#06-21-08

Bulletin

July 14, 2006

Minnesota Department of Human Services □ P.O. Box 64941 □ St. Paul, MN 55164-0941

OF INTEREST TO

- County Directors
- Financial Assistance Supervisors and Financial Workers
- Social Services Supervisors and Staff
- Tribal Social Services Directors
- MilleLacs Tribal TANF
- MinnesotaCare Managers, Supervisors & Enrollment Reps
- Community Organizations

ACTION/DUE DATE

Begin using the HCAPP on 8/1/06. Begin using the Renewal form for renewals that are due for 9/1/06.

EXPIRATION DATE

Expires in six months.

Redesign of the Minnesota Health Care Programs Application and Renewal Forms

TOPIC

The Minnesota Health Care Program Application (HCAPP) and Renewal forms have been redesigned.

PURPOSE

To provide information on the purpose and the changes that have been made to the HCAPP and Renewal forms.

CONTACT

MinnesotaCare Operations, Counties and Tribal Agencies, submit policy questions to HealthQuest.
Direct all other questions to:

Health Care Eligibility and Access (HCEA)
PO Box 64989
540 Cedar Street
St. Paul, MN 55164-0989

SIGNED

BRIAN J. OSBERG
Assistant Commissioner
Health Care Administration

I. Background

The Minnesota Health Care Programs Application (HCAPP) and Renewal forms were last revised in September 2005.

II. Introduction

DHS has been working closely with the Center for Literacy to meet a goal of providing an easy to read, easy to complete and easy to understand application and renewal form for low-level readers.

The new Minnesota Health Care Programs Application (HCAPP) and Renewal form are designed to:

- Meet legislative requirements and the need to be in compliance with changes in Federal and State laws.
- Allow for shorter processing periods because eligibility workers can collect needed information at the beginning of the process.
- Create a user friendly application and renewal form that provide larger print, white space and more detailed explanations when asking for information and required proofs.
- Take steps to begin preparing for HealthMatch to collect detailed information and proofs that will be needed for the system to determine eligibility.

The HCAPP (Attachment A) and the Renewal form (Attachment B) are included with this bulletin.

DHS will mail a different format of the Renewal form to enrollees. It has been printed in two sections to allow the enrollee to keep the informational section and fill out and return the section asking for information. These forms are 3418B (Attachment C) and 3418C (Attachment D).

To view or download the Redesigned HCAPP and Renewal forms from the DHS website, go to http://edocs.dhs.state.mn.us/lfserver/Legacy/dhs-3417-eng for the HCAPP (available on 8/1/06) or http://edocs.dhs.state.mn.us/lfserver/Legacy/DHS-3418-eng for the Renewal.

DHS is sending initial supplies of the 07/06 HCAPP and Renewal to MinnesotaCare Operations, counties and the Mille Lacs Band Tribal Agency.

To order additional supplies of the redesigned HCAPP and Renewal form through DHS Forms Supply, complete the "Requisition for DHS Forms" (DHS-0121) and following the instructions.

Translation of these documents is in process. DHS will notify agencies administering the health care programs when the translated versions are available.

III. Action Required

► Upon receipt of the 07/06 version of the HCAPP and Renewal, recycle all previous versions of these forms because they do not include all of the current required language.

► Continue to accept and process all prior versions of the completed HCAPP and Renewal forms and follow up to get any additional needed information or proofs.

►Send out and request the return of the Required Questions for People Applying for Coverage to Pay for Long-Term Care or Waiver Services (DHS-4803) to applicants and enrollees requesting MA payment of long-term care or waiver services. To download this form go to:

http://edocs.dhs.state.mn.us/lfserver/Legacy/DHS-4803-ENG.

► Continue to accept the Combined Application Form (CAF) for health care programs applications.

► Review all of the changes and revisions on the new versions as described below.

A. HCAPP revisions

1. General revisions

The HCAPP has several new features including the following:

- All instructions, Notice of Privacy Rights and other important information are now shaded green. Applicants are told to keep the green pages. This makes it easier for them to know what to keep and what to fill out and send in. We are legally mandated to be sure that applicants know their rights and the legal requirements for the Minnesota Health Care Programs.

- The format of the questions has changed to allow more white space throughout the form. Many questions have been pulled out of a table format and numbered individually. This helps to visually make the information easier to read for both the applicant and the worker who is reviewing the completed form.

- Questions are designed so applicants have to answer only those questions that apply to them. If they check "yes" they are told to fill out the information, and if "no" to go to the next question.

- Questions regarding long-term care information have been included. This eliminates the need for a separate application for those people who are or will be residing in a facility. The Minnesota Health Care Programs Application for People who have a Disability and Seniors age 65 and older, DHS 3531 is obsolete. Recycle all applications. Continue to accept and process all completed applications that are submitted.

- The form is no longer designed with an address page as self mailer. Insert the application into an envelope when mailing. A brochure covering all health care programs is being designed to mail to applicants along with the application. DHS will send an initial supply to counties as soon as it is printed.

2. Cover page

The cover page lists the populations who should use this application to apply for health care coverage. People are able to look at the list and identify themselves as someone who may apply

with this form.

► The language block is now included on the inside cover of the application.

3. Page A
   This page has information on how to apply, when to apply, and where to call with questions. Two sections were removed from the first page:

   - "What do I need to include with my application?" was removed. Information on documents of proof are now shown in green shaded boxes along with the question asking for that information.

   - "Where do I take or send my application?" was removed and the instruction to look for the address for their county office or the State MinnesotaCare office has been added. Report any county address changes to the Health Care Information Line at (651) 431 – 2670 or (800) 657- 3739.

4. Pages B – C
   These pages list all of the names and addresses of the county agencies and the State MinnesotaCare office. Applicants can identify the address for their county or mail their application to the State MinnesotaCare office.

5. Pages D – F (Notice of Privacy Practices)

   a. Section moved:
   Immigration information has been moved to Page F along with additional information on new Federal requirements regarding proof of citizenship.

   b. Section changed:
   "What if you question the information?" has been changed to "What if you believe the information we have about you is wrong?" The wording in the section is changed slightly and the title is more descriptive.

   c. Section added:
   "What are our responsibilities under this notice?" This new section tells people what we must do if we change our privacy policy.

6. Pages F – G
   These pages include:

   a. The section formerly called "File a Complaint" that is now "What if you believe your privacy rights have been violated?" This is the same information but with a new title that is more descriptive.
   b. A new section on "Proof of Citizenship or National Status." It includes the new Federal requirements for verification of U. S. Citizenship. Page C provides information on citizenship verification requirements. Information on this page lists who is required to provide proof.

On Friday, July 7th the Centers for Medicare and Medicaid Services (CMS) issued Final Interim Regulations governing the documentation of citizenship requirements. CMS could still make some changes to the regulations based on comments received during the 30-day comment period. However, at this time the regulations are final. The regulations clarify the following:

- People enrolled in or entitled to Medicare are exempt from the citizenship verification requirement.

- We can verify the citizenship and identity of Supplemental Security Income (SSI) and Minnesota Supplemental Aid (MSA) recipients through the Social Security Administration State Data Exchange (SDX).

- DHS expects to be able to verify the citizenship of people born in Minnesota through a data match with the Minnesota Department of Health.

A stuffer (Attachment E) is being mailed with the Renewal form to provide information on who needs to verify citizenship and what information they can provide. DHS will continue to mail the stuffer until the Renewal form language is revised. This form will be available on Edocs and is form number DHS 4832.

DHS will issue further instructions to counties prior to August 1st. Until then, counties should not change current policies or ask clients to begin obtaining documentation of citizenship.

c. Information on the right to Fair Treatment and the right to ask for a hearing (formerly called "Appeal Rights."

7. Pages G – H
These two pages have information about the rules on not giving false information, the use of membership cards, and what happens if the rules are broken. The new sections are:

- Breaking the Rules
- What are the rules?
- What happens if I break these rules?

8. Page H

a. Sections changed:

- "Responsibilities" has been renamed "Child Support" to be more clear on what the section is about. It includes the section on providing child support information, claiming good cause, and child support assignment.
- "Quality Control Reviews" is now called just "Reviews." This was changed to be more user friendly.

- "Income and Eligibility Verification System (IEVS) is now "Reporting Systems." This change is to be more clear to clients.

b. A new section was added (State as Annuity Beneficiary) to inform applicants of this law.

9. Page I
The section on reporting changes has been expanded to include more explanation.

10. HCAPP Questions

Question 1: Language information
► This was separated from the name information for more clarity.

Question 2: Who is the head of this household?
► Now includes an explanation of what "head of household" means.

Question 3: Address
► Now asks if an applicant is homeless or a migrant worker. This will help to not require follow up.

Question 4: Have you and your household lived in Minnesota more than six months?
► Question revised. More space is allowed for this question for explanation, if needed.

Question 5: Write the names and phone numbers of people we can call during the day.
► Not new but stated differently.

Question 6: Do you want someone else to help you and act on your behalf?
► Stated in this way it meets the appropriate reading level requirements. This was previously stated as an authorized representative or authorizing someone to act on your behalf.

Question 6a: New question:
► Do you have a legal guardian or conservator, or is there a power of attorney? Asks if fees are being paid and the amount. This will help to not require follow up.

Question 7: Are any household members under age 18 emancipated?
► This is a new question. This will help to not require follow up.

Question 8: This is a green box reminder that information about U. S. Citizenship will need to be given for each person in the household who is applying. Despite the guidance provided in this box, Final Interim Regulations from CMS require clients to present original documents as proof of citizenship and identity. DHS will issue further instructions in a bulletin to counties prior to August 1, 2006, outlining the implementation guidance for this verification requirement.

Question 8a through 8f: Asks for required information for each household member. Separates needed information from members who are applying and members who are not applying. Members who are not applying are not required to give Social Security Numbers, immigration information and race and ethnicity information.

Question 9: Are any household members pregnant?
► The only change is that more space is allowed for the answers.

Question 10: Are any household members living away from home for a short time?
► This is just a change in wording. The question used to ask if any family members were temporarily living away from home. Rephrasing this reduces the reading level, making it easier for lower level readers to understand.

Question 11: Are you or is any household member a student?
► This is not a new question but is now listed separately asking for more detailed information. This will help to not require follow up.

Question 12: Are you or any household members blind or have serious medical problems?
► Not a new question, rephrased and listed separately now.

Question 13: In what month and year do you want health care coverage to start?
► This now includes an explanation on who may get coverage for three months retroactively. This will help to not require follow up.

Question 14: Are both parents of all children living in the home?
► This section asks the questions about an absent parent. Not a new question. It has been laid out differently so it is easier to read, understand and answer.

Question 15: Are you or any household members getting services from the Center for Victims of Torture?
► Not a new question.

Question 16: Do any household members have a medical emergency?
► Not a new question.

Question 17: Are you or are any household members getting or expecting wages or a salary from a job?
► More detail added to get needed information. Information also added to assist in verifying Employer Subsidized Insurance for MinnesotaCare applicants. This will help to not require follow up. More space allowed to write more specific information than there was previously.

Question 18: Are you or any household members self-employed?
► The previous application did not specifically ask about self-employment. This will help to not require follow up.

Question 19: Are any household members getting or expecting to get other types of income?
► Information on other income is listed more clearly than before.

Question 20: Do you or any household members pay for child or adult day care while they work?
► Same question as previously, but more space allowed.

Question 21: Do you or any household members pay court-ordered child or medical support?
► Same question but more space allowed.

Question 22: Do any disabled or blind household members have work expenses?
► This is a new question to gather information on the application. This will help to not require follow up.

Question 23: Do you or any household members have medical bills that have not been paid?
► This is a new question to gather information on the application. This will help to not require follow up. If they answer yes, they are instructed to fill in the information requested in 23a.

Question 23a: Do you or any household members have medical bills from the past three months?
► There is space allowed to fill in medical bills, date of service, provider name, amount, and if it has been paid or not. This will help to not require follow up.

Questions 24 – 28: Do you and your household members have any assets?
► The format of this question has changed with more space allotted for each type of asset. The sections for life insurance policies and burial contracts have been separated so more description can be included for each. This will help to not require follow up.

Question 29: This question about giving away or selling assets has been expanded.
► More description is included and more space allotted to fill in items, their value and what was done with the asset.

Questions 30 – 36: Health Insurance questions
► We now need to ask more specific questions to be sure we are getting the information needed for other health coverage that may be available. This

will help to limit the amount of follow-up needed to get the information on other health coverage. This will help to not require follow up.

Question 37: Is any household member who is applying getting medical care for an accident or injury that happened in the last six years?
► More space has been allotted for this question.

Question 38: Do any household members have Medicare coverage?
► This question has not changed.

Questions 39 – 45: Questions for applicants who are living in a long-term care facility or are planning to get waiver program services.
► These questions will replace the need for a separate application for these people. This will help to not require follow up. If applicants answer "No" to the first question, it directs them to the Signature Page. They will not have to answer the remainder of these questions.

Pages 21 – 22 Signature page:
► This has been expanded to two pages for greater reading ease. The information remains the same.

Pages 23 – 24 Employer Health Insurance Form:
► This request for information has been added in an effort to get full information on any insurance available through an employer or union for MinnesotaCare applicants.

B. Renewal revisions

1. General revisions

Most general revisions are the same as for the HCAPP. See section A. 1. of this bulletin.

- Instructions, Notice of Data Privacy and other important information are shaded green. Enrollees are told to keep the green pages.
- More white space is allowed throughout the form for greater reading ease.
- Enrollees only need to answer questions that apply to them.
- Questions regarding long-term care or waiver services are included.

2. Cover page

The cover page has the instruction section that was at the top of the first page in the previous version. It has now been expanded into a full page for better readability. Two questions have been changed slightly to provide more information. The two changed questions are:

- "What do I need to do with this form?" tells the enrollee to read and keep the green pages and to fill out all the questions on the white pages.

- "What do I need to include with the renewal?" includes information about including proofs such as pay stubs and that more information about proof of U. S. citizenship or national status is on Page C. Despite the guidance provided on the cover page and on Page C, Final Interim Regulations from CMS require clients to present original documents as proof of citizenship and identity. DHS will issue further instructions in a bulletin to counties prior to August 1, 2006, outlining the implementation guidance for this verification requirement.

► The language block has been moved to the back side of the cover page.

3. Pages A – F
   These pages include information legally required to be given to enrollees at the time of a renewal. They have been moved from the end of the form to the beginning of the form and are shaded green. Enrollees are instructed to keep all of the green pages.

4. Pages A – B Notice of Privacy Practices

   a. Section moved:
      Immigration information has been moved to Page C along with additional information on new Federal requirements regarding proof of citizenship.

   b. Section changed:
      "What if you question the information?" has been changed to "What if you believe the information we have about you is wrong?" The wording in the section is changed slightly and the title is more descriptive.

   c. Section added:
      "What are our responsibilities under this notice?" This new section tells people what we must do if we change our privacy policy.

5. Page C – D
   These pages include:

   a. The section formerly called "File a Complaint" that is now "What if you believe your privacy rights have been violated?" This is the same information but with a new title that is more descriptive.

   b. A new section on "Proof of Citizenship or National Status." It includes the new Federal requirements for verification of U. S. Citizenship. Refer to the above cover page section for information about this new verification requirement.

   c. Information on the right to Fair Treatment and the right to ask for a hearing, formerly called "Appeal Rights."

6. Page D

   a. This page has information about the rules on not giving false information, the use of membership cards, and what happens if the rules are broken. The new sections are:

      - Breaking the Rules
      - What are the rules?
      - What happens if I break these rules?

   b. Sections changed:

      - "Responsibilities" has been renamed "Child Support" to be more clear on what the section is about. It includes the section on providing child support information, claiming good cause, and child support assignment.

      - "Quality Control Reviews" is now called just "Reviews." This was changed to be more client friendly.

      - "Income and Eligibility Verification System (IEVS) is now "Reporting Systems." This change is to be clearer to clients.

7. Page E

   a. New section "State as Annuity Beneficiary" was added to inform enrollees of this law.

   b. "Changes" section on reporting changes has been expanded to include more explanation on what needs to be reported.

8. Page F Health Care Coverage Options in Minnesota

   This is all new information for the Renewal form. It emphasizes the importance of telling us about any insurance they may already have and other options they may have for insurance coverage. DHS is required by law to inform certain enrollees yearly of other health care options available in Minnesota.

9. Renewal questions:

Questions 1:	Language information ► This was separated from the name information for more clarity.
Questions 2:	Who is the household member that is filling out this renewal? ► Now includes an explanation of what "head of household" means.
Question 3:	What is your address? ► Now asked separate from the name information.

Questions 4: Write the names and phone numbers of people we can call during the day.
► Not a new questions, but stated differently.

Question 5: Are any household members pregnant?
► More space is allowed for this information as well as a description of proof needed.

Question 6: Did any new members move into your household or do you want to apply for a household member who is not getting coverage now?
► Not a new question, but more space is allowed for information.

Question 7: List your household members below.
► More space is allowed for listing information.

Question 8: Are any other household members who are not already listed living away from home for a short time?
► This question was not on the previous version of the renewal. This will help to not require follow up.

Question 9: Are you or any household members getting or expecting wages or a salary from a job?
► The new, easier to read job information section includes space for three different jobs. This will help to not require follow up.

Question 10: Do you have more jobs to report?
► Tells enrollees to write information for other jobs on a separate piece of paper.

Question 11: Are you or any household members self-employed?
► More space is allowed for specific information.

Question 12: Are any household members getting or expecting to get other types of income?
► More space is allowed for more information on unearned income.

Question 13: Do any household members pay for child or adult day care while they work?
► More space is allowed.

Questions 14: Do you or any household members pay child or medical support that is court ordered?
► More space allowed and stated more clearly.

Question 15: Is anyone blind or disabled?
► Added information here asks about work expenses when appropriate. This will help to not require follow up.

Questions 16 – 20 Assets

► Separate questions are asked about each type of asset, with ample space allowed for listing them. This will help to not require follow up.
Additional information is requested as specific to the type of asset in order to gather all appropriate information.

Question 21: This question about giving away or selling assets has been expanded.
► More description is included and more space allotted to fill in items, their value and what was done with the asset.

Question 22 – 24: Questions about household member living in a long term care facility (LTCF) or planning to get waiver program services.
► These are new question now included on the Renewal form. This will help to not require follow up.

Question 25: Do you or household members have health insurance coverage?
► This is a new question that has been added. This will help to not require follow up.

Question 26: List changes below that took place in the past year or may occur during the next year.
► This list of possible changes was in the previous Renewal, however, some of the previous items are now asked separately.

Pages 10 – 11 Signature page:
► This has been expanded to two pages for greater reading ease. The information remains the same.

IV. Legal References

Citizenship requirements:
Laws of Minnesota 2006, Chapter 282, Article 17, Sections 34 & 35

Additional verification requirements:
Laws of Minnesota 2005, FIRST SPECIAL SESSION, CHAPTER 4, Art. 8, §26

ESI verification:
Laws of Minnesota 2005, FIRST SPECIAL SESSION, CHAPTER 4, Art. 8, §65

V. Attachments

Attachment A - Minnesota Health Care Programs Application (DHS 3417-ENG)
Attachment B - Minnesota Health Care Programs Renewal (DHS 3418-ENG)
Attachment C - Minnesota Health Care Programs Renewal (DHS 3418B-ENG)
Attachment D - Minnesota Health Care Programs Renewal (DHS 3418C-ENG)
Attachment E - Renewal Stuffer with information about citizenship verification

VI. Special Needs

This information is available in other forms to people with disabilities by contacting us at (651) 431-2283 or toll free at (800) 938-3224 or through the Minnesota Relay Service at (800) 627-3529 (TDD), 711 or (877) 627-3848 (speech to speech relay service).

