MINNESOTA DEPARTMENT of HUMAN SERVICES

CLIENT PLACEMENT AUTHORIZATION (CPA) - CCDTF

DHS-2780-ENG 6-08

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 M = Married U = Unknown D = Divorced N = Never Married W = Widowed L = Legally Separated S = Living Apart	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 4 = American Indian 8 = Other 2 = Black 5 = Asian/Pacific Islander 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)	25. LIMITED ELIGIBILITY M = Minor A = Adult with Minor P = Pregnant O = Other	26. NON-RESERVATION AMERICAN INDIAN? (MOD1) UB = Yes N = No
___/___/___	I ☐ II ☐ III ☐ IV ☐ V ☐ VI ☐		

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 04 = Civil Commitment 08 = Adolescent 02 = Special Populations 06 = Child Protection 99 = None	29. ANNUAL INCOME	30. HOUSEHOLD SIZE
		$	__

Service Line 1

31. PROCEDURE CODE (if applicable)	32. REVENUE CODE	33. DRUG CODE (if applicable) M = Methadone N = Naltrexone A = Antabuse B = Buphenorphine	34. SERVICE START DATE	35. SERVICE END DATE	36. SERVICE RATE
	1003		___/___/___	___/___/___	$ 127.76

37. TOTAL # UNITS	38. TOTAL AMOUNT	39. NPI #	40. PROVIDER NAME
90	$ 11,498.40	1003022518	Phoenix Group Homes - New Richland

41. PROVIDER ADDRESS & TAXONOMY/CONTRACT ID (if necessary)	42. RESERVE FUND ELIGIBILITY E = Tier I/Entitled V = Voucher O = Other (Must choose "Y" in box 43)	43. COUNTY PAY 100% Y = County Will Pay 100% N = County will Not Pay 100%

Service Line 2

31. PROCEDURE CODE (if applicable)	32. REVENUE CODE	33. DRUG CODE (if applicable) M = Methadone N = Naltrexone A = Antabuse B = Buphenorphine	34. SERVICE START DATE	35. SERVICE END DATE	36. SERVICE RATE
H2035	0944 / 0945		___/___/___	___/___/___	$ 41.40

37. TOTAL # UNITS	38. TOTAL AMOUNT	39. NPI #	40. PROVIDER NAME
84	$ 3,477.60	1164675344	Phoenix Adolescent OP - Mankato

41. PROVIDER ADDRESS & TAXONOMY/CONTRACT ID (if necessary)	42. RESERVE FUND ELIGIBILITY E = Tier I/Entitled V = Voucher O = Other (Must choose "Y" in box 43)	43. COUNTY PAY 100% Y = County Will Pay 100% N = County will Not Pay 100%

Service Line 3

31. PROCEDURE CODE (if applicable)	32. REVENUE CODE	33. DRUG CODE (if applicable) M = Methadone N = Naltrexone A = Antabuse B = Buphenorphine	34. SERVICE START DATE	35. SERVICE END DATE	36. SERVICE RATE
			___/___/___	___/___/___	$

37. TOTAL # UNITS	38. TOTAL AMOUNT	39. NPI #	40. PROVIDER NAME
	$		

41. PROVIDER ADDRESS & TAXONOMY/CONTRACT ID (if necessary)	42. RESERVE FUND ELIGIBILITY E = Tier I/Entitled V = Voucher O = Other (Must choose "Y" in box 43)	43. COUNTY PAY 100% Y = County Will Pay 100% N = County will Not Pay 100%

Private Ins.

44. EMPLOYER NAME AND ADDRESS	45. MEDICARE CLAIM #

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

50. POLICYHOLDER NAME AND ADDRESS (if not the client)	51. EMPLOYER OR POLICYHOLDER	52. 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