemical Health Service Records
- ☐ Home Health Care Records
- ☐ Hospice Records
- ☐ Psychiatry/Psychology Records

Types of Documents to be Released:
- ☐ History & Physical
- ☐ Lab Reports
- ☐ Diagnostic Testing
- ☐ Clinic/Case Notes
- ☐ Operative Reports
- ☐ Other (specify): _____

Purpose of Disclosure:

- ☐ Treatment/continued care
- ☐ Attorney/Legal
- ☐ Disability Determination
- ☐ LCTS Title IV-E Funding
- ☐ Insurance Claim/Application
- ☐ Investigation (specify):_____
- ☐ Case prep/management
- ☐ Other (specify):_____

This authorization is voluntary. I understand the information to be released may include records related to behavioral and/or mental health care, alcohol and drug abuse treatment, HIV/AIDS, and genetics. The information to be released is private and any subsequent use and release is controlled under the MN Government Data Privacy Act (MN Stat. chapter 13) I understand Mower County and the other parties named above may not condition my receiving services based on my providing this authorization unless the information is necessary for determining my eligibility for services or for providing services. I understand that if I refuse to sign this authorization, Mower County and the other party named above may not be able to provide some or all of the services I may need or request. I understand that the individual(s) or entities to which my information is being disclosed may not be subject to state or federal privacy laws. My information may not be protected by law if the entity that receives it is either required or permitted to disclose it to someone else. I understand that I may revoke this authorization at any time by giving written notice of revocation to Mower County or the parties named above. I understand that revocation of this authorization will not affect any action taken by Mower County or the other parties named above in reliance upon the authorization prior to receiving my written notice of revocation. I have received a copy of this statement, which I can retain. This **authorization will expire one year from** the date of signing unless I have indicated an earlier date or event here:_____.

Signature of individual authorizing release (if client is 18 years of age or older) Date

Signature of parent or guardian (if client is 17 years of age or younger, unless exception exists under state or federal law) Date

Signature of Witness and/or Interpreter Date

Minnesota Department of **Human Services**

Notice of Privacy Practices

(Effective Date: November 2016)

This notice tells how private information about you may be used and disclosed and how you can get this information. Please review it carefully.

Why do we ask for this information?

- In order to determine whether and how we can help you, we collect information:
  - To tell you apart from other people with the same or similar name
  - To decide what you are eligible for
  - To help you get medical, mental health, financial or social services and decide if you can pay for some services
  - To decide if you or your family need protective services
  - To decide about out-of-home care and in-home care for you or your children
  - To investigate the accuracy of the information in your application
- After we have begun to provide services or support to you, we may collect additional information:
  - To make reports, do research, do audits, and evaluate our programs
  - To investigate reports of people who may lie about the help they need
  - To collect money from other agencies, like insurance companies, if they should pay for your care
  - To collect money from the state or federal government for help we give you.
  - When you or your family's circumstances change and you are required to report the change (see Client Responsibilities and Rights – DHS-4163)

Why do we ask you for your Social Security number?

We need your Social Security number to give you medical assistance, some kinds of financial help, or child support enforcement services (42 CFR 435.910 [2006]; Minn. Stat. 256D.03, subd.3(h); Minn. Stat.256L.04, subd. 1a; 45 CFR 205.52 [2001]; 42 USC 666; 45 CFR 303.30 [2001]). We also need your Social Security Number to verify identity and prevent duplication of state and federal benefits. Additionally, your Social Security Number is used to conduct computer data matches with collaborative, nonprofit and private agencies to verify income, resources, or other information that may affect your eligibility and/or benefits.

You do not have to give us the Social Security Number:

- For persons in your home who are not applying for coverage
- If you have religious objections
- If you are not a United States citizen and are applying for Emergency Medical Assistance only
- If you are from another country, in the United States on a temporary basis and do not have permission from the United States Citizenship and Immigration Services to live in the United States permanently
- If you are living in the United States without the knowledge or approval of the U.S. Citizenship and Immigration Services.

Do you have to answer the questions we ask?

You do not have to give us your personal information. Without the information, we may not be able to help you. If you give us wrong information on purpose, you can be investigated and charged with fraud.

With whom may we share information?

