APPLICATION FOR ELIGIBILITY DETERMINATION

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
BEHAVIORAL HEALTH DIVISION (BHD)
SFN 985 (9-2021)

Clear Fields

Community Connect is designed to assist individuals and families who may be experiencing difficult life circumstances to address any struggles and live a life at their full potential. The questions asked in this application will only be used to determine program eligibility.

For questions please email comconnect@nd.gov or visit https://www.behavioralhealth.nd.gov/community-connect.

PART I. PARTICIPANT INFORMATION (required)

We will be contacting you as part of the program, please ensure that your contact information is correct.

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

* PRIVACY STATEMENT: Disclosure of the social security number is voluntary and is requested for the purpose of accurate identification. Failure to disclose a social security number will not affect the disclosure of other information. The Department will not condition treatment on your agreement to authorize disclosure of your health information. The Department may, however, require that you authorize disclosure of your health information if needed to make a determination about your eligibility for benefits or enrollment in a Department health plan.

If you are a Free Through Recovery participant you are not eligible for Community Connect at this time and should not submit this application.
If you are a current Community Connect participant and want to transfer providers, do not submit this application. Contact an Administrator at (701) 298-4636 or email comconnect@nd.gov

PART II: PARTICIPANT DEMOGRAPHICS (optional)

Gender
☐ Male ☐ Female ☐ Non-Conforming ☐ Prefer not to Answer

Age

Served in Military
☐ Yes ☐ No

Highest Level of Education
☐ High School ☐ GED ☐ Some College ☐ Graduate ☐ Other

Race (check all that apply)
☐ American Indian or Alaskan Native
☐ Asian
☐ White
☐ Black or African American
☐ Unknown
☐ Native Hawaiian or Other Pacific Islander
☐ Samoan
☐ Other

Enrolled Tribal Member
☐ Yes-Specify Tribe: ☐ No
☐ Three Affiliated Tribes ☐ Spirit Lake Nation ☐ Standing Rock Sioux ☐ Turtle Mountain Chippewa
☐ Sisseton - Wahpeton Oyate ☐ Other

Marital Status
☐ Single, never been married ☐ Married ☐ Divorced ☐ Widowed

Employment Status
☐ Employed ☐ Unemployed ☐ Job Hunting ☐ Disabled

PART III: HEALTHCARE COVERAGE (required)

Currently have Healthcare Coverage
☐ Yes-Answer Healthcare/Insurance questions below: ☐ No-Continue to Part IV: Eligibility Criteria

Healthcare/Insurance Provider
☐ Sanford Health Medicaid Expansion
☐ Sanford Health Non-Medicaid Expansion
☐ Blue Cross/Blue Shield of ND
☐ Medicaid
☐ Medicare

PART IV: ELIGIBILITY CRITERIA (required)

Answer the following questions regarding your current situation. **The questions asked in this application will only be used to determine program eligibility.**

1. Are you the parent or primary caregiver for any children in your household under the age of 22?* ☐ Yes ☐ No	If Yes, Number of children

* Below are some scenarios to help guide your answer. These are only examples to help you answer this question.
- If you currently do not have physical custody of your children but are taking steps to gain custody of your children, this qualifies as yes.
- If you are living in a transitional facility or shelter where you cannot have your children but once you have housing your children will return to live with you, this qualifies as yes.
- I am working towards reunification with my children and will have custody or share custody with another parent or caregiver, this qualifies as yes.

2. Are you pregnant?
☐ Yes-what is your due date: ☐ No ☐ NA

RESIDENCY

3. Are you currently homeless or have been homeless in the past 6 months?
☐ Yes-skip to question 6 ☐ No

4. Are you currently living in a facility that provides shelter, such as a treatment facility or halfway house and do not have housing in the community arranged for after discharge?
☐ Yes-describe below and skip to question 6 ☐ No

If Yes, describe needs to be added

5. Are you currently at risk of becoming homeless?
At risk of homelessness means that you currently have a place to live or stay but you could become homeless. For example, you are living in an apartment/house, but haven't been able to pay your rent or mortgage and are at risk for eviction or foreclosure.
☐ Yes-describe below ☐ No

