#07-21-12

Bulletin

December 7, 2007

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

OF INTEREST TO

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

ACTION/DUE DATE

Please begin using the new applications as soon as your agency receives them.

EXPIRATION DATE

December 7, 2008

Redesign of Minnesota Health Care Programs Application and Introduction of Long-Term Care and Waiver Services Application

TOPIC

The Minnesota Health Care Programs Application (HCAPP) has been redesigned and a separate application targeted to individuals seeking Medical Assistance (MA) payment of long-term care (LTC) services, including waiver services, has been developed.

PURPOSE

To provide information on changes made to the HCAPP and to introduce a new Long-term Care and Waiver Services application.

CONTACT

MinnesotaCare Operations, counties and tribal agencies should submit policy questions to HealthQuest.

All others should direct questions to:

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

SIGNED

BRIAN J. OSBERG
Assistant Commissioner
Health Care Administration

I. Background

The Department of Human Services has significantly reduced the size of the Minnesota Health Care Programs Application (HCAPP) in response to concerns that the length of the application may have discouraged people from applying for health care coverage. The revised application is the result of input received from consumers, advocacy groups, county agencies, MinnesotaCare Operations, and the Center for Literacy.

II. Introduction

Consumers played a significant role in the development of the shortened HCAPP. Consumer testing identified how an applicant perceives the application. Listed below are the concerns that arose during the testing and an explanation of how those concerns are addressed by the new applications.

A. Concerns addressed by the new application

1. **Lengthy instructions confused instead of informed applicants.**
   Instructions are now brief and appear on the front of the application.

2. **Informational pages prior to the application were overwhelming and intimidating.**
   Agency addresses, Notice of Privacy Practices, and Important Information pages are now at the back of the application. The Notice of Privacy Practices and Important Information have been shortened. They are designed to be detached from the application so applicants can keep them for further review.

3. **Concerns about answering questions correctly prevented applicants from completing and submitting the application.**
   We now advise applicants to answer the questions the best they can and that someone will contact them if additional information is needed.

4. **Applicants were confused about submitting the application if they did not have proofs available.**
   The application now tells them to return the application even if they do not have all proofs. Proofs are listed on a separate page that applicants may detach and keep.

5. **It was difficult for applicants to determine how to answer a question when the question did not apply.**
   A “not applicable (N/A)” option has been added to these questions.

6. **Applicants found it difficult to decide if certain questions applied to them.**
   Simplified questions eliminate references to “your household,” population parameters and clarify for what time period information is required.

7. **Applicants attempted to complete information that did not apply to them.**
   If a “yes” or “no” response requires additional information to be filled-in below, the response that requires additional information is presented as the last option to allow a seamless flow to the additional information area.

8. **There was confusion regarding questions that related to applying for long-term care and waiver services.**
   Questions pertaining to long-term care and waiver services have been removed from the HCAPP. A new application containing these questions has been developed for applicants seeking MA payment of LTC services, including waiver services.

B. New applications

Two different health care applications are now available.

1. **Minnesota Health Care Programs Application (HCAPP) (DHS-3417-ENG 12-07)**
   The HCAPP is designed for persons who wish to apply for Minnesota Health Care Programs coverage but are not requesting MA payment for LTC services, including waiver services.

2. **Minnesota Health Care Programs Application for Long-Term Care and Waiver Services (DHS-3531-ENG 12-07)**
   The Minnesota Health Care Programs Application for Long-Term Care and Waiver Services is designed for individuals who are requesting MA payment of LTC services, including waiver services. The application should be used by persons who reside in or are moving into a long-term care facility (LTCF) or expect to receive LTC services or services from the Elderly Waiver (EW), Community Alternatives for Disabled Individuals (CADI), Community Alternative Care (CAC), Traumatic Brain Injury (TBI) or Developmental Disabilities (DD) waiver, previously known as the Mental Retardation and Related Conditions (MR/RC) waiver.

Both the shortened HCAPP and Long-Term Care and Waiver Services Application ask only those questions required to accurately determine eligibility or to decide if additional information is needed to complete an eligibility determination.

