Hennepin County Rule 24 Eligibility Screening/Determination

Reason seeking assessment/treatment services/what is the primary drug of concern in the past 12 months.

From: Program Name/Location/Phone/Fax/contact person/ email

Application for SUD CCDTF/BH Funding

Today's Date:

Dates of service: Admission: Discharge (if known):

Client Name: Client Alias, if any

DOB: PMI# SS#

Marital Status Sex: Race: Language Hispanic?

Street Address:

City: County: State: Zip code:

Phone

Is this address a private residence? If not Describe

If in a facility where did you live prior to entering this facility?

If homeless where, how long etc.?

Do you have a county case manager/SW? If yes which county?

Household Size: Number of Adults: (count self and married spouse)
Number of children living with you under age 18 you parented or adopted:
Total Household size

Annual Household Gross Income (before taxes) (minus Court ordered child support):

Income Source:

None Job SSDI SSI GA MFIP Unemployment Other

Name of Employer:

Address:
Insurance Information

Client Signature Date Staff Signature Date