If Yes, describe

BEHAVIORAL HEALTH

6. Have you ever been diagnosed with any of the following substance abuse disorders:	**Yes**	**No**
Alcohol Use Disorder	☐	☐
Cannabis (Marijuana) Use Disorder	☐	☐
Opioid Use Disorder	☐	☐
Stimulant (amphetamine) Use Disorder	☐	☐
Other	☐	☐
None	☐	☐

Have you ever been diagnosed with any of the following mental health disorders:	Yes	No
Bipolar and Related Disorders	☐	☐
Borderline Personality Disorder	☐	☐
Delusional Disorder	☐	☐
Major Depressive Disorder	☐	☐
Obsessive Compulsive Disorder	☐	☐
Panic Disorder	☐	☐
Post-Traumatic Stress Disorder	☐	☐
Generalized Anxiety Disorder	☐	☐
Psychotic Disorders of all Types including Schizophrenia	☐	☐
Other	☐	☐
None	☐	☐

7. Have you ever had a hit to your head, had a lack of oxygen to the brain or been "knocked out"?
☐ Yes ☐ No ☐ Unsure

	Yes	No
8. Have you been to the Emergency Room or a detox center in the past 6 months?	☐	☐
If yes, decribe:		
9. Are you injecting illicit drugs via IV or have you in the past 6 months?	☐	☐

10. Are you currently or have you in the past 6 months working with child protective services through a local human service zone or tribal social service office? (If you are not a parent or primary caregiver for any children in your household under the age of 22 please select no.)
☐ Yes ☐ No ☐ Unsure

If Yes, describe

11. Currently or in the past 6 months has your substance use or mental health condition impacted your ability to maintain or obtain a place to live?

Below are some examples of how substance use and/or mental health conditions impact a person's ability to maintain or obtain a place to live. These are only examples to help you answer this question:

- I cannot pay my rent/mortgage because I cannot maintain employment due to the impact of my mental health or substance abuse.
- I am living in a transitional facility or shelter due to impacts from my substance abuse or mental health condition.
- I am living with a family member or friend, but I won't be able to for much longer due to my substance use or mental health.

☐ Yes-specify severity: ☐ No ☐ Unsure

☐ Significantly
☐ Some
☐ Minimally

If Yes, describe:

12. Currently or in the past 6 months has your substance use or mental health condition impacted your ability to maintain or secure employment or maintain financial stability?

Below are some examples of how substance use and/or mental health conditions impact a person's ability to maintain or secure employment or maintain financial stability. These are only examples to help you answer this question:

- I cannot make it to a job or job search due to the severity of my mental health or substance use.
- I had a job but was let go due to the impact from my substance use or mental health.
- I am unable to pay my bills due to my substance use or mental health.

☐ Yes-specify severity: ☐ No ☐ Unsure

- ☐ Significantly
- ☐ Some
- ☐ Minimally

If Yes, describe:

13. Currently or in the past 6 months has your substance use or mental health condition caused any physical health concerns?

Below are some examples of how substance use and/or mental health conditions impact a person's physical health. These are only examples to help you answer this question:

- I experience headaches, stomach aches or other physical health conditions due to my substance use or mental health.
- I have impaired kidney/liver/heart functioning due to my substance use.
- I engage in high risk behavior that led to a disease such as hepatitis, tuberculosis or another disease that is currently impacting my life.

☐ Yes-specify severity: ☐ No ☐ Unsure

- ☐ Significantly
- ☐ Some
- ☐ Minimally

If Yes, describe:

14. Currently or in the past 6 months has your substance use or mental health condition impacted your ability to parent?

Parenting includes your ability to discipline, communicate, spend time with, show affection, provide praise, and facilitate activities with your children. This includes your ability to provide for their shelter, food, clothing, medical care and protection from harm.

Below are some examples of how substance use and/or mental health conditions impact a person's ability to parent. These are only examples to help you answer this question:

- I cannot attend my child's school conferences or events due to my substance use or mental health.
- I have been incarcerated as a result of my substance use or mental health and unable to parent.
- I am not working due to my substance use or mental health condition and haven't been able to provide shelter, food or clothing for my children.

☐ Yes-specify severity: ☐ No ☐ Unsure ☐ NA (mark NA if you are not currently a parent or caregiver for a child under the age of 22 in your household)

- ☐ Significantly
- ☐ Some
- ☐ Minimally

If Yes, describe:

15. Currently or in the past 6 months has your substance use or mental health condition caused struggles with family or social relationships, or overall wellbeing not already described above?

