MINNESOTA DEPARTMENT of HUMAN SERVICES

DHS-2780-ENG 7-11

CLIENT PLACEMENT AUTHORIZATION (CPA) – CCDTF

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 (MMDDYYYY)	7. 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 NUMBER	13. LANGUAGE	14. HISPANIC?
/ /		- -		Y = Yes N = No

15. MARITAL STATUS	16. GENDER	17. A NOTIFICATION LETTER IS AUTOMATICALLY SENT TO THE CLIENT. CHECK THE BOX IF CLIENT DOESN'T WANT A LETTER SENT.	18. CHEMICAL HEALTH #
D = Divorced L = Legally separated M = Married N = Never Married S = Living Apart U = Unknown W = Widowed	M = Male F = Female		

Placement & Financial

19. CLIENT ADDRESS (ADDRESS, CITY, STATE, ZIP)	20. RACE
	1 - White 4 - American Indian 8 – Other 2 – Black 5 - Asian/Pacific Islander 9 - Unknown

21. FINANCIALLY RESPONSIBLE PERSON (LAST NAME, 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)	25. LIMITED ELIGIBILITY	26.
/ /	I II III IV V VI	M = Minor A = Adult with Minor P = Pregnant O = Other	

27. HAVE CLIENT INITIAL BOX IF CLIENT IS A MINOR AND APPROVES NOTIFICATION LETTERS BEING SENT TO THE FINANCIALLY RESPONSIBLE PERSON	28. PLACEMENT EXCEPTION	29. ANNUAL INCOME	30. HOUSEHOLD SIZE
	01 - Distant 04. - Civil Commitment 99. - None 02 – Special Populations 06 – Child Protection	$	

Service Line 1

31. PROCEDURE CODE (If applicable)	32. MODIFIER(S)	33. REVENUE CODE	34. DRUG CODE (if applicable) M= Methadone N= Naltrexone A= Antabuse B= Buphenorphine		35. SERVICE START DATE	36. SERVICE END DATE	37. SERVICE RATE
H2035	HQ/ / /				/ /	/ /	$ 35.03

38. TOTAL # UNITS	39. TOTAL AMOUNT	40. NPI #	41. PROVIDER NAME
	$	1992152821	Evergreen Recovery

42. PROVIDER ADDRESS & TAXONOMY/CONTRACT ID (if necessary)	43. RESERVE FUND ELIGIBILITY		44. COUNTY PAY 100%?	
1400 Energy Park Dr-Ste 21 Saint Paul, MN 55108	E= Tier 1/Entitled V= Voucher O = Other (Must choose "Y" in box 43)		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 N= Naltrexone A= Antabuse B= Buphenorphine		35. SERVICE START DATE	36. SERVICE END DATE	37. SERVICE RATE
H2035	/ / /				/ /	/ /	$ 72.11

38. TOTAL # UNITS	39. TOTAL AMOUNT	40. NPI #	41. PROVIDER NAME
	$	1992152821	Evergreen Recovery

42. PROVIDER ADDRESS & TAXONOMY/CONTRACT ID (if necessary)	43. RESERVE FUND ELIGIBILITY		44. COUNTY PAY 100%?	
1400 Energy Park Dr-Ste 21 Saint Paul, MN 55108	E= Tier 1/Entitled V= Voucher O = Other (Must choose "Y" in box 43)		Y = County Will Pay 100% N = County Will Not Pay 100%	

Service Lines 3 & 4

31. PROCEDURE CODE (If applicable)	32. MODIFIER(S)	33. REVENUE ODE	34. DRUG CODE (if applicable) M= Methadone N= Naltrexone A= Antabuse B= Buphenorphine		35. SERVICE START DATE	36. SERVICE END DATE	37. SERVICE RATE
T1016 H0038	U8/HN/ /U8				/ / / /	/ / / /	$ 11.71 $ 15.02

38. TOTAL # UNITS	39. TOTAL AMOUNT	40. NPI #	41. PROVIDER NAME
	$ $	1992152821	Evergreen Recovery

42. PROVIDER ADDRESS & TAXONOMY/CONTRACT ID (if necessary)	43. RESERVE FUND ELIGIBILITY		44. COUNTY PAY 100%?	
1400 Energy Park Dr-Ste 21 Saint Paul, MN 55108	E= Tier 1/Entitled V= Voucher O = Other (Must choose "Y" in box 43)		Y = County Will Pay 100% N = County Will Not Pay 100%	

Private Ins.

45. EMPLOYER NAME & ADDRESS	46. MEDICARE CLAIM #

47. HEALTH INSURANCE COMPANY NAME & ADDRESS	48. CERTIFICATE/POLICY #	49. GROUP NAME #	50. PRE-CERTIFICATION #

51. POLICYHOLDER NAME & ADDRESS (If not the client)	52. EMPLOYER OF 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 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