The HCAPP (Attachment A) and the Minnesota Health Care Programs Application for Long-Term Care and Waiver Services (Attachment B) are included with this bulletin. To view or download the applications, click on the following links:
http://edocs.dhs.state.mn.us/lfserver/Legacy/DHS-3417-ENG for the shortened HCAPP or
http://edocs.dhs.state.mn.us/lfserver/Legacy/DHS-3531-ENG for the Long-Term Care and Waiver Services Application.

Initial supplies of both applications will be sent to MinnesotaCare Operations, counties and the Mille Lacs Band Tribal Agency as soon as they are available. When these supplies are received, destroy all old versions of the applications. To order additional supplies of the applications through DHS Forms Supply, complete the "Requisition for DHS Forms" (DHS-0121).

DHS plans to translate the HCAPP into other languages, beginning with Spanish. DHS will notify agencies who administer health care programs when the translated versions are available.

C. Overview of new applications

1. The cover page has information about who should use the application and whom to contact with questions, and includes instructions for completing the application.

2. The list of county agencies' addresses and phone numbers, Notice of Privacy Practices and Important Information have been moved to the back of the application. Notice of Privacy Practices and Important Information are updated and shortened.

3. Questions are presented in a table format.

4. Questions specific to determining eligibility for MA payment of LTC services, including waiver services, have been removed from the HCAPP and are now in a separate application.

5. Each page of the application contains a reference to the Required Proofs page and provides instructions if more space is needed to answer a question.

6. The Signature Page is updated with details on who must read the information on the page and who must sign. All release and information language is updated. A section has been added to remind applicants to sign and date the form, attach proofs and return the form right away.

7. Required proofs are listed on a separate page and appear opposite of the Signature Page to provide a visual reminder that proofs are required. Applicants can tear off and keep the page listing the required proofs. In an effort to prevent overwhelming applicants with an extensive list of proofs that may discourage them from completing the application process, only proofs most commonly requested of all applications are listed. Requested proofs are specific to the application.

8. The Employer Health Insurance Form (DHS-3348) has been removed from the application since not all applicants are required to complete this form. Continue to use this form as a tool to verify access to Employer Subsidized Insurance (ESI).

III. Action Required

A. Using and accepting applications.

1. Begin using the 12/07 version of the HCAPP and the Long-Term Care and Waiver Services Application as soon as your agency receives them.

2. Provide the appropriate application based on services for which an applicant is seeking coverage. Give the Long-Term Care and Waiver Services application to persons applying for payment of these services. Give the HCAPP to all other applicants for health care, including children applying for coverage under the TEFRA option.

3. Require completion of the Required Questions for General Assistance Medical Care form (DHS-3423) for anyone applying for GAMC.

4. Accept any application to set the date of application. Follow-up to get additional required information and proofs. Continue to accept and process all prior versions of the completed HCAPP. Continue to accept the Combined Application Form (CAF) for health care programs.

5. Request completion of the New Applicant Request for Payment of Long-Term Care Services, DHS-4803 (Attachment C) for applicants requesting MA payment of LTC services, including waiver services who complete the CAF, 12/07 HCAPP or versions of the HCAPP prior to 7/06. This form is updated and available on Edocs.

   Note: HCAPPs dated 7/06 and 9/06 include the Long-Term Care questions so the DHS-4803 is not required.

6. Accept the Long-Term Care and Waiver Services Application for all applicants even if they are not requesting MA payment of LTC services, including waiver services. Do not require completion of the HCAPP. Request missing or incomplete information and proofs required to determine eligibility.

7. Review any application received to determine if it is complete. Contact the applicant to obtain the response to unanswered questions. Review each question and corresponding required verifications to determine if all the information and verifications needed to approve or deny health care eligibility exists or if additional follow-up is required.

8. Continue to follow current policy requirements for processing applications as outlined in the Health Care Programs Manual (HCPM), Chapter 07 and verification policy in HCPM, Chapter 09. There are no policy changes regarding processing of applications.

B. HCAPP

The HCAPP has several revisions and new features. Each question is described below, along with action that is needed for that question. Action items are identified with the ► symbol.

