#07-21-03

Bulletin

March 26, 2007

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

OF INTEREST TO

- County Directors
- DHS Family Planning Unit
- Financial Assistance Supervisors and Financial Workers
- Social Services Supervisors and Staff
- MinnesotaCare Operations
- Mille Lacs Tribal TANF
- Tribal Social Services
- County Public Health Departments
- Health Care Providers
- Community Organizations

ACTION/DUE DATE

Please implement immediately.

EXPIRATION DATE

October 1, 2007

After this date refer to the Health Care Programs Manual for instructions.

Changes and Clarifications to Minnesota Family Planning Program (MFPP) Announced

TOPIC

Changes and clarifications to the MFPP policies and procedures.

PURPOSE

Provide information on changes and clarifications to policies, procedures and forms for the Minnesota Family Planning Program.

CONTACT

Refer questions about the Minnesota Family Planning Program to the DHS Family Planning Unit at (651) 431-3480 (Twin Cities metro) or (888) 702-9968 (outside Twin Cities metro).

State Family Planning Program Unit please submit questions to HealthQuest.

SIGNED

BRIAN J. OSBERG
Assistant Commissioner
Health Care Administration

I. Background

The 2001 Minnesota Legislature enacted legislation directing the commissioner of the Department of Human Services (DHS) to establish a Medical Assistance (MA) demonstration project to determine whether improved access to coverage of pre-pregnancy family planning services reduces MA and Minnesota Family Investment Program (MFIP) costs. DHS submitted a demonstration project proposal to the Centers for Medicare and Medicaid Services (CMS) for approval. CMS approved Minnesota's demonstration project in July 2004. Now called the Minnesota Family Planning Program (MFPP), the project provides family planning services to men and women between the ages of 15 and 50 whose household incomes are at or below 200 percent of the federal poverty guidelines (FPG).

II. Introduction

DHS implemented the MFPP on July 1, 2006 to run for a five-year period through June 30, 2011 with publication of bulletin #06-21-07. Eligibility Specialists in the MFPP unit at DHS have been processing MFPP applications since July 1, 2006. Several areas have been found to need changes or further clarification. Those changes and clarifications are explained in this bulletin.

III. Action Required

Effective immediately, make the changes and follow the clarifications that are provided here for the following areas:

- Dependent child income exclusion
- Medical Support
- 12-Month Ineligibility Period
- Medical Assistance – Breast and Cervical Cancer (MA-BC)
- Verification of Residency
- Confidentiality Reminder
- Application

A. Dependent Child Income Exclusion

1. Current policy

Eligibility Specialists were previously instructed not to apply the dependent child income exclusion when calculating MFPP income.

2. New policy

New interpretation of the policy changes the previous instruction for Eligibility Specialists only.

a. Apply the dependent child income exclusion when calculating income for the MFPP. See HCPM 0911.09.05.

b. Do not verify this excluded income.

Note: Certified MFPP Providers do not apply the dependent child income exclusion to an applicant's gross income when determining presumptive eligibility.

B. Medical Support

Bulletin #06-21-07 incorrectly stated that the County Child Support Enforcement Office (IV-D) will notify the DHS Family Planning Unit if an MFPP enrollee must be closed for non-cooperation. Instead, IV-D will contact a child's MA or MinnesotaCare worker if an MFPP-enrolled parent must be closed for non-cooperation.

The information below clarifies medical support policy and procedures for the DHS Family Planning Unit, counties and MinnesotaCare Operations.

1. DHS Family Planning Unit

a. Do not refer child MFPP enrollees to IV-D for medical support.

b. IV-D will contact the child's MA or MinnesotaCare worker if a parent must be closed for non-cooperation. The child's worker will contact the DHS Family Planning Unit if a caretaker's MFPP coverage must be closed. Close MFPP coverage with a 10-day notice.

