APPLICATION FOR MENTAL HEALTH CLIENT ASSISTANCE PROGRAM

Name (Last, First, MI)	DOB:	Phone:	Street Address, City, State, Zip

Marital Status *	Hispanic Heritage	Race**	Social Security Number:
○N ○M ○S ○L ○D ○W	☐ Yes ☐ No	○N ○A ○B ○P ○W	

*Married codes: N – Never, M-Married living with spouse, S- Single, L – Legally separated, D – Divorced, W – Widowed
**Race Codes: N – American Indian/Alaskan Native, A – Asian, B – Black or African American, P – Pacific Island/Native Hawaiian, W- White

Other Household Members

Name	Date of Birth	Relationship

Financial Information

Do you receive assistance from: **Circle one**

1. Diversionary Work Program (DWP / MN Family Investment Project (MFIP) ○Y ○N
2. Are you an adult caretaker of children who receive DWP/MFIP ○Y ○N
3. Do you receive Supplemental Security Income (SSI)? ○Y ○N
   If "YES" check one: ☐ Aged ☐ Blind ☐ Disabled
4. Do you receive Minnesota Supplemental Aide (MSA)? ○Y ○N
5. Do you receive Medical Assistance (MA)? ○Y ○N

Complete the information below for all family members (including yourself) who are age 14 or older.

Kind of income *	**Monthly Gross Amount**			
*Please provide proof of all income for the past three months (or) include a copy of your most recent Income Tax Statement.	**Person 1**	**Person 2**	**Person 3**	**Person 4**
Wage or Salary				
Wage or Salary				
NET Income from Self Employment				
NET Farm Income				
Social Security				
Social Security				
Dividends – Interest – Rentals – Royalties				
General Assistance				
Pensions and Annuities				
Unemployment Compensation				
Workers Compensation				
Alimony				
Child Support				
Child Support				
Veterans Pensions				
Sub-TOTALS				
TOTAL Monthly Household Income	$			

Do you have private insurance? ☐Y ☐N If yes, please complete the back of this form.

Family Size: _____ Total Monthly Income: _____Monthly Fee: _____

Insurance Waiver Appeal: Please state reason the waiver should be granted on back of form:
Insurance Waiver Appeal: You may request that your application for the Mental Health Client Assistance Program be considered if you feel there are special and unusual circumstances. Special or unusual circumstances could include mental health services not being a covered service with your current insurance or the inability to pay large deductibles or copays. The appeal must be in writing stating the reasons the waiver should be granted and desire for review. The Mental Health Supervisor, in consultation with the Director, will review requests and determine if waiver will be granted. If the waiver is granted, the Mental Health Client Assistance Program fee schedule will be utilized to assess any potential fees.

My signature below authorizes the exchange of information between **Southern Minnesota Behavioral Health** and **Brown County Human Services** to include:

- All information provided on this application
- Copies of proof of income reported.
- Diagnostic information including mental health professional recommendations
- Service dates and services provided

I understand this information is needed in order to process my application for the Client Assistance Program and will not be used for any other purpose other than eligibility determination for the Client Assistance Program. I understand the request for Mental Health Client Assistance Program funding and I agree with this request for assistance. I understand that the consent will automatically expire one year from the date of my signature. I understand that I may revoke this consent at any time upon written notice (not retroactive) and if I revoke my consent to share information with Brown County Human services my eligibility for the Mental Health Client Assistance Program will also be revoked.

_____ _____

Client/Legal Guardian Signature Date