We will only share information about you as needed and as allowed or required by law. We may share your information with the following agencies or persons who need the information to do their jobs:

- Employees or volunteers with other state, county, local, federal, collaborative, nonprofit and private agencies
- Researchers, auditors, investigators, and others who do quality of care reviews and studies or commence prosecutions or legal actions related to managing the human services programs.
- Court officials, county attorney, attorney general, other law enforcement officials, child support officials, and child protection and fraud investigators
- Human services offices, including child support enforcement offices
- Governmental agencies in other states administering public benefits programs
- Health care providers, including mental health agencies and drug and alcohol treatment facilities
- Health care insurers, health care agencies, managed care organizations and others who pay for your care
- Guardians, conservators or persons with power of attorney

- Coroners and medical investigators if you die and they investigate your death
- Credit bureaus, creditors or collection agencies if you do not pay fees you owe to us for services
- Anyone else to whom the law says we must or can give the information.

What are your rights regarding the information we have about you?

- You and people you have given permission to may see and copy private information we have about you. You may have to pay for the copies.
- You may question if the information we have about you is correct. Send your concerns in writing. Tell us why the information is wrong or not complete. Send your own explanation of the information you do not agree with. We will attach your explanation any time information is shared with another agency.
- You have the right to ask us in writing to share information with you in a certain way or in a certain place. For example, you may ask us to send health information to your work address instead of your home address. If we find that your request is reasonable, we will grant it.
- You have the right to ask us to limit or restrict the way that we use or disclose your information, but we are not required to agree to this request.
- If you do not understand the information, ask your worker to explain it to you. You can ask the Minnesota Department of Human Services for another copy of this notice.

What are our responsibilities?

- We must protect the privacy of your private information according to the terms of this notice.
- We may not use your information for reasons other than the reasons listed on this form or share your information with individuals and agencies other than those listed on this form unless you tell us in writing that we can.
- We must follow the terms of this notice, but we may change our privacy policy because privacy laws change. We will put changes to our privacy rules on our website at: http://edocs.dhs.state.mn.us/lfserver/Public/DHS-3979-ENG

What privacy rights do children have?

If you are under 18, when parental consent for medical treatment is not required, information will not be shown to parents unless the health care provider believes not sharing the information would risk your health. Parents may see other information about you and let others see this information, unless you have asked that this information not be shared with your parents. You must ask for this in writing and say what information you do not want to share and why. If the agency agrees that sharing the information is not in your best interest, the information will not be shared with your parents. If the agency does not agree, the information may be shared with your parents if they ask for it.

What if you believe your privacy rights have been violated?

If you think that the Minnesota Department of Human Services has violated your privacy rights, you may send a written complaint to the U.S. Department of Health and Human Services to the address below:

Minnesota Department of Human Services
Attn: Privacy Official
PO Box 64998
St. Paul, MN 55164-0998

Attention. If you need free help interpreting this document, ask your worker or call the number below for your language.

ያስተውሉ፡ ይህንን ዶኩመንት ለመተርጎም እርዳታ የሚፈልጉ ከሆነ፡ የጉዳዮን ሰራተኛ ይጠይቁ ወይም በሰልክ ቁጥር 1-844-217-3547 ይደውሉ።

ملحظة: إذا أردت مساعدة مجانية لترجمة هذه الوثيقة، اطلب ذلك من مشرفك أو اتصل على الرقم 1-800-358-0377.

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請注意，如果您需要免費協助傳譯這份文件，請告訴您的工作人員或撥打 1-844-217-3564。

Attention. Si vous avez besoin d'une aide gratuite pour interpréter le présent document, demandez à votre agent chargé du traitement de cas ou appelez le 1-844-217-3548.

Thov ua twb zoo nyeem. Yog hais tias koj xav tau kev pab txhais lus rau tsab ntaub ntawv no pub dawb, ces nug koj tus neeg lis dej num los sis hu rau 1-888-486-8377.

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알려드립니다. 이 문서에 대한 이해를 돕기 위해 무료로 제공되는 도움을 받으시려면 담당자에게 문의하시거나 1-844-217-3565으로 연락하십시오.