2. County and MinnesotaCare workers

When a child is receiving MA or MinnesotaCare and the caretaker is receiving MFPP:

a. Make a medical support referral when a child receiving MA or MinnesotaCare lives with a caretaker who receives MFPP, if at least one of the conditions outlined in HCPM 16.05 Referral Required, exists.

b. Follow HCPM 16.05 when determining if a referral to IV-D for medical support should be made.

c. If IV-D determines that a caretaker must be closed for non-cooperation, contact the DHS Family Planning Unit to coordinate closing the parent's MFPP eligibility.

Example 1
Lotta receives the MFPP. Her 5-year old daughter, Trudi, receives MinnesotaCare. Trudi's father does not live in the home and he is not complying with an order to provide medical support. Lotta does not claim good cause. MinnesotaCare should refer Trudi's case to IV-D following the procedures in HCPM 0906.12.03. IV-D will notify MinnesotaCare if Lotta is not cooperating. MinnesotaCare should contact the DHS Family Planning Unit to coordinate the closing of Lotta's MFPP coverage.

Example 2
Elena is a 15-year-old enrolled in the MFPP. She lives with her mother who receives MA. Her father does not live in the home and he is not complying with an order to provide medical support. Do not refer Elena to IV-D.

C. 12-Month Ineligibility Period

Bulletin #06-21-07 explained that MFPP applicants and enrollees are subject to a 12-month penalty period if they fail to report a change that would have resulted in ineligibility within 10 days of learning about the change. This bulletin clarifies that this penalty period does not apply if an applicant or enrollee does not report a pregnancy within 10 days.

1. Applicant or enrollee fails to report a pregnancy within 10 days.

a. Deny/disenroll pregnant applicants and enrollees who failed to report a pregnancy within 10 days of learning of the pregnancy.

b. Explain to the applicant/enrollee that she may be eligible for MA or MinnesotaCare.

c. Send a HCAPP and assist her in the application process.

d. Close MFPP coverage with a 10-day notice.

e. Do not apply a 12-month penalty period. These women may reapply for the MFPP at the end of the pregnancy.

Example 3
Stephanie became pregnant while enrolled in the MFPP. DHS learned of the pregnancy through a third party. Contact Stephanie and confirm she is pregnant. Close the MFPP and send her a HCAPP. Stephanie is eligible for MA. At the end of her postpartum period she applies for the MFPP. Do not apply a 12-month ineligibility period.

2. Women who are no longer pregnant did not report the pregnancy within 10 days.

a. Do not deny/disenroll non-pregnant applicants/enrollees who did not report their pregnancy within 10 days of learning they were pregnant.

b. Remind the applicant/enrollee of the obligation to report changes within 10 days.

c. Do not apply a 12-month penalty period.

Example 4
Stephanie becomes pregnant while enrolled in the MFPP. DHS learns of the pregnancy through a third party. DHS contacts Stephanie and discovers that she is no longer pregnant. MFPP eligibility is not closed and Stephanie is not subject to a 12-month penalty.

3. **Applicants/enrollees fail to report a pregnancy <u>plus</u> do not report another change that would have resulted in ineligibility**

   a. Deny/disenroll pregnant and non-pregnant applicants/enrollees who failed to report both a pregnancy and another change that would have resulted in ineligibility within 10-days of learning of the change.

   b. Close MFPP coverage with a 10-day notice.

   c. Apply the 12-month penalty period and document in case notes.

Example 5
Stephanie becomes pregnant while enrolled in the MFPP. She moves to Wisconsin to live with her parents. She does not report either change. After Stephanie has the baby, she moves back to Minnesota. DHS learns about the changes. Stephanie's failure to report the pregnancy has no consequences. However, her failure to report the change in residency results in disenrollment and a 12-month ineligibility period.

D. MA-BC Clarification

This is a clarification only, not a policy change.

1. **Creditable coverage**
   MFPP is not considered creditable coverage for purposes of determining MA-BC eligibility.

2. **Coordination of coverage**
   If a MFPP enrollee is eligible for MA-BC coverage, open MA-BC and coordinate closure of the MFPP with the DHS Family Planning unit.

E. Verification of Residency Clarification

This is a clarification only, not a policy change.

