



**SUBSTANCE USE DISORDER (SUD) VOUCHER INDIVIDUAL APPLICATION**  
 NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES  
 BEHAVIORAL HEALTH DIVISION (BHD)  
 SFN 880 (7-2022)

Thank you for your interest in applying through the North Dakota Substance Use Disorder (SUD) Voucher. Our goal is to increase access to quality services for individuals to reach their full potential.

**The following information may be needed to complete this application:**

- Medicaid Number
  - If not receiving Medicaid, proof of income examples include tax returns, pay stubs, etc.
- Other forms of health insurance coverage information including:
  - Policy number
  - Deductible information
  - Contact information
  - Explanation of benefits
- Social Security Number \*

\* 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 number. Disclosure of your social security number (SSN) is voluntary and it is requested for identification purposes. Failure to disclose SSNs will not affect participation in the program but could possibly delay processing your request.

**SECTION 1: ELIGIBILITY**

Live in North Dakota <input type="checkbox"/> No <input type="checkbox"/> Yes	18 Years of Age or Older <input type="checkbox"/> No <input type="checkbox"/> Yes	14-17 Years of Age <input type="checkbox"/> No <input type="checkbox"/> Yes
If adolescent, is the parent/guardian financially responsible for services? <input type="checkbox"/> No <input type="checkbox"/> Yes - If yes, Section 3 must be completed. Release of Information form must be included with the application.		Release of Information form can be found at <a href="https://www.nd.gov/eforms/Doc/sfn01059.pdf">https://www.nd.gov/eforms/Doc/sfn01059.pdf</a>
Have Medicaid or Medicaid Expansion? <input type="checkbox"/> No <input type="checkbox"/> Yes	If Yes, List Medicaid Number	

**SECTION 2: APPLICANT INFORMATION**

Applicant Name (First, Middle, Last)		Date of Birth	Social Security Number*									
Physical Address		City	State	ZIP Code								
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Gender Non-Conforming	If female, are you pregnant? <input type="checkbox"/> No <input type="checkbox"/> Yes											
How did you learn about the SUD Voucher Program? <input type="checkbox"/> Friend <input type="checkbox"/> Website <input type="checkbox"/> Treatment Agency <input type="checkbox"/> Employer <input type="checkbox"/> Another SUD Voucher Participant												
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		Living Environment <input type="checkbox"/> Homeless <input type="checkbox"/> Independent <input type="checkbox"/> Dependent										
Number of Children You Have Under the Age of 18		Number of Children That Live With You										
Enrolled Tribal member <input type="checkbox"/> No <input type="checkbox"/> Yes - select the Tribe you are affiliated with: <table style="width: 100%; margin-left: 20px;"> <tr> <td><input type="checkbox"/> Spirit Lake Nation</td> <td><input type="checkbox"/> Turtle Mountain Band of Chippewa</td> </tr> <tr> <td><input type="checkbox"/> Sisseton-Wahpeton Oyate Tribe</td> <td><input type="checkbox"/> Standing Rock Nation</td> </tr> <tr> <td><input type="checkbox"/> Three Affiliated Tribes</td> <td><input type="checkbox"/> Other (specify): _____</td> </tr> </table>					<input type="checkbox"/> Spirit Lake Nation	<input type="checkbox"/> Turtle Mountain Band of Chippewa	<input type="checkbox"/> Sisseton-Wahpeton Oyate Tribe	<input type="checkbox"/> Standing Rock Nation	<input type="checkbox"/> Three Affiliated Tribes	<input type="checkbox"/> Other (specify): _____		
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<input type="checkbox"/> Three Affiliated Tribes	<input type="checkbox"/> Other (specify): _____											
Served in the Military <input type="checkbox"/> No <input type="checkbox"/> Yes												
Highest Level of Education <table style="width: 100%; margin-left: 20px;"> <tr> <td><input type="checkbox"/> Some Middle School</td> <td><input type="checkbox"/> Working Towards GED</td> <td><input type="checkbox"/> Some College</td> <td><input type="checkbox"/> Bachelor's Degree</td> </tr> <tr> <td><input type="checkbox"/> Some High School</td> <td><input type="checkbox"/> GED/High School Diploma</td> <td><input type="checkbox"/> Associates Degree</td> <td><input type="checkbox"/> Master's Degree or Higher</td> </tr> </table>					<input type="checkbox"/> Some Middle School	<input type="checkbox"/> Working Towards GED	<input type="checkbox"/> Some College	<input type="checkbox"/> Bachelor's Degree	<input type="checkbox"/> Some High School	<input type="checkbox"/> GED/High School Diploma	<input type="checkbox"/> Associates Degree	<input type="checkbox"/> Master's Degree or Higher
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Race (check all that apply)		
<input type="checkbox"/> American Indian or Alaskan Native	<input type="checkbox"/> Black or African American	<input type="checkbox"/> Native Hawaiian or Other Pacific Islander
<input type="checkbox"/> Asian	<input type="checkbox"/> Hispanic or Latino	<input type="checkbox"/> Samoan
<input type="checkbox"/> White	<input type="checkbox"/> Unknown	<input type="checkbox"/> Other
Received Substance Use Disorder Treatment Services in the Past		
<input type="checkbox"/> No <input type="checkbox"/> Yes - Number of times substance use disorder treatment was received in the past:		
If Adolescent, Currently Under Care of Division of Juvenile Services		Release of Information form can be found at <a href="https://www.nd.gov/efrms/Doc/sfn01059.pdf">https://www.nd.gov/efrms/Doc/sfn01059.pdf</a>
<input type="checkbox"/> No <input type="checkbox"/> Yes - Release of Information must be included with the application		
Engaged in IV Drug Use in the Past	If Adult, Currently on Probation or Parole	Pending Legal Issues
<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes

