DEPARTMENT OF HUMAN SERVICES

DHS-2780A-ENG 10-21

BEHAVIORAL HEALTH DIVISION

Behavioral Health Fund Request (BHF)

1. FINANCIAL ELIGIBILITY START DATE (DATE OF COMP ASSESSMENT OR AFTER)	2. PMI NUMBER (RECIPIENT ID), IF ANY		
3. CLIENT LAST NAME	FIRST NAME	MI	
4. CLIENT ADDRESS	CITY	STATE	ZIP CODE

5. RACE
◯ 1 = White ◯ 2 = Black ◯ 4 = American Indian ◯ 5 = Asian or Pacific Islander ◯ 8 = Other ◯ 9 = Unknown

6. CLIENT ALIAS, IF ANY	7. DATE OF BIRTH	8. COUNTY OF RESIDENCE	9. SOCIAL SECURITY NUMBER
10. LANGUAGE	11. HISPANIC ◯ Yes ◯ No	12. MARITAL STATUS	13. GENDER ◯ Male ◯ Female

Financial

14. FINANCIALLY RESPONSIBLE PERSON LAST NAME	FIRST NAME	MI	
15. FINANCIALLY RESPONSIBLE PERSON'S ADDRESS (if different from client)	CITY	STATE	ZIP CODE

16. LIMITED ELIGIBLITY
◯ M = Minor ◯ A = Adult with Minor ◯ P = Pregnant ◯ O = Other

17. ANNUAL INCOME (PER SFY ELIG GUIDELINES)	18. HOUSEHOLD SIZE (PER SFY ELIG GUIDELINES)

Private Insurance

19. EMPLOYER NAME			
STREET ADDRESS	CITY	STATE	ZIP CODE
20. MEDICARE CLAIM NUMBER			
21. HEALTH INSURANCE COMPANY NAME			
STREET ADDRESS	CITY	STATE	ZIP CODE

22. CERTIFICATE OR POLICY NUMBER	23. GROUP NAME NUMBER	24. PRE-CERTIFICATION NUMBER

25. POLICYHOLDER NAME			
STREET ADDRESS	CITY	STATE	ZIP CODE
26. 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 substance use 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.

27. CLIENT SIGNATURE	28. DATE
29. FINANCIALLY RESPONSIBLE PERSON SIGNATURE (AND/OR POLICYHOLDER IF NOT THE CLIENT)	30. DATE

CONTACT NAME	PHONE NUMBER	FAX NUMBER	EMAIL ADDRESS

Instructions for completing the BHF Request (DHS-2780A)

Box 1. Financial Eligibility Start Date – Enter the start date as the first billable date of service. This could be the date of the comprehensive assessment or the first date of treatment services provided. The date of the comprehensive assessment must be included in this span in order for the provider to be paid for it.

Box 2. PMI Number, if any – Recipient PMI can be found in MN-Its Eligibility Search by doing a search of a combination of the recipient's name, date of birth, and social security number. If one is not found in MN-Its eligibility search then leave this field blank and the County/Tribe will set the client up with one. Providers must search in MN-Its eligibility search to find the new PMI number after the County/Tribe assigns one for the client.

Box 3. PMI Number, if any – Recipient PMI can be found in MN-Its Eligibility Search by doing a search of a combination of the recipient's name, date of birth, and social security number. If one is not found in MN-Its eligibility search then leave this field blank and the County/Tribe will set the client up with one. Providers must search in MN-Its eligibility search to find the new PMI number after the County/Tribe assigns one for the client.

Box 4. PMI Number, if any – Client Address, City, State, Zip Code – Enter the clients address as reported by the client.

Box 5. Race – Check the box representing the race of the client as reported by the client.

Box 6. Client Alias, if any – Enter any other name this client has been known as previously such as nicknames, maiden names, prior married names, etc.

Box 7. Date of Birth – Enter the client's date of birth as reported by the client.

Box 8. County of Residence – Enter the three digit county code from the drop down menu that represents the county in which the client currently resides.

Box 9. Social Security Number – Enter SSN as reported by client

Box 10. Language – Enter the language the client understands best as reported by the client

Box 11. Hispanic – Check whether the client is Hispanic or not.

Box 12. Marital Status – Enter a valid value from the drop down menu that best describes the client's marital status.

Box 13. Enter the gender in which the client associates with most. This field is in the process of being updated to be more inclusive and the form will be updated as appropriate.