1. **Do not verify residency.**
   Do not verify address or residency if there is no conflicting information provided.

2. **Follow up with the applicant if you receive conflicting information.**
   With the implementation of the citizenship and identity documentation policy, eligibility specialists are seeing more out-of-state drivers' licenses, which conflict with the applicant's current address.

   a. Follow HCPM 09.05.05 Inconsistent Information and HCPM 13.20 Temporary Absence from Minnesota.

   b. Submit a HealthQuest if it is not clear if verification of the inconsistent information is required or if the situation qualifies as a temporary absence.

F. Confidentiality Reminder

This is not a change, but a reminder to all partner agencies of the Minnesota Department of Human Services (DHS) of the requirement to comply with federal and state laws that protect the privacy and security of individually identifiable client information.

1. Responsibility to protect private data

You are responsible to protect individually identifiable information about applicants for, or enrollees in DHS services and program benefits.

IMPORTANT: Privacy protection applies to MFPP eligibility and benefits information. This information is private data on individuals. It cannot be released to anyone other than the subject of the data without the data subject's consent, or unless the law otherwise allows.

2. Responsibility to protect privacy of minors

Remember that minors may apply for the MFPP without parental consent.

IMPORTANT*:* Do not release information about a minor's MFPP eligibility or benefits to a parent, guardian or caretaker without the minor's informed consent.

G. MFPP Application

1. The MFPP application has been modified to:

a. Accommodate requirements to document citizenship and identity.

b. Collect information needed to apply the dependent child income exclusion.

c. Reword, reorganize and reformat confusing questions.

d. Reduce the length of the application.

2. Availability of the new application

a. The MFPP application (DHS-4740 02/07, Attachment A) can be viewed or downloaded from the DHS Web site at http://www.dhs.state.mn.us/provider/mfpp or http://www.dhs.state.mn.us/familyplanning.

b. Beginning 03/26/07, providers may order applications through DHS Forms Supply. To order, complete and submit Requisition for DHS Forms (DHS-0121) available at http://edocs.dhs.state.mn.us/lfserver/Legacy/DHS-0121-ENG.

3. Procedures for the DHS Family Planning Unit

a. Recycle all previous versions of the MFPP application.

b. Continue to accept and process previous versions of the MFPP application and follow up to get any additional information or proofs.

c. Accept a faxed copy of page one of the new MFPP application (02-07) as a presumptive eligibility approval if a Certified MFPP Provider has completed the "Provider Use Only" boxes. The information required by DHS to enter the presumptive eligibility span to MMIS is now included on page one of the application.

1) Do not require Certified MFPP Providers to complete and fax DHS-4774 for each presumptive eligibility approval.

2) Do not require Certified MFPP Providers to include the national provider identifier (NPI), at this time.

3) Enter the presumptive eligibility span in MMIS following current procedures.

d. Review all changes and revisions on the updated application as described below.

1) Cover page
The cover page includes instructions for completing the application, information on how coverage can begin immediately, and contact phone numbers.

2) Pages A – D

- The "Notice of Privacy Practices" now begins on page A and includes minor formatting and wording changes.

- The "Important Information" section includes updated information on "Proof of Citizenship or National Status". This section also includes minor wording and formatting changes.

3) "Provider Use Only" boxes
This was added to page one of the application to streamline the presumptive eligibility approval process for Certified MFPP Providers. Certified MFPP Providers approving presumptive eligibility must complete the information in these boxes and fax page one of the application to DHS. This process replaces the requirement that Certified MFPP Providers complete DHS-4774 for each presumptive eligibility approval.

4) Question 1: Write your information below.

- Question 1 merges former questions 1, 2 and 3 to shorten the application.

- Student status is needed to apply the dependent child income exclusion.

- The question "Do you plan to make Minnesota your home?" was removed. Presume applicants intend to remain in Minnesota if they have a home address

in Minnesota and there is no conflicting information in the file. See HCPM 13.05

5) Question 2: Do you have health insurance?
Question 2 is reworded and reorganized. It incorporates former questions 6a and 6b.

