PUBLIC HEALTH &
HUMAN SERVICES

COOK COUNTY COURTHOUSE
411 W 2ND STREET
GRAND MARAIS, MN 55604
PH: 218.387.3620
FAX: 218.387.3020
TOLL FREE: 1.800.663.6771
WWW.CO.COOK.MN.US

Behavioral Health Funding (formerly known as the Consolidated Chemical Dependency Treatment Fund) is non-emergency public funding for substance use disorder treatment. If you are found to be eligible, this funding will pay for a substance use disorder needs assessment and recommended treatment. ***You must apply for Behavioral Health Fund through your county of residence.***

If you have a Managed Care plan through Medical Assistance or MN Care, (such as Health Partners, Blue Plus or UCare) you already have coverage for treatment and ***do not*** need to apply for Behavioral Health Fund. Please contact your Managed Care Provider for coverage information and appointments. If you have insurance through an employer, you may apply for assistance in covering your deductible.

To apply for Medical Assistance please visit www.mnsure.org. If you would like a paper application, please contact us at 218-387-3620, or by email at phhs@co.cook.mn.us.

If you DO NOT have Medical Assistance or MN Care or have insurance with limited Substance Use Disorder coverage *and* are of low income, you can apply for Behavioral Health funding to cover the cost of an assessment and recommended treatment. Please complete the attached application and provide all requested verifications. If you would prefer to apply by phone, please call 218-387-3620.

Completed applications and all verifications can be submitted in one of the following ways:

Fax to: (218)387-3020 Attn: Behavioral Health Fund

Mail to, or drop off at: Cook County Public Health and Human Services
Attn: Behavioral Health Fund
411 W 2nd Street
Grand Marais, MN 55604

Email to: phhs@co.cook.mn.us

Once your complete application and verifications are received, you will be notified if you are eligible or not. If you have questions about this application, please contact our office at 218-387-3620.

Cook County, Minnesota
Behavioral Health Fund Application

NOTE: IF YOU HAVE MEDICAL ASSISTANCE OR MNCARE OR A PRE-PAID MEDICAL PLAN (i.e UCare, Blue Plus, Health Partners, etc.), THEN YOU HAVE COVERAGE FOR CHEMICAL DEPENDENCY SERVICES, and do not need to apply for Behavioral Health Fund. If you do not have coverage, you need to apply as soon as possible by visiting www.mnsure.org. **You must apply for behavioral health fund through your county of residence.**

***Please make sure you complete this application fully and submit with verifications. Applications that are submitted without verifications or that are incomplete will be returned. ***

____
(Last, First, Middle Names)

____
(Street, Apt #/ City/State/Zip Code)

Phone: ______________________________
Birthdate: ______________________________
Social Security Number: ______________________________
Gender: ❑Female ❑Male
Marital Status: ______________________________
Race: ______________________________

Do you have private insurance? **(If yes, provide a copy of your insurance card.)** ❑ Yes ❑No

Are you or your spouse employed, or have unemployment income? ❑Yes ❑No

Total **MONTHLY HOUSEHOLD** income (includes spouse, parents, child support, etc.) **PLEASE SUBMIT EITHER LAST PAYSTUBS OR A CURRENT BANK STATEMENT.** ______________

Total number of residents in the household: ______________

Have you had a substance use disorder assessment in the last 45 days? ❑Yes ❑No

If yes, and you are pursuing funding for residential or outpatient treatment, please submit a copy of your assessment and recommendations with this application. For treatment, you must have an assessment within 45 days to be eligible for Behavioral Health Fund.

Declarations

Why the County needs this information: The information that you give us will be used to decide what kind of help you need and if we can pay for it. Unless the law says we can or unless you tell us we can with a signed release, we will not give anyone else any information about you. You have the right to see any information that we have about you. If you do not tell us the information that we need to know, we may not be able help you.

Behavioral Health Fund Applicant: By my signature below I attest that the information provided in this application is true and correct. I know that I may have to pay a fee based upon my income. I agree to pay the fee, if any. I acknowledge that I may have to pay the full cost of these services if I do not tell the truth in this application.

I also understand that until ALL verifications requested in this application are provided that my application cannot be processed.

____ ____________________

Client Signature Date