SUBSTANCE USE DISORDER (SUD) VOUCHER ADOLESCENT APPLICATION

DEPARTMENT OF HEALTH AND HUMAN SERVICES
BEHAVIORAL HEALTH DIVISION (BHD)
SFN 911 (6-2025)

Clear Fields

This application is for an individual who is 12 to 17 years old.

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

If you get approved for the SUD Voucher program and **don't already have Medicaid**, but it seems like you might qualify, someone who helps with Medicaid will call you to help you apply. If you **already have Medicaid but lose coverage**, you'll need to work with them to reinstate it. To keep getting help from the SUD Voucher program, you must complete the Medicaid application or reinstatement process. If you don't, you won't be able to get help from the SUD Voucher program anymore.

☐ **I agree that if I don't currently have Medicaid but seem eligible, I will apply for it. If I have Medicaid but lose coverage, I will work to reinstate it.**

The following information may be needed to complete this application:

- Medicaid ID (if you have Medicaid)
- Proof of your monthly income (pay stubs, tax return, etc.)
- Details about your income (wages, child support, retirement benefits, etc.)
- Social Security number (optional, but it helps process your application faster)

* 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.

APPLICANT INFORMATION

1. Name	2. Date of Birth	3. Social Security Number*

4. Primary Phone Number

5. Current Living Situation

☐ Homeless - You do not have regular, fixed housing. You may be staying at friends' houses, aunts/uncles/grandparents, or a shelter. (Go to Question 7)

☐ Independent - You are financially responsible for things like rent/mortgage payments, utilities, and food. No one else is helping to pay *these bills.* (Go to Question 6)

☐ Dependent - *You have regular, fixed housing and do not pay more than 50% of the bills for the household, including rent/mortgage, food and utilities.* (Go to Question 6)

6. Current Street Address	Apt. No.	City	State	ZIP Code

7. County of Residence

APPLICANT DEMOGRAPHICS

1. Gender	2. Are you currently pregnant?
☐ Male (Go to Question 3) ☐ Female ☐ Gender Non-Conforming	☐ Yes ☐ No

3. Number of children you have under the age of 18	How many live with you?

4. Race (check all that apply)

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

5. Are you an enrolled Tribal member?	6. Which Tribe are you enrolled in?	
☐ Yes	☐ MHA Nation	☐ Standing Rock Sioux Tribe
☐ No	☐ Sisseton-Wahpeton Oyate Tribe	☐ Turtle Mountain Band of Chippewa
	☐ Spirit Lake Nation	☐ My Tribe is not on the list

7. Veteran's Status
☐ I am a veteran or active member ☐ I am not a veteran or active member

8. Highest Level of Education Completed
☐ Some Middle School ☐ High School Diploma/GED ☐ Associate (2 year) Degree ☐ Masters Degree or Higher
☐ Some High School ☐ Certificate/Diploma (0.5-1 year degree) ☐ Bachelor (4 year) Degree

APPLICANT HISTORY

1. How did you learn about the SUD Voucher Program?
☐ Friend/Family Member ☐ Treatment Agency ☐ Another SUD Voucher Participant ☐ Legal Entity
☐ Website ☐ Employer ☐ Peer Support Specialist/Care Coordinator ☐ First Link/211

2. Have you received substance use disorder treatment in the past? ☐ Yes (Go to Question 3) ☐ No (Go to Question 4)	3. How many times?
4. Have you engaged in intravenous (IV) drug use in the past? ☐ Yes (Go to Question 5) ☐ No (Go to Question 6)	5. Have you done so in the last year? ☐ Yes ☐ No
6. Are you currently under the care of the Division of Juvenile Services? ☐ Yes ☐ No	7. Do you have any pending legal issues? ☐ Yes ☐ No

APPLICANT HEALTHCARE COVERAGE

1. Do you have healthcare coverage?
☐ Yes ☐ No (Go to Question 9)

2. Provider
☐ Blue Cross Blue Shield ☐ Medicaid Expansion ☐ Sanford Health
☐ Medicaid ☐ Medicare ☐ Other (specify): _____