- The question now includes a clearer explanation of how DHS uses the information about other health insurance and how this could affect the applicant.

- Applicants can include a copy of their health insurance card instead of completing the detailed information about their insurance.

6) Question 3: Who lives with you?
Question 3 merges former questions 4 and 5 to shorten the length of the application.

- Rewording the question allows DHS to collect information about whether the applicant lives with a parent or guardian. We need this information to apply the dependent child income exclusion.

- Although this question now gathers information about parents and guardians, the policy for calculating household size is unchanged. Only include the applicant, the applicant's spouse and the applicant's children and stepchildren in the household size. Do not include parents and guardians in the household size.

7) Question 4: What is your monthly gross income?
This question is reformatted, reworded and requests additional information.

- The question now directs applicants with income to complete the detailed income questions.

- An additional question asks applicants with zero income to explain how they meet their living expenses to help eliminate follow up. It directs applicants who do not have an income to skip the detailed income questions. Do not require children under age 18 to explain how they meet their living expenses.

8) Question 5: Do you have a job?
This is not a new question, but it is reformatted and reworded.

- The previous version of the application asked for earned income information for both the applicant and the applicant's spouse in the same question. Because applicants often fail to complete income information for their spouse, question six now asks for earned income information about the applicant's spouse.

- This question asks whether the applicant works less than 37 ½ hours per week. This information is needed to apply the dependent child income exclusion.

9) Question 6: Does your husband or wife have a job?

- This is a new question.

10) Question 7: Are you or your husband or wife self-employed?

- This is not a new question, but it is reworded.

11) Question 8: Are you or your husband or wife getting or expecting to get other types of income?

- This is not a new question, but it is reworded.

12) Question 9: Are you a U.S. citizen or national?

- This question was revised to accommodate new citizenship documentation policies. (See Bulletin 06-21-09C)

13) Former Question 12: Do you want someone else to help you and act on your behalf?

- This question was removed to shorten the length of the application. Applicants who want an authorized representative may use the form Giving Permission for Someone to Act on My Behalf (DHS-3437A).

14) Signature page

- The information on the signature page is now on a single page to shorten the length of the application. The DHS mailing address is now included on the signature page. There are minor wording changes.

4. Procedures for MinnesotaCare Operations, Counties and Tribes

a. Recycle all previous versions of the MFPP application.

b. Continue to forward any completed MFPP applications submitted to your agency to the DHS Family Planning Unit for processing.

5. Procedures for Certified MFPP Providers

Certified MFPP Providers must follow these steps when determining presumptive eligibility:

a. Continue to check the Eligibility Verification System (EVS) or MN-ITS to determine if a potential applicant

- Is currently enrolled in another MHCP, or

- Has received presumptive eligibility in the past 12 months.

b. Give applicants the revised (02-07) MFPP application.
DHS will mail an initial supply of applications to Certified MFPP Providers during the week of 03/26/2007. Providers may also:

- View and download the revised application, or
- Order new applications from DHS Forms Supply.

c. Use the information in questions 1, 3 and 4 to determine presumptive eligibility.

- Question 1 contains the information about date of birth, pregnancy and residency.
- Question 3 contains the information needed to calculate household size.
- Question 4 contains the gross monthly income.

d. Follow current policies for determining age, pregnancy and income.

- Although Question 3 asks whether the applicant lives with a parent or guardian, the policy for calculating household size has not changed. Do not count parents or guardians in the household size. Continue to count the applicant, the applicant's spouse and children in the household size.

e. Apply the following new policy when determining residency.

- Do not require applicants to indicate that they plan to make Minnesota their home. This question was removed from the application.
- Consider applicants with a home address in Minnesota to be Minnesota residents.
- The exceptions for migrant workers and the homeless are unchanged from the existing policy.

f. Give the form Giving Permission for Someone to Act on My Behalf (DHS-3437A) to applicants who want an authorized representative.

- The authorized representative question (former question 12) is no longer on the application.
- If an applicant requests an authorized representative, mail DHS-3437 with the MFPP application to DHS.