Minnesota Department of **Human Services**

Minnesota Health Care Programs Application

Fill out this application to apply for health care coverage for the following people:

- Families
- Children
- Married couples
- People who are single
- People who are blind or disabled
- People who live in a nursing home

Attention. If you want free help translating this information, ask your worker or call the number below for your language.

ملاحظة: إذا أردت مساعدة مجانية في ترجمة هذه المعلومات، فاسأل مساعدك في مكتب الخدمة الاجتماعية أو اتصل على الرقم 1-800-358-0377.

កំណត់សំគាល់ បើអ្នកចង់បានជំនួយបកប្រែពត៌មាននេះដោយមិនគិតថ្លៃ សូមសួរអ្នកកាន់សំណុំរឿងរបស់អ្នក ឬ ទូរស័ព្ទទៅលេខ 1-888-468-3787 ។

Pažnja. Ako vam je potrebna besplatna pomoć za prevod ove informacije, pitajte vašeg radnika ili nazovite 1-888-234-3785.

Ceeb toom. Yog koj xav tau kev pab txhais cov xov no rau koj dawb, nug koj tus neeg lis dej num (worker) lossis hu 1-888-486-8377.

ໂປດຊາບ. ຖ້າທ່ານຕ້ອງການ ການຊ່ວຍເຫຼືອໃນການແປຂໍ້ຄວາມດັ່ງກ່າວນີ້ຟຣີ, ຈົ່ງຖາມນຳພນັກງານຊ່ວຍເຫຼືອ ຂອງທ່ານ ຫຼືໂທຮຫາ ຕາມເລກໂທຣ 1-888-487-8251.

Hubaddhu. Yoo akka odeeffannoon kun sii hiikamu gargaarsa tolaa feeta ta’e, hojjataa kee gaafaddhu ykn lakkoofsa kana bilbili 1-888-234-3798.

Внимание: если вам нужна бесплатная помощь в переводе этой информации, обратитесь к своему социальному работнику или позвоните по следующему телефону: 1-888-562-5877.

Ogow. Haddii aad dooneyso in lagaa kaalmeeyo tarjamadda macluumaadkani oo lacag la’aan ah, weydii hawlwadeenkaaga ama wac lambarkan 1-888-547-8829.

Atención. Si desea recibir asistencia gratuita para traducir esta información, consulte a su trabajador o llame al 1-888-428-3438.

Chú Ý. Nếu quý vị cần dịch thông-tin nầy miễn phí, xin gọi nhân-viên xã-hội của quý vị hoặc gọi số 1-888-554-8759.

LB #2 (12-03)

Minnesota Health Care Programs Application

How do I apply for health care coverage?

- Answer all of the questions on the white pages of the application.
- Make sure that the application is signed and dated by each person age 18 and older who wants health care coverage.
- Find all the proofs you need and include them with your application. Each question tells you if you need proof. Proof includes items such as pay stubs, bank statements and car titles. Proof also includes information you write on Form A at the back of the application. You may not get coverage if we do not get proofs. Tell us if you need help getting proofs.
- Read the information on the green pages (A through I) at the beginning of the application. **Tear off the green pages and keep them.** This will save you postage money if you mail the application.
- To apply for all Minnesota health care programs, take or mail your application to the human service office in the county where you live.
- To apply for MinnesotaCare only, either:
  * Take or mail your application to the state office or
  * Ask your county office if they accept applications for MinnesotaCare.
- County and state mailing addresses, phone numbers and fax numbers are listed on the next two pages. Add extra postage if you mail the application.

If you want to apply for cash benefits or Food Support, ask your county office for a different application to fill out. Do not wait for that application if you want health care. Fill out this health care application right away or you may lose some months of coverage.

How soon should I apply for health care?

Turn in your application as soon as you fill it out, sign it and date it. In some cases, coverage may start three months before you turn in your application. In other cases, coverage can only begin on the day you turn in the application.

For most people who have a monthly payment for health care, coverage will start on the first day of the month after we get the payment. For example, if we get your payment in May, your coverage will start on June 1.

What if I need help or have questions?

Call your county human services office. The list of county offices and the state office is on the next two pages of this application.

If you are disabled or age 65 or older, you may also call the Linkage Line at (800) 333-2433.

Keep this page.

Agency Addresses

Aitkin County
204 First Street NW
Aitkin, MN 56431-1291
218-927-7200/800-328-3744
Fax: 218-927-7210

Anoka County
2100 Third Avenue
Anoka, MN 55303-2264
763-422-7246
Fax: 763-422-6987

Becker County
P.O. Box 1637
Detroit Lakes, MN 56502-1637
218-847-5628
Fax: 218-847-6738

Beltrami County
616 America Ave NW
Suite 270
Bemidji, MN 56601-3802
218-759-8300
Fax: 218-333-4150

Benton County
P.O. Box 740
Foley, MN 56329-0740
320-968-5087/800-530-6254
Fax: 320-968-5330

Big Stone County
P.O. Box 338
Ortonville, MN 56278-0338
320-839-2555
Fax: 320-839-3966

Blue Earth County
P.O. Box 3526
Mankato, MN 56002-3526
507-304-4335
Fax: 507-304-4336

Brown County
P.O. Box 788
New Ulm, MN 56073-0788
507-354-8246/800-450-8246
Fax: 507-359-6542

Carlton County
1215 Ave. C
Cloquet, MN 55720-1610
218-879-4583/800-642-9082
Fax: 218-878-2500

Carver County
602 East Fourth Street
Chaska, MN 55318-2102
952-361-1600
Fax: 952-361-1660

Cass County
P.O. Box 519
Walker, MN 56484-0519
218-547-1340
Fax: 218-547-1448

Chippewa County
719 North Seventh Street
Suite 200
Montevideo, MN 56265-1397
320-269-6401/877-450-6401
Fax: 320-269-6405

Chisago County
313 North Main St - Rm 239
Center City, MN 55012-9665
651-213-0324/888-234-1246
Fax: 651-213-0317

Clay County
715 North 11th St - Suite 102
Moorhead, MN 56560-2095
218-299-5200/800-757-3880
Fax: 218-299-7515

Clearwater County
P.O. Box X
Bagley, MN 56621-0682
218-694-6164/800-245-6064
Fax: 218-694-3535

Cook County
411 West Second Street
Grand Marais, MN 55604
218-387-3620
Fax: 218-387-3020

Cottonwood County
P.O. Box 9
Windom, MN 56101-0009
507-831-1891
Fax: 507-831-0126

Crow Wing County
P.O. Box 686
204 Laurel St - Suite 22
Brainerd, MN 56401-0686
218-824-1250/888-772-8212
Fax: 218-824-1141

Dakota County
1 Mendota Road West, # 100
West St. Paul, MN 55118-4773
651-554-5611
Fax: 651-554-5793

Dodge County
22 Sixth Street East, Dept. 401
Mantorville, MN 55955
507-635-6170/888-600-5169
Fax: 507-635-6186

Douglas County
809 Elm St - Suite 1186
Alexandria, MN 56308
320-762-2302
Fax: 320-762-3833

Faribault County
P.O. Box 217
Blue Earth, MN 56013-0217
507-526-3265
Fax: 507-526-2039

Fillmore County
902 Houston St NW - # 1
Preston, MN 55965-1080
507-765-2175
Fax: 507-765-3895

Freeborn County
P.O. Box 1246
Albert Lea, MN 56007-1246
507-377-5400
Fax: 507-377-5498

Goodhue County
426 West Avenue
Red Wing, MN 55066-0031
651-385-3200
Fax: 651-385-3205

Grant County
P.O. Box 1006
Elbow Lake, MN 56531-1006
218-685-4417/800-291-2827
Fax: 218-685-4978

Hennepin County
330 South 12th Street
Minneapolis, MN 55404-9760
612-596-1300
Fax: 612-348-8228

Houston County
P.O. Box 310
Caledonia, MN 55921-0310
507-725-5811
Fax: 507-725-3990

Hubbard County
310 Court Avenue
Park Rapids, MN 56470-1483
218-732-1451/877-450-1451
Fax: 218-732-3231

Isanti County
553 18th Avenue SW
Cambridge, MN 55008-9386
763-689-1711
Fax: 763-689-9877

Itasca County
1209 SE Second Avenue
Grand Rapids, MN 55744-3983
218-327-2941/800-422-0312
Fax: 218-327-5547

Jackson County
P.O. Box 67
Jackson, MN 56143-0067
507-847-4000
Fax: 507-847-5616

Kanabec County
905 Forest Ave. East #150
Mora, MN 55051-1316
320-679-6350
Fax: 320-679-6351

Kandiyohi County
2200 23rd St NE
Willmar, MN 56201-9423
320-231-7800/877-464-7800
Fax: 320-231-6285

Kittson County
410 South Fifth St - Suite 100
Hallock, MN 56728
218-843-2689/800-672-8026
Fax: 218-843-2607

Koochiching County
1000 Fifth Street
Int'l Falls, MN 56649-2485
218-283-7000/800-950-4630
Fax: 218-283-7013

Lac qui Parle County
P.O. Box 7
Madison, MN 56256-0007
320-598-7594
Fax: 320-598-7597

Lake County
616 Third Avenue
Two Harbors, MN 55616-1560
218-834-8400
Fax: 218-834-8412

Lake of the Woods County
P.O. Box 158
Baudette, MN 56623-0200
218-634-2642
Fax: 218-634-4520

LeSueur County
88 South Park Avenue
LeCenter, MN 56057-1646
507-357-8288
Fax: 507-357-6122

Lincoln County
P.O. Box 44
Ivanhoe, MN 56142-0044
507-694-1452/800-657-3781
Fax: 507-694-1859

Lyon County
607 West Main
Marshall, MN 56258-3099
507-537-6747/800-657-3760
Fax: 507-537-6088

McLeod County
1805 Ford Ave North - #100
Glencoe, MN 55336
320-864-3144/800-247-1756
Fax: 320-864-5265

Mahnomen County
P.O. Box 460
Mahnomen, MN 56557-0460
218-935-2568
Fax: 218-935-5459

Keep this page.

Marshall County
208 East Colvin Ave - Suite 14
Warren, MN 56762-1695
218-745-5124/800-642-5444
Fax: 218-745-5260

Martin County
115 West First Street
Fairmont, MN 56031-1815
507-238-4757
Fax: 507-238-1574

Meeker County
114 North Holcombe Ave #180
Litchfield, MN 55355-2273
320-693-5300/800-915-5300
Fax: 320-693-5344

Mille Lacs County
525 Second Street SE
Milaca, MN 56353
320-983-8208/888-270-8208
Fax: 320-983-8306

MinnesotaCare State Office
PO Box 64838
St. Paul, MN 55164-0838
651-297-3862/800-657-3672

Morrison County
213 SE First Avenue
Little Falls, MN 56345-3196
320-632-2951/800-269-1464
Fax: 320-632-0225

Mower County
1301 18th Ave NW - Suite A
Austin, MN 55912-3317
507-437-9700
Fax: 507-437-9774

Murray County
3095 20th Street
Slayton, MN 56172-1493
507-836-6144/800-657-3811
Fax: 507-836-8841

Nicollet County
108 South Minnesota Ave - #200
St. Peter, MN 56082-2516
507-934-8559/800-247-5044
Fax: 507-931-9562

Nobles County
901 Fourth Avenue
318 9th Street
PO Box 189
Worthington, MN 56187-0189
507-372-2157
Fax: 507-372-5094

Norman County
15 Second Avenue East,
Room 108
Ada, MN 56510-1389
218-784-5400
Fax: 218-784-7142

Olmsted County
151 Fourth Street SE
Rochester, MN 55904-3711
507-285-8382
Fax: 507-287-7118

Otter Tail County
535 West Fir
Fergus Falls, MN 56537-2703
218-998-8230
Fax: 218-998-8270

Pennington County
P.O. Box 340
Thief River Falls, MN 56701-0340
218-681-2880
Fax: 218-683-7013

Pine County
130 Oriole St East - Suite 1
Sandstone, MN 55072-5134
320-245-3020/800-450-7263
Fax: 320-245-3060

Pipestone County
P.O. Box 157
Pipestone, MN 56164-0157
507-825-6720/888-632-4325
Fax: 507-825-6727

Polk County
223 7th St - Suite 109
Crookston, MN 56716-1474
218-281-3127/800-281-3127
Fax: 218-281-7347

Pope County
211 East MN Ave - Suite 200
Glenwood, MN 56334-1628
320-634-5750
Fax: 320-634-0164

Ramsey County
160 East Kellogg Blvd.
St. Paul, MN 55101-1494
651-266-4444
Fax: 651-266-4439

Red Lake County
P.O. Box 356
Red Lake Falls, MN 56750-0356
218-253-4131/877-294-0846
Fax: 218-253-2926

Redwood County
P.O. Box 510
Redwood Falls, MN 56283
507-637-4050/888-234-1292
Fax: 507-637-4055

Renville County
301 South Seventh Street
Olivia, MN 56277-1301
320-523-2202
Fax: 320-523-3565

Rice County
P.O. Box 718
Faribault, MN 55021-0718
507-332-6115
Fax: 507-332-6247

Rock County
P.O. Box 715
Luverne, MN 56156-0715
507-283-5070
Fax: 507-283-5074

Roseau County
300 Sixth Street SW
Roseau, MN 56751-1451
218-463-2411/866-255-2932
Fax: 218-463-3872

St. Louis County
320 W 2nd St - Room 301
Duluth, MN 55802-1495
218-726-2101/800-450-9777
Fax: 218-733-2975
Or
307 1st St So - 2nd Floor
Virginia, MN 55792-1148
218-749-7100
Fax: 218-749-7123
Or
118 S 4th Ave E
Ely, MN 55731-1465
218-365-8210
Fax: 218-365-3217
Or
1814 14th Ave E
Hibbing, MN 55746-1314
218-262-6000
Fax: 218-262-6049

Scott County For Adults
Government Center 300
200 Fourth Ave West
Shakopee, MN 55379-1375
952-445-7751
Fax: 952-496-8551
Or
Scott County for Families
Workforce Center
752 Canterbury Road
Shakopee, MN 55379-1375
952-496-8686
Fax: 952-496-8685

Sherburne County
13880 Highway 10
Elk River, MN 55330-4600
763-241-2600/800-433-5239
Fax: 763-241-2698

Sibley County
P.O. Box 237
Gaylord, MN 55334-0237
507-237-4000
Fax: 507-237-4031

Stearns County
P.O. Box 1107
St. Cloud, MN 56302-1107
320-656-6000/800-450-3663
Fax: 320-656-6447

Steele County
P.O. Box 890
Owatonna, MN 55060-0890
507-444-7500
Fax: 507-451-5947

Stevens County
10 East Highway 28
Morris, MN 56267
320-589-7400/800-950-4429
Fax: 320-589-3972

Swift County
P.O. Box 208
Benson, MN 56215-0208
320-843-3160
Fax: 320-843-4582

Todd County
212 Second Avenue South
Long Prairie, MN 56347-1640
320-732-4500/888-838-4066
Fax: 320-732-4540

Traverse County
P.O. Box 46
Wheaton, MN 56296
320-563-8255/800-721-8277
Fax: 320-563-4230

Wabasha County
625 Jefferson Avenue
Wabasha, MN 55981-1589
651-565-3351/888-315-8815
Fax: 651-565-3084

Wadena County
124 First Street SE
Wadena, MN 56482-1553
218-631-7605/888-662-2737
Fax: 218-631-7616

Waseca County
123 Third Avenue NW
Waseca, MN 56093-2498
507-835-0560
Fax: 507-835-0566

Washington County
14949 62nd Street North
P.O. Box 30
Stillwater, MN 55082-0030
651-430-6459
Fax: 651-430-6636

Watonwan County
P.O. Box 31
St. James, MN 56081-0031
507-375-3294/888-299-5941
Fax: 507-375-7359

Wilkin County
P.O. Box 369
Breckenridge, MN 56520-0369
218-643-7161
Fax: 218-643-7175

Winona County
202 West Third Street
Winona, MN 55987-3146
507-457-6200
Fax: 507-454-9382

Wright County
10 2nd Street NW Room 300
Buffalo, MN 55313-1736
763-682-8920/800-362-3667
Fax: 763-682-7701

Yellow Medicine County
930 4th Street - #4
Granite Falls, MN 56241-1367
320-564-2211
Fax: 320-564-4165

Keep this page.

Notice of Privacy Practices

Minnesota Department of Human Services

(Effective Date: April 14, 2003)

This notice describes how medical information and other private information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

You have privacy rights under the Minnesota Government Data Practices Act and the federal Health Insurance Portability and Accountability Act (HIPAA). These laws protect your privacy, but also let us give information about you to others if a law requires it.

Why do we ask for this information?

- To tell you apart from other people with the same or similar name
- To decide what you are eligible for
- To help you get medical, mental health, financial or social services
- To decide if you can pay for some of your services
- To make reports, do research, do audits, and evaluate our programs
- To investigate reports of people who may lie about the help they need
- To decide about out-of-home care and in-home care for you or your children
- To collect money from other agencies, like insurance companies, if they should pay for your care
- To decide if you or your household members need protective services
- To collect money from the state or federal government for help we give you.

Do you have to answer the questions we ask?

Generally, the law does not say you have to give us this information. We need your social security number in order to give you some kinds of financial help or child support enforcement services (45 CFR 205.52 [2001]; 42 USC 666; 45 CFR 303.30 [2001]).

What will happen if you do not answer the questions we ask?

We need information about you to tell if you can get help from any program. Without the information, we may not be able to help you. If you give us wrong information on purpose, you can be investigated and charged with fraud.

With whom may we share the information about you?

We may give information about you to the following agencies if they need it for investigations, or to help you, or to help us help you.

We don't always share information about you with these people, but the law says we may share information with them. If you have questions about when we give these people information, ask your worker.

- U.S. Department of Agriculture
- U.S. Department of Health and Human Services
- U.S. Department of Labor
- United States Citizenship and Immigration Services
- Internal Revenue Service
- Social Security Administration
- Minnesota Department of Employment and Economic Development
- Minnesota Department of Education
- Minnesota Department of Human Rights
- Minnesota Department of Human Services
- Minnesota Department of Labor and Industry
- Minnesota Department of Public Safety
- Minnesota Department of Revenue
- Minnesota Department of Veterans Affairs
- Minnesota Historical Society
- American Indian tribes, if your household is in need of human services at a tribal reservation
- Higher education coordinating board
- State hospitals or long-term care facilities

Keep this page.