Below are some examples of how substance use and/or mental health conditions impact a person's family and social relationships, or overall wellbeing not described above. These are only examples to help you answer this question:

- I no longer have a relationship with some family due to my substance use or mental health.
- I have lost friends or social connections due to my substance use or mental health.
- I do not have a community support system due to my substance use or mental health.

☐ Yes-specify severity: ☐ No ☐ Unsure

- ☐ Significantly
- ☐ Some
- ☐ Minimally

If Yes, describe:

16. In the past 6 months have you been continually worried or anxious about several events or activities in your daily life?

☐ Yes-answer question 17 ☐ No-proceed to question 18

17. Have these worries or anxieties prevented you from doing something you wanted to do?

☐ Yes ☐ No

If Yes, describe:

18. In the past 6 months, have you had thoughts of helplessness or hopelessness?

Below are some examples to help you answer this question. These are only examples.

- I feel like my life won't get better.
- I have lost interest in things that used to bring me joy.
- I feel worthless.

☐ Yes ☐ No

If Yes, describe:

19. In the past 6 months, have you had thoughts of wanting to die or killing yourself?

Below are some examples to help you answer this question. These are only examples.

- I hope I don't wake up in the morning.
- My family and friends would be better off without me.

☐ Yes ☐ No

If Yes, describe:

20. In the past 6 months, have you attempted suicide?

☐ Yes ☐ No

If Yes, describe:

PART V: SUICIDE PREVENTION LIFELINE

Most people who struggle with thoughts of suicide get better. Help and hope begins with talking about it. 1-800-273-TALK(8255)

PART VI: ALTERNATE CONTACT PERSON

21. Did an individual help you fill out this application or would you like to have an Alternate Contact Person listed that can be contacted regarding your application and any application information?

☐ Yes ☐ No

Alternate Contact Name	Relationship to Applicant	Telephone Number
Email Address		

☐ By checking this box, you are authorizing the North Dakota Department of Human Services, Behavioral Health Division to discuss this application and applicable information with the identified individual.

PART VII: SIGNATURES

I agree that my electronic signature is the legal equivalent of my handwritten 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 of Applicant	Date

If you are filling this application out with a current provider, or have already selected a community provider, please complete the authorization to disclose information below. Information regarding community providers can be found at https://www.behavioralhealth.nd.gov/community-connect under "Find a Provider". Once you have selected a provider please fill out the authorization to disclose information below with the name of the provider.

If you do not select a program provider, we will reach out to you after determining eligibility to assist you with selecting a community provider. You do not need to fill out the authorization below if you have not selected a community provider.

Department of Human Services Behavioral Health Division
Community Connect Program
Authorization to Disclose Information

As a participant in the Community Connect Program, I understand my treatment and recovery support services will be coordinated through the North Dakota Department of Human Services, Behavioral Health Division and my Community Connect Program Provider.

I authorize the North Dakota Department of Human Services, Behavioral Health Division and

Name of Provider

to mutually exchange the following information:

> Demographic information including name, address, phone number, date of birth, age, gender, and Social Security Number. Participant identification number; reason for referral and justification for care coordination and recovery support services; care plan including strengths and outcomes; identified goals and progress or lack of progress made toward goals; date, provider name, and type of care coordination or recovery support provided; progress of my identified outcomes regarding housing, financial, employment, and education; legal status; and such other information as is necessary to provide effective care coordination and recovery support services I receive.

The above information will be used for the purpose of facilitating the provision and payment of XFR care coordination and recovery support services, and the health care operations including, review, quality assessment, audit, and compliance of the program.

This authorization expires 30 days after program discharge.

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 photocopy 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.

By typing my name below, I am signing this authorization form electronically. I agree that my electronic signature is the legal equivalent of my handwritten 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 of Participant or Legal Representative	Date

Please email or mail this application to:
EMAIL: comconnect@nd.gov
MAIL: North Dakota Behavioral Health Division
600 East Boulevard Avenue, Dept 325
Bismarck ND 58505-0250

If you have any questions or need assistance with any portion of this application please call 701-328-8920 or email comconnect@nd.gov with any questions.