MINNESOTA DEPARTMENT of HUMAN SERVICES

DHS-2780-ENG 7-11

CLIENT PLACEMENT AUTHORIZATION (CPA) – CCDTF

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 (MMDDYYYY)	7. 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 NUMBER	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. CHEMICAL HEALTH #

Placement & Financial

19. CLIENT ADDRESS (ADDRESS, CITY, STATE, ZIP)	20. RACE 1 - White 4 - American Indian 8 – Other 2 – Black 5 - Asian/Pacific Islander 9 - Unknown

21. FINANCIALLY RESPONSIBLE PERSON (LAST NAME, 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 A = Adult with Minor P = Pregnant 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 - Distant 04. - Civil Commitment 99. - None 02 – Special Populations 06 – Child Protection	29. ANNUAL INCOME $	30. HOUSEHOLD SIZE

Service Line 1

31. PROCEDURE CODE (If applicable)	32. Modifiers	33. REVENUE CODE	34. DRUG CODE (if applicable) M= Methadone N= Naltrexone A= Antabuse 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 1/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%	

Service Line 2

31. PROCEDURE CODE (If applicable)	32. Modifiers	33. REVENUE CODE	34. DRUG CODE (if applicable) M= Methadone N= Naltrexone A= Antabuse 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 1/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%	

Service Lines 3 & 4

31. PROCEDURE CODE (If applicable)	32. Modifiers	33. REVENUE CODE	34. DRUG CODE (if applicable) M= Methadone N= Naltrexone A= Antabuse 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 1/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%	

Private Ins.

45. EMPLOYER NAME & ADDRESS	46. MEDICARE CLAIM #

47. HEALTH INSURANCE COMPANY NAME & ADDRESS	48. CERTIFICATE/POLICY #	49. GROUP NAME #	50. PRE-CERTIFICATION #

51. POLICYHOLDER NAME & ADDRESS (If not the client)	52. EMPLOYER OF 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 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)**:** _____ **Date:** _____

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

Green Copy – County, Tribe or Managed Care Organization White Copy - Client

Clear Form

Minnesota Department of **Human Services**

DHS-2794-ENG 12-13

Rule 25 Assessment and Placement Summary

CLIENT NAME	PMI
ASSESSOR	ASSESSMENT DATE

General Guideline

◯ Original ◯ Update

Clients should be offered the least restrictive referral consistent with sound clinical judgment. All items must be clearly documented in the Assessment Tool. This form must remain in the client file. Check the severity rating for each dimension and document the provider(s) who will meet the identified needs.

Dimension	Severity Rating	Provider Name and Contact Information
I Intoxication/ Withdrawal	◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 = Crisis	
II Biomedical	◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 = Crisis	
III Emotional/ Behavioral/ Cognitive	◯ 0 ◯ 1 ◯ 2 ◯ 3 = SC + R&B ◯ 4 = Crisis	
IV Readiness for Change	◯ 0 ◯ 1 ◯ 2 ◯ 3 = SC ◯ 4 = SC + R&B	
V Relapse and Continued Use	◯ 0 ◯ 1 ◯ 2 ◯ 3 = SC ◯ 4 = SC + R&B	
VI Recovery Environment	◯ 0 ◯ 1 ◯ 2 ◯ 3 = SC ◯ 4 = SC + R&B	
Service Coordination *(if required above)*		
Room & Board, if not paid for through the CCDTF *(if required above)*		