Ramsey County Community Services

Application Date:

Authorization:

Chemical Health Services

Rule 25 Assessment Application

Name:_____

DOB:_____SS#:_____

Ramsey County Resident: Yes □ No □
If yes, bring residency verification. (Anything with your name and address such as an electric bill, credit card bill, or a letter signed by you or who you live with to verify how long you have lived at your current address).

Address:_____

_____

Please provide verification of your address.
(Example: A copy of a lease or recent utility bill with your name on it, a copy of mail from the homeowner you are living with, or a signed statement from the homeowner that you currently live with).
If you are homeless please give your last permanent address with the dates you resided at that address.

Phone #_____Cell # _____

Gender:M □ F □

Race:_____1- Caucasion 2- African American 4- American Indian
5- Asian/Pacific Islander 8- Other 9- Unknown

Non-Reservation American Indian: Yes □ No □
Hispanic: Yes □ No □

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 Address:_____

Employer Name:_____

Employer Address_____

Policy/Name/Number:_____

Contact Person with Phone_____

Coverage Type:_____

Any Limitation/CO-Pay:_____

EMPLOYED: Yes □ No □ **what counts as income is listed below, please fill in amounts as specified and attach documentation or recent payment.** (Based on current month's income).

$_____Cash for Wages or Salary (attach last 2 pay stubs)
$_____Veterans Benefits
$_____GA, SSI Disability
$_____Private or Government pensions
$_____Insurance
$_____Unemployment Compensation
$_____Interest
$_____Rental income from rental owned properties
$_____Child Support
$_____Military Family Allotments
$_____Social Security
$_____Railroad Retirement
$_____Annuities
$_____Royalties

Household Size:_____
Income: _____(Total based on above check list)
Minus _____(Court ordered child support payment—include verification)
Total Income: $_____

Client Signature_____Date_____

Ramsey County reserves the right to terminate treatment immediately if any of above information is found to be fraudulent.

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 trough 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:_____DOB:_____Date_____

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