- State and federal auditors
- Court officials
- Anyone under contract with the Minnesota Department of Human Services or U.S. Department of Health and Human Services, or the county social services agency
- Local and state health departments
- County human services boards
- Child or adult protection teams
- People who investigate child or adult protection
- Other human services offices, including child support enforcement offices
- Fraud prevention and control units
- Employees or volunteers of any welfare agency who need the information to do their jobs
- County attorney, attorney general or other law enforcement officials
- Mental health centers
- Ombudsman for families
- Ombudsman for mental health and mental retardation
- County advocates for Minnesota Managed Health Care Programs
- Guardian, conservator or person who has power of attorney for you
- Local collaborative agencies
- Community food shelves or surplus food programs
- Health care providers
- School districts
- Schools and other institutions of higher education
- Coroner/medical examiner if you die and they investigate your death
- Hospitals if you, a friend, or relative has an emergency and we need to contact someone
- Others who may pay for your care
- Insurance companies to check health care benefits you or your children may get
- Managed care organizations about your health care or benefits
- Credit bureaus
- Creditors
- Collection agencies, if you do not pay fees you owe to us for services
- Minnesota Board on Aging
- Anyone else to whom the law says we can give the information

You have the right to information we have about you.

- You may ask if we have any information about you and get copies. You may have to pay for the copies.
- You may give other people permission to see and have copies of private information about you.
- Unless we get special written permission from you, we will only use your health information for the purposes listed on this form.
- You may question the accuracy of any information we have about you.
- You have the right to ask us to share health information with you in a certain way or in a certain place. For example, you may ask us to send health information to your work address instead of your home address. You must make this request in writing. You do not have to explain the basis for your request. If we find that your request is reasonable, we will grant it.
- You can ask us to restrict uses or disclosures of your health information. Your request must be in writing. You must explain what information you want to restrict from being disclosed and to whom you want these restrictions to apply. You can request to end these restrictions at any time by calling us or by writing to us. We are not required to agree to your restrictions.
- You have the right to receive a record of the people or organizations that we have shared your health information with. We must keep a record of each time we share your health information for six years from the date it was shared. This record will be started on April 14, 2003.
  It will NOT include those times when we have shared your information in order to treat you, pay or bill for your health care services or to run our programs. If you want a copy of this record, you must send a request in writing to our Privacy Official.
- If you do not understand the information, ask your worker to explain it to you. You can ask DHS for another copy of this notice.

Keep this page.

What are our responsibilities under this notice?

We may change our privacy policy in the future. We might do this, for example, because privacy laws change and require us to change our practices.

When we change our privacy rules we will publish them on our Web site at:

http://edocs.dhs.state.mn.us/lfserver/Legacy/DHS-3979-ENG.

Until we publish new privacy rules, we will abide by the terms of this notice.

What if you believe the information we have about you is wrong?

Send your concerns in writing, telling us why the information is not accurate or complete. You may send your own explanation of the facts you disagree with. Your explanation will be attached any time that information is shared with another agency.

What privacy rights do children have?

If you are under 18, parents may see information about you and allow others to see this information, unless you have asked that this information not be shared with your parents or it involved medical treatment for which parental consent was not required. You must make this request in writing and say what information you want withheld and why. If the agency agrees that sharing the information is not in your best interest, the information will not be shared with your parents. If the agency does not agree, the information will be shared with your parents if they ask for it.

When parental consent for medical treatment is not required, information will not be shown to parents unless the health care provider believes failing to share the information would jeopardize your health.

What if you believe your privacy rights have been violated?

You may complain if you believe your privacy rights have been violated. You cannot be denied service or treated badly because you have made a complaint. If you believe that your medical privacy was violated by your doctor or clinic, a health insurer, a health plan, or a pharmacy, you may send a written complaint either directly to that organization or to:

- U.S. Department of Health and Human Services
  Office for Civil Rights, Region V
  233 N. Michigan Avenue, Suite 240
  Chicago, IL 60601
  (312) 886-2359 (Voice) or
  toll free (800) 368-1019 or (866) 282-0659
  (312) 353-5693 (TTY/TDD)
  (312) 886-1807 (Fax)

If you think that the Minnesota Department of Human Services has violated your privacy rights, you may send a written complaint to the U.S. Department of Health and Human Services at the address above or to:

- Minnesota Department of Human Services
  Appeals and Regulations
  PO Box 64941
  St. Paul, MN 55164-0941

Important Information

Proof of Citizenship or National Status

Parents and caretakers, children, pregnant women, people with disabilities and people age 65 or over must give us proof that they are United States (U.S.) citizens or nationals. National status includes people from American Samoa and Swains Island.

Adults without children are not required to give us proof that they are U.S. citizens or nationals.

Proof can be one of the following:

1. U.S. passport
2. Certificate of Naturalization
3. Certificate of U.S. Citizenship

If you do not have one of the above documents, you must give us one item from List #1 and one from List #2 below. If you do not have or cannot get these items, ask your worker for help right away.

List #1

1. U.S. birth certificate
2. Report of Birth Abroad of a U.S. Citizen
3. U.S. Citizen ID card
4. Hospital record of birth in one of the 50 states, the District of Columbia, Puerto Rico, Guam, the U.S. Virgin Islands, American Samoa, Swains Island or the Northern Mariana Islands.

Keep this page.

List #2

1. Current State driver's license with picture
2. Minnesota ID card with picture
3. School ID card with picture.
4. Nursery or daycare records for children under 16.

Immigration

All immigration information you give to us is private. We use it to see if you can get coverage. We only share it when the law allows it or requires it. In most cases, applying will not affect your immigration status. However, it may if you are applying to pay for long-term care services.

You do not have to give us your immigration information if you are:

- Applying only for emergency medical care.
- Only helping someone else apply.
- A non-immigrant or undocumented person who is pregnant.
- Applying for your children or other household members, but not yourself.

You Have the Right to Fair Treatment

We cannot treat you different because of your race, color, national origin, religion, sex, marital status, sexual orientation or political beliefs. We cannot treat you different because you have a physical, mental or emotional disability. If you feel the State or local agency did not treat you fairly, you may file a complaint. You can contact any of the following places to file a complaint:

- Minnesota Department of Human Services
  Office for Equal Opportunity
  PO Box 64997, St. Paul, MN 55164-0997
- Minnesota Department of Human Rights
  190 E. Fifth Street, Suite 700
  St. Paul, MN 55101
- U.S. Department of Health and Human Services
  Office of Civil Rights - Region V
  233 N. Michigan Avenue, Suite 240
  Chicago, IL 60601

You Have the Right to Ask for a Hearing

If you feel that your benefits are not right you may ask for a fair hearing. You can ask for a hearing by telling your worker or by writing to the:

- Minnesota Department of Human Services
  Appeals and Regulations
  PO Box 64941
  St. Paul, MN 55164-0941

A person from the State office will check the facts of your case. They will tell you if your benefits are correct or not according to the laws.

You must ask for a hearing within 30 days from the day you get a notice. You must say that you feel a decision is wrong. If you cannot ask for a hearing within 30 days, you can ask for more time. You will need to show that you have a good reason for not asking for hearing on time. If a person from the State office decides you had a good reason, they will accept your appeal up to 90 days after you received the notice of action on your case.

If you ask for a hearing after 30 days, you will not be able to have your health care continue until the hearing. If you want your health care to continue, you must ask for a hearing before the date your coverage will be reduced or within 10 days from the date of the notice, whichever is later.

Breaking the Rules

The below rules apply to some people who are enrolled in certain health care programs. If the rules apply to you, it explains what will happen if you break the rules.

What are the rules?

- Do not give false information or hide information to get or continue to get health care program coverage.
- Do not trade or sell your membership cards.
- Do not help others get medical services that you know they should not get.
- Do not use someone else's membership card for yourself or other household members.

Keep this page.

What happens if I break these rules?

If you break the rules you may not be able to keep your coverage. The first time you break the rules, your coverage will stop for one year. The second time you break the rules you will not get coverage for two years. If you break the rules a third time, you will not get coverage forever. Also, if you break these rules we can prosecute you for fraud. The maximum penalty is a fine of $250,000 or a jail term of 20 years, or both.

Social Security Numbers

Most people who apply for coverage must give a Social Security Number. We use them to check who you are, for system matches, and for reviews and audits to make sure your case is correct.

You do not have to give us a number if you:

- Do not want coverage
- Have religious objections
- Are not a U. S. Citizen and are applying for Emergency Medical only
- Are a non-immigrant or a person without documentation.

Child Support

If you are applying for yourself and your children and you do not live with the other parent, the law says that you may have to give information to child support staff.

If you were not married to the other parent when your child was born, you may also have to help child support staff prove who the father is. This means that you may need to give information to get medical support for your child. If you do not help child support, your children will still get coverage. You will not get coverage unless you are pregnant. Your coverage will stop if you are already getting coverage.

Do you have fear that the other parent may cause harm to you or your child? If you do, and you can give proof to support your fears, you may not have to give information to child support staff. A group of people at the county or state office will review your proof. After the review, they will tell you if you still need to give information about the other parent.

If you are already getting child support services, they will stop during the review. If they make a decision that you must give information about the other parent, child support services will start again.

A law says that the State of Minnesota gets to keep medical support payments for the person who is applying for or getting coverage. The State can not keep more than it pays out. This is also true even if you are applying only for a child.

Reviews

The State or Federal Office may pull your case at random to review. They will review the information you put on your application and renewal forms. They will also check to make sure we did your case correctly. They will let you know if they will need to ask you questions. If you refuse to answer their questions, your coverage may stop.

Reporting Systems

The State uses systems to check the information you give. If we get information that does not match yours, we will write to you. You will need to give us proof or give us permission to check your information. If you refuse, your coverage may stop. If you want more information, ask your worker for the "Notice About Income and Eligibility Verification System and Work Reporting System" (DHS-Form #2759).

Other Health Care

You and your household members may need to accept and keep a health insurance policy that is good. This includes Medicare. We will review your policy. We will tell you if you can or cannot cancel it.

In some cases, if we tell you that you cannot cancel it, we may help pay the premiums. If you refuse to give us information about your policy, you may not get coverage.

State As Annuity Beneficiary

The state becomes a remainder beneficiary of some annuities when we pay for long-term care services.

Keep this page.

Liens and Estate Claims

The state or county may try to recover the cost of medical services that MA or GAMC paid for you. They do this by filing a claim against your estate or by filing a lien against your real property.

The state may file a claim against your estate if you received:

- General Assistance Medical Care (GAMC) at any age.
- MA when you were over age 55.
- MA when you were under 55 and lived in a long-term care facility (LTCF) for six months or more.

Liens can be set up against:

- Your life estate.
- Real property that you own by yourself.
- Real property that you own with someone else. If you own property with another person, the lien is only against your share of it.

The state will not file a lien against your property if you are in a long-term care facility and will be returning home.

Before you die, the State can file a Notice of Potential Claim (Notice). The Notice must:

- List the real property you own.
- Note if you have a life estate.
- State if other people own any real property with you.

When you die, a lien is set up against your portion of the property that was listed in the Notice. Your interest in real property that is part of your estate may be used to pay that claim.

Note that this is a very general explanation of the rights that the state and counties have regarding claims and liens. You should talk to your lawyer or advisor if you have questions about how these laws apply to your property.

Changes

You must report changes to your worker within 10 days of the change happening. If you do not report changes, you may have to go through a fraud investigation. You may have to pay money back to the State for what we paid if you were not eligible.

If you are not sure if you should report a change, call your worker and explain what is happening. Your worker will tell you if you need to report it or not.

Examples of changes you need to report may include:

- **Starting:**
  - A new job; changing jobs, or stopping a job.
  - To get Social Security or other retirement income.
  - To get child support, unemployment or worker's comp income.
  - To get health insurance or Medicare.
- **When you:**
  - Sell your home.
  - Move to a new address.
  - Get an inheritance or a settlement.
  - Transfer or give away assets or income.
- **When someone in your household:**
  - Becomes pregnant or has a baby.
  - Moves in or out of your home.
  - Dies, gets married or gets a divorce.
  - Becomes disabled.
  - Starts or stops school.

Keep this page.

DHS-3417-ENG 7-06

Minnesota Health Care Programs Application

Instructions

- Answer all questions and print clearly.
- Write with blue or black ink. Do not use a pencil.
- You may need more space to answer a question. Write the question number and answer on a separate piece of paper. Include it with this application.

1. Language information

What is the main language your household speaks? ☐ English ☐ Spanish ☐ Other_____

What is the main language your household writes? ☐ English ☐ Spanish ☐ Other_____

Do you need someone who speaks your language to help you? ☐ **Yes** ☐ **No**

2. Who is the head of this household?

The head of the household is a husband, a wife, a parent of a child, or yourself if you live alone. The head of household could be a person under age 18 who is living on their own. If someone other than a household member is filling out this application, write the name of the head of household below.

First Name_____ Middle_____ Last_____

3. What is your address?

☐ Check this box if you are homeless.

Street address_____ Apt #_____ City_____

State_____ Zip code _____ What county do you live in?_____

Mailing address where you want your notices sent (if different from the one above):

Street address_____

City_____ State_____ Zip code _____

Do you want us to send you a voter registration card? ☐ **Yes** ☐ **No**

☐ Check this box if you are a migrant worker.

4. Have you and your household lived in Minnesota more than six months?

☐ **Yes** - go to question 5 ☐ **No** - write the date you began living in Minnesota_____

Do you plan to make Minnesota your home? ☐ **Yes** ☐ **No** - explain_____

_____

5. Write the names and phone numbers of people we can call during the day.

We will only call if we have questions about this application.

Name _____ Phone number ( )_____

Name _____ Phone number ( )_____

6. Do you want someone else to help you and act on your behalf?

☐ **Yes** – fill out this person's information below ☐ **No** – go to question 6a

This person:

- Must be age 18 or older
- Can be a friend, relative, or someone else who knows all of your information
- Can help you fill out forms and give us information we need
- Must report changes to us within 10 days

You can allow this person to get your notices about your:

- Health care application and renewals
- Health care eligibility and benefits
- Fair hearings

First name _____ MI_____ Last_____

What is this person's relationship to you? (Example - son, daughter or friend)_____

Street address_____

City_____ Apt # _____ State_____ Zip code_____

Daytime phone number (_____) _____ - _____

Do you want us to mail your notices and other information to this person also? ☐ **Yes** ☐ **No**

6a. Do you have a legal guardian or conservator, or is there a power of attorney?

☐ **Yes** – we will need a copy of the legal document ☐ **No**

What is that person's full name?_____

Do you pay this person a fee? ☐ **Yes** – how much? $_____ How often?_____ ☐ **No**

7. Are any household members under age 18 emancipated?

Emancipation means: a child under the age of 18 is married; was married; is serving in the armed forces; or a judge signed an order stating this child is no longer under the legal control of his or her parents.

☐ **Yes** – write their full names_____ ☐ **No**

8. Fill out the information below for all household members.

- You must tell us if each person applying is a U.S. citizen, a national, or a non-citizen.
- Nationals include people from American Samoa and Swains Island.
- **Citizens and nationals must give us proof of U.S. citizenship or national status.** See the list of proofs on green pages F and G.
- **People who are not U.S. citizens must give us copies of immigration documents.** All immigration information you give us is private. See the information on green page G.
- Let us know if you need help getting proofs.

8a. Head of household (Read the explanation by question 2.)

First name_____ Middle_____ Last_____

Date of birth_____/_____/_____ City and state of birth _____

Name at birth _____ Sex ☐ Male ☐ Female

Marital Status_____ Are you applying? ☐ **Yes** - continue ☐ **No** - go to question 8b

Social Security Number_____-_____-_____ Are you a U.S. citizen or national? ☐ **Yes** ☐ **No**

If no: Immigration status_____

Date of entry into U.S. _____/_____/_____ Do you have a sponsor? ☐ **Yes** ☐ **No**

You do not have to answer the next two questions if you do not want to. We use it for reports only.

Are you Latino or Hispanic? ☐ **Yes** ☐ **No**

What is your race? ☐ White ☐ Asian ☐ American Indian or Alaskan Native
☐ Black/African American ☐ Pacific Islander or Native Hawaiian

8b. Do you live alone? ☐ **Yes** - go to question 9 ☐ **No** - go to question 8c

8c. Second household member

First name_____ Middle_____ Last _____

Date of birth_____/_____/_____ City and state of birth _____

Name at birth _____ Sex ☐ Male ☐ Female

Relationship to head of household _____ Marital Status_____

Is this person applying? ☐ **Yes** - continue ☐ **No** - go to next person

Social Security Number _____-_____-_____ U.S. citizen or national? ☐ **Yes** ☐ **No**

If no: Immigration status_____

Date of entry into U.S. _____/_____/_____ Do you have a sponsor? ☐ **Yes** ☐ **No**

You do not have to answer the next two questions if you do not want to. We use it for reports only.

Is this person Latino or Hispanic? ☐ **Yes** ☐ **No**

What is this person's race? ☐ White ☐ Asian ☐ American Indian or Alaskan Native
☐ Black/African American ☐ Pacific Islander or Native Hawaiian

8d. Third household member

First name_____ Middle_____ Last _____

Date of birth_____/_____/_____ City and state of birth _____

Name at birth _____ Sex ☐ Male ☐ Female

Relationship to head of household _____ Marital Status_____

Is this person applying? ☐ **Yes** - continue ☐ **No** - go to next person

Social Security Number _____-_____-_____ U.S. citizen or national? ☐ **Yes** ☐ **No**

If no: Immigration status_____

Date of entry into U.S. _____/_____/_____ Do you have a sponsor? ☐ **Yes** ☐ **No**

You do not have to answer the next two questions if you do not want to. We use it for reports only.

Is this person Latino or Hispanic? ☐ **Yes** ☐ **No**

What is this person's race? ☐ White ☐ Asian ☐ American Indian or Alaskan Native
☐ Black/African American ☐ Pacific Islander or Native Hawaiian

8e. Fourth household member

First name_____ Middle_____ Last _____

Date of birth_____/_____/_____ City and state of birth _____

Name at birth _____ Sex ☐ Male ☐ Female

Relationship to head of household _____ Marital Status_____

Is this person applying? ☐ **Yes** - continue ☐ **No** - go to next person

Social Security Number _____-_____-_____ U.S. citizen or national? ☐ **Yes** ☐ **No**

If no: Immigration status_____

Date of entry into U.S. _____/_____/_____ Do you have a sponsor? ☐ **Yes** ☐ **No**

You do not have to answer the next two questions if you do not want to. We use it for reports only.

Is this person Latino or Hispanic? ☐ **Yes** ☐ **No**

What is this person's race? ☐ White ☐ Asian ☐ American Indian or Alaskan Native
☐ Black/African American ☐ Pacific Islander or Native Hawaiian

8f. Fifth household member

First name_____ Middle_____ Last _____

Date of birth_____/_____/_____ City and state of birth _____

Name at birth _____ Sex ☐ Male ☐ Female

Relationship to head of household _____ Marital Status_____

Is this person applying? ☐ **Yes** - continue ☐ **No** - go to next person

Social Security Number _____-_____-_____ U.S. citizen or national? ☐ **Yes** ☐ **No**

If no: Immigration status_____

Date of entry into U.S. _____/_____/_____ Do you have a sponsor? ☐ **Yes** ☐ **No**

You do not have to answer the next two questions if you do not want to. We use it for reports only.

Is this person Latino or Hispanic? ☐ **Yes** ☐ **No**

What is this person's race? ☐ White ☐ Asian ☐ American Indian or Alaskan Native
☐ Black/African American ☐ Pacific Islander or Native Hawaiian

If there are more household members: Write "Question 8" on a separate piece of paper. Write the above information for each person. Include it with this application.

You must give us copies of documents that show citizenship, national status or immigration status for each household member who is applying. You may not get coverage if we do not get proof.