Example 7
Naomi takes her daughter Jennifer to the doctor for birth control. Jennifer wants her

mom to fill out the MFPP application, answer DHS requests for information, and receive notices. Give Jennifer a copy of DHS-3437 to complete. Attach it to the MFPP application when you mail the application to DHS.

g. Continue to provide applicants with all required notices and forms.

h. Complete the "Provider Use Only" boxes on page one of the application for all applications that are approved for presumptive eligibility.

- Do NOT complete the "Provider Use Only" boxes if presumptive eligibility is denied.

- Provider numbers and the national provider identifier (NPI) are private data. Do not add the provider number or NPI to the application until after you collect the application from the applicant.

- Providers are not required to include the NPI at this time.

i. Fax page one of the application only to DHS at (651) 431-7532 or (800) 204-0639 for all applications that are approved for presumptive eligibility.

- Do NOT fax the entire application.

- Do NOT fax page one if presumptive eligibility is denied.

j. Continue to mail the entire application, including any proofs, to DHS for a determination of ongoing eligibility.

k. Do NOT complete and fax the MFPP Presumptive Approvals form (DHS-4774). This form is now obsolete. Page one of the revised application replaces this form.

IV. Legal References

Minnesota Statutes §256B.04

Minnesota Rules, parts 9505.5300 – 9505.5325

V. Attachments

Attachment A – Minnesota Family Planning Program application (DHS-4740 02/07)

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 (888) 938-3224 or through the Minnesota Relay Service at (800) 627-3529 (TDD), 711 or (877) 627-3848 (speech to speech relay service).

Attachment A

Minnesota Family Planning Program Application/Renewal

(Part of Minnesota Health Care Programs)

Who is this program for?

- Men and women between the ages of 15 and 50 who are not enrolled in Medical Assistance, MinnesotaCare or General Assistance Medical Care.

Can I get coverage right away?

- Some clinics use this application to see if you can get short-term coverage. Short-term coverage begins right away and lasts for up to two months.
- For a list of clinics that can give short-term coverage call the Minnesota Family Planning Program at the numbers below.

What do I need to do with this form?

- Read the important information on the colored pages, A through D. Tear off the colored pages and keep them.
- Answer all of the questions on the white pages, 1 through 4. Use blue or black ink. Print clearly.
- Use one application for each person who is applying.
- Sign and date the application.
- Mail or fax the completed application with proofs to:
  Minnesota Department of Human Services
  P.O. Box 64960
  St. Paul, MN 55164-0960
  Fax: (651) 431-7532

Questions

If you have questions or need help, call the Minnesota Family Planning Program at (651) 431-3480 (Twin Cities metro area) or (888) 702-9968 (outside Twin Cities metro area).

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.

ចំណាប់អារម្មណ៍៖ បើអ្នកចង់បានជំនួយបកប្រែព័ត៌មាននេះដោយឥតគិតថ្លៃ សូមសួរបុគ្គលិកដែលទទួលបន្ទុកករណីរបស់អ្នក 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. ຖ້າຫາກທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປຂໍ້ຄວາມເຫຼົ່ານີ້ໂດຍບໍ່ເສັຽຄ່າ, ຈົ່ງຖາມພະນັກງານຊ່ວຍເຫຼືອ ຂອງທ່ານຫຼືໂທຫາຕາມເລກໂທ 1-888-487-8251.

Hubachiisa. Yoo akka odeeffannoon kun sii hiikamu gargaarsa tolaa feeta ta'e, hojjataa kee gaafadhu 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 lagu kaalmeeyo tarjamadda macluumaadkani oo lacag la'aan ah, weydii hawl-wadeenkaaga 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.

General

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 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
- U.S. 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 (DHS) 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. (effective 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

Keep this page.

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
  P.O. Box 64941
  St. Paul, MN 55164-0941

Important Information

Proof of citizenship or national status

If you declare to be a U.S. citizen or national you must give us proof that you are a U.S. citizen or national. National status includes people from American Samoa and Swains Island.