ໂປຣດຊາບ. ຖ້າຫາກ ທ່ານຕ້ອງການການຊ່ວຍເຫ ຼ ືອໃນການແປເອກະສານນຟ, ຈ ົ ່ ຖາມພະນ ັ ກງານກ ່ ານ ັ ກ ານຊ ່ ວຍເຫ ຼ ືອ ຂ ອງທ ່ ານ ຫ ຼ ື ໂທຣໄປ ' ີ 1-888-487-8251.

Hubachiisa. Dokumentiin kun bilisa akka siif hiikamu gargaarsa hoo feete, hojjettoota kee gaafadhu ykn afaan ati dubbattuuf bilbilli 1-888-234-3798.

Внимание: если вам нужна бесплатная помощь в устном переводе данного документа, обратитесь к своему социальному работнику или позвоните по телефону 1-888-562-5877.

Digniin. Haddii aad u baahantahay caawimaad lacag-la'aan ah ee tarjumaadda qoraalkan, hawlwadeenkaaga weydiiso ama wac lambarka 1-888-547-8829.

Atención. Si desea recibir asistencia gratuita para interpretar este documento, comuníquese con su trabajador o llame al 1-888-428-3438.

Chú ý. Nếu quý vị cần được giúp đỡ dịch tài liệu này miễn phí, xin gọi nhân viên xã hội của quý vị hoặc gọi số 1-888-554-8759.

LBI (8-15)

ADA Advisory

For accessible formats of this publication, ask your county worker.
For assistance with additional equal access to human services, contact your county's ADA Coordinator. (ADA4 [9-15])

Appendix J

MOWER COUNTY
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

Mower County provides many types of services, such as health and social services. County staff must collect information about you to provide these services. Mower County knows that information we collect about you and your health is private. The County is required to protect this information by Federal and State law. We call this information "protected health information (PHI)."

The Notice of Privacy Practices will tell you how the County may use or disclose information about you. Not all situations will be described. Mower County is required to give you a notice of our privacy practices for the information we collect and keep about you. The County is required to follow the terms of the notice currently in effect.

****Mower County May Use and Disclose Information Without Your Authorization:***

• **For Treatment.** The County may use or disclose information with health care providers who are involved in your health care. For example, information may be shared to create and carry out a plan for your treatment.

• **For Payment.** The County may use or disclose information to get payment or to pay for the health care services you receive. For example, The County may provide PHI to bill your health plan for health care provided to you.

• **For Health Care Operations.** The County may use or disclose information in order to manage its programs and activities. For example, The County may use PHI to review the quality of services you receive.

• **Appointments and Other Health Information.** The County may send you reminders for medical care or checkups. The County may send you information about health services that may be of interest to you.

• **For Public Health Activities.** The County is the public health agency that keeps and updates vital records, such as births and deaths, and tracks some diseases.

• **For Health Oversight Activities.** The County may use or disclose information to inspect or investigate health care providers.

• **As Required by Law and For Law Enforcement.** The County will use and disclose information when required or permitted by federal or state law or by a court order.

• **For Abuse Reports and Investigations.** The County is required by law to receive and investigate reports of abuse.

• **For Government Programs.** The County may use and disclose information for public benefits under other government programs. For example, The County may disclose information for the determination of Supplemental Security Income (SSI) benefits.

• **To Avoid Harm.** The County may disclose PHI to law enforcement in order to avoid a serious threat to the health and safety of a person or the public.

• **For Research.** The County uses information for studies and to develop reports. These reports do not identify specific people.

• **Disclosures to Family, Friends, and Others.** The County may disclose information to your family or other persons who are involved in your medical care. You have the right to object to the sharing of this information.

• **Other Uses and Disclosures Require Your Written Authorization**
For other situations, The County will ask for your written authorization before using or disclosing information. You may cancel this authorization at any time in writing. The County cannot take back any uses or disclosures already made with your authorization.

• **Other Laws Protect PHI.** Many the County programs have other laws for the use and disclosure of information about you. For example, you must give your written authorization for The County to use and disclose your mental health and chemical dependency treatment records.

Your PHI Privacy Rights

When information is maintained by Mower County as a public health agency, the public health records are governed by other State and Federal laws and is not subject to the rights described below.