9. Are any household members pregnant?

☐ **Yes** - fill out the information below ☐ **No** - go to question 10

Who is pregnant? _____ What is her due date?_____/____/_____

You must give us proof of the pregnancy from a doctor, midwife or clinic. The proof needs to tell us the date she became pregnant and when the baby is due. You may not get coverage if we do not get proof.

10. Are any household members living away from home for a short time?

☐ **Yes** - fill out the information below ☐ **No** - go to question 11

First name _____ Middle _____ Last_____

Date of birth _____/_____/_____ Relationship to head of household _____

Date person left_____/_____/_____ Date person will return_____/_____/ _____

Why is this person living away? _____

11. Are you or is any household member a student?

☐ **Yes** - write each student's name and their grade below. ☐ **No** - go to question 12

Full name of student	Elementary school	High School		College	
		Full time	Part time	Undergrad	Graduate

If more students live in the household: Write "Question 11" on a separate piece of paper. Write the above information for each student. Include it with this application.

12. Are you or any household members blind or have serious medical problems?

☐ **Yes** - write their names below ☐ **No** - go to question 13

Name _____ Has this person worked in the past year? ☐ **Yes** ☐ **No**

Name _____ Has this person worked in the past year? ☐ **Yes** ☐ **No**

13. In what month and year do you want health care coverage to start?

Are you pregnant, a parent or caretaker of a child under age 18, blind, disabled, under age 21 or age 65 or older? If you are, the coverage start date may go back three months from the date you turn in your application. Otherwise, coverage cannot start until the date you turn in this application. In most cases, if you have a monthly payment, coverage starts the month after we get your payment.

Month_____ Year_____

You must give us proof of income and you may need to give us proof of assets for each prior month that you want coverage. You may not get coverage if we do not get proof.

Worker Notes

14. Are both parents of all children living in the home?

☐ **Yes** - go to question 15
☐ **No** - fill out information below for each child whose parent lives somewhere else

	First child	Second child	Third child
Child's name			
Name(s) of other parent(s) - List both parents if neither one lives with the child			
Is the parent's name on the **birth certificate?**	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**
Is there a signed **Recognition of Parentage**?	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**
Is there a court order for **paternity**?	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**
Is there a court order for **medical support**?	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**
If paternity is not established do you want help getting Medical Support?	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**

If the parents of more children live somewhere else: Write "Question 14" on a separate piece of paper. Write the above information for each child. Include it with this application.

15. Are you or any household members getting services from the Center for Victims of Torture?

☐ **Yes** - write their full names _____ ☐ **No** - go to question 16

16. Do any household members have a medical emergency?

A medical emergency means someone needs to get medical help right away. The person's health or life will be at risk without medical help.

☐ **Yes** - write their full names_____ ☐ **No** - go to question 17

Worker Notes

17. Are you or are any household members getting or expecting wages or a salary from a job?

This includes wages or a salary from an employer, seasonal employment, temporary jobs and cash jobs. If you are age 21 or older and living with your parents, you only need to give us your income.

☐ **Yes -** fill out the information below for each job and for each person who is working

☐ **No -** go to question 18

17a. Name of person working_____ Start date _____

Name of employer_____ Employer's phone number (____) _____

Contact person _____ ☐ Check this box if employment is seasonal or temporary.

How often paid? ☐ Every week ☐ Every two weeks ☐ Once a month ☐ _____

Date of most recent paycheck_____

Amount of income before taxes and other deductions are taken out $ _____

Does this employer offer health insurance? ☐ **Yes -** ☐ Single coverage **or** ☐ Household coverage ☐ **No**

17b. Name of person working_____ Start date _____

Name of employer_____ Employer's phone number (____) _____

Contact person _____ ☐ Check this box if employment is seasonal or temporary.

How often paid? ☐ Every week ☐ Every two weeks ☐ Once a month ☐ _____

Date of most recent paycheck_____

Amount of income before taxes and other deductions are taken out $ _____

Does this employer offer health insurance? ☐ **Yes -** ☐ Single coverage **or** ☐ Family coverage ☐ **No**

If you have other jobs to report: write "Question 17" on a separate piece of paper. Write the above information for each person and job. Include it with this application.

You must give us proof of income. Proof can be pay stubs from the last 30 days or a statement from the employer. You may not get coverage if we do not get proof.

You must give us proof that shows if employers offers health insurance. For each employed person, fill out Form A at the back of this application. You may not get coverage if we do not get proof.

Worker Notes

18. Are you or any household members self-employed?

☐ **Yes** - fill out the information below and give us proof ☐ **No** - go to question 19

Name of person	Name of business	Start date of business	Gross yearly income
			$
			$

Do the net business assets of all businesses total $200,000 or less? ☐ **Yes** ☐ **No**

You must give us proof of this income. Proof can be the most recent income tax returns and all related schedules, or business records if taxes are not filed. You may not get coverage if we do not get proof.

19. Are any household members getting or expecting to get other types of income?

Other income may include: child support, spousal support, unemployment, worker's comp, Social Security, Supplemental Security Income (SSI), pensions, Veteran's benefits, retirement, annuities, trusts, interest, dividends, contracts for deed, rent, property agreements, public assistance payments and other types of income.

☐ **Yes** - fill out the information below and give us proof. ☐ **No** - go to question 20

Name	Where is the income from?	Amount	How often is it received? (Every week, every two weeks, once a month)	Date of the last payment
		$		
		$		
		$		
		$		

You must give us proof of this income. Proof can be a statement from the place that sends the income, or a direct deposit statement from your bank. You may not get coverage if we do not get proof.

20. Do you or any household members pay for child or adult day care while they work?

☐ **Yes** - fill out the information below ☐ **No** - go to question 21

Name of person who is working	Name of person(s) in daycare	Amount paid each month
		$
		$

21. Do you or any household members pay court-ordered child or medical support?

☐ **Yes** - fill out the information below and give us proof ☐ **No** - go to question 22

Name of person paying support	Amount paid each month
	$
	$

You must give us proof of the amount. Proof can be a copy of the court order. You may not get coverage if we do not get proof.

22. Do any disabled or blind household members have work expenses?

☐ **Yes** - fill out the information below ☐ **No** - go to question 23

Name of person who is working	Type of expense	Amount paid each month
		$
		$
		$

Worker Notes

23. Do you or any household members have medical bills that have not been paid?

☐ **Yes** - fill out the information below ☐ **No**

23a. Do you or any household members have medical bills from the past three months?

☐ **Yes** - fill out the information below ☐ **No** - go the question 24

Name of person	Date of service	Provider name	Amount	Has this bill been paid?
			$	☐ Yes ☐ No
			$	☐ Yes ☐ No
			$	☐ Yes ☐ No
			$	☐ Yes ☐ No
			$	☐ Yes ☐ No
			$	☐ Yes ☐ No
			$	☐ Yes ☐ No
			$	☐ Yes ☐ No
			$	☐ Yes ☐ No
			$	☐ Yes ☐ No

If you have more medical bills: List them on a separate piece of paper and include the list with this application.

You must give us copies of these medical bills and proof of any health insurance payments. You may not get coverage if we do not get proof.

Worker Notes

24. Do you and your household members have any assets?

Assets are things you own. They include items such as: cash, bank accounts, certificates of deposit, stocks, bonds, retirement accounts, interest in annuities, trusts, property agreements, contracts for deed, timeshares, rental property, life estates, livestock, tools, and farm machinery. You will list vehicles in question 25.

☐ **Yes** - fill out the information below and give us proof. ☐ **No** - go to question 25

Owner's name	**Type of asset**	**Name of bank/company**	**Value of asset**	**Amount of loan** (If none, write "0")
			$	$
			$	$
			$	$
			$	$
			$	$
			$	$

You must give us proof of assets. Proof can be statements from the bank or company. The proof must be dated within the last 30 days. You may not get coverage if we do not get proof.

25. Do you or any household members have vehicles?

Vehicles include cars, trucks, snowmobiles, four-wheelers, motorcycles, boats, motors, trailers, campers, and motor homes.

☐ **Yes** - fill out the information below and give us proof ☐ **No** - go to question 26

Owner's name	**Vehicle year / make / model**	**Value of asset**	**Amount of loan** (If none, write "0")
		$	$
		$	$
		$	$
		$	$

You must give us proof of all vehicles and proof of loan balances. Proof can be the registration card or title **and** a statement from the bank or loan company showing the loan balance. You may not get coverage if we do not get proof.

26. Do you or any household members own or are buying real estate?

Real estate includes homes, cabins, lake homes, land and other property that you rent to someone else.

☐ **Yes** - fill out the information below ☐ **No** - go to question 27

Name of owner(s)	**Address of real estate**	**Value**	**Loan amount** (If none, write "0")	**Do you live here?**
		$	$	☐ **Yes** ☐ **No**
		$	$	☐ **Yes** ☐ **No**

You must give us proof of all real estate that you own that is not where you live. Proof can be real estate tax statements and loan balance statements. You may not get coverage if we do not get proof.

27. Do you or any household members have life insurance policies?

☐ **Yes** - fill out the information below and give us proof. ☐ **No** - go to question 28

Owner's name	**Name of insurance company**	**Face value**	**Cash surrender value**
		$	$
		$	$

You must give us proof of the face value and the cash surrender value of all life insurance policies. Proof can be a copy of the policy or a statement from the insurance company that is dated within the last 30 days. You may not get coverage if we do not get proof.

28. Do you or any household members have a burial contract or money for burial?

☐ **Yes** - fill out the information below and give us proof. ☐ **No** - go to question 29

Owner's name	**Name of funeral home or company that holds the burial agreement**	**Value**	**Date of the agreement**
		$	
		$	

You must give us proof of burial agreements. Proof can be a copy of the agreement or a statement from the company or funeral home with the statement of goods and services. You may not get coverage if we do not get proof.

29. In the last five years, did you or any household member:

- Sell any assets for less than what they were worth?
- Trade assets or income?
- Transfer assets or income?
- Give away assets or income?
- Not accept an inheritance?
- Purchase an annuity, life estate in another person's home, promissory note, loan or mortgage?

☐ **Yes -** fill out the information below ☐ **No -** go to the Health Insurance Section on page 15

Owner(s) of the asset or income	**Type of asset or income**	**Value of asset or income**	**Who was it given to or sold to?**	**When?** mm/dd/yy	**How much were you paid for the asset?**
		$			$
		$			$
		$			$
		$			$
		$			$
		$			$

If you have more transfers: List them on a separate piece of paper and include the list with this application.

You must give us proof to show what was sold or given away. You may not get coverage if we do not get proof.

Worker Notes

Health Insurance Section

Health insurance is coverage through:

- Your spouse
- Your parents
- An employer
- Medicare
- Union or other group
- A private insurance company
- A college
- An HMO (Health Maintenance Organization)

Do not cancel any health insurance coverage until we look at the policy. When we look at the policy, we will see if we can help pay for the cost.

You must give us proof of all health insurance polices. Proof can be a copy of the policy and/or both sides of the member identification card. You may not get coverage if we do not get proof.

30. Did you or any household members have health insurance that ended during the last four months?

☐ **Yes** - fill out the information below ☐ **No** - go to question 31

List the first and last names of household members whose coverage ended

_____ _____

_____ _____

_____ _____

Month, day and year that the insurance ended _____/_____/_____

Why did the insurance end? _____

_____

31. Do you or any household members have health insurance now?

This includes health insurance through an employer, a union or group, a spouse, a parent, a private insurance company, long-term care insurance and prescription drug coverage.

☐ **Yes** - fill out the information below ☐ **No** - go to question 32

Check a box for each type of coverage:

☐ Individual ☐ Group ☐ Long-term care ☐ Prescription Drug Coverage

☐ Other - explain the type of coverage _____

_____

What is the policyholder's first and last name? _____

What is the name of insurance company? _____

What is the address of the insurance company? _____

_____

What is the policy number? _____ What is the group number? _____

Date the insurance coverage started _____/_____/_____

The first and last name of household members covered by this policy

_____ _____

_____ _____

How much is the deductible per person? $_____

How much is the deductible for the family? $_____

How much is the co-pay for each doctor visit? $_____

How much is the co-pay for each prescription? $_____

32. Is this health insurance through an employer or union?

You may have to ask your employer for this information.

☐ **Yes** - fill out the information below ☐ **No** - go to question 33

Employer's name _____ Street Address _____

City _____ State _____ Zip code _____

How much does the employee pay for the premium each month? $_____

How much does the employer/union pay for the employee's premium each month? $_____

How much does the employer/union pay for family coverage each month? $_____

How much does the employee pay for family coverage each month? $_____

If you have more insurance policies: Write "Insurance" and information about the policy on a separate piece of paper. Include it with this application.

33. Did you or any household member turn down health insurance from a current employer?

This means an employer offered health insurance and someone did not take the coverage.

☐ **Yes** - explain_____ ☐ **No**

34. Did you or any household member drop health insurance from a current employer?

This means someone had health insurance through their employer and ended the coverage.

☐ **Yes** - explain_____ ☐ **No**

35. Did a current employer who offered health insurance in the past 18 months stop offering it?

This means that someone works for an employer who gave them health insurance and then stopped offering it. ☐ **Yes** ☐ **No**

36. If college students are applying, can they get health insurance through their parents or through their school?

☐ **Yes** - name(s) of college student(s)_____ ☐ **No**

37. Is any household member who is applying getting medical care for an accident or injury that happened in the last six years?

☐ **Yes** - fill out the information below ☐ **No** - go to question 38

Name of Person	Date of accident or injury	Does someone have coverage to help pay the medical costs?	Is there a lawsuit?
		☐ **Yes** - Who?_____ ☐ **No**	☐ **Yes** ☐ **No**
		☐ **Yes** - Who?_____ ☐ **No**	☐ **Yes** ☐ **No**

38. Do any household members have Medicare coverage?

☐ **Yes** - fill out the information below ☐ **No** - go to question 39

Name of Person	Medicare ID number	Part A Start Date	Part B Start Date	Part D Start Date

Worker Notes

39. Are you or is any household member living in a long-term care facility (LTCF) or planning to get waiver program services?

- LTCF includes a skilled nursing facility, intermediate care facility and nursing facility care in an inpatient hospital.
- Waiver programs include Elderly Waiver (EW), Community Alternatives for Disabled Individuals (CADI), Community Alternative Care (CAC), Traumatic Brain Injury (TBI), and Mental Retardation and Related Conditions (MR/RC).

☐ **Yes** - fill out the information below ☐ **No** - go to the Signature Page

Check the one that applies:

☐ This person lives in a long-term care facility. ☐ This person expects to get waiver program services.

Person's first name_____ MI ___ Last name_____

40. Has this person ever had a long-term care insurance policy?

☐ **Yes** - fill out the information below ☐ **No** - go to question 41

Is this policy paying benefits now? ☐ **Yes** ☐ **No**

Did this policy ever pay benefits? ☐ **Yes** - when?_____ ☐ **No**

Name of insurance company _____

First name of policy holder_____ MI___ Last name_____

Date the insurance policy was issued_____ Policy number _____

Street address of insurance company_____

City _____ State_____ Zip code _____

41. Does this person own a home?

☐ **Yes** - fill out the information below ☐ **No** - go to question 42

Does a spouse, a child under the age of 21, or a blind or disabled child of any age live in the home?

☐ **Yes** - go to question 42 ☐ **No** - fill out the information below

Name of owner(s)	**Address of home**	**Value**	**Amount of loan** (If none, write "0")	**Do you live here?**
		$	$	☐ **Yes** ☐ **No**

You must give us proof. Proof can be the real estate tax statement and a statement showing the mortgage or loan balance. You may not get coverage if we do not get proof.

42. Does this person want to give income to a spouse, a child under age 21, or another dependent?

Dependents may include a child over age 21 who is blind or disabled, or parents or siblings who are listed as dependents on tax forms.

☐ **Yes** - fill out the information below ☐ **No** - go to question 44

	Spouse	**Child or Dependent**	**Child or Dependent**
Name of spouse or dependent			
Date of birth			
Relationship to person applying			
Type of income (Write "0" if none)			
Amount	$	$	$
How often is income received?			

If this person wants to give income to more dependents: Write "Question 43" on a separate piece of paper. Write the above information for each person. Include it with this application.

42a. Is the spouse getting help from the Elderly Waiver program?

☐ **Yes** ☐ **No**

42b. Does the spouse have housing expenses?

☐ **Yes** - fill out the information below ☐ **No** - go to question 44

Write how much the spouse pays for each expense:	
Monthly rent or mortgage	$
Last year's real estate taxes	$
Last year's homeowner's insurance	$
Monthly heating bill	$
Monthly cooling bill	$
Monthly electricity bill	$
Monthly telephone bill	$
Other costs (such as an association fee) What is the expense?_____	$

43. Was an Asset Assessment ever completed in a county or another state?

This means a staff person reviewed all assets owned by both spouses.

☐ **Yes -** when?_____/_____/_____ In what county or state?_____ ☐ **No**

44. Is this person or the spouse a veteran?

☐ **Yes** - what is the veteran's name?_____ ☐ **No**

45. Facility Information

Fill out this information if the person lives in a facility such as a nursing home, intermediate care facility, assisted living, nursing facility care in an inpatient hospital, Group Residential Housing or other group home.

Date this person began living in this facility (mm/dd/yy) _____

Name of the facility _____

Facility street address _____

City_____ State_____ Zip code _____

In what county is the facility?_____

Phone number of the facility ( ) _____ - _____

Was this person in a hospital before moving to the facility or getting home care services?

☐ **Yes -** from (mm/dd/yy) _____ to _____ ☐ **No**

What was the person's address before moving to the facility? Street address _____

City_____ State_____ Zip code_____ County _____

Worker Notes

Signature Page

All adults must read all of the following information and sign below.

Fraud Investigation Release

I give third parties permission to share information about me with authorized state and county staff conducting investigations regarding fraud, fraud prevention and misrepresentation. Third parties include but are not limited to financial institutions, credit reporting agencies, landlords, public housing agencies, schools, utility companies, insurance agencies, employers, other government agencies and others as they apply. I further authorize taxing authorities to release copies of my income tax returns. I also understand that my permission for release is effective for six months after my benefits stop.

Medical Assignment of Benefits

I assign all medical payments to the State of Minnesota. This assignment includes medical care payments from all other persons or entities. This assignment covers medical care payments for myself. It also covers anyone else for whom I apply.

It takes effect right away when health care coverage starts. I agree to cooperate with the State in any action to recover payment of medical expenses. If I claim good cause and good cause is approved, I may not have to cooperate.

Medical Release

I give consent to my health providers and health plan, including their contractors, to share my Minnesota Health Care Programs (MHCP) health records with the State of Minnesota, its agents, contractors and their subcontractors, Ombudsman and County Advocates for managed care. I know I need to share this information to:

- Decide if I can get federally funded health care,
- Pay my health care providers,
- Provide and coordinate health care,
- Do quality of care reviews and studies, and
- Help in record reviews, prosecutions or legal actions related to managing the health care programs.

If I have Medicare Part B, I give Medicare consent to pay my health providers for the care I get while on MHCP. This release also applies to the MHCP health records of my minor children in this application.

This medical release is good while I am enrolled in MHCP, not to exceed one year, or longer if the law permits. I can refuse to sign or cancel the medical release. If I cancel I must do this in writing. I understand that the law overrides my canceling this release for these reasons:

- To share health information with health care consultants,
- To pay my health care bills,
- If fraud is suspected, or
- For quality of care reviews and studies.