If you are eligible for Medicare, SSI (Supplemental Security Income) or SSDI (Supplemental Security Disability Income), you do not have to prove you are a U.S. citizen.

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 these 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. State driver's license with picture
2. Minnesota ID card with picture
3. School ID card with picture
4. Nursery or day care 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. Applying will not affect your immigration status.

You do not have to give us your immigration information if you are applying for short-term coverage at a health care provider's office.

You have the right to fair treatment

We cannot treat you differently because of your race, color, national origin, religion, sex, marital status, sexual orientation or political beliefs. We cannot treat you differently 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
  P.O. 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
  P.O. 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 the Minnesota Family Planning Program.
- 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 these rules we can prosecute you for fraud.

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 a non-immigrant or a person without documentation
- Are being screened for short-term coverage by a health care provider.

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 computer 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).

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 when you:

- Start a new job, change jobs, or stop a job
- Start to get child support, unemployment or worker's compensation income
- Start to get health insurance or Medicare
- Move to a new address
- Become pregnant
- Get married or divorced
- Start or stop school.

Keep this page.

DHS-4740-ENG 2-07

Minnesota Family Planning Program Application/Renewal

(Part of Minnesota Health Care Programs)

Provider Use Only (If PE approved, complete the information below and fax page 1 to (651) 431-7532 or (800) 204-0639.)			
PROVIDER NAME	PROVIDER ADDRESS		
PROVIDER NUMBER	NPI NUMBER	PROVIDER PHONE	DATE PE APPROVED

1. Write your information below.

FIRST NAME	MI	LAST NAME		
DATE OF BIRTH (MM/DD/YYYY)	SOCIAL SECURITY NUMBER	DAYTIME PHONE NUMBER	GENDER ☐ M ☐ F	ARE YOU PREGNANT? ☐ YES ☐ NO

☐ Check this box if you are homeless. ☐ Check this box if you are a migrant worker.

HOME STREET ADDRESS			APT. NUMBER
CITY	STATE	ZIP	COUNTY
MAILING STREET ADDRESS (where you would like notices sent if different from the address above)			APT. NUMBER
CITY	STATE	ZIP	

Full-time or part-time high school student? ☐ FULL-TIME ☐ PART-TIME ☐ NOT A STUDENT	If you are a high school student, do you expect to graduate by age 19? ☐ YES ☐ NO

SPOKEN LANGUAGE ☐ ENGLISH ☐ SPANISH ☐ OTHER:	WRITTEN LANGUAGE ☐ ENGLISH ☐ SPANISH ☐ OTHER:	If you do not speak English well, do you need someone who speaks your language to help you? ☐ YES ☐ NO

ARE YOU LATINO OR HISPANIC? (optional) ☐ YES ☐ NO	WHAT IS YOUR RACE? (optional) ☐ WHITE ☐ ASIAN ☐ AMERICAN INDIAN OR ALASKAN NATIVE ☐ BLACK/AFRICAN AMERICAN ☐ PACIFIC ISLANDER OR NATIVE HAWAIIAN

2. Do you have health insurance?

☐ **No**, I do not have health insurance. Go to question 3.

☐ **Yes**, I have health insurance, but I do not want you to contact my insurance company. Go to question 3.

☐ **Yes**, I have health insurance. You may contact my insurance company to see if they will pay for my services. I understand the insurance company may tell the policyholder about the services I get. Complete the information below or send us a copy of the front and back of your insurance card.

TYPE OF COVERAGE ☐ INDIVIDUAL ☐ GROUP ☐ PRESCRIPTION DRUG ☐ MEDICARE ☐ OTHER	POLICYHOLDER'S NAME	
INSURANCE COMPANY NAME	INSURANCE COMPANY ADDRESS	
POLICY NUMBER	GROUP NUMBER	DATE INSURANCE COVERAGE STARTED

3. Who lives with you?

Include people who are living away from home for a short time.

