NorthCare Network Substance Use Disorder Services
1230 Wilson Street, Marquette, MI 49855
Phone: (906) 225-7222 Toll-Free: (800) 305-6564 Fax: (248) 406-1286

Certification of Eligibility/Notification of Rights

GENERAL STATEMENT OF ELIGIBILITY
I understand that residency and income eligibility requirements must be met to receive funding assistance for treatment. Proof of income and residency must be provided to the treatment provider or NorthCare Substance Use Disorder Services. A valid Medicaid card is documentation of residency and income.

CERTIFICATION OF RESIDENCY
My permanent county of residency is:_____(SPECIFY)

I have been a resident of the above county for _____years or _____ months.

CERTIFICATION OF INCOME {check applicable option(s) below}
□ My total household income for the past 12 months is $_____ with a family size of _____, which means I am eligible for funding.
Generally, financial eligibility is determined by income over a 12-month period. Yearly income can be based on the following alternative method for a valid reason such as recent unemployment.
The formula is: Last 3 months of income X 4 (quarters in a year) = $(Projected 12 month income).
□ I have a valid Medicaid card. My recipient ID # is: _____.
□ I have Healthy Michigan. My recipient ID # is:_____.
□ I meet eligibility criteria for State Disability
□ I am enrolled in the MI Health Link program. My recipient ID # is:_____.

NOTIFICATION OF RECIPIENT RIGHTS; CONFIDENTIALITY; FASD, HIV/AIDS, TB & Hepatitis C INFORMATION
I affirm that I have received the "Client Notice of Confidentiality" and the brochure entitled "Know Your Rights," along with pamphlets/information concerning Fetal Alcohol Spectrum Disorders (FASD), HIV/AIDS,TB and Hepatitis C. This information has been explained to me, and I was given an opportunity to ask questions about this information. I understand that additional information about my rights are available from the Program Rights Advisor.

NOTIFICATION OF MEDICAID GRIEVANCE PROCEDURE & Customer Handbook (Medicaid/Healthy Michigan recipients)
I acknowledge having been provided with notification of my right to file a request for an administrative hearing if a benefit is denied, terminated, suspended, or reduced. I have also received a copy of the current NorthCare Network Customer Handbook.
Client Signature:_____

CLIENT CERTIFICATION
I have read this agreement or have had this agreement read to me by treatment program and/or NorthCare staff. By signing, I certify that all information reported on this application is correct. If changes occur while I am receiving services under this project, I will report them immediately. If information in this application is found to be untrue or if proof of income and residency are not provided, benefits may be forfeited. I understand that only substance use disorder therapy services are covered and **that I am responsible for paying any services that are not covered under this program.**

_____ _____
Client Signature Date

_____ | | | | | | | | | |
Client Name Clearly Printed Social Security Number

Staff Certification- I have attempted to obtain proof of residency and income for this client and have documented my efforts in his/her chart.

_____ _____ _____
Staff Signature Date Treatment Program