If I refuse to sign or if I cancel the release, I will not be able to enroll or stay enrolled in Minnesota Health Care Programs. I understand that this release allows my MHCP health records to be shared with others if the law permits. Privacy laws may no longer protect the information shared with others.

By signing below:

- I agree that I have read the Notice of Privacy Practices and the list of my responsibilities in that Notice.
- I understand that my information will be shared if fraud is suspected.
- I agree to the release of my Minnesota Health Care Programs health records to the parties listed above.
- I agree to assign my medical benefits as stated above.
- I agree to allow the State of Minnesota, its agents, contractors, and subcontractors to contact my employer(s) for the purpose of verifying access to employer subsidized health insurance.
- I declare that, under penalty of perjury, all parts of this application, to the best of my knowledge, are true and correct statements. I understand what happens to people convicted of perjury (not telling the truth). They may be sentenced to prison for up to five years, a fine up to $10,000, or both.

All adults age 18 and older who are applying must sign below.

- You must sign this application even if you are authorizing someone to act on your behalf.
- The person you are authorizing must also sign.
- If an applicant is unable to sign, provide copies of legal documents of conservatorship or power of attorney.

Your signature	Date
Signature of spouse	Date
Signature of household member age 18 and older who is applying	Date
Signature of household member age 18 and older who is applying	Date
Signature of household member age 18 and older who is applying	Date
Signature of person acting on your behalf (if you answered "Yes" to question 12)	Date

Minnesota Department of Human Services

Minnesota Health Care Programs
Employer Health Insurance Form

Use Language Block Stuffer

Form A

Are you or is anyone in your household working?

If the answer is yes, we need proof to tell us if the employer or union offers health insurance. You must give us proof for each household member who is working. If anyone is working at more than one job, we need proof from each employer or union. **If we do not get proof, you may not get coverage or coverage may stop.**

There are three options for giving us proof.

- Get the proof yourself. To do this you need to sign the bottom of this page and give it to your employer or union to fill out. They must fill out the back side and sign it. After your employer has completed the form, return this form with your application or renewal. Make a copy of this if you need more than one form.
- Give us copies of the open enrollment papers or health insurance benefit papers from your employer or union. Return these papers with your application or renewal.
- Allow us to contact the employer or union to get the proof. To do this, the person who is working must fill out and sign the information below.

The employee needs to complete the information below and give it to their employer.

Employee first name _____ MI _____ Last name _____

Social Security Number _____ Date of birth _____

Write the name and phone number of the person that we can contact.

Contact Name _____ Phone number _____

Authorization for Release of Information

Giving Permission: I give permission to the employer/union listed above to release the requested information to the above agency. This information is used to figure my eligibility for public assistance and/or services.

Consequences: State and Federal privacy laws protect my records. I know:

- Why I am being asked to share/release this information.
- I do not have to consent to this authorization, but it may affect my benefits or services if I do not give my consent.
- That, generally, I must give my written consent for this person/agency to give out this information, but if I do not consent, this information will not be released unless the law otherwise allows it.
- I may stop the authorization with a written notice at any time, but this written notice will not affect information the agency has already shared/requested.
- The person or agency who gets my information may be able to pass it on to others.
- If my information is passed on to others by DHS, it may no longer be protected by this authorization.
- This authorization will end one year from the date I sign it, unless the law allows for a longer period.

Employee Signature _____ Date _____

This information is available in other forms to people with disabilities by contacting us at (651) 431-2670 (voice) or toll free at (800) 657-3739. TTY/TDD users can call the Minnesota Relay at 711 or (800) 627-3529. For the Speech-to-Speech Relay, call (877) 627-3848.

Employer or Union - Please fill out this form.

Employee first name _____ MI _____ Last name _____

Social Security Number _____ Date of birth _____

Please indicate if you offer health insurance for the employee and/or employee's dependents. (Check Yes or No.)

Health Insurance is offered for this employee. ☐ Yes (Complete A below) ☐ No

Health Insurance is offered for the employee's spouse. ☐ Yes (Complete B below) ☐ No

Health Insurance is offered for the employee's dependents. ☐ Yes (Complete B below) ☐ No

Name(s) of dependents and relationship _____

_____

On what date **was** this employee first eligible for health insurance? _____/_____/_____

or On what date **will** this employee be eligible for health insurance? _____/_____/_____

Who is enrolled currently? ☐ Employee ☐ Spouse ☐ Dependents

A. List the cost of insurance for the employee only

1. Employee pays: $_____ per _____
2. Employer/union pays: $_____ per _____
3. **Total cost**: $_____ per _____

B. List the cost of insurance for the spouse/dependents

1. Employee pays: $_____ per _____
2. Employer/union pays: $_____ per _____
3. **Total cost:** $_____ per _____

C. Total cost of insurance for employee/spouse/dependents

Add the two Total Costs from Line 3: $_____ + $_____ = $_____ per _____

D. Do you offer a cafeteria-style health insurance plan?

☐ No

☐ Yes - The employer/union pays: $_____ per _____

E. Do you offer money in lieu of insurance or for the purchase of health insurance?

☐ No

☐ Yes - The employer/union pays: $_____ per _____

Please attach a copy of your employee benefits summary or other plan information, if available.

NAME OF INDIVIDUAL COMPLETING THIS FORM *(please print)*	TITLE	PHONE ( )
SIGNATURE		DATE

Minnesota Department of **Human Services**

Minnesota Health Care Programs Renewal

What do I need to do with this form?

Read the important information on the green shaded pages at the beginning of the renewal. These pages are A through F. Tear off these green pages and keep them. Fill out all the questions on the white pages. Please use blue or black ink. Sign and date it and return it to see if coverage can continue. Tell us about changes. Every family member who is age 18 and older and getting coverage, must sign and date this form. If you are mailing this form, you may need to add extra postage.

What do I need to include with the renewal?

Include proofs such as pay stubs from the past 30 days.

You may have to give us proof of U.S. citizenship or national status. Look on Page C. It tells you who must give us proof and what proofs you can give us. If we do not get these proofs, coverage may stop.

What will happen if I do not return this form?

Coverage will stop if you do not return this form by the due date.

What if I have questions?

If you have questions or need help, call your worker right away.

Attention. If you want free help translating this information, ask your worker or call the number below for your language.

ملاحظة: إذا أردت مساعدة مجانية في ترجمة هذه المعلومات، فاسأل مساعدك في مكتب الخدمة الاجتماعية أو اتصل على الرقم 1-800-358-0377.

កំណត់សំគាល់ បើអ្នកចង់បានជំនួយបកប្រែពត៌មាននេះដោយមិនគិតថ្លៃ សូមសួរអ្នកកាន់សំណុំរឿងរបស់អ្នក ឬ ទូរស័ព្ទទៅលេខ 1-888-468-3787 ។

Pažnja. Ako vam je potrebna besplatna pomoć za prevod ove informacije, pitajte vašeg radnika ili nazovite 1-888-234-3785.

Ceeb toom. Yog koj xav tau kev pab txhais cov xov no rau koj dawb, nug koj tus neeg lis dej num (worker) lossis hu 1-888-486-8377.

ໂປດຊາບ. ຖ້າຫາກທ່ານຕ້ອງການ ການຊ່ວຍເຫຼືອໃນການແປຂໍ້ຄວາມດັ່ງກ່າວນີ້ຟຣີ, ຈົ່ງຖາມນຳພນັກງານຊ່ວຍວຽກ ຂອງທ່ານ ຫຼືໂທຮຫາ ຕາມເລກໂທຣ 1-888-487-8251.

Hubaddhu. Yoo akka odeeffannoon kun sii hiikamu gargaarsa tolaa feeta ta’e, hojjataa kee gaafaddhu ykn lakkoofsa kana bilbili 1-888-234-3798.

Внимание: если вам нужна бесплатная помощь в переводе этой информации, обратитесь к своему социальному работнику или позвоните по следующему телефону: 1-888-562-5877.

Ogow. Haddii aad dooneyso in lagaa kaalmeeyo tarjamadda macluumaadkani oo lacag la’aan ah, weydii hawlwadeenkaaga ama wac lambarkan 1-888-547-8829.

Atención. Si desea recibir asistencia gratuita para traducir esta información, consulte a su trabajador o llame al 1-888-428-3438.

Chú Ý. Nếu quý vị cần dịch thông-tin nầy miễn phí, xin gọi nhân-viên xã-hội của quý vị hoặc gọi số 1-888-554-8759.

LB #2 (12-03)

This information is available in other forms to people with disabilities by contacting us at (651) 431-2670 (voice) or toll free at (800) 657-3739. TTY/TDD users can call the Minnesota Relay at 711 or (800) 627-3529. For the Speech-to-Speech Relay, call (877) 627-3848.

Notice of Privacy Practices

Minnesota Department of Human Services

(Effective Date: April 14, 2003.)

This notice describes how medical information and other private information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

You have privacy rights under the Minnesota Government Data Practices Act and the federal Health Insurance Portability and Accountability Act (HIPAA). These laws protect your privacy, but also let us give information about you to others if a law requires it.

Why do we ask for this information?

- To tell you apart from other people with the same or similar name
- To decide what you are eligible for
- To help you get medical, mental health, financial or social services
- To decide if you can pay for some of your services
- To make reports, do research, do audits, and evaluate our programs
- To investigate reports of people who may lie about the help they need
- To decide about out-of-home care and in-home care for you or your children
- To collect money from other agencies, like insurance companies, if they should pay for your care
- To decide if you or your household needs protective services
- To collect money from the state or federal government for help we give you.

Do you have to answer the questions we ask?

Generally, the law does not say you have to give us this information. We need your social security number in order to give you some kinds of financial help or child support enforcement services (45 CFR 205.52 [2001]; 42 USC 666; 45 CFR 303.30 [2001]).

What will happen if you do not answer the questions we ask?

We need information about you to tell if you can get help from any program. Without the information, we may not be able to help you. If you give us wrong information on purpose, you can be investigated and charged with fraud.

With whom may we share the information about you?

We may give information about you to the following agencies, if they need it for investigations or to help you or to help us help you. We don't always share information about you with these people, but the law says we may share information with them. If you have questions about when we give these people information, ask your worker.

- U.S. Department of Agriculture
- U.S. Department of Health and Human Services
- U.S. Department of Labor
- United States Citizenship and Immigration Services
- Internal Revenue Service
- Social Security Administration
- Minnesota Department of Employment and Economic Development
- Minnesota Department of Education
- Minnesota Department of Human Rights
- Minnesota Department of Human Services
- Minnesota Department of Labor and Industry
- Minnesota Department of Public Safety
- Minnesota Department of Revenue
- Minnesota Department of Veterans Affairs
- Minnesota Historical Society
- American Indian tribes, if your household is in need of human services at a tribal reservation
- Higher education coordinating board
- State hospitals or long-term care facilities
- State and federal auditors
- Court officials
- Anyone under contract with the Minnesota Department of Human Services or U.S. Department of Health and Human Services or the county social services agency
- Local and state health departments
- County human services boards
- Child or adult protection teams
- People who investigate child or adult protection
- Other human services offices, including child support enforcement offices
- Fraud prevention and control units
- Employees or volunteers of any welfare agency who need the information to do their jobs
- County attorney, attorney general or other law enforcement officials
- Mental health centers
- Ombudsman for families
- Ombudsman for mental health and mental retardation

Keep this page.

- County advocates for Minnesota Managed Health Care Programs
- Guardian, conservator or person who has power of attorney for you
- Local collaborative agencies
- Community food shelves or surplus food programs
- Health care providers
- School districts
- Schools and other institutions of higher education
- Coroner/medical examiner if you die and they investigate your death
- Hospitals if you, a friend, or relative has an emergency and we need to contact someone
- Others who may pay for your care
- Insurance companies to check health care benefits you or your children may get
- Managed care organizations about your health care or benefits
- Credit bureaus
- Creditors
- Collection agencies, if you do not pay fees you owe to us for services
- Minnesota Board on Aging
- Anyone else to whom the law says we can give the information

You have the right to information we have about you.

- You may ask if we have any information about you and get copies. You may have to pay for the copies.
- You may give other people permission to see and have copies of private information about you.
- Unless we get special written permission from you, we will only use your health information for the purposes listed on this form.
- You may question the accuracy of any information we have about you.
- You have the right to ask us to share health information with you in a certain way or in a certain place. For example, you may ask us to send health information to your work address instead of your home address. You must make this request in writing. You do not have to explain the basis for your request. If we find that your request is reasonable, we will grant it.
- You can ask us to restrict uses or disclosures of your health information. Your request must be in writing. You must explain what information you want to restrict from being disclosed and to whom you want these restrictions to apply. You can request to end these restrictions at any time by calling us or by writing to us. We are not required to agree to your restrictions.
- You have the right to receive a record of the people or organizations that we have shared your health information with. We must keep a record of each time we share your health information for six years from the date it was shared. This record will be started on April 14, 2003. It will NOT include those times when we have shared your information in order to treat you, pay or bill for your health care services or to run our programs. If you want a copy of this record, you must send a request in writing to our Privacy Official.
- If you do not understand the information, ask your worker to explain it to you. You can ask DHS for another copy of this notice.

What are our responsibilities under this notice?

We may change our privacy policy in the future. We might do this, for example, because privacy laws change and require us to change our practices. When we change our privacy rules we will publish them on our Web site at http://edocs.dhs.state.mn.us/lfserver/Legacy/DHS-3979-ENG. Until we publish new privacy rules, we will abide by the terms of this notice.

What if you believe the information we have about you is wrong?

Send your concerns in writing, telling us why the information is not accurate or complete. You may send your own explanation of the facts you disagree with. Your explanation will be attached any time that information is shared with another agency.

What privacy rights do children have?

If you are under 18, parents may see information about you and allow others to see this information, unless you have asked that this information not be shared with your parents or it involved medical treatment for which parental consent was not required. You must make this request in writing and say what information you want withheld and why. If the agency agrees that sharing the information is not in your best interest, the information will not be shared with your parents. If the agency does not agree, the information will be shared with your parents if they ask for it.

When parental consent for medical treatment is not required, information will not be shown to parents unless the health care provider believes failing to share the information would jeopardize your health.

Keep this page.

What if you believe your privacy rights have been violated?

You may complain if you believe your privacy rights have been violated. You cannot be denied service or treated badly because you have made a complaint. If you believe that your medical privacy was violated by your doctor or clinic, a health insurer, a health plan, or a pharmacy, you may send a written complaint either directly to that organization or to:

U.S. Department of Health and Human Services
Office for Civil Rights, Region V
233 N. Michigan Avenue, Suite 240
Chicago, IL 60601
(312) 886-2359 (Voice) or
toll free (800) 368-1019 or (866) 282-0659
(312) 353-5693 (TTY/TDD)
(312) 886-1807 (Fax)

If you think that the Minnesota Department of Human Services has violated your privacy rights, you may send a written complaint to the U.S. Department of Health and Human Services at the address above, or to:

Minnesota Department of Human Services
Appeals and Regulations
PO Box 64941
St. Paul, MN 55164-0941

Important Information

Proof of Citizenship or National Status

Parents and caretakers, children, pregnant women, people with disabilities and people age 65 or over must give us proof that they are United States (U.S.) citizens or nationals. National status includes people from American Samoa and Swains Island.

Adults without children are not required to give us proof that they are U.S. citizens or nationals.

Proof can be one of the following:

1. U.S. passport
2. Certificate of Naturalization
3. Certificate of U.S. Citizenship

If you do not have one of the above documents, you must give us one item from List #1 and one from List #2 below. If you do not have or cannot get these items ask your worker for help right away.

List #1

1. U.S. birth certificate
2. Report of Birth Abroad of a U.S. Citizen
3. U.S. Citizen ID card
4. Hospital record of birth in one of the 50 states, the District of Columbia, Puerto Rico, Guam, the U.S. Virgin Islands, American Samoa, Swains Island or the Northern Mariana Islands.

List #2

1. Current State driver's license with picture
2. Minnesota ID card with picture.
3. School ID card with picture.
4. Nursery or daycare records for children under 16.

Immigration

All immigration information you give to us is private. We use it to see if you can get coverage. We only share it when the law allows it or requires it. In most cases, applying will not affect your immigration status. However, it may if you are applying to pay for long-term care services.

You do not have to give us your immigration information if you are:

- Applying only for emergency medical care.
- Only helping someone else apply.
- A non-immigrant or undocumented person who is pregnant.
- Applying for your children or other household members but not yourself.

You Have the Right to Fair Treatment

We cannot treat you different because of your race, color, national origin, religion, sex, marital status, sexual orientation, or political beliefs. We cannot treat you different because you have a physical, mental or emotional disability. If you feel the State or local agency did not treat you fairly, you may file a complaint. You can contact any of the following places to file a complaint:

- Minnesota Department of Human Services, Office for Equal Opportunity, PO Box 64997, St. Paul, MN 55164-0997
- Minnesota Department of Human Rights, 190 E. Fifth Street, Suite 700, St. Paul, MN 55101
- U.S. Department of Health and Human Services, Office of Civil Rights - Region V, 233 N. Michigan Avenue, Suite 240, Chicago, IL 60601

You Have the Right to Ask for a Hearing

If you feel that your benefits are not right you may ask for a fair hearing. You can ask for a hearing by telling your worker or by writing to the:

Minnesota Department of Human Services, Appeals & Regulations, PO Box 64941, St. Paul, MN 55164-0941.

Keep this page.

A person from the State office will check the facts of your case. They will tell you if your benefits are correct or not according to the laws.

You must ask for a hearing within 30 days from the day you get a notice. You must say that you feel a decision is wrong. If you cannot ask for a hearing within 30 days, you can ask for more time. You will need to show that you have a good reason for not asking for a hearing on time. If a person from the State office decides you had a good reason, they will accept your appeal up to 90 days after you received the notice of action on your case.

If you ask for a hearing after 30 days, you will not be able to have your health care continue until the hearing. If you want your health care to continue, you must ask for a hearing before the date your coverage will be reduced or within 10 days from the date of the notice, whichever is later.

Breaking the Rules

The below rules apply to some people who are enrolled in certain health care programs. If the rules apply to you, it explains what will happen if you break the rules.

What are the rules?

- Do not give false information or hide information to get or continue to get health care program coverage.
- Do not trade or sell your membership cards.
- Do not help others get medical services that you know they should not get.
- Do not use someone else's membership card for yourself or other household members.

What happens if I break these rules?

If you break the rules you may not be able to keep your coverage. The first time you break the rules, your coverage will stop for one year. The second time you break the rules you will not get coverage for two years. If you break the rules a third time, you will not get coverage forever. Also, if you break these rules we can prosecute you for fraud. The maximum penalty is a fine of $250,000 or a jail term of 20 years, or both.

Social Security Numbers

Most people who apply for coverage must give a Social Security Number. We use them to check who you are, for system matches, and for reviews and audits to make sure your case is correct. You do not have to give us a number if you

- Do not want coverage
- Have religious objections
- Are not a U.S. Citizen and are applying for Emergency Medical only
- Are a non-immigrant or a person without documentation.

Child Support

If you are applying for yourself and your children and you do not live with the other parent, the law says that you may have to give information to child support staff.

