SUBSTANCE USE DISORDER (SUD) VOUCHER INDIVIDUAL APPLICATION

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
BEHAVIORAL HEALTH DIVISION
SFN 783 (9-2016)

Clear Fields

Thank you for your interest in receiving services through the North Dakota Substance Use Disorder Voucher (SUD Voucher). The SUD Voucher is a state-funded program allowing individuals choice of substance use disorder treatment providers while improving access to quality services. All services reimbursed through the program will assist individuals to remain engaged in their substance use recovery while providing recovery oriented, person centered, and trauma informed care.

A Substance Use Disorder Treatment Provider will assist individuals in completing the application. The application must be completed in its entirety and signed by the individual and the Substance Use Disorder Treatment Provider. Please contact the Behavioral Health Division with any questions.

I. APPLICANT INFORMATION

Name (First, Middle Initial, Last)				
Date of Birth	Age	Social Security Number *	County	
Address		City	State	ZIP Code
Telephone Number	Cell Phone Number	Email Address		

Preferred Method of Receiving Documentation:
☐ Email ☐ Mail ☐ Other (specify):

* The Privacy Act of 1974 (P.L. 93-579, Section 7) requires the following information be provided when individuals are requested to disclose their social security numbers. Disclosure of the social security number is voluntary and it is requested for identification purposes. Failure to disclose this information will not affect participation in this program.

II. DEMOGRAPHIC INFORMATION**

Gender
☐ Male ☐ Female

Marital Status
☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Number of Children Under 18

Are you currently enlisted or have ever served in the military?
☐ Yes ☐ No

Living Environment
☐ Homeless ☐ Independent ☐ Dependent

Race
☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Hispanic or Latino
☐ Native Hawaiian or Other Pacific Islander ☐ Samoan ☐ White
☐ More than one race reported ☐ Unknown ☐ Prefer not to answer

Tribal Affiliation
☐ None ☐ Sisseton-Wahpeton Oyate Tribe ☐ Standing Rock Nation
☐ Three Affiliated Tribes ☐ Turtle Mountain Band of Chippewa ☐ Other

Education
☐ Some High School ☐ GED/High School Diploma ☐ Some College ☐ Associates Degree
☐ Bachelor's Degree ☐ Master's Degree or Higher

Previous Substance Disorder Treatment Services
☐ Yes ☐ No If yes, how many?

IV Drug Use in the Last Year
☐ Yes ☐ No

Pregnant
☐ Yes ☐ No

III. INCOME VERIFICATION

Annual Household Income (from last tax return)	Household Size	Income from Employment the last 90 Days
Are you employed? ☐ Yes ☐ No	Current Employer	Position

III. INCOME VERIFICATION (continued)

Other Sources of Income	Amount	Assets (savings account, CDs, equity)	Amount
☐ None		☐ None	
☐ Unemployment		☐ Savings Account	
☐ Pensions		☐ CD's	
☐ Social Security		☐ Equity	
☐ Retirement Accounts		☐ Other	
☐ Alimony Received			
☐ Net Farming and Fishing			
☐ Net Rental Royalty			
☐ Other-Type:			

IV. HEALTH CARE COVERAGE INFORMATION

Do you have Medicaid Coverage? ☐ Yes ☐ No ☐ N/A If no, are you eligible? ☐ Yes ☐ No ☐ Unknown If not covered, do you plan to apply? ☐ Yes ☐ No ☐ Unknown	Medicaid Number
If you applied for and were denied Medical Assistance, what was the reason?	
Do you have Medicare Coverage? ☐ Yes ☐ No ☐ N/A	Medicare Number

Name of Third Party Insurance Company (if covered)		Telephone Number	Fax Number
Address	City	State	ZIP Code
Name of Policy Holder		Telephone Number	Fax Number
Policy Number	Does the Insurance have a deductible? ☐ Yes ☐ No		Amount of Deductible

V. APPLICANT NEEDS

Description of Present Needs (include current symptoms, severity and nature of present needs): Please be as detailed as possible.

VI. APPLICANT SIGNATURE

I attest, subject to the penalties for perjury: a.) I am the individual completing this application; b.) I have provided accurate information; and c.) I do not have Medicaid and/or third party payment resources, or my Medicaid and/or third party resources will not cover all costs for treatment; and d.) I have a household income no greater than two hundred percent of federal poverty guidelines, or an Exception Request form (SFN 787) has been completed. I have signed a release to the Department and grant the Department access to treatment and payment records consistent with the confidentiality requirements found under title 42, Code of Federal Regulations, part 3 and title 45, Code of Federal Regulations, part 164.

Name	
Signature	Date

VII. PROVIDER SIGNATURE

I attest, subject to the penalties for perjury the individual applying for the voucher needs the services requested, and a) the individual does not have Medicaid and/or third party insurance, or the individual's Medicaid and/or third party payment resources will not cover all costs for services, or the individual has a medical assistance application pending; and b) the household income is no greater than two hundred percent of federal poverty guidelines, or an Exception Request Form has been completed.

Signature (your typed name will represent your signature)	Date
Provider/Organization Name	Certificate Number

** does not impact eligibility

Please submit application and questions in one of the three following ways to:
North Dakota Department of Human Services
Behavioral Health Division
Attn: SUD Vouchers

1. **Mail:** 1237 West Divide Avenue; Suite 1C
   Bismarck, ND 58501-1208

2. **Email:** sudvoucher@nd.gov

3. **Fax:** 701-328-8979