

CLIENT PLACEMENT AUTHORIZATION (CPA) - CCDTF

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

19. R.25 ASSESSMENT DATE ____/____/____		20. CD ASSESSMENT 1- Abusive <input type="checkbox"/> 2- Dependency <input type="checkbox"/>		21. RULE 25 LEVEL OF CARE DETERMINATION 1- Primary Inpatient <input type="checkbox"/> 2- Primary Outpatient <input type="checkbox"/>		3- Extended Care <input type="checkbox"/> 4- Halfway House <input type="checkbox"/> 5- Combination Inpatient Portion <input type="checkbox"/>		22. NON-RESERVATION AMERICAN INDIAN? (MOD1) UB= Yes <input type="checkbox"/> N= No <input type="checkbox"/>			
23. SPECIAL PLACEMENT CONSIDERATION N= None S= Sex M= Mental Illness P= Sexual Orientation R= Race A= Age H= Hearing Impaired I= Indian Health Service O= Other <input type="checkbox"/>				24. PLACEMENT EXCEPTION 01- Outpatient too far <input type="checkbox"/> 02- Cultural <input type="checkbox"/>		03- Age, Sex, Sexual Pref. <input type="checkbox"/> 04- Civil Commitment <input type="checkbox"/> 05- Fund Source Limits <input type="checkbox"/>		06- Child Protection <input type="checkbox"/> 07- Adol. Admit. Inpatient- Abuse Diagnosis <input type="checkbox"/> 08- Adol. Admit. Ext. Care- 3 Criteria <input type="checkbox"/>		09- Chronic <input type="checkbox"/> 10- Halfway House <input type="checkbox"/> 99- None <input type="checkbox"/>	
25. CLIENT ADDRESS (ADDRESS, CITY, STATE, ZIP) _____						26. RACE 1- White 4- Am. Indian 9- Unknown 2- Black 8- Other <input type="checkbox"/>		27. HAVE CLIENT INITIAL BOX IF CLIENT IS A MINOR AND APPROVES NOTIFICATION LETTERS BEING SENT TO THE FINANCIALLY RESPONSIBLE PERSON. <input type="checkbox"/>			

28. PROCEDURE CODE (if applicable) _____		29. REVENUE CODE _____		30. SERVICE START DATE ____/____/____		31. SERVICE END DATE ____/____/____		32. SERVICE RATE \$ _____		33. TOTAL # UNITS _____		34. TOTAL AMOUNT \$ _____	
35. PROVIDER NUMBER _____			36. PROVIDER NAME _____									37. _____	

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38. FINANCIALLY RESPONSIBLE PERSON (LAST NAME, FIRST, MI) _____				39. FINANCIALLY RESPONSIBLE PERSONS ADDRESS (ADDRESS, CITY, STATE, ZIP) (If not the client) _____				40. ANNUAL INCOME \$ _____			
41. HOUSEHOLD SIZE ____		42. LIMITED ELIGIBILITY M= Minor A= Adult with Minor P= Pregnant O= Other <input type="checkbox"/>		43. RESERVE FUND ELIGIBILITY E= Tier I/Entitled U= Tier II/Non-entitled V= Voucher O= Other (Must choose "Yes" in box 44) <input type="checkbox"/>		44. COUNTY PAY 100%? Y= County Will Pay 100% N= County Will Not Pay 100% <input type="checkbox"/>		45. _____			
46. EMPLOYER NAME & ADDRESS _____						47. MEDICARE CLAIM NUMBER _____					
48. HEALTH INSURANCE COMPANY NAME & ADDRESS _____				49. CERTIFICATE/POLICY NUMBER _____		50. GROUP NAME/NUMBER _____		51. PRE-CERTIFICATION NUMBER _____			
52. POLICYHOLDER NAME & ADDRESS (If not the client) _____				53. EMPLOYER OF POLICYHOLDER _____				54. 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): _____ Date: _____

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

PRIVACY of ALCOHOL and DRUG ABUSE RECORDS

State laws and federal rules protect your placement and treatment records. The federal rule is Title 42, part 2 of the Code of Federal Regulations. The state laws are Minnesota Statutes, chapter 13 and Minnesota Statutes, section 254A.09. The agency must not identify you to others without your consent. Your consent must be in writing.

You do not have to answer the questions on this form. However, the state will not pay for your treatment unless you answer the questions.

Your records are private. Agency employees working on your placement in treatment can see the records. Workers in this agency who arrange for payment have access to your records. Workers from the Minnesota Department of Human Services who send out treatment payments or check county records also have access to your records.

Your records may be released outside the agency with your consent. Your records may also be released under the following conditions:

1. You are not identified as an alcohol or drug abuser in any way. This means a treatment center that treats other problems can release your name, but not say you are receiving alcohol or drug services.
2. A court orders the release of records after a hearing.
3. The disclosure is made during a medical emergency to medical treatment providers.
4. The disclosure is made to an agency which provides services such as bill collecting to the program.
5. A child abuse or neglect report is made. The report identifies the child, the child's caretaker and the alleged abuser. The amount and type of abuse and the identity of the reporter are also in the report. The abuse may be reported to local welfare or police agencies.
6. Staff in this agency and the Minnesota Department of Human services need the information to do their jobs.

Your alcohol and drug abuse record normally may not be used in criminal investigations. Crimes in programs or against program workers may be reported to police. A threat to commit a crime also may be reported to police. A court may order release of records if the crime is very serious.

You have the right to see your record. You have the right to obtain a copy of your record. The agency may charge you for the cost of finding the record and making copies. If you only want to see the record, the agency must provide it at no cost.

Breaking the federal privacy rule is a crime. The penalty is a fine of not more than \$500 for the first offense and not more than \$5,000 for repeat offences.

Suspected violations may be reported to:

United States Attorney
Fourth Judicial District
District of Minnesota
110 South 4th Street, Room 514
Minneapolis, Minnesota 55401

You may complain if your record is wrong. You may also complain if your record is not complete. The agency must reply within 30 days. If you disagree with the agency's decision, you may appeal to the State Department of Administration. Your appeal should include:

1. Your name, address, and telephone number,
2. The name and address of the agency which has the records,
3. Description of the dispute and the date it happened, and
4. The relief you want.

If an agency breaks the state privacy law, you may also sue. Damages of not less than \$100 or not more than \$10,000 can be assessed by a court against the agency. Workers who break this law are guilty of a misdemeanor.

DISCRIMINATION COMPLAINT PROCESS

If you believe you have been discriminated against because of your race, color, creed, religion, national origin, disability, sex, sexual orientation, public assistance status, or age, while requesting or receiving alcohol or other drug abuse treatment services, you may file a discrimination complaint with one or more of the agencies listed below:

Minnesota Department of Human Services
Office for Equal Opportunity
444 Lafayette Road
St. Paul, MN 55155-3812

Minnesota Department of Human Rights
Army Corps of Engineers Center
190 East Fifth Street, Suite 700
St. Paul, MN 55101

U.S. Department of Health and Human Services
Office for Civil Rights, Region V-Chicago
233 North Michigan Avenue, Suite 240
Chicago, IL 60601-5519