**SECTION 3: INCOME INFORMATION OF APPLICANT OR RESPONSIBLE PARTY**  
**(Do not need to complete this section if applicant currently has Medicaid/or Expansion)**

Household Size (includes applicant, spouse, and any other legal dependents listed on income tax forms, Include any children expected to live in your household in the next 9 months. If applicant is adolescent, include legal caregiver and spouse, and legally declared dependents, including children expected to live in household in next 9 months)			
Employed	If Yes, Place of Employment	If No, Last Date of Employment	Past 90 Days Income
<input type="checkbox"/> No <input type="checkbox"/> Yes			
Annual Household Income (money received from wages, self-employment wages, child support, social security benefits, and other retirement benefits) * Attach proof of income documents or images			

**SECTION 4: HEALTHCARE COVERAGE**

Currently have Healthcare Coverage Other than Medicaid/Medicaid Expansion?		
<input type="checkbox"/> No - Continue to Section 5 Contact Information Section	<input type="checkbox"/> Yes - Answer Healthcare/insurance questions below:	
Healthcare/Insurance Provider		
<input type="checkbox"/> North Dakota Medicaid Expansion	<input type="checkbox"/> Blue Cross Blue Shield of ND	
<input type="checkbox"/> North Dakota Medicaid	<input type="checkbox"/> Medicare	
<input type="checkbox"/> Self Pay		
<input type="checkbox"/> Other (specify): _____		
Policyholder Name	Start Date	Deductible Amount

**SECTION 5: CONTACT INFORMATION**

At times we may contact you to send out written communication. An example of this would be your approval letter or to gain feedback on our program.

Contact Method			
<input type="checkbox"/> E-mail	<input type="checkbox"/> Mail to My Personal Address	<input type="checkbox"/> Mail to an Alternate Address	
Mailing Address	City	State	ZIP Code
Email Address		Primary Telephone Number	
<b>Important Information Regarding Email:</b> If you choose to receive email communications, please be advised the security of email cannot be guaranteed. There is some risk that any protected health information or other confidential information contained in such email may be misdirected, disclosed to, or intercepted by an unauthorized third party. To reduce the risk, our emails are sent encrypted (secure) unless you specify below that you want to receive unencrypted (unsecure) email.			
By signing below, I am requesting to receive unencrypted (unsecure) email. I understand that unencrypted (unsecure) email means the added security protections that safeguard the contents of an email are removed. I understand and accept the risks associated with unencrypted (unsecure) email.			
Signature			Date

**SECTION 6: TREATMENT PROVIDER**

Have you selected a treatment program? <input type="checkbox"/> No <input type="checkbox"/> Yes	If Yes, Specify Primary Treatment Provider
If Working With More Than One Treatment Provider, Specify Other Provider	

**SECTION 7: MEDICAID REQUIREMENTS**

If you are approved for the SUD Voucher program, do not have Medicaid, and appear to meet the Medicaid eligibility requirements, an eligibility specialist will contact you to assist you with submitting a Medicaid application. To remain eligible for the SUD Voucher Program, you must complete all steps of the Medicaid application process. Individuals who do not complete the Medicaid application process will have their SUD Voucher program benefits discontinued.

I acknowledge and understand the Medicaid requirements and will follow through with the Medicaid application process.

**SECTION 8: SIGNATURE**

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

Signature	Date
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**Mail application to:**

North Dakota Department of Human Services  
 Behavioral Health Division  
 Attn: SUD Voucher  
 600 E Boulevard Ave. - Dept 325  
 Bismarck, ND 58505-0250

OR FAX application to: 701-328-8979

Questions can be emailed to: [sudvoucher@nd.gov](mailto:sudvoucher@nd.gov)