If you were not married to the other parent when your child was born, you may also have to help child support staff prove who the father is. This means that you may need to give information to get medical support for your child. If you do not help child support, your children will still get coverage. You will not get coverage unless you are pregnant. Your coverage will stop if you are already getting coverage.

Do you have fear that the other parent may cause harm to you or your child? If you do, and you can give proof to support your fears, you may not have to give information to child support staff. A group of people at the county or state office will review your proof. After the review, they will tell you if you still need to give information about the other parent.

If you are already getting child support services, they will stop during the review. If they make a decision that you must give information about the other parent, child support services will start again.

A law says that the State of Minnesota gets to keep medical support payments for the person who is applying for or getting coverage. The State can not keep more than it pays out. This is also true even if you are applying only for a child.

Reviews

The State or Federal Office may pull your case at random to review. They will review the information you put on your application and renewal forms. They will also check to make sure we did your case correctly. They will let you know if they will need to ask you questions. If you refuse to answer their questions, your coverage may stop.

Reporting Systems

The State uses systems to check the information you give. If we get information that does not match yours, we will write to you. You will need to give us proof or give us permission to check your information. If you refuse, your coverage may stop. If you want more information, ask your worker for the "Notice About Income and Eligibility Verification System and Work Reporting System" (DHS Form #2759).

Keep this page.

Other Health Care

You and your household members may need to accept and keep a health insurance policy that is good. This includes Medicare. We will review your policy. We will tell you if you can or cannot cancel it. In some cases, if we tell you that you cannot cancel it, we may help pay the premiums. If you refuse to give us information about your policy, you may not get coverage.

State as Annuity Beneficiary

The state becomes a remainder beneficiary of some annuities when we pay for long-term services.

Liens and Estate Claims

The State or county may try to recover the cost of medical services that MA or GAMC paid for you. They do this by filing a claim against your estate or by filing a lien against your real property.

The state may file a claim against your estate if you received:

- General Assistance Medical Care (GAMC) at any age.
- MA when you were over age 55.
- MA when you were under 55 and lived in a long-term care facility (LTCF) for six months or more.

Liens can be set up against:

- Your life estate
- Real property that you own by yourself
- Real property that you own with someone else. If you own property with another person, the lien is only against your share of it.

The state will not file a lien against your property if you are in a long-term care facility and will be returning home.

Before you die, the State can file a Notice of Potential Claim (Notice). The Notice must:

- List the real property you own.
- Note if you have a life estate.
- State if other people own any real property with you.

When you die, a lien is set up against your portion of the property that was listed in the Notice. Your interest in real property that is part of your estate may be used to pay that claim.

Note that this is a very general explanation of the rights that the state and counties have regarding claims and liens. You should talk to your lawyer or advisor if you have questions about how these laws apply to your property.

Changes

You must report changes to your worker within 10 days of the change happening. If you do not report changes, you may have to go through a fraud investigation. You may have to pay money back to the State for what we paid if you were not eligible.

If you are not sure if you should report a change, call your worker and explain what is happening. Your worker will tell you if you need to report it or not.

Examples of changes you may need to report include:

Starting:

- A new job, changing jobs or stopping a job.
- To get Social Security or other retirement income.
- To get child support, unemployment or worker's comp income.
- To get health insurance or Medicare.

When you:

- Sell your home.
- Move to a new address.
- Get an inheritance or a settlement.
- Transfer or give away assets or income.

When someone in your household:

- Becomes pregnant or has a baby.
- Moves in or out of your home.
- Dies, gets married or gets a divorce.
- Becomes disabled.
- Starts or stops school.

Keep this page.

Health Care Coverage Options in Minnesota

It is important to have health care coverage. If you do not qualify for Minnesota Health Care Programs here is information about other options.

Private Health Insurance

Can you or a family member get health insurance through an employer?

People may be able to get health insurance through their work. Ask your employer if the company offers health insurance. Call the Minnesota Department of Commerce at (651) 296-2488 or (800) 657-3602. For TTY/TDD, call (800) 627-3529.

Can you get private health insurance through an insurance company?

Many insurance companies sell health insurance policies. People should compare policies and decide what they can afford. An agent can tell you about different types of health care policies, medical services that are covered, and the cost of policies. You can find insurance agent phone numbers in the yellow pages. You can also get a list of insurance agents from the Minnesota Department of Commerce at (651) 296-2488. TTY/TDD users call (800) 627-3529.

Can you or a family member get short term insurance?

Short Term Insurance is health coverage sold by private insurance companies. Short Term Insurance may cover a person up to 185 days. It may not cover prior medical conditions. A person may want short term insurance while waiting for other health coverage to start. Call an insurance agent. You can find numbers in your telephone yellow pages under "Insurance."

Do you or a family member qualify for COBRA insurance?

COBRA is a law that lets people keep health insurance through their employer for a time period after their jobs end. The employer will send a COBRA notice within 14 days after the person leaves the job. The person must ask for COBRA during the next 60 days. When COBRA insurance ends, the person can buy another type of insurance. To learn more about COBRA, call your former employer, The Minnesota Department of Commerce at (651) 296-2488 or (800) 657-3602 or The Minnesota Department of Health at (800) 657-3916. TTY/TDD users call (800) 627-3529.

Do you or a family member qualify for Minnesota Comprehensive Health Association (MCHA)?

MCHA is insurance for people who live in Minnesota and cannot get other health care coverage. MCHA sells insurance to people when other health insurance was denied, coverage for a medical condition was denied, or coverage ended through no fault of the person. To learn more about MCHA, call Medica (the MCHA Administrator) at (952) 945-8000 or (800) 952-3455. TTY/TDD users call (952) 992-3190.

Is Medicare an option for you or a family member?

Medicare is a federal health care benefit for people who:

- Are over age 65
- Have a disability, or
- Have End-Stage Renal Disease.

To learn more about Medicare, call (800) 633-4227. TTY/TDD users call (877) 486-2048. You can also visit the web site at www.medicare.gov.

Keep this page.

Minnesota Health Care Programs Renewal

Instruction: Answer all questions and print clearly. Please use blue or black ink. You may need more space to answer questions. Write the question number and the answers on a separate piece of paper. Include it with this renewal.

1. Language information

What is the main language your household speaks? ☐ English ☐ Spanish ☐ Other _____

What is the main language your household writes? ☐ English ☐ Spanish ☐ Other _____

Do you need someone who speaks your language to help you? ☐ Yes ☐ No

2. Who is the household member that is filling out this renewal?

The head of the household is a husband, a wife, a parent of a child, or yourself if you live alone. This includes a person under age 18 who is living on their own. If someone other than a household member is filing out this application, write the name of the head of household below.

First Name _____ Middle Name _____ Last Name _____

3. What is your address?

☐ Check this box if you are homeless.

Street address _____ Apt. # _____ City _____

State_____ Zip Code _____ What county do you live in? _____

Mailing address (if different than the one above)

Street Address_____

City _____ State _____ Zip Code_____

☐ Check this box if you are a migrant worker.

4. Write the name and the phone number for a household member where we can call during the day.

We will only call if we have questions about this renewal.

Name _____ Phone number ( ) _____

5. Are any household members pregnant?

☐ Yes - fill out the information below. ☐ No - go to question 6.

Who is pregnant?_____ What is her due date?_____/_____/_____

We need proof of the pregnancy from a doctor, midwife or clinic. The proof needs to tell us the date she became pregnant and when her baby is due.

6. Did any new members move into your household or do you want to apply for a household member who is not getting coverage now?

☐ Yes - fill out the information below. ☐ No - go to question 7.

What is their full name?_____

What is their date of birth?_____ What is their relationship to you? _____

When did they move in?_____ Do they want to apply? ☐ Yes - continue. ☐ No - go to question 7.

What is this person's Social Security number?_____

Does this person get income? ☐ Yes - what type of income?_____ ☐ No

What is the gross monthly amount?_____ Do they have health insurance? ☐ Yes ☐ No

Does this person have assets? ☐ Yes - list them below. ☐ No

_____

7. List your household members below.

First and last name	Date of birth	Relationship to you	U.S. citizen or national?	Place of birth City and State	Birth name
			☐ Yes ☐ No		
			☐ Yes ☐ No		
			☐ Yes ☐ No		
			☐ Yes ☐ No		
			☐ Yes ☐ No		

You must give us copies of documents that show citizenship or national status. This is needed for each person who is getting or applying for coverage. Look for more information on page C. If you need help, tell your worker right away.

8. Are any other household members who are not already listed living away from home for a short time?

☐ Yes - fill out the information below. ☐ No - go to question 9.

First and last name of this person_____

Date of birth_____ Date they left_____ Date they will return_____

Write the reason for living away_____ Do they want to apply? ☐ Yes ☐ No

9. Are you or any household members getting or expecting wages or a salary from a job?

This includes wages or a salary from an employer, seasonal or temporary employment, and cash jobs.

☐ Yes - fill out the information on the next page for each job and for each person who is working.

☐ No - go to question 10.

You must give us proof of income. Proof can be pay stubs from the last 30 days or a statement from the employer. If we do not get proof, coverage may stop

You must also give us proof to show us if the employer offers health insurance. If you are a MinnesotaCare enrollee, fill out Form A for each employed person. If we do not get proof, coverage may stop.

Name of person working____________________ Start date __________

Name of employer____________________ Employer's phone number (   )______

Contact person__________________________

☐ Check this box if this is seasonal or temporary employment.

How often paid? ☐ Every week ☐ Every two weeks ☐ Once a month ☐ Other __________

Write the gross amount of the wages on paycheck before taxes are taken out $ __________

Write the date that the last paycheck was received____________________

Does this employer offer health insurance? ☐ Yes - ☐ Single coverage or ☐ Family coverage. ☐ No

Name of person working____________________ Start date __________

Name of employer____________________ Employer's phone number (   )______

Contact person__________________________

☐ Check this box if this is seasonal or temporary employment.

How often paid? ☐ Every week ☐ Every two weeks ☐ Once a month ☐ Other __________

Write the gross amount of the wages on paycheck before taxes are taken out $ __________

Write the date that the last paycheck was received____________________

Does this employer offer health insurance? ☐ Yes - ☐ Single coverage or ☐ Family coverage. ☐ No

Name of person working____________________ Start date __________

Name of employer____________________ Employer's phone number (   )______

Contact person__________________________

☐ Check this box if this is seasonal or temporary employment.

How often paid? ☐ Every week ☐ Every two weeks ☐ Once a month ☐ Other __________

Write the gross amount of the wages on paycheck before taxes are taken out $ __________

Write the date that the last paycheck was received____________________

Does this employer offer health insurance? ☐ Yes - ☐ Single coverage or ☐ Family coverage. ☐ No

10. Do you have more jobs to report?

☐ Yes - for each job, write the question number and the above information on a separate piece of paper. Include it with this renewal. ☐ No - go to question 11.

11. Are you or any household members self-employed?

☐ Yes - fill out the information below and give us proof. ☐ No - go to question 12.

Name of person	Name of business	Start date of business	Gross yearly income
			$
			$
			$

Do the net business assets of all businesses total $200,000 or less? ☐ Yes ☐ No

You must give us proof of this income. Proof can be the most recent income tax returns and all related schedules or the business records if taxes are not filed. If we do not get proof, coverage may stop.

12. Are any household members getting or expecting to get other types of income?

Other income may include child support, spousal support, unemployment, worker's comp., Social Security, Supplemental Security Income (SSI), pensions, Veteran's benefits, retirement, rent, annuities, trusts, interest, dividends, contracts for deed, property agreements, public assistance payments and other types of income.

☐ Yes - fill out the information below. **You must give us proof.** ☐ No - go to question 13.

Name	Where is the income from?	Amount	How often is it received? ☐ Weekly ☐ Bi-weekly ☐ Monthly	Write the date the last payment was received
		$		
		$		
		$		
		$		
		$		

You must give us proof of this income. Proof can be a statement from where the income comes from or a direct deposit statement from your bank. If we do not get proof, coverage may stop.

13. Do any household members pay for child or adult day care while they work?

☐ Yes - fill out the information below. ☐ No - go to question 14.

Name of person working	Name of person(s) in day care	Total amount paid each month
		$
		$

14. Do you or any household members pay child or medical support that is court ordered?

☐ Yes - fill out the information below and give us proof. ☐ No - go to question 15.

Name of person paying support	Amount of payment each month
	$

You must give us a copy of the court order if we do not have one.

15. Is anyone blind or disabled?

☐ Yes - continue. ☐ No - go to question 16.

Does this person have work expenses? ☐ Yes - fill out the information below. ☐ No - go to question 16.

Name of person working	Type of expense	Amount paid per month
		$
		$
		$
		$
		$

16. Do you and your household members have any assets?

Assets include items such as cash, bank accounts, certificates of deposit, stocks, bonds, retirement accounts, interest in annuities, trusts, property agreements, contracts for deed, time shares, rental property, life estates, livestock, tools, and farm machinery. Note, you will list your vehicles for question 17.

☐ Yes - fill out the information below and give us proof. ☐ No - go to question 17.

Name of owner(s)	Type of asset	Name of bank /or company	Value of asset	Amount of loan (if none, list zero)
			$	$
			$	$
			$	$
			$	$
			$	$
			$	$

You must give us proof of assets. Proof can be bank statements or a statement from the bank or the company. The proof must be dated within the last 30 days. If we do not get proof, coverage may stop.

17. Do you or any household members have vehicles?

Vehicles include cars, trucks, snowmobiles, four-wheelers, motorcycles, boats, motors, trailers, campers, and motor homes. ☐ Yes - fill out the information below and give us proof. ☐ No - go to question 18

Name of owner(s)	Year/make/model	Value	Amount of loan (if none, list zero)
		$	$
		$	$
		$	$
		$	$
		$	$

You must give us proof of all of the vehicles and proof of the loan balance. Proof can be the registration card or title and a statement from the bank or loan company showing the loan balance. If we do not get proof, coverage may stop.

18. Do you or any household members own or are buying real estate?

Real estate may include homes, cabins, lake homes, land and other property that you rent out.

☐ Yes - fill out the information below. ☐ No - go to question 19.

Name of owner(s)	Address of real estate	Value	Amount of loan (if none, list zero)	Do you live here?
		$	$	☐ Yes ☐ No
		$	$	☐ Yes ☐ No

If you own real estate, you must give us proof. Proof can be the real estate tax statement and a statement showing the loan balance. If we do not get proof, coverage may stop.

19. Do you or any household members have life insurance policies?

☐ Yes - fill out the information below and give us proof. ☐ No - go to question 20.

Name of owner(s)	Name of insurance company	Face value	Cash surrender value
		$	$
		$	$
		$	$

You must give us proof of the face value and cash surrender value of the life insurance policies. Proof can be a copy of the policy or a statement from the insurance company that is dated within the last 30 days. If we do not get proof, coverage may stop.

20. Do you or any household members have money for burial or burial contracts?

☐ Yes - fill out the information below. ☐ No - go to question 21.

Name of owner(s)	Name of funeral home or company that holds this burial agreement	Value	Date of the agreement
		$	
		$	
		$	
		$	

You must give us proof. Proof can be a copy of the agreement or a statement from the company or funeral home and the statement of goods and services. If we do not get proof, coverage may stop.

21. During the last year, did you or any household members:

- Sell any assets for less than what they were worth?
- Trade assets or income?
- Transfer assets or income?
- Give away assets or income?
- Not accept an inheritance?
- Purchase an annuity, life estate in another person's home, promissory note, loan or mortgage?

☐ Yes - fill out the information below and give us proof. ☐ No - go to question 22.

Owner(s) of the asset or income	Type of asset or income	Value of the asset or income	Who was it given or sold to?	When? mm/dd/yy	How much did you get paid for the asset?
		$			$
		$			$
		$			$
		$			$

Do you have more to list?

☐ Yes - list them on a separate piece of paper and include it with this application. ☐ No

You must give us proof to show us what has been done. If we do not get proof, coverage may stop

22. Are you or is any household member living in a long term care facility (LTCF) or planning to get waiver program services?

- LTCF includes skilled nursing facility, intermediate care facility services and nursing facility care in an inpatient hospital.
- Waiver programs include Elderly Waiver (EW), Community Alternatives for Disabled Individuals (CADI), Community Alternatives Care (CAC), Traumatic Brain Injury (TBI), and Mental Retardation and Related conditions (MR/RC).

☐ Yes - fill out the information below. ☐ No - go to the Signature Page.

Check the box below that applies:

☐ This person lives in a long term care facility. ☐ This person expects to get waiver program services.

Person's first name _____ MI ____ Last name _____

23. Has this person ever had a long-term care insurance policy?

☐ Yes - fill out the information below. ☐ No - go to question 24.

Is this policy paying benefits now? ☐ Yes ☐ No

Did this policy ever pay benefits? ☐ Yes - when? _____ ☐ No

Name of insurance company _____

First name of policy holder _____ MI _____ Last name _____

Date the insurance policy was issued _____ Policy number _____

Street address of insurance company _____

City _____ State _____ Zip Code _____

24. Does this person own a home?

☐ Yes - fill out the information below. ☐ No - go to question 25.

Does a spouse, a child under the age of 21, or a blind or disabled child of any age live in the home?

☐ Yes - go to question 25. ☐ No - fill out the information below.

Name of owner(s)	**Address of homestead**	**Value**	**Amount of loan (if non, write zero)**	**Do you live here?**
		$	**$**	☐ **Yes** ☐ **No**

You must give us proof. Proof can be the real estate tax statement and a statement showing the mortgage or loan balance. If we do not get proof, you may not get coverage.

25. Do you or household members have health insurance coverage?

☐ Yes - if yes, what is the name of the insurance company? _____

☐ No

26. List changes below that took place in the past year or may occur during the next year.

Marriage/Divorce ☐ Yes. Who?_____When?_____ ☐ No

Student status ☐ Yes. Who?_____When?_____ ☐ No

Disability status ☐ Yes. Who?_____When?_____ ☐ No

Medicare benefits ☐ Yes. Who?_____When?_____ ☐ No

Immigration status ☐ Yes. Who?_____When?_____ ☐ No

Income ☐ Yes. Who?_____When?_____ ☐ No

Other_____

Signature Page

All adults must read all of the following information and sign below.

Fraud Investigation Release

I give third parties permission to share information about me with authorized state and county staff conducting investigations regarding fraud, fraud prevention and misrepresentation. Third parties include but are not limited to financial institutions, credit reporting agencies, landlords, public housing agencies, schools, utility companies, insurance agencies, employers, other government agencies and others as they apply. I further authorize taxing authorities to release copies of my income tax returns. I also understand that my permission for release is effective for six months after my benefits stop.

Medical Assignment of Benefits

I assign all medical payments to the State of Minnesota. This assignment includes medical care payments from all other persons or entities. This assignment covers medical care payments for myself. It also covers anyone else for whom I apply.

It takes effect right away when health care coverage starts. I agree to cooperate with the State in any action to recover payment of medical expenses. If I claim good cause and good cause is approved, I may not have to cooperate.

Medical Release

I give consent to my health providers and health plan, including their contractors, to share my Minnesota Health Care Programs (MHCP) health records with the State of Minnesota, its agents, contractors and their subcontractors, Ombudsman and County Advocates for managed care. I know I need to share this information to:

- Decide if I can get federally funded health care,
- Pay my health care providers,
- Provide and coordinate health care,
- Do quality of care reviews and studies, and
- Help in record reviews, prosecutions or legal actions related to managing the health care programs.