1. HCAPP Questions

Question 1: Name and address

The name and address of the head of household appears as the first question; however, the reference to "Head of Household" has been removed. Applicants intuitively list the person completing the application or whomever they consider the head of their household.

Question 2: Others living with you

All other household members are listed in this section, which allows all members of a household to be listed on the first page of the application. This question clarifies who should be listed in this section.

Question 3: Is anyone living away from home for a short time?
This question now follows other household member information allowing workers to determine household size and composition more readily.

Question 4: Applicant information
This question asks for the Social Security Number and place of birth for each person who is applying who is a U.S. citizen. Listing the place of birth for a U.S. citizen allows the application to be used as a signed affidavit of identity for children under age 16 when the parent, guardian or caretaker signs the application.

Question 5: Is everyone applying a U.S. citizen or U.S. national?
This question places immigration information for all household members in one section.

- ► Require proof of citizenship and identity for all applicants who indicate they are U.S. citizens or U.S. nationals and who are not exempt from citizenship and identity requirements (HCPM 11.05).

- ► Obtain proof of immigration status for all applicants who are documented non-citizens (HCPM 11.10).

- ► For undocumented or ineligible non-citizens who apply, determine if a medical emergency exists, including pregnancy. Refer to the answers for pregnancy and help paying medical bills in Question #9 for help with this determination. Require proof of a medical emergency accordingly (HCPM 03.45.05).

- ► If applicable, request proof of sponsorship and sponsors' income and assets (HCPM 11).

Question 6: Does everyone plan to make Minnesota their home?
Previously, only people who had been in Minnesota for less than six months completed this question. This did not provide adequate information for all programs.

- ► Require all applicants to answer this question.

- ► Clarify why an applicant does not intend to make Minnesota their home and determine if the applicant may be exempt from residency requirements due to migrant status (HCPM 13).

Question 7: Has anyone lived in Minnesota for less than six months?
This is a change in wording only.

Question 8: Do you want someone to act on your behalf as an authorized representative?
Information was added to this question to inform applicants of the legal responsibilities of an authorized representative. The question no longer asks if the applicant wants the authorized representative to receive their notices and other information. A person listed as an authorized representative in this section will receive forms, eligibility notices and premium notices on the applicant's behalf.

Question 9: Additional household information
This new section requests miscellaneous information about the household. Questions about pregnancy, student status, disability, emancipation, services from the Center for Victims of Torture (CVT) and potential retroactive coverage are addressed in this section. A "Not Applicable (N/A)" option was added to the pregnancy, student and emancipation questions.

- ► Use the answer to "Do you want help paying for medical bills from the past three months?" to determine the need for retroactive coverage. Consider retroactive coverage for the earliest month listed as program policies allow (HCPM 07.20.25).

- ► Follow procedures in place for transferring applications from MinnesotaCare Operations to a county agency for a determination of eligibility for retroactive coverage under Medical Assistance (HCPM 07.20.35).

Question 10: Does each child under age of 18 have both parents living with them?
A "Not Applicable (N/A)" option has been added. Other additions include asking if there is a court order to provide health insurance and if the absent parent is providing health insurance.

- ► Use the answers to these questions to assist in determining if a referral to Support and Collections is required (HCPM 16.05).

Question 11: Did anyone work this month or does anyone expect to work next month?
A specific time period was added for which information is required, with space to indicate if the job has ended and if so, when it ended.

- ► Note the start date and, if applicable, the end date of listed employment.

- ► Request additional employment information if retroactive coverage is applicable and the listed employment started after the date in which retroactive coverage is being considered. If the employment start date is prior to the retroactive coverage date, assume that no other employment existed during the retroactive time period unless you have information to the contrary. Contrary information may include other employment that is listed in an existing case file.

- ► Consider and, if applicable, request proof of work expenses for blind and disabled applicants (HCPM 21.50.45).

- ► Require proof of actual income received in each retroactive coverage month (HCPM 20.15).

- ► Proofs of income may contain enough information to verify how often the person is paid and when payment is received. Follow up to obtain this information, if necessary, in order to calculate earned income accurately.

