SUBSTANCE USE DISORDER (SUD) VOUCHER INDIVIDUAL APPLICATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES
BEHAVIORAL HEALTH DIVISION (BHD)
SFN 880 (4-2024)

Clear Fields

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 ☐ No ☐ Yes	18 Years of Age or Older ☐ No ☐ Yes	12-17 Years of Age ☐ No ☐ Yes
If adolescent, is the parent/guardian financially responsible for services? ☐ No ☐ Yes - If yes, Section 3 must be completed. Release of Information must be included with the application.		Release of Information form can be found at https://www.nd.gov/eforms/Doc/sfn01059.pdf
Have Medicaid or Medicaid Expansion? ☐ No ☐ 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 ☐ Male ☐ Female ☐ Gender Non-Conforming	If female, are you pregnant? ☐ No ☐ Yes		
How did you learn about the SUD Voucher Program? ☐ Friend ☐ Website ☐ Treatment Agency ☐ Employer ☐ Another SUD Voucher Participant			
Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	Living Environment ☐ Homeless ☐ Independent ☐ Dependent		
Number of Children You Have Under the Age of 18	Number of Children That Live With You		

Enrolled Tribal member
☐ No ☐ Yes - select the Tribe you are affiliated with:

☐ Spirit Lake Nation
☐ Sisseton-Wahpeton Oyate Tribe
☐ Three Affiliated Tribes
☐ Turtle Mountain Band of Chippewa
☐ Standing Rock Nation
☐ Other (specify):_____

Served in the Military
☐ No ☐ Yes

Highest Level of Education

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

Race (check all that apply)

☐ American Indian or Alaskan Native ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander
☐ Asian ☐ Hispanic or Latino ☐ Samoan
☐ White ☐ Unknown ☐ Other

Received Substance Use Disorder Treatment Services in the Past

☐ No ☐ Yes - Number of times substance use disorder treatment was received in the past:

If Adolescent, Currently Under Care of Division of Juvenile Serives

☐ No ☐ Yes - Release of Information must be included with the application

Release of Information form can be found at https://www.nd.gov/eforms/Doc/sfn01059.pdf

Engaged in IV Drug Use in the Past	If Adult, Currently on Probation or Parole	Pending Legal Issues
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ 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 30 Days Income
☐ No ☐ 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?

☐ No - Continue to Section 5 Contact Information Section ☐ Yes - Answer Healthcare/insurance questions below:

Healthcare/Insurance Provider

☐ North Dakota Medicaid Expansion ☐ Blue Cross Blue Shield of ND ☐ Self Pay
☐ North Dakota Medicaid ☐ Medicare ☐ 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

☐ E-mail ☐ Mail to My Personal Address ☐ Mail to an Alternate Address

Mailing Address	City	State	ZIP Code

Email Address	Primary Telephone Number

Important Information Regarding Email: 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? ☐ No ☐ 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

Mail application to:

Department of Health and 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