If I have Medicare Part B, I give Medicare consent to pay my health providers for the care I get while on MHCP. This release also applies to the MHCP health records of my minor children in this application.

This medical release is good while I am enrolled in MHCP, not to exceed one year, or longer if the law permits. I can refuse to sign or cancel the medical release. If I cancel I must do this in writing. I understand that the law overrides my canceling this release for these reasons:

- To share health information with health care consultants,
- To pay my health care bills,
- If fraud is suspected, or
- For quality of care reviews and studies.

If I refuse to sign or cancel the release, I will not be able to enroll or stay enrolled in Minnesota Health Care Programs. I understand that this release allows my MHCP health records to be shared with others if the law permits. Privacy laws may no longer protect the information shared with others.

By signing below:

- I agree that I have read the Notice of Privacy Practices and the list of my responsibilities in that Notice.
- I understand that my information will be shared if fraud is suspected.
- I agree to the release of my Minnesota Health Care Programs health records to the parties listed above.
- I agree to assign my medical benefits as stated above.
- I agree to allow the State of Minnesota, its agents, contractors, and subcontractors to contact my employer(s) for the purpose of verifying access to employer subsidized health insurance.
- I declare that, under penalty of perjury, all parts of this renewal, to the best of my knowledge, are true and correct statements. I understand what happens to people convicted of perjury (not telling the truth). They may be sentenced to prison for up to five years, a fine up to $10,000, or both.

All adults age 18 and older who are getting coverage must sign below.

Your Signature	Date
Signature of spouse	Date
Signature of household member age 18 and older who is getting coverage	Date
Signature of household member age 18 and older who is getting coverage	Date
Signature of household member age 18 and older who is getting coverage	Date
Signature of person acting on your behalf	Date

Minnesota Department of **Human Services**

Minnesota Health Care Programs Renewal

(Read and keep this part)

What do I need to do with this form?

Read the important information on pages A through F. Keep this part for your records. Fill out all the questions on the Renewal form. Please use blue or black ink. Sign and date it and return it to see if coverage can continue. Tell us about changes. Every family member who is age 18 and older and getting coverage, must sign and date this form. If you are mailing this form, you may need to add extra postage.

What do I need to include with the renewal?

Include proofs such as pay stubs from the past 30 days.

You may have to give us proof of U.S. citizenship or national status. Look on Page C. It tells you who must give us proof and what proofs you can give us. If we do not get these proofs, coverage may stop.

What will happen if I do not return this form?

Coverage will stop if you do not return the Renewal form by the due date.

What if I have questions?

If you have questions or need help, call your worker right away.

Attention. If you want free help translating this information, ask your worker or call the number below for your language.

ملاحظة: إذا أردت مساعدة مجانية في ترجمة هذه المعلومات، فاسأل مساعدك في مكتب الخدمة الاجتماعية أو اتصل على الرقم 1-800-358-0377.

កំណត់សំគាល់ បើអ្នកចង់បានជំនួយបកប្រែពត៌មាននេះដោយមិនគិតថ្លៃ សូមសួរអ្នកកាន់សំណុំរឿងរបស់អ្នក ឬ ទូរស័ព្ទទៅលេខ 1-888-468-3787 ។

Pažnja. Ako vam je potrebna besplatna pomoć za prevod ove informacije, pitajte vašeg radnika ili nazovite 1-888-234-3785.

Ceeb toom. Yog koj xav tau kev pab txhais cov xov no rau koj dawb, nug koj tus neeg lis dej num (worker) lossis hu 1-888-486-8377.

ໂປດຊາບ. ຖ້າຫາກທ່ານຕ້ອງການ ການຊ່ວຍເຫຼືອໃນການແປຂໍ້ຄວາມດັ່ງກ່າວນີ້ຟຣີ, ຈົ່ງຖາມນຳພນັກງານຊ່ວຍວຽກ ຂອງທ່ານ ຫຼືໂທຮຫາ ຕາມເລກໂທຣ 1-888-487-8251.

Hubaddhu. Yoo akka odeeffannoon kun sii hiikamu gargaarsa tolaa feeta ta’e, hojjataa kee gaafaddhu ykn lakkoofsa kana bilbili 1-888-234-3798.

Внимание: если вам нужна бесплатная помощь в переводе этой информации, обратитесь к своему социальному работнику или позвоните по следующему телефону: 1-888-562-5877.

Ogow. Haddii aad dooneyso in lagaa kaalmeeyo tarjamadda macluumaadkani oo lacag la’aan ah, weydii hawlwadeenkaaga ama wac lambarkan 1-888-547-8829.

Atención. Si desea recibir asistencia gratuita para traducir esta información, consulte a su trabajador o llame al 1-888-428-3438.

Chú Ý. Nếu quý vị cần dịch thông-tin nầy miễn phí, xin gọi nhân-viên xã-hội của quý vị hoặc gọi số 1-888-554-8759.

LB #2 (12-03)

This information is available in other forms to people with disabilities by contacting us at (651) 431-2670 (voice) or toll free at (800) 657-3739. TTY/TDD users can call the Minnesota Relay at 711 or (800) 627-3529. For the Speech-to-Speech Relay, call (877) 627-3848.

Notice of Privacy Practices

Minnesota Department of Human Services

(Effective Date: April 14, 2003.)

This notice describes how medical information and other private information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

You have privacy rights under the Minnesota Government Data Practices Act and the federal Health Insurance Portability and Accountability Act (HIPAA). These laws protect your privacy, but also let us give information about you to others if a law requires it.

Why do we ask for this information?

- To tell you apart from other people with the same or similar name
- To decide what you are eligible for
- To help you get medical, mental health, financial or social services
- To decide if you can pay for some of your services
- To make reports, do research, do audits, and evaluate our programs
- To investigate reports of people who may lie about the help they need
- To decide about out-of-home care and in-home care for you or your children
- To collect money from other agencies, like insurance companies, if they should pay for your care
- To decide if you or your household needs protective services
- To collect money from the state or federal government for help we give you.

Do you have to answer the questions we ask?

Generally, the law does not say you have to give us this information. We need your social security number in order to give you some kinds of financial help or child support enforcement services (45 CFR 205.52 [2001]; 42 USC 666; 45 CFR 303.30 [2001]).

What will happen if you do not answer the questions we ask?

We need information about you to tell if you can get help from any program. Without the information, we may not be able to help you. If you give us wrong information on purpose, you can be investigated and charged with fraud.

With whom may we share the information about you?

We may give information about you to the following agencies, if they need it for investigations or to help you or to help us help you. We don't always share information about you with these people, but the law says we may share information with them. If you have questions about when we give these people information, ask your worker.

- U.S. Department of Agriculture
- U.S. Department of Health and Human Services
- U.S. Department of Labor
- United States Citizenship and Immigration Services
- Internal Revenue Service
- Social Security Administration
- Minnesota Department of Employment and Economic Development
- Minnesota Department of Education
- Minnesota Department of Human Rights
- Minnesota Department of Human Services
- Minnesota Department of Labor and Industry
- Minnesota Department of Public Safety
- Minnesota Department of Revenue
- Minnesota Department of Veterans Affairs
- Minnesota Historical Society
- American Indian tribes, if your household is in need of human services at a tribal reservation
- Higher education coordinating board
- State hospitals or long-term care facilities
- State and federal auditors
- Court officials
- Anyone under contract with the Minnesota Department of Human Services or U.S. Department of Health and Human Services or the county social services agency
- Local and state health departments
- County human services boards
- Child or adult protection teams
- People who investigate child or adult protection
- Other human services offices, including child support enforcement offices
- Fraud prevention and control units
- Employees or volunteers of any welfare agency who need the information to do their jobs
- County attorney, attorney general or other law enforcement officials
- Mental health centers
- Ombudsman for families
- Ombudsman for mental health and mental retardation

Keep this page.

- County advocates for Minnesota Managed Health Care Programs
- Guardian, conservator or person who has power of attorney for you
- Local collaborative agencies
- Community food shelves or surplus food programs
- Health care providers
- School districts
- Schools and other institutions of higher education
- Coroner/medical examiner if you die and they investigate your death
- Hospitals if you, a friend, or relative has an emergency and we need to contact someone
- Others who may pay for your care
- Insurance companies to check health care benefits you or your children may get
- Managed care organizations about your health care or benefits
- Credit bureaus
- Creditors
- Collection agencies, if you do not pay fees you owe to us for services
- Minnesota Board on Aging
- Anyone else to whom the law says we can give the information

You have the right to information we have about you.

- You may ask if we have any information about you and get copies. You may have to pay for the copies.
- You may give other people permission to see and have copies of private information about you.
- Unless we get special written permission from you, we will only use your health information for the purposes listed on this form.
- You may question the accuracy of any information we have about you.
- You have the right to ask us to share health information with you in a certain way or in a certain place. For example, you may ask us to send health information to your work address instead of your home address. You must make this request in writing. You do not have to explain the basis for your request. If we find that your request is reasonable, we will grant it.
- You can ask us to restrict uses or disclosures of your health information. Your request must be in writing. You must explain what information you want to restrict from being disclosed and to whom you want these restrictions to apply. You can request to end these restrictions at any time by calling us or by writing to us. We are not required to agree to your restrictions.
- You have the right to receive a record of the people or organizations that we have shared your health information with. We must keep a record of each time we share your health information for six years from the date it was shared. This record will be started on April 14, 2003. It will NOT include those times when we have shared your information in order to treat you, pay or bill for your health care services or to run our programs. If you want a copy of this record, you must send a request in writing to our Privacy Official.
- If you do not understand the information, ask your worker to explain it to you. You can ask DHS for another copy of this notice.

What are our responsibilities under this notice?

We may change our privacy policy in the future. We might do this, for example, because privacy laws change and require us to change our practices. When we change our privacy rules we will publish them on our Web site at http://edocs.dhs.state.mn.us/lfserver/Legacy/DHS-3979-ENG. Until we publish new privacy rules, we will abide by the terms of this notice.

What if you believe the information we have about you is wrong?

Send your concerns in writing, telling us why the information is not accurate or complete. You may send your own explanation of the facts you disagree with. Your explanation will be attached any time that information is shared with another agency.

What privacy rights do children have?

If you are under 18, parents may see information about you and allow others to see this information, unless you have asked that this information not be shared with your parents or it involved medical treatment for which parental consent was not required. You must make this request in writing and say what information you want withheld and why. If the agency agrees that sharing the information is not in your best interest, the information will not be shared with your parents. If the agency does not agree, the information will be shared with your parents if they ask for it.

When parental consent for medical treatment is not required, information will not be shown to parents unless the health care provider believes failing to share the information would jeopardize your health.

Keep this page.

What if you believe your privacy rights have been violated?

You may complain if you believe your privacy rights have been violated. You cannot be denied service or treated badly because you have made a complaint. If you believe that your medical privacy was violated by your doctor or clinic, a health insurer, a health plan, or a pharmacy, you may send a written complaint either directly to that organization or to:

U.S. Department of Health and Human Services
Office for Civil Rights, Region V
233 N. Michigan Avenue, Suite 240
Chicago, IL 60601
(312) 886-2359 (Voice) or
toll free (800) 368-1019 or (866) 282-0659
(312) 353-5693 (TTY/TDD)
(312) 886-1807 (Fax)

If you think that the Minnesota Department of Human Services has violated your privacy rights, you may send a written complaint to the U.S. Department of Health and Human Services at the address above, or to:

Minnesota Department of Human Services
Appeals and Regulations
PO Box 64941
St. Paul, MN 55164-0941

Important Information

Proof of Citizenship or National Status

Parents and caretakers, children, pregnant women, people with disabilities and people age 65 or over must give us proof that they are United States (U.S.) citizens or nationals. National status includes people from American Samoa and Swains Island.

Adults without children are not required to give us proof that they are U.S. citizens or nationals.

Proof can be one of the following:

1. U.S. passport
2. Certificate of Naturalization
3. Certificate of U.S. Citizenship

If you do not have one of the above documents, you must give us one item from List #1 and one from List #2 below. If you do not have or cannot get these items ask your worker for help right away.

List #1

1. U.S. birth certificate
2. Report of Birth Abroad of a U.S. Citizen
3. U.S. Citizen ID card
4. Hospital record of birth in one of the 50 states, the District of Columbia, Puerto Rico, Guam, the U.S. Virgin Islands, American Samoa, Swains Island or the Northern Mariana Islands.

List #2

1. Current State driver's license with picture
2. Minnesota ID card with picture.
3. School ID card with picture.
4. Nursery or daycare records for children under 16.

Immigration

All immigration information you give to us is private. We use it to see if you can get coverage. We only share it when the law allows it or requires it. In most cases, applying will not affect your immigration status. However, it may if you are applying to pay for long-term care services.

You do not have to give us your immigration information if you are:

- Applying only for emergency medical care.
- Only helping someone else apply.
- A non-immigrant or undocumented person who is pregnant.
- Applying for your children or other household members but not yourself.

You Have the Right to Fair Treatment

We cannot treat you different because of your race, color, national origin, religion, sex, marital status, sexual orientation, or political beliefs. We cannot treat you different because you have a physical, mental or emotional disability. If you feel the State or local agency did not treat you fairly, you may file a complaint. You can contact any of the following places to file a complaint:

- Minnesota Department of Human Services, Office for Equal Opportunity, PO Box 64997, St. Paul, MN 55164-0997
- Minnesota Department of Human Rights, 190 E. Fifth Street, Suite 700, St. Paul, MN 55101
- U.S. Department of Health and Human Services, Office of Civil Rights - Region V, 233 N. Michigan Avenue, Suite 240, Chicago, IL 60601

You Have the Right to Ask for a Hearing

If you feel that your benefits are not right you may ask for a fair hearing. You can ask for a hearing by telling your worker or by writing to the:

Minnesota Department of Human Services, Appeals & Regulations, PO Box 64941, St. Paul, MN 55164-0941.

Keep this page.

A person from the State office will check the facts of your case. They will tell you if your benefits are correct or not according to the laws.

You must ask for a hearing within 30 days from the day you get a notice. You must say that you feel a decision is wrong. If you cannot ask for a hearing within 30 days, you can ask for more time. You will need to show that you have a good reason for not asking for a hearing on time. If a person from the State office decides you had a good reason, they will accept your appeal up to 90 days after you received the notice of action on your case.

If you ask for a hearing after 30 days, you will not be able to have your health care continue until the hearing. If you want your health care to continue, you must ask for a hearing before the date your coverage will be reduced or within 10 days from the date of the notice, whichever is later.

Breaking the Rules

The below rules apply to some people who are enrolled in certain health care programs. If the rules apply to you, it explains what will happen if you break the rules.

What are the rules?

- Do not give false information or hide information to get or continue to get health care program coverage.
- Do not trade or sell your membership cards.
- Do not help others get medical services that you know they should not get.
- Do not use someone else's membership card for yourself or other household members.

What happens if I break these rules?

If you break the rules you may not be able to keep your coverage. The first time you break the rules, your coverage will stop for one year. The second time you break the rules you will not get coverage for two years. If you break the rules a third time, you will not get coverage forever. Also, if you break these rules we can prosecute you for fraud. The maximum penalty is a fine of $250,000 or a jail term of 20 years, or both.

Social Security Numbers

Most people who apply for coverage must give a Social Security Number. We use them to check who you are, for system matches, and for reviews and audits to make sure your case is correct. You do not have to give us a number if you

- Do not want coverage
- Have religious objections
- Are not a U.S. Citizen and are applying for Emergency Medical only
- Are a non-immigrant or a person without documentation.

Child Support

If you are applying for yourself and your children and you do not live with the other parent, the law says that you may have to give information to child support staff.

If you were not married to the other parent when your child was born, you may also have to help child support staff prove who the father is. This means that you may need to give information to get medical support for your child. If you do not help child support, your children will still get coverage. You will not get coverage unless you are pregnant. Your coverage will stop if you are already getting coverage.

Do you have fear that the other parent may cause harm to you or your child? If you do, and you can give proof to support your fears, you may not have to give information to child support staff. A group of people at the county or state office will review your proof. After the review, they will tell you if you still need to give information about the other parent.

If you are already getting child support services, they will stop during the review. If they make a decision that you must give information about the other parent, child support services will start again.

A law says that the State of Minnesota gets to keep medical support payments for the person who is applying for or getting coverage. The State can not keep more than it pays out. This is also true even if you are applying only for a child.

Reviews

The State or Federal Office may pull your case at random to review. They will review the information you put on your application and renewal forms. They will also check to make sure we did your case correctly. They will let you know if they will need to ask you questions. If you refuse to answer their questions, your coverage may stop.

Reporting Systems

The State uses systems to check the information you give. If we get information that does not match yours, we will write to you. You will need to give us proof or give us permission to check your information. If you refuse, your coverage may stop. If you want more information, ask your worker for the "Notice About Income and Eligibility Verification System and Work Reporting System" (DHS Form #2759).

Keep this page.

Other Health Care

You and your household members may need to accept and keep a health insurance policy that is good. This includes Medicare. We will review your policy. We will tell you if you can or cannot cancel it. In some cases, if we tell you that you cannot cancel it, we may help pay the premiums. If you refuse to give us information about your policy, you may not get coverage.

State as Annuity Beneficiary

The state becomes a remainder beneficiary of some annuities when we pay for long-term services.

Liens and Estate Claims

The State or county may try to recover the cost of medical services that MA or GAMC paid for you. They do this by filing a claim against your estate or by filing a lien against your real property.

The state may file a claim against your estate if you received:

- General Assistance Medical Care (GAMC) at any age.
- MA when you were over age 55.
- MA when you were under 55 and lived in a long-term care facility (LTCF) for six months or more.

Liens can be set up against:

- Your life estate
- Real property that you own by yourself
- Real property that you own with someone else. If you own property with another person, the lien is only against your share of it.

The state will not file a lien against your property if you are in a long-term care facility and will be returning home.

Before you die, the State can file a Notice of Potential Claim (Notice). The Notice must:

- List the real property you own.
- Note if you have a life estate.
- State if other people own any real property with you.

When you die, a lien is set up against your portion of the property that was listed in the Notice. Your interest in real property that is part of your estate may be used to pay that claim.

Note that this is a very general explanation of the rights that the state and counties have regarding claims and liens. You should talk to your lawyer or advisor if you have questions about how these laws apply to your property.

Changes

You must report changes to your worker within 10 days of the change happening. If you do not report changes, you may have to go through a fraud investigation. You may have to pay money back to the State for what we paid if you were not eligible.

If you are not sure if you should report a change, call your worker and explain what is happening. Your worker will tell you if you need to report it or not.

Examples of changes you may need to report include:

Starting:

- A new job, changing jobs or stopping a job.
- To get Social Security or other retirement income.
- To get child support, unemployment or worker's comp income.
- To get health insurance or Medicare.

When you:

- Sell your home.
- Move to a new address.
- Get an inheritance or a settlement.
- Transfer or give away assets or income.

When someone in your household:

- Becomes pregnant or has a baby.
- Moves in or out of your home.
- Dies, gets married or gets a divorce.
- Becomes disabled.
- Starts or stops school.

Keep this page.

Health Care Coverage Options in Minnesota

It is important to have health care coverage. If you do not qualify for Minnesota Health Care Programs here is information about other options.

Private Health Insurance

Can you or a family member get health insurance through an employer?

