Clear Form

MINNESOTA DEPARTMENT of HUMAN SERVICES

CLIENT PLACEMENT AUTHORIZATION (CPA) - CCDTF

DHS-2780-ENG 6-11

1. AGREEMENT START DATE	2. AGREEMENT END DATE	3. PMI# (RECIP ID)	4. CLIENT NAME (LAST NAME, FIRST, MI)	
5. CLIENT ALIAS, if any	6. DOB (MM/DD/YYYY)	7. CO/TRIBE OF SERVICE DELIVERY	8. COUNTY OF RESIDENCE	9. CO/TRIBE OF FINANCIAL RESPONSIBILITY
10. DATE OF SIGNATURE	11. AUTHORIZED COUNTY/TRIBAL SIGNATURE	12. SOCIAL SECURITY #	13. LANGUAGE	14. HISPANIC? Y = Yes N = No ☐
15. MARITAL STATUS D = Divorced L = Legally Separated M = Married N = Never Married S = Living Apart U = Unknown W = Widowed ☐	16. GENDER M = Male F = Female ☐	17. A NOTIFICATION LETTER IS AUTOMATICALLY SENT TO THE CLIENT. CHECK THE BOX IF CLIENT DOESN'T WANT A LETTER SENT. ☐	18. SERVICE AGREEMENT #	

Placement & Financial

19. CLIENT ADDRESS (ADDRESS, CITY, STATE, ZIP)		20. RACE 1 = White 2 = Black 4 = American Indian 5 = Asian/Pacific Islander 8 = Other 9 = Unknown ☐
21. FINANCIALLY RESPONSIBLE PERSON (LAST, FIRST, MI)	22. FINANCIALLY RESPONSIBLE PERSONS ADDRESS (ADDRESS, CITY, STATE, ZIP) (if different than the client)	
23. RULE 25 ASSESSMENT DATE	24. ASSESSMENT SEVERITY RATINGS (0-4) I ☐ II ☐ III ☐ IV ☐ V ☐ VI ☐	25. LIMITED ELIGIBILITY M = Minor P = Pregnant A = Adult with Minor O = Other ☐ / 26.
27. HAVE CLIENT INITIAL BOX IF CLIENT IS A MINOR AND APPROVES NOTIFICATION LETTERS BEING SENT TO THE FINANCIALLY RESPONSIBLE PERSON ☐	28. PLACEMENT EXCEPTION 01 = Distance 02 = Special Populations 04 = Civil Commitment 08 = Adolescent 99 = None ☐	29. ANNUAL INCOME $_____ / 30. HOUSEHOLD SIZE __ __

Service Line 1

31. PROCEDURE CODE (if applicable)	32. MODIFIER(S) __ __ /__ __ /__ __ /__ __	33. REVENUE CODE	34. DRUG CODE (if applicable) M = Methadone A = Antabuse N = Naltrexone B = Buphenorphine ☐	35. SERVICE START DATE	36. SERVICE END DATE	37. SERVICE RATE $_____
38. TOTAL # UNITS ___ ___ ___	39. TOTAL AMOUNT $_____	40. NPI # ___ ___ ___ ___ ___ ___ ___ ___ ___ ___	41. PROVIDER NAME			
42. PROVIDER ADDRESS & TAXONOMY/CONTRACT ID (if necessary)		43. RESERVE FUND ELIGIBILITY E = Tier I/Entitled V = Voucher O = Other (Must choose "Y" in box 43) ☐	44. COUNTY PAY 100% Y = County Will Pay 100% N = County will Not Pay 100% ☐			

Service Line 2

31. PROCEDURE CODE (if applicable) __ __ __ __ __	32. MODIFIER(S) __ __ /__ __ /__ __ /__ __	33. REVENUE CODE __ __ __ __	34. DRUG CODE (if applicable) M = Methadone A = Antabuse N = Naltrexone B = Buphenorphine ☐	35. SERVICE START DATE ___ / ___ / ___	36. SERVICE END DATE ___ / ___ / ___	37. SERVICE RATE $_____
38. TOTAL # UNITS ___ ___ ___	39. TOTAL AMOUNT $_____	40. NPI # ___ ___ ___ ___ ___ ___ ___ ___ ___ ___	41. PROVIDER NAME			
42. PROVIDER ADDRESS & TAXONOMY/CONTRACT ID (if necessary)		43. RESERVE FUND ELIGIBILITY E = Tier I/Entitled V = Voucher O = Other (Must choose "Y" in box 43) ☐	44. COUNTY PAY 100% Y = County Will Pay 100% N = County will Not Pay 100% ☐			