Parent(s) or Guardian(s) ☐ YES ☐ NO

Husband or Wife ☐ YES ☐ NO If you live with your wife, is she pregnant? ☐ YES ☐ NO

Your children or your stepchildren ☐ YES ☐ NO If yes, how many are under age 21? _____

4. What is your monthly gross income?

GROSS MONTHLY INCOME
$

- If you are under age 21, include only your income. If you are age 21 or older, include your income and your husband's or your wife's income.
- If you have an income, go to question 5.
- If you do not have an income, explain in the box below how you pay for your living expenses (food, housing, clothing). Go to question 9.

5. Do you have a job?

☐ **Yes** – fill out the information below. Attach additional pieces of paper if necessary. ☐ **No** – go to question 6.

EMPLOYER NAME	START DATE	DO YOU WORK LESS THAN 37½ HOURS PER WEEK? ☐ YES ☐ NO
☐ THIS IS A SEASONAL OR TEMPORARY JOB	HOW OFTEN ARE YOU PAID? ☐ EVERY WEEK ☐ EVERY TWO WEEKS ☐ ONCE A MONTH ☐ OTHER:	
GROSS WAGES $	CASH OR TIPS $	DATE OF MOST RECENT PAYCHECK

You must give us proof of this income. Proof can be pay stubs from the last 30 days or a statement from the employer.

6. Does your husband or wife have a job?

☐ **Yes** – fill out the information below. Attach additional pieces of paper if necessary. ☐ **No** – go to question 7.

EMPLOYER NAME	START DATE
☐ THIS IS A SEASONAL OR TEMPORARY JOB	HOW OFTEN ARE YOU PAID? ☐ EVERY WEEK ☐ EVERY TWO WEEKS ☐ ONCE A MONTH ☐ OTHER:
GROSS WAGES $	CASH OR TIPS $	DATE OF MOST RECENT PAYCHECK

You must give us proof of this income. Proof can be pay stubs from the last 30 days or a statement from the employer.

7. Are you or your husband or wife self-employed?

☐ **Yes** – fill out the information below. ☐ **No** – go to question 8.

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

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

8. Are you or your husband or wife getting or expecting to get other types of income?

Other income may include: Child support, spousal support, unemployment, worker's compensation, Social Security, 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. Attach additional pieces of paper if necessary. ☐ **No** – go to question 9.

Name of person	Where is this income from?	Amount	How often is it received?	Date of last payment received

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.

9. Are you a U.S. citizen or national?

☐ **Yes** – if you are a U.S. citizen or national, fill out the information below.

CITY AND STATE WHERE YOU WERE BORN	FULL NAME AT BIRTH

☐ **No** – if you are not a U.S. citizen or national, fill out the information below.

IMMIGRATION STATUS	DATE OF U.S. ENTRY	DO YOU HAVE A SPONSOR? ☐ YES ☐ NO

You must give us proof of your citizenship or immigration status. If you are a citizen, see page C at the front of this application for a list of proofs. If you are not a citizen, give us copies of your immigration documents.

Sign and date the application on the signature page.

Signature Page

Read the following, then sign and date below.

I understand that this is an application for the Minnesota Family Planning Program (MFPP), which covers only family planning services and supplies. I understand that if I want additional health care coverage, I must fill out a Minnesota Health Care Programs application.

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, including their contractors, to share my MFPP health records with the State of Minnesota, its agents, contractors and their subcontractors. 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 the MFPP.

This medical release is good while I am enrolled in the MFPP, 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 the MFPP. I understand that this release allows my MFPP 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 I am applying for the MFPP, which only covers family planning services/supplies.
- I understand that my information will be shared if fraud is suspected.
- I agree to the release of my MFPP health records to the parties listed above.
- I agree to assign my medical benefits as stated above.
- 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 a person 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.

YOUR SIGNATURE	DATE

Mail or fax the completed application and any additional information to:

Minnesota Department of Human Services
P.O. Box 64960
St. Paul, MN 55164-0960
Fax: (651) 431-7532 or (800) 204-0639

Use this space to include any additional information.


Minnesota Department of Human Services