# SUBSTANCE USE DISORDER (SUD) VOUCHER INDIVIDUAL APPLICATION

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
BEHAVIORAL HEALTH
SFN 806 (10-2018)

Thank you for your interest in receiving services through the North Dakota Substance Use Disorder (SUD) Voucher. The SUD Voucher is a state-funded program allowing individuals choice of substance use disorder treatment providers while improve access to quality services.

## 1. Eligibility

| 1. Eighteen Years of Age or Older | 2. Resides in North Dakota | 3. Need Substance Use Disorder Services |
|---|---|---|
| ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |

4. Annual Income No Greater Than 200% of Federal Property Guidelines
☐ Yes ☐ No

| Household Size | 200% |
|---|---|
| 1 | $23,540 |
| 2 | $31,860 |
| 3 | $40,180 |
| 4 | $48,500 |

| Household Size | 200% |
|---|---|
| 5 | $56,820 |
| 6 | $65,140 |
| 7 | $73,460 |
| 8 | $81,780 |

If the above 4 questions are “yes” - you meet eligibility requirements for the SUD Voucher. The Behavioral Health Division will be in contact with you in 5 business days. Please proceed to **Section 2: Applicant Information**.

5. If Question 4 is No, please complete the following:

a. Identify Reason for Further Need of the SUD Voucher (Check all that apply)

- ☐ Medicaid Expansion Copay prohibits access to services
- ☐ Title XIX Circumstance (gap in coverage, waiting for application, etc.) prohibits access to services
- ☐ Insurance copay/deductible prohibits access to services
- ☐ Financial hardship prohibits access to services
- ☐ Other - Describe: ____________________

b. Monthly Income and Expenses (Must be completed and supportive documentation provided (child support, rent, utilities, collections, etc.). Use additional page if necessary.

| | Monthly Income | Monthly Expenses |
|---|---|---|
| | | |
| | | |
| | | |
| Total | | |

## 2. Applicant Information

| Name | Date of Birth | Social Security Number | |
|---|---|---|---|
| Address | City | State | ZIP Code |
| E-mail Address | Telephone Number | Cell Phone Number | |

Preferred Method of Receiving Approval Letter and Other Documentation
☐ Email ☐ Mail ☐ Other - Specify:

## 3. Demographic Information

| Gender | Marital Status |
|---|---|
| ☐ Male ☐ Female | ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed |

| Number of Children Under 18 | Served in the Military | Living Environment |
|---|---|---|
| | ☐ Yes ☐ No | ☐ Homeless ☐ Independent ☐ Dependent |

Race (check all that apply)
☐ American Indian or Alaska Native ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander
☐ Asian ☐ Hispanic or Latino ☐ Samoan ☐ White
☐ More Than One Race ☐ Unknown ☐ Prefer Not to Answer

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

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

| Previous Substance Use Disorder Treatment Services ☐ Yes ☐ No | If Yes, How Many | IV Drug Use in Last Year ☐ Yes ☐ No | Pregnant ☐ Yes ☐ No ☐ NA |
|---|---|---|---|

| Currently on Probation or Parole ☐ Yes ☐ No | Ever Been on Probation or Parole ☐ Yes ☐ No | Pending Legal Issues ☐ Yes ☐ No |
|---|---|---|

## 4. Healthcare Coverage Information

| Have Medicaid ☐ Yes ☐ No | If Yes, Medicaid Number | If No, Are You Eligible ☐ Yes ☐ No ☐ Unknown | If Not Covered, Plan to Apply ☐ Yes ☐ No |
|---|---|---|---|

| Medicare Coverage ☐ Yes ☐ No ☐ Unknown | If Yes, Medicare Number |
|---|---|

Third Party Insurance Coverage
☐ Yes ☐ No If yes, complete the following section

| Third Party Insurance Company Name | Telephone Number | FAX Number | |
|---|---|---|---|
| Address | City | State | ZIP Code |
| Policy Holder Name | Telephone Number | Policy Number | |

| Insurance Has a Deductible ☐ Yes ☐ No - Continue to Section 5 | If Yes, Amount of Deductible |
|---|---|

## 5. Income Verification (Skip this section if receiving Medicaid with an active Medicaid number)

| Annual Household Income (from last tax return) | Household Size | Income From Last 90 Days of Employment |
|---|---|---|

| Employed ☐ Yes ☐ No | If Yes, Current Employer | Position |
|---|---|---|

**Other Sources of Income** ☐ None

| Unemployment Income | Pension Income | Social Security Income | Retirement Account Income |
|---|---|---|---|

| Alimony Income | Net Farming & Fishing Income | Net Royalty Income | Other Income | Other Income Type |
|---|---|---|---|---|

**Assets (savings account, CDs, equity)** ☐ None

| Savings Account | CDs | Equity | Other Assets |
|---|---|---|---|

## 6. Signatures

I attest, subject to the penalties for perjury that I am the individual completing this application and I have provided accurate information.

| Typed Name to Represent Your Signature | Date |
|---|---|

**Please submit application and questions in one of the four 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 questions:** **sudvoucher@nd.gov**

3. **Email completed form:**

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