Service Line 3

31. PROCEDURE CODE (if applicable) __ __ __ __ __	32. MODIFIER(S) __ __ /__ __ /__ __ /__ __	33. REVENUE CODE __ __ __ __	34. DRUG CODE (if applicable) M = Methadone A = Antabuse N = Naltrexone B = Buphenorphine ☐	35. SERVICE START DATE ___ / ___ / ___	36. SERVICE END DATE ___ / ___ / ___	37. SERVICE RATE $_____
38. TOTAL # UNITS ___ ___ ___	39. TOTAL AMOUNT $_____	40. NPI # ___ ___ ___ ___ ___ ___ ___ ___ ___ ___	41. PROVIDER NAME			
42. PROVIDER ADDRESS & TAXONOMY/CONTRACT ID (if necessary)		43. RESERVE FUND ELIGIBILITY E = Tier I/Entitled V = Voucher O = Other (Must choose "Y" in box 43) ☐	44. COUNTY PAY 100% Y = County Will Pay 100% N = County will Not Pay 100% ☐			

Private Ins.

45. EMPLOYER NAME AND ADDRESS			46. MEDICARE CLAIM #
47. HEALTH INSURANCE COMPANY NAME AND ADDRESS	48. CERTIFICATE/POLICY #	49. GROUP NAME #	50. PRE-CERTIFICATION #
51. POLICYHOLDER NAME AND ADDRESS (if not the client)	52. EMPLOYER OR POLICYHOLDER		53. RELATIONSHIP TO CLIENT

I certify that to the best of my knowledge and belief, the information provided above is complete and correct. I understand that if the information provided is false or incomplete, I may be responsible for the total cost of treatment provided. I authorize access to medical information needed to determine health care and/or Medicare benefits payable for chemical dependency services. I authorize payment of any third party benefits directly to the Department of Human Services. This authorization expires one year from the date services were rendered. I understand that I may revoke this authorization at any time except to the extent that actions have taken in advance of my revocation. If I revoke this authorization, I may be responsible for the total cost of treatment.

Client Signature (Parent/Guardian if Client is a minor): _____ **Date:** _____

Financially Responsible Person Signature _____ **Date:** _____
(and/or Policyholder if not the Client)

Green Copy - County, Tribe or Managed Care Organization White Copy - Client

Privacy of Alcohol and Drug Abuse Records

State laws and federal rules protect your placement and treatment records. The federal rule is Title 42, part 2 of the Code of Federal Regulations. The state laws are Minnesota Statutes, chapter 13 and Minnesota Statutes, section 254A.09. The agency must not identify you to others without your consent. Your consent must be in writing.

You do not have to answer the questions on this form. However, the state will not pay for your treatment unless you answer the questions.

Your records are private. Agency employees working on your placement in treatment can see the records. Workers in this agency who arrange for payment have access to your records. Workers from the Minnesota Department of Human Services who send out treatment payments or check county records also have access to your records.

Your records may be released outside the agency with your consent. Your records may also be released under the following conditions:

1. You are not identified as an alcohol or drug abuser in any way. This means a treatment center that treats other problems can release your name, but not say you are receiving alcohol or drug services.
2. A court orders the release of records after a hearing.
3. The disclosure is made during a medical emergency to medical treatment providers.
4. The disclosure is made to an agency which provides services such as bill collecting to the program.
5. A child abuse or neglect report is made. The report identifies the child, the child's caretaker and the alleged abuser. The amount and type of abuse and the identity of the reporter are also in the report. The abuse may be reported to local welfare or police agencies.
6. Staff in this agency and the Minnesota Department of Human services need the information to do their jobs.

Your alcohol and drug abuse record normally may not be used in criminal investigations. Crimes in programs or against program workers may be reported to police.
A threat to commit a crime also may be reported to police. A court may order release of records if the crime is very serious.