- ► For seasonal employment, follow up to determine if the seasonal employment is established or new seasonal employment. Obtain months in which the seasonal employment occurs (HCPM 20.25.20).

Question 12: Is anyone self-employed this month or does anyone expect to be self-employed next month?
A specific time period was added for which information is required, with space to indicate a business end date, if applicable.

- ► Note the start date and, if applicable, the end date of the business.

- ► Require additional employment information if retroactive coverage is applicable, and if the business started after the date in which retroactive coverage is being considered.

Question 13: Did anyone get money this month or does anyone expect to get money next month from sources other than work?
A specific time period was added for which information is required. Examples are included to clarify that applicants need to list any money they receive from sources other than work. A space is added to indicate if the income has ended and if so, when it ended.

- ► Note the type of income. Follow-up may be required for persons reporting unemployment to determine if unemployment benefits are being received based on seasonal employment (HCPM 20.25.20).

Question 14: Is anyone paying for day care for a child or adult while they work?
This question is clarified to show they should list day care costs for a child or an adult.

Question 15: Is anyone in the home court-ordered to pay child or medical support?
This clarifies that the person paying support must live in the home and has an additional space to address payment status of court-ordered support.

Questions 16 - 19: Asset questions

- ► Determine if total counted assets reported in these questions are within applicable asset limits. Use the value reported by the applicant. If the total exceeds the applicable asset limit, follow up to determine if an amount is owed on each of the counted assets listed. Obtain proof of the value and the amount owed, if required (HCPM 19).

Question 16: Does anyone have cash, a savings or checking account, or certificates of deposit?
A separate section was added for these assets since they are the most commonly reported liquid assets. It specifies "current balance" to clarify what amount should be entered.

Question 17: Does anyone own or co-own stocks, bonds, retirement accounts, life insurance, burial contacts, annuities, trusts, contracts for deed, or other assets?
A separate section for these assets requests the required information. It asks for estimated value to alleviate applicants' apprehension about listing a value if they are unsure of the exact value. "Amount of loan" was removed from this section because this generally does not apply to these types of assets and the amount is usually not readily available to applicants.

Question 18: Does anyone have a vehicle?
The value of the vehicle is no longer asked to alleviate applicants' concerns about listing an accurate value of a vehicle they own. "Amount of loan" was removed since most vehicles are excluded regardless of equity value and the amount is usually not readily available to applicants.

- ► Determine if a listed vehicle can be excluded. Use the listed National Automobile Dealer's Association (NADA) book trade-in value at www.nadaguides.com. If the NADA value causes excess assets, contact the applicant to determine if the condition of the vehicle may warrant a lower value or if there is a loan against the

vehicle. Obtain proof of the revised value and the amount owed, if required (HCPM 19.25.25).

Question 19: Does anyone own or co-own a home, life estate, cabin, land, time-share, rental property or any real estate?
Types of property are listed in the question for clarification and the estimated value is requested to alleviate applicants' apprehension about listing a value if they are unsure. "Amount of loan" was removed since the amount is usually not readily available to applicants.

► Determine if a listed property meets the homestead exclusion. Compare the address of the property with the household's address listed in Question #1 to assist with this determination (HCPM 19.25.15.05).

Question 20: Did anyone do any of the following in the last 60 months?
This question was shortened and simplified.

Question 21: Is anyone getting medical care for an accident or injury that happened in the last six years?
Updates to this question request the type of information that is recorded on the MAXIS ACCI panel.

Question 22: Health insurance information.
Health insurance questions are combined into one section to include the questions regarding Medicare coverage, potential access to Employer Subsidized Insurance (ESI) and cost effective insurance.

► Obtain Medicare information through a TPQY response, if possible. Initiate a request via SVES/QURY. If Medicare information is unavailable through a TPQY response, follow up to obtain the Medicare ID number and Part A and Part B start dates.

► Use the answer to "Can anyone get health insurance through a current employer?" along with other information in this section to assist in determining if verification of access to ESI or a cost-effective determination is required. Verify access for each employer reported in Question #11 (HCPM 15.05.20 and 15.10.05).