Box 14. Financially Responsible Person Last Name, First Name, Middle initial – Enter the full name of the financially responsible person

Box 15. Financially Responsible Person's Address, City, State, Zip Code if different from client – Enter the full address of the financially responsible person if different than that of the client.

Box 16. Limited Eligibility – choose one of the valid values to identify the eligibility of the client.

Box 17. Annual Income – (link to annual income guidelines on our website) Enter the annual income calculated prospectively from the date of the first date of service forward one year. This is different from the MA determinations which calculate retrospectively, BHF calculates forward one year. This allows a recipient to gain immediate funding for their treatment needs under BHF and then pursue Medicaid enrollment while receiving treatment. Upon retro MA approval, previously paid claims will be reprocessed under MA so that no county share is applied.

Box 18. Household Size – (link to annual income guidelines) Enter the number of people in the household as defined as such on the Income Guidelines

Box 19. Employer Name and Address– Enter the name and address of the employer where the insurance is issued

Box 20. Medicare Claim Number – Enter the Medicare claim number assigned for a Medicare enrolled recipient

Box 21. Health Insurance Company Name and address – Enter the name and address of the health insurance company

Box 22. Certificate or Policy Number – Enter the insurance certificate or policy number

Box 23. Group Name Number – Enter the insurance group name or number

Box 24. Pre-Certification Number -

Box 25. Policyholder Name and address – Enter the name and address of the Insurance policyholder

Box 26. Relationship to client – Enter one of the following values:

1. Self
2. Spouse
3. Child

Box 27. Client signature – Client signs attesting the statement above is accurate and authorizing third party billing

Box 28. Date of client signature

Box 29. Financially responsible persons signature – have the financially responsible person sign if not the client

Box 30. Date of financially responsible person's signature

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 Opportunity
PO Box 64997
St. Paul, MN 55164-0997
Minnesota Department of Human Rights

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 need free help interpreting this document, call the above number.

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ملاحظة: إذا أردت مساعدة مجانية لترجمة هذه الوثيقة، اتصل على الرقم أعلاه.

သတိ။ ဤစာရွက်စာတမ်းအားအခမဲ့ဘာသာပြန်ပေးခြင်း အကူအညီလိုအပ်ပါက၊ အထက်ပါဖုန်းနံပါတ်ကိုခေါ်ဆိုပါ။

កំណត់សំគាល់ ។ បើអ្នកត្រូវការជំនួយក្នុងការបកប្រែឯកសារនេះដោយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទតាមលេខខាងលើ ។

請注意，如果您需要免費協助傳譯這份文件，請撥打上面的電話號碼。

Attention. Si vous avez besoin d’une aide gratuite pour interpréter le présent document, veuillez appeler au numéro ci-dessus.

Thov ua twb zoo nyeem. Yog hais tias koj xav tau kev pab txhais lus rau tsab ntaub ntawv no pub dawb, ces hu rau tus najnpawb xov tooj saum toj no.

ဟ်သူဉ်ဟ်သးဘဉ်တက့ၢ်.ဖဲနမ့ၢ်လိဉ်ဘဉ်တၢ်မၤစၢၤကလီလၢတၢ်ကကျိးထံဝဲဒဉ်လံာ်တီလံာ်မီတခါအံၤန့ဉ်,ကိးဘဉ်လီတဲစိနီၢ်ဂံၢ်လၢထးအံၤန့ဉ်တက့ၢ်.

알려드립니다. 이 문서에 대한 이해를 돕기 위해 무료로 제공되는 도움을 받으시려면 위의 전화번호로 연락하십시오.

ໂປຣດຊາບ. ຖ້າຫາກ ທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປເອກະສານນີ້ຟຣີ, ຈົ່ງໂທຣໄປທີ່ໝາຍເລກຂ້າງເທິງນີ້.

Hubachiisa. Dokumentiin kun tola akka siif hiikamu gargaarsa hoo feete, lakkoobsa gubbatti kenname bilbili.

Внимание: если вам нужна бесплатная помощь в устном переводе данного документа, позвоните по указанному выше телефону.

Digniin. Haddii aad u baahantahay caawimaad lacag-la’aan ah ee tarjumaadda (afcelinta) qoraalkan, lambarka kore wac.

Atención. Si desea recibir asistencia gratuita para interpretar este documento, llame al número indicado arriba.

Chú ý. Nếu quý vị cần được giúp đỡ dịch tài liệu này miễn phí, xin gọi số bên trên.

LB2 (10-20)

For accessible formats of this information, ask your county worker. For assistance with additional equal access to human services, contact your county's ADA coordinator. ADA4 (2-18)