3. Policy Number	4. Deductible
5. Policyholder Name	6. Policy Provider Phone Number
7. Policy Effective Date	8. Policy End Date (Go to next section)

9. Tell us about your current healthcare coverage situation

INCOME

1. Household Size *(includes applicant, any legally identified financially responsible caregivers, and legally identified financial dependents belonging to those caregivers mentioned. Including those dependents expected to live in the household in the next 9 months.)*

2. Are your legal caregivers currently employed?

☐ Yes	Place of Employment	☐ No	Date of Last Employment	Income in Last 30 Days

3. Annual Household Income *(include money received from wages, self-employment wages, child support, social security benefits, and other retirement benefits)*

Attach proof of income with application. Documents or photos of pay stubs, wages, tax return, child support, retirement, etc.

EXPENSES

Skip this section if you are on Medicaid or Medicaid Expansion.

List all monthly expenses for your household.

Expense Type	Expense Amount
Example: Rent	$1,200.00

CONTACT PREFERENCE

What is your preferred method for contact?

☐ Email — Email Address

☐ Mail to my address listed previously

☐ Mail to address below:

Current Street Address	Apt. No.	City	State	ZIP Code

TREATMENT PROVIDER

Are you already working with a treatment provider? ☐ No ☐ Yes	If Yes, Specify Your Primary Treatment Provider
If working with more than one treatment provider, list additional providers	

AUTHORIZATION TO DISCLOSE INFORMATION

We need this form to share information about substance use disorder (SUD) treatment.
If you are 14 or older, you need to sign to share your SUD information.
If you are younger than 14, both you and your parent need to sign to share your SUD information.
This form authorizes us to speak with your parent or guardian regarding your application. The authorization is in effect for one year after you sign it.

I _____ hereby authorize permission to **mutually exchange with the ND Department of Health and Human Services** the following information:
Name and other personal identifying information of individual receiving substance use disorder treatment services, behavioral health treatment information necessary to support services, level of care, and medical necessity including, diagnosis, screening, assessment, treatment plan, progress notes, urine analysis, discharge summary and billing and payment information.

The information identified above will be used for: **coordination of care/treatment/discharge planning, billing/payment, eligibility determination, collateral, and pertaining to SUD Voucher Program and Medicaid.**

This authorization is voluntary and remains in effect until the expiration date unless specifically revoked. This authorization may be revoked by written notice, at any time except to the extent that action has been taken in reliance on it. Refer to the Department's Notice of Privacy Practices for further description of revocation rights. Unless otherwise agreed in writing, information may be disclosed under this authorization in any form or medium, including verbal, written or electronic transmission. A photo copy of this authorization is as effective as the original.

Except for information protected under the federal regulations governing Confidentiality of Substance Use Disorder Patient Records, 42 C.F.R. Part 2, there is a potential for information disclosed pursuant to this authorization to be subject to re-disclosure by the recipient and no longer protected by state or federal privacy laws.

SUBSTANCE USE DISORDER INFORMATION is protected under the federal regulations governing Confidentiality of Substance Use Disorder Patient Records, 42 C.F.R. Part 2, and cannot be disclosed without written consent unless otherwise provided for in the regulations. In accordance with North Dakota law, the signature of a minor 14 years of age or older is required to disclose substance use disorder information. Both the signature of a minor 13 years of age or younger and the signature of the minor's legal representative is required to authorize the disclosure of substance use disorder information.

☐ I would like a copy of this Authorization to Disclose Information – one will be sent to your preferred contact method previously entered on this application form.

☐ I do not want a copy of this Authorization to Disclose Information.

SIGNATURE

☐ By checking this box I agree to provide additional information that may be requested by the SUD Voucher Administrative Team. I will provide this information within two weeks. If I do not provide the information, I acknowledge that my application will be removed from processing.

☐ By checking this box I agree I agree for my parent/guardian to be interviewed after submitting this application, to verify the information provided.

Applicant 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