► Use the answer to "Did anyone have health insurance that ended during the last four months?" to determine if health insurance coverage existed during any months of retroactive coverage. If insurance existed in the last four months, note the coverage end date and follow up to obtain information about the coverage as required.

Question 23: Did anyone have health insurance this month or does anyone expect to have health insurance next month?
This shortened section includes only information that is readily available to most applicants. It asks for the information needed to determine ESI in order to limit additional follow-up.

► Follow up to obtain details about other health insurance coverage for applicants who are eligible for Minnesota Health Care Program coverage. This information is needed to adequately enter insurance information in the Third Party Liability (TPL) Resource File in MMIS and to fulfill cost-effective requirements. Refer to the MMIS User Manual, TPL Resource File and HCPM 15.10.05 and 15.05.10 for additional information.

2. Application for Long-Term Care and Waiver Services questions

This application follows the same format as the shortened HCAPP. Questions are directed to the person living in or planning to live in a long-term care facility, or planning to get services from a waiver program. Questions relevant to this population that were part of the previous HCAPP now appear in this application.

Each question is described below, along with action that is needed for that question. Action items are identified with the ► symbol.

Question 1: Person living in or planning to live in a long-term care facility or planning to get services from a waiver program.
The name of the person requesting coverage of their long-term care or waiver services is listed in this section along with their personal information.

Question 2: Address and phone number
The applicant enters the address where he or she is currently living. If the applicant resides in a facility, this should be the facility address. If applicable, the facility name and the applicant's address prior to entering the facility appear in this section.

► Note if an applicant residing in a LTCF plans to return to his or her home. If applicable, apply homestead exclusion and home maintenance allowance policies appropriately (HCPM 19.25.15.05 and 23.40.20).

Question 3: Are you a U.S. citizen or U.S. national?
This question addresses the citizenship status of only the person listed in Question #1.

► Require proof of citizenship and identity if the applicant indicates he or she is a U.S. citizen or U.S. national and is not exempt from citizenship and identity requirements (HCPM 11.05).

- ► Obtain proof of immigration status for all applicants who are documented non-citizens (HCPM 11.10).

- ► For undocumented or ineligible non-citizens who apply determine if a medical emergency exists, including pregnancy. Require proof of a medical emergency accordingly (HCPM 03.45.05).

- ► If applicable, request proof of sponsorship and sponsors' income and assets (HCPM 11).

Question 4: Do you want someone to act on your behalf as an authorized representative?
This informs applicants of the legal responsibilities of a person they name as an authorized representative. The question no longer asks if the applicant wants the authorized representative to receive their notices and other information. A person listed as an authorized representative in this section will receive forms, eligibility notices and premium notices on the applicant's behalf.

Questions 5 – 10: Asset questions

- ► Request proof of the value of reported assets and the amount owed on each asset. Determine if total counted assets are within applicable asset limits (HCPM 19).

Question 5: Do you or a spouse have cash, a savings or checking account, or certificates of deposit?
Value of these assets is not requested to alleviate applicant's apprehension about listing values. Proof is required and is requested on the proofs page.

Question 6: Do you or a spouse own or have an interest in an annuity?
This separate question on annuities asks for the information needed to determine the impact an annuity may have on the applicant's eligibility for payment of services.

Question 7: Do you or a spouse have life insurance, a burial contract or money set aside for burial expenses?
This question assists in assessing funds that are most commonly evaluated under the burial exclusion policy. Value is not requested to alleviate applicant's apprehension about listing values. Proof is required and is requested on the proofs page.

Question 8: Do you or a spouse own or co-own stocks, bonds, retirement accounts, trusts, contracts for deed, or other assets?

The value is not requested to alleviate applicant's apprehension about listing values. Proof is required and is requested on the proofs page.

Question 9: Do you or a spouse have a vehicle?
The value of the vehicle is not requested to alleviate applicant's concerns about listing an accurate value of a vehicle he or she owns.

