Ramsey County

Community Services

Application Date: ☐

Authorization: ☐

Chemical Health Services

Rule 25 Assessment Application

Name:____

DOB:__________________SS#:____________________

Ramsey County Resident: Yes ☐ No ☐

If yes, bring residency verification. (Anything with your name and address such as an electric bill, credit card bill, or a letter signed by you or who you live with to verify how long you have lived at your current address).

Address:____

____

Please provide verification of your address.

(Example: A copy of a lease or recent utility bill with your name on it, a copy of mail from the homeowner you are living with, or a signed statement from the homeowner that you currently live with).

If you are homeless please give your last permanent address with the dates you resided at that address.

Phone #__________________________Cell #______________________________

Gender: M ☐ F ☐

Race:__________ 1-Caucasion 2-African American 4-American Indian 5- Asian/Pacific Islander 8- Other 9- Unknown

Non-Reservation American Indian: Yes ☐ No ☐

Hispanic: Yes ☐ No ☐

DWI: Yes ☐ No ☐

Court Ordered Yes ☐ No ☐ What County:______________________________

What was the charge?____

Probation Officer:______________________________PO's Phone #________________

Medical Assistance (MA), General Assistance Medical Care (GAMC), or Minnesota Care:

Yes ☐ No ☐

(If checked yes, MA# :______________________)

Chemical Health Services

Private Insurance or HMO coverage: Yes ☐ No ☐
(If yes, please complete the following or send a copy of your insurance card).

Insurance Company Name:______________________________

Insurance Address:______________________________

Employer Name:______________________________

Employer Address______________________________

Policy/Name/Number:______________________________

Contact Person with Phone______________________________

Coverage Type:______________________________

Any Limitation/CO-Pay:______________________________

EMPLOYED: Yes ☐ No ☐ **what counts as income is listed below, please fill in amounts as specified and attach documentation or recent payment.** (Based on current month's income).

$______________Cash for Wages or Salary (attach last 2 pay stubs)
$______________Veterans Benefits
$______________GA, SSI Disability
$______________Private or Government pensions
$______________Insurance
$______________Unemployment Compensation
$______________Interest
$______________Rental income from rental owned properties
$______________Child Support
$______________Military Family Allotments
$______________Social Security
$______________Railroad Retirement
$______________Annuities
$______________Royalties

Household Size:______________
Income: ______________(Total based on above check list)
Minus ______________(Court ordered child support payment—include verification)
Total Income: $______________

Client Signature______________________________Date______________

Ramsey County reserves the right to terminate treatment immediately if any of the above information is found to be fraudulent.

Phone: 651-266-4008 Fax: 651-266-4435

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Chemical Health Services

Statement of Income and Health Care Benefits

I,____, confirm that on this date______________________I do not have a source of financial income trough employment or other sources. I, also, do not have health insurance coverage of any kind and am in need of Rule 25 assistance to complete an appropriate treatment placement.

Client:____DOB:__________________Date___________________

Note: Provider information that is inaccurate or untrue is fraudulent and may be investigated.