• **Right to See and Get Copies of Your Records.** In most cases, you have the right to look at or get copies of your records. You must make the request in writing. You may be charged a fee for the cost of copying your records.

• **Right to Request a Correction or Update of Your Records.** You may ask The County to change or add missing information to your records if you think there is a mistake. You must make the request in writing, and provide a reason for your request.

• **Right to Get a List of Disclosures.** You have the right to ask The County for a list of disclosures made after April 14, 2003. You must make the request in writing. This list will not include the times that information was disclosed for treatment, payment, or health care operations. The list will not include information provided directly to you or your family, or information that was sent with your authorization.

• **Right to Request Limits on Uses or Disclosures of PHI.** You have the right to ask that The County limit how your information is used or disclosed. You must make the request in writing and tell The County what information you want to limit and to whom you want the limits to apply. The County is not

required to agree to the restriction. You can request that the restrictions be terminated in writing or verbally.

• **Right to Revoke Permission.** If you are asked to sign an authorization to use or disclose information, you can cancel that authorization at any time. You must make the request in writing. This will not affect information that has already been shared.

• **Right to Choose How We Communicate with you.** You have the right to ask that The County share information with you in a certain way or in a certain place. For example, you may ask The County to send information to your work address instead of your home address. You must make this request in writing. You do not have to explain the basis for your request.

• **Right to File a Complaint.** You have the right to file a complaint if you do not agree with how The County has used or disclosed information about you.

• **Right to Get a Paper Copy of this Notice.** You have the right to ask for a paper copy of this notice at any time.

How to Contact the County to Review, Correct, or Limit Your Protected Health Information (PHI)

You may contact the County office you are receiving services from or the County Privacy Officer at the address listed at the end of this notice to:

• Ask to look at or copy your records
• Ask to correct or change your records
• Ask to limit how information about you is used or disclosed
• Ask for a list of the times the County disclosed information about you
• Ask to cancel your authorization

The County may deny your request to look at, copy or change your records. If the County denies your request, The County will send you a letter that tells you why your request is being denied and how you can ask for a review of the denial. You will also receive information about how to file a complaint with the County or with the U.S. Department of Health and Human Services, Office for Civil Rights.

How to File a Complaint or Report a Problem

You may contact any of the people listed below if you want to file a complaint or to report a problem with how the County has used or disclosed information about you. Your benefits will not be affected by any complaints you make. The County cannot retaliate against you for filing a complaint, cooperating in an investigation, or refusing to agree to something that you believe to be unlawful.

Office for Civil Rights
Medical Privacy, Complaint Division
U.S. Department of Health and Human Services (DHHS)
200 Independence Avenue, SW, HHH Building, Room 509H
Washington, D.C. 20201
Phone: 866-627-7748 TTY: 886-788-4989 Email: www.hhs.gov/ocr

Mower County Privacy/Client Information Officer:
County Coordinator
Mower County Courthouse
201 1st Street NE
Austin, MN 55912
Phone: 507-437-9549

Mower County Attorney
Mower County Courthouse
201 1st Street NE
Austin, MN 55912
Phone: 507-437-9549

In the future, The County may change its Notice of Privacy Practices. Any changes will apply to information the County already has, as well as any information the County receives in the future. A copy of the new notice will be posted at each County site and facility and provided as required by law. **You may ask for a copy of the current Notice anytime you visit a County facility.*

For More Information

If you have any questions about this notice or need more information, please contact the County Office you are receiving services from or the Mower County Privacy Officer.

Thank you!

Appendix K

Notice of Privacy Practices – *Acknowledgement of Receipt*

PLEASE REVIEW THIS CAREFULLY

"The Notice of Privacy Practices tells you how Mower County may use or disclose information about you."

Not all situations will be described. Mower County is required to give you a notice of our privacy practices for the information we collect and keep about you.

I, _____
(client's name), have been given a copy of Mower County's Notice of Privacy Practices and have had a chance to ask questions about how my information will be used.

_____ _____
Client's signature Date

_____ _____
Legal or Personal Representative of Client (if applicable) Relationship

For Office Use Only:

Please have this document completed and signed by the individual receiving the Notice of Privacy Practices. Provide a copy to the individual, if they request one; file the original in their case record.