People may be able to get health insurance through their work. Ask your employer if the company offers health insurance. Call the Minnesota Department of Commerce at (651) 296-2488 or (800) 657-3602. For TTY/TDD, call (800) 627-3529.

Can you get private health insurance through an insurance company?

Many insurance companies sell health insurance policies. People should compare policies and decide what they can afford. An agent can tell you about different types of health care policies, medical services that are covered, and the cost of policies. You can find insurance agent phone numbers in the yellow pages. You can also get a list of insurance agents from the Minnesota Department of Commerce at (651) 296-2488. TTY/TDD users call (800) 627-3529.

Can you or a family member get short term insurance?

Short Term Insurance is health coverage sold by private insurance companies. Short Term Insurance may cover a person up to 185 days. It may not cover prior medical conditions. A person may want short term insurance while waiting for other health coverage to start. Call an insurance agent. You can find numbers in your telephone yellow pages under "Insurance."

Do you or a family member qualify for COBRA insurance?

COBRA is a law that lets people keep health insurance through their employer for a time period after their jobs end. The employer will send a COBRA notice within 14 days after the person leaves the job. The person must ask for COBRA during the next 60 days. When COBRA insurance ends, the person can buy another type of insurance. To learn more about COBRA, call your former employer, The Minnesota Department of Commerce at (651) 296-2488 or (800) 657-3602 or The Minnesota Department of Health at (800) 657-3916. TTY/TDD users call (800) 627-3529.

Do you or a family member qualify for Minnesota Comprehensive Health Association (MCHA)?

MCHA is insurance for people who live in Minnesota and cannot get other health care coverage. MCHA sells insurance to people when other health insurance was denied, coverage for a medical condition was denied, or coverage ended through no fault of the person. To learn more about MCHA, call Medica (the MCHA Administrator) at (952) 945-8000 or (800) 952-3455. TTY/TDD users call (952) 992-3190.

Is Medicare an option for you or a family member?

Medicare is a federal health care benefit for people who:

- Are over age 65
- Have a disability, or
- Have End-Stage Renal Disease.

To learn more about Medicare, call (800) 633-4227. TTY/TDD users call (877) 486-2048. You can also visit the web site at www.medicare.gov.

Keep this page.

Minnesota Health Care Programs Renewal Form

(Fill out and return this part)

Instruction: Answer all questions and print clearly. Please use blue or black ink. You may need more space to answer questions. Write the question number and the answers on a separate piece of paper. Include it with this renewal.

1. Language information

What is the main language your household speaks? ☐ English ☐ Spanish ☐ Other _____

What is the main language your household writes? ☐ English ☐ Spanish ☐ Other _____

Do you need someone who speaks your language to help you? ☐ Yes ☐ No

2. Who is the household member that is filling out this renewal?

The head of the household is a husband, a wife, a parent of a child, or yourself if you live alone. This includes a person under age 18 who is living on their own. If someone other than a household member is filing out this application, write the name of the head of household below.

First Name _____ Middle Name _____ Last Name _____

3. What is your address?

☐ Check this box if you are homeless.

Street address _____ Apt. # _____ City _____

State_____ Zip Code _____ What county do you live in? _____

Mailing address (if different than the one above)

Street Address_____

City _____ State _____ Zip Code_____

☐ Check this box if you are a migrant worker.

4. Write the name and the phone number for a household member where we can call during the day.

We will only call if we have questions about this renewal.

Name _____ Phone number ( ) _____

5. Are any household members pregnant?

☐ Yes - fill out the information below. ☐ No - go to question 6.

Who is pregnant?_____ What is her due date?_____/_____/_____

We need proof of the pregnancy from a doctor, midwife or clinic. The proof needs to tell us the date she became pregnant and when her baby is due.

6. Did any new members move into your household or do you want to apply for a household member who is not getting coverage now?

☐ Yes - fill out the information below. ☐ No - go to question 7.

What is their full name?_____

What is their date of birth?_____ What is their relationship to you? _____

When did they move in?_____ Do they want to apply? ☐ Yes - continue. ☐ No - go to question 7.

What is this person's Social Security number?_____

Does this person get income? ☐ Yes - what type of income?_____ ☐ No

What is the gross monthly amount?_____ Do they have health insurance? ☐ Yes ☐ No

Does this person have assets? ☐ Yes - list them below. ☐ No

_____

7. List your household members below.

First and last name	Date of birth	Relationship to you	U.S. citizen or national?	Place of birth City and State	Birth name
			☐ Yes ☐ No		
			☐ Yes ☐ No		
			☐ Yes ☐ No		
			☐ Yes ☐ No		
			☐ Yes ☐ No		

You must give us copies of documents that show citizenship or national status. This is needed for each person who is getting or applying for coverage. Look for more information on page C. If you need help, tell your worker right away.

8. Are any other household members who are not already listed living away from home for a short time?

☐ Yes - fill out the information below. ☐ No - go to question 9.

First and last name of this person_____

Date of birth_____ Date they left_____ Date they will return_____

Write the reason for living away_____ Do they want to apply? ☐ Yes ☐ No

9. Are you or any household members getting or expecting wages or a salary from a job?

This includes wages or a salary from an employer, seasonal or temporary employment, and cash jobs.

☐ Yes - fill out the information on the next page for each job and for each person who is working.

☐ No - go to question 10.

You must give us proof of income. Proof can be pay stubs from the last 30 days or a statement from the employer. If we do not get proof, coverage may stop

You must also give us proof to show us if the employer offers health insurance. If you are a MinnesotaCare enrollee, fill out form DHS-4742 for each employed person. If we do not get proof, coverage may stop.

Name of person working________________________________ Start date ______________

Name of employer______________________________ Employer's phone number ( )________

Contact person____

☐ Check this box if this is seasonal or temporary employment.

How often paid? ☐ Every week ☐ Every two weeks ☐ Once a month ☐ Other ______________

Write the gross amount of the wages on paycheck before taxes are taken out $ ________________

Write the date that the last paycheck was received_______________________________________

Does this employer offer health insurance? ☐ Yes - ☐ Single coverage or ☐ Family coverage. ☐ No

Name of person working________________________________ Start date ______________

Name of employer______________________________ Employer's phone number ( )________

Contact person____

☐ Check this box if this is seasonal or temporary employment.

How often paid? ☐ Every week ☐ Every two weeks ☐ Once a month ☐ Other ______________

Write the gross amount of the wages on paycheck before taxes are taken out $ ________________

Write the date that the last paycheck was received_______________________________________

Does this employer offer health insurance? ☐ Yes - ☐ Single coverage or ☐ Family coverage. ☐ No

Name of person working________________________________ Start date ______________

Name of employer______________________________ Employer's phone number ( )________

Contact person____

☐ Check this box if this is seasonal or temporary employment.

How often paid? ☐ Every week ☐ Every two weeks ☐ Once a month ☐ Other ______________

Write the gross amount of the wages on paycheck before taxes are taken out $ ________________

Write the date that the last paycheck was received_______________________________________

Does this employer offer health insurance? ☐ Yes - ☐ Single coverage or ☐ Family coverage. ☐ No

10. Do you have more jobs to report?

☐ Yes - for each job, write the question number and the above information on a separate piece of paper. Include it with this renewal. ☐ No - go to question 11.

11. Are you or any household members self-employed?

☐ Yes - fill out the information below and give us proof. ☐ No - go to question 12.

Name of person	Name of business	Start date of business	Gross yearly income
			$
			$
			$

Do the net business assets of all businesses total $200,000 or less? ☐ Yes ☐ No

You must give us proof of this income. Proof can be the most recent income tax returns and all related schedules or the business records if taxes are not filed. If we do not get proof, coverage may stop.

12. Are any household members getting or expecting to get other types of income?

Other income may include child support, spousal support, unemployment, worker's comp., Social Security, Supplemental Security Income (SSI), pensions, Veteran's benefits, retirement, rent, annuities, trusts, interest, dividends, contracts for deed, property agreements, public assistance payments and other types of income.

☐ Yes - fill out the information below. **You must give us proof.** ☐ No - go to question 13.

Name	Where is the income from?	Amount	How often is it received? ☐ Weekly ☐ Bi-weekly ☐ Monthly	Write the date the last payment was received
		$		
		$		
		$		
		$		
		$		

You must give us proof of this income. Proof can be a statement from where the income comes from or a direct deposit statement from your bank. If we do not get proof, coverage may stop.

13. Do any household members pay for child or adult day care while they work?

☐ Yes - fill out the information below. ☐ No - go to question 14.

Name of person working	Name of person(s) in day care	Total amount paid each month
		$
		$

14. Do you or any household members pay child or medical support that is court ordered?

☐ Yes - fill out the information below and give us proof. ☐ No - go to question 15.

Name of person paying support	Amount of payment each month
	$

You must give us a copy of the court order if we do not have one.

15. Is anyone blind or disabled?

☐ Yes - continue. ☐ No - go to question 16.

Does this person have work expenses? ☐ Yes - fill out the information below. ☐ No - go to question 16.

Name of person working	Type of expense	Amount paid per month
		$
		$
		$
		$
		$

16. Do you and your household members have any assets?

Assets include items such as cash, bank accounts, certificates of deposit, stocks, bonds, retirement accounts, interest in annuities, trusts, property agreements, contracts for deed, time shares, rental property, life estates, livestock, tools, and farm machinery. Note, you will list your vehicles for question 17.

☐ Yes - fill out the information below and give us proof. ☐ No - go to question 17.

Name of owner(s)	Type of asset	Name of bank /or company	Value of asset	Amount of loan (if none, list zero)
			$	$
			$	$
			$	$
			$	$
			$	$
			$	$

You must give us proof of assets. Proof can be bank statements or a statement from the bank or the company. The proof must be dated within the last 30 days. If we do not get proof, coverage may stop.

17. Do you or any household members have vehicles?

Vehicles include cars, trucks, snowmobiles, four-wheelers, motorcycles, boats, motors, trailers, campers, and motor homes. ☐ Yes - fill out the information below and give us proof. ☐ No - go to question 18

Name of owner(s)	Year/make/model	Value	Amount of loan (if none, list zero)
		$	$
		$	$
		$	$
		$	$
		$	$

You must give us proof of all of the vehicles and proof of the loan balance. Proof can be the registration card or title and a statement from the bank or loan company showing the loan balance. If we do not get proof, coverage may stop.

18. Do you or any household members own or are buying real estate?

Real estate may include homes, cabins, lake homes, land and other property that you rent out.

☐ Yes - fill out the information below. ☐ No - go to question 19.

Name of owner(s)	Address of real estate	Value	Amount of loan (if none, list zero)	Do you live here?
		$	$	☐ Yes ☐ No
		$	$	☐ Yes ☐ No

If you own real estate, you must give us proof. Proof can be the real estate tax statement and a statement showing the loan balance. If we do not get proof, coverage may stop.

19. Do you or any household members have life insurance policies?

☐ Yes - fill out the information below and give us proof. ☐ No - go to question 20.

Name of owner(s)	Name of insurance company	Face value	Cash surrender value
		$	$
		$	$
		$	$

You must give us proof of the face value and cash surrender value of the life insurance policies. Proof can be a copy of the policy or a statement from the insurance company that is dated within the last 30 days. If we do not get proof, coverage may stop.

20. Do you or any household members have money for burial or burial contracts?

☐ Yes - fill out the information below. ☐ No - go to question 21.

Name of owner(s)	Name of funeral home or company that holds this burial agreement	Value	Date of the agreement
		$	
		$	
		$	
		$	

You must give us proof. Proof can be a copy of the agreement or a statement from the company or funeral home and the statement of goods and services. If we do not get proof, coverage may stop.

21. During the last year, did you or any household members:

- Sell any assets for less than what they were worth?
- Trade assets or income?
- Transfer assets or income?
- Give away assets or income?
- Not accept an inheritance?
- Purchase an annuity, life estate in another person's home, promissory note, loan or mortgage?

☐ Yes - fill out the information below and give us proof. ☐ No - go to question 22.

Owner(s) of the asset or income	Type of asset or income	Value of the asset or income	Who was it given or sold to?	When? mm/dd/yy	How much did you get paid for the asset?
		$			$
		$			$
		$			$
		$			$

Do you have more to list?

☐ Yes - list them on a separate piece of paper and include it with this application. ☐ No

You must give us proof to show us what has been done. If we do not get proof, coverage may stop

22. Are you or is any household member living in a long term care facility (LTCF) or planning to get waiver program services?

- LTCF includes skilled nursing facility, intermediate care facility services and nursing facility care in an inpatient hospital.
- Waiver programs include Elderly Waiver (EW), Community Alternatives for Disabled Individuals (CADI), Community Alternatives Care (CAC), Traumatic Brain Injury (TBI), and Mental Retardation and Related conditions (MR/RC).

☐ Yes - fill out the information below. ☐ No - go to the Signature Page.

Check the box below that applies:

☐ This person lives in a long term care facility. ☐ This person expects to get waiver program services.

Person's first name _____ MI ____ Last name _____

23. Has this person ever had a long-term care insurance policy?

☐ Yes - fill out the information below. ☐ No - go to question 24.

Is this policy paying benefits now? ☐ Yes ☐ No

Did this policy ever pay benefits? ☐ Yes - when? _____ ☐ No

Name of insurance company _____

First name of policy holder _____ MI _____ Last name _____

Date the insurance policy was issued _____ Policy number _____

Street address of insurance company _____

City _____ State _____ Zip Code _____

24. Does this person own a home?

☐ Yes - fill out the information below. ☐ No - go to question 25.

Does a spouse, a child under the age of 21, or a blind or disabled child of any age live in the home?

☐ Yes - go to question 25. ☐ No - fill out the information below.

Name of owner(s)	**Address of homestead**	**Value**	**Amount of loan (if non, write zero)**	**Do you live here?**
		$	**$**	☐ **Yes** ☐ **No**

You must give us proof. Proof can be the real estate tax statement and a statement showing the mortgage or loan balance. If we do not get proof, you may not get coverage.

25. Do you or household members have health insurance coverage?

☐ Yes - if yes, what is the name of the insurance company? _____

☐ No

26. List changes below that took place in the past year or may occur during the next year.

Marriage/Divorce ☐ Yes. Who?_____When?_____ ☐ No

Student status ☐ Yes. Who?_____When?_____ ☐ No

Disability status ☐ Yes. Who?_____When?_____ ☐ No

Medicare benefits ☐ Yes. Who?_____When?_____ ☐ No

Immigration status ☐ Yes. Who?_____When?_____ ☐ No

Income ☐ Yes. Who?_____When?_____ ☐ No

Other_____

Signature Page

All adults must read all of the following information and sign below.

Fraud Investigation Release

I give third parties permission to share information about me with authorized state and county staff conducting investigations regarding fraud, fraud prevention and misrepresentation. Third parties include but are not limited to financial institutions, credit reporting agencies, landlords, public housing agencies, schools, utility companies, insurance agencies, employers, other government agencies and others as they apply. I further authorize taxing authorities to release copies of my income tax returns. I also understand that my permission for release is effective for six months after my benefits stop.

Medical Assignment of Benefits

I assign all medical payments to the State of Minnesota. This assignment includes medical care payments from all other persons or entities. This assignment covers medical care payments for myself. It also covers anyone else for whom I apply.

It takes effect right away when health care coverage starts. I agree to cooperate with the State in any action to recover payment of medical expenses. If I claim good cause and good cause is approved, I may not have to cooperate.

Medical Release

I give consent to my health providers and health plan, including their contractors, to share my Minnesota Health Care Programs (MHCP) health records with the State of Minnesota, its agents, contractors and their subcontractors, Ombudsman and County Advocates for managed care. I know I need to share this information to:

- Decide if I can get federally funded health care,
- Pay my health care providers,
- Provide and coordinate health care,
- Do quality of care reviews and studies, and
- Help in record reviews, prosecutions or legal actions related to managing the health care programs.

If I have Medicare Part B, I give Medicare consent to pay my health providers for the care I get while on MHCP. This release also applies to the MHCP health records of my minor children in this application.

This medical release is good while I am enrolled in MHCP, not to exceed one year, or longer if the law permits. I can refuse to sign or cancel the medical release. If I cancel I must do this in writing. I understand that the law overrides my canceling this release for these reasons:

- To share health information with health care consultants,
- To pay my health care bills,
- If fraud is suspected, or
- For quality of care reviews and studies.

If I refuse to sign or cancel the release, I will not be able to enroll or stay enrolled in Minnesota Health Care Programs. I understand that this release allows my MHCP health records to be shared with others if the law permits. Privacy laws may no longer protect the information shared with others.

By signing below:

- I agree that I have read the Notice of Privacy Practices and the list of my responsibilities in that Notice.
- I understand that my information will be shared if fraud is suspected.
- I agree to the release of my Minnesota Health Care Programs health records to the parties listed above.
- I agree to assign my medical benefits as stated above.
- I agree to allow the State of Minnesota, its agents, contractors, and subcontractors to contact my employer(s) for the purpose of verifying access to employer subsidized health insurance.
- I declare that, under penalty of perjury, all parts of this renewal, to the best of my knowledge, are true and correct statements. I understand what happens to people convicted of perjury (not telling the truth). They may be sentenced to prison for up to five years, a fine up to $10,000, or both.

All adults age 18 and older who are getting coverage must sign below.

Your Signature	Date
Signature of spouse	Date
Signature of household member age 18 and older who is getting coverage	Date
Signature of household member age 18 and older who is getting coverage	Date
Signature of household member age 18 and older who is getting coverage	Date
Signature of person acting on your behalf	Date

Minnesota Department of **Human Services**

Attachment E

DHS-4832 7-06

Minnesota Health Care Programs

Please read! Important information about your Renewal!

We are writing to tell you about a new change for some people who are getting Medical Assistance (MA) and MinnesotaCare.

What is the change?

A new law requires some MA and MinnesotaCare enrollees to give us proof of identity and proof that shows they are U.S. citizens when they renew their coverage. This includes U.S. nationals from American Samoa and Swains Island.

You must give us this proof for coverage to continue *unless*:

- You are an adult without children and you are on MinnesotaCare.
- You are on General Assistance Medical Care.
- Your worker can verify that you were born in Minnesota. You will still need to give us proof of your identity, such as a driver's license. Your worker will get proof of your birth record from the Minnesota Department of Health.
- You are getting Medicare benefits.
- You are getting SSI (Supplemental Security Income) or MSA (Minnesota Supplemental Aid).

If you have to give proof of identity and citizenship, you can give us a:

- U.S. passport
- Certificate of naturalization ***or***
- Certificate of citizenship.

If you do not have one of the proofs listed above, you must give us:

- A birth certificate ***or*** other proof that you are a U.S. citizen or were born in American Samoa or Swains Island

and

- Proof of your identity, such as a driver's license or state ID.

Can you give us a copy of the document?

No. We need to look at the original documents.

- You cannot give us copies.
- You may mail the proofs with your renewal, or you can bring them to your county or MinnesotaCare office.
- If you mail the original documents, we will look at them, make a copy and mail them back to you.

What if I need help or have questions?

If you need help or if you have questions contact your County Human Services Office or the MinnesotaCare office right away. **We will help you get the proofs.**

This information is available in other forms to people with disabilities by contacting us at (651) 431-2670 (voice) or toll free at (800) 657-3739. TTY/TDD users can call the Minnesota Relay at 711 or (800) 627-3529. For the Speech-to-Speech Relay, call (877) 627-3848.