You have the right to see your record. You have the right to obtain a copy of your record. The agency may charge you for the cost of finding the record and making copies. If you only want to see the record, the agency must provide it at no cost.

Breaking the federal privacy rule is a crime. The penalty is a fine of not more than $500 for the first offense and not more than $5,000 for repeat offences.

Suspected violations may be reported to:

United States Attorney
District of Minnesota
300 South 4th Street, Room 600
Minneapolis, Minnesota 55401

You may complain if your record is wrong. You may also complain if your record is not complete. The agency must reply within 30 days.
If you disagree with the agency's decision, you may appeal to the State Department of Administration. Your appeal should include:

1. Your name, address, and telephone number,
2. The name and address of the agency which has the records,
3. Description of the dispute and the date it happened, and
4. The relief you want.

If an agency breaks the state privacy law, you may also sue. Damages of not less than $100 or not more than $10,000 can be assessed by a court against the agency. Workers who break this law are guilty of a misdemeanor.

Discrimination Complaint Process

If you believe you have been discriminated against because of your race, color, creed, religion, national origin, disability, sex, sexual orientation, public assistance status, or age, while requesting or receiving alcohol or other drug abuse treatment services, you may file a discrimination complaint with one or more of the agencies listed below:

Minnesota Department of Human Services
Office for Equal Opportuniity
PO Box 64997
St. Paul, MN 55164-0997
Minnesota Department of Human Rights

Army Corps of Engineers Center
190 East Fifth Street, Suite 700
St. Paul, MN 55101

U.S. Department of Health and Human Services
Office for Civil Rights, Region V-Chicago
233 North Michigan Avenue, Suite 240
Chicago, IL 60601-5519

Attention. If you want free help translating this information, ask your worker or call the number below for your language.

ملاحظة: إذا أردت مساعدة مجانية في ترجمة هذه المعلومات، فاسأل مساعدك في مكتب الخدمة الاجتماعية أو اتصل على الرقم 1-800-358-0377.

កំណត់សំគាល់ បើអ្នកចង់បានជំនួយបកប្រែពត៌មាននេះដោយមិនគិតថ្លៃ សូមសួរអ្នកកាន់សំណុំរឿងរបស់អ្នក ឬ ទូរស័ព្ទទៅលេខ 1-888-468-3787 ។

Pažnja. Ako vam je potrebna besplatna pomoć za prevod ove informacije, pitajte vašeg radnika ili nazovite 1-888-234-3785.

Ceeb toom. Yog koj xav tau kev pab txhais cov xov no rau koj dawb, nug koj tus neeg lis dej num (worker) lossis hu 1-888-486-8377.

ໂປດຊາບ. ຖ້າຫາກທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປຂໍ້ຄວາມດັ່ງກ່າວນີ້ຟຣີ, ຈົ່ງຖາມນຳພນັກງານຊ່ວຍງານ ຂອງທ່ານຫຼືໂທຣ໌ຫາຕາມເລກໂທຣ໌ 1-888-487-8251.

Hubaddhu. Yoo akka odeeffannoon kun sii hiikamu gargaarsa tolaa feeta ta'e, hojjataa kee gaafaddhu ykn lakkoofsa kana bilbili 1-888-234-3798.

Внимание: если вам нужна бесплатная помощь в переводе этой информации, обратитесь к своему социальному работнику или позвоните по следующему телефону: 1-888-562-5877.

Ogow. Haddii aad dooneyso in lagaa kaalmeeyo tarjamadda macluumaadkani oo lacag la'aan ah, weydii hawl-wadeenkaaga ama wac lambarkan 1-888-547-8829.

Atención. Si desea recibir asistencia gratuita para traducir esta información, consulte a su trabajador o llame al 1-888-428-3438.

Chú Ý. Nếu quý vị cần dịch thông tin nầy miễn phí, xin gọi nhân-viên xã-hội của quý vị hoặc gọi số 1-888-554-8759.

LB2-0001 (10-09)

ADA4 (5-09)

This information is available in alternative formats to individuals with disabilities by calling (651) 431-2460. TTY users can call through Minnesota Relay at (800) 627-3529. For Speech-to-Speech, call (877) 627-3848. For additional assistance with legal rights and protections for equal access to human services programs, contact your agency's ADA coordinator.