- ► Determine if listed vehicles can be excluded. Use the listed National Automobile Dealer's Association (NADA) book trade-in value at www.nadaguides.com. If the NADA value causes excess assets, contact the applicant to determine if the condition of the vehicle may warrant a lower value or if there is a loan against the vehicle. Obtain proof of the revised value and amount owed, if required (HCPM 19.25.25).

Question 10: Do you or a spouse own or co-own a home, life estate, cabin, land, time-share, rental property or any real estate?
Value is not requested to alleviate applicant's apprehension about listing values. Proof is required and is requested on the proofs page.

- ► Note who lives in the property listed. Determine if the property may be excluded as the residence of the applicant or a qualified relative (HCPM 19.25.15.05).

- ► Obtain proof of the fair market value and, if applicable, apply the home equity limit to an applicant receiving MA payment of LTC services, including waiver services (HCPM 19.55 and 19.55.10).

Question 11: Did you or a spouse create a trust in the last 60 months?
This question addresses potential transfers during the 60-month transfer timeline for creation of trusts and the potential impact creation of a trust may have on the applicant's eligibility for MA payment of LTC services, including waiver services (HCPM 19.25.35 and 19.40).

Question 12: Did you or a spouse buy an annuity, life estate in another person's home, a promissory note, loan or mortgage in the last 36 months?
This question addresses the 36-month transfer timeline for these types of acquisitions and the potential impact the acquisition may have on the applicant's eligibility for MA payment of LTC services, including waiver services (HCPM 19.40 and 19.40.20).

Question 13: Did you or a spouse not accept items or income you could have taken, such as an inheritance or a pension, in the last 36 months?
This question addresses the 36-month transfer timeline that affects this

action and the potential impact that refusal to accept items or income may have on the applicant's eligibility for MA payment of LTC services, including waiver services (HCPM 19.40).

Question 14: Did you or a spouse sell, trade or give away items or income for less than they were worth in the last 36 months?
This question addresses the 36-month transfer timeline for transfer of items or income and the potential impact the transfer may have on the applicant's eligibility for MA payment of LTC services, including waiver services (HCPM 19.40).

Question 15: Did you work this month or do you expect to work next month?
This question includes a specific period for which information is required.

- ► Note the start date and, if applicable, the end date of listed employment.
- ► Request additional employment information if retroactive coverage is applicable and the listed employment started after the date in which retroactive coverage is being considered. If the employment start date is prior to the retroactive coverage date, assume that no other employment existed during the retroactive time period, unless you have information to the contrary. Contrary information may include other employment that is listed in an existing case file.
- ► Require proof of actual income received in each retroactive coverage month (HCPM 20.15).
- ► Review proofs of income to see if they contain enough information to verify how often the person is paid and when payment is received. Follow up to obtain this information, if necessary, in order to calculate earned income accurately.

Question 16: Were you self-employed this month or do you expect to be self-employed next month?
This question includes the specific period for which information is required and asks whether the applicant plans to continue the business.

Question 17: Did you get money this month or do you expect to get money next month from sources other than work?
A specific period is listed for which information is required and clarifies that applicants need to list any money received from sources other than work.

Question 18: Expenses
This section includes questions regarding expenses that may be deducted

from income when calculating net income. It also includes a question to determine the potential need for retroactive coverage.

- ► Request proof of work expenses for blind or disabled applicants with earned income (HCPM 21.50.45).

- ► Use the answer to "Do you want help paying for medical bills from the past three months?" to determine the need for retroactive coverage. Consider retroactive coverage for the earliest month listed as program policies allow (HCPM 07.20.25).

Question 19: Do you have medical expenses?
Medical expenses an applicant has are listed to assist in determining if the applicant may have medical expenses that may not be covered under Minnesota Health Care Programs.

- ► Determine if there are medical expenses including copays that may be used as a deduction from the applicant's income. Request proof of expenses accordingly (HCPM 23.40.50).

Question 20: Are you getting medical care for an accident or injury that happened in the last six years?

- ► Update the MAXIS ACCI panel with the third-party liability information reported in this section.

Question 21: Have you had long-term care insurance at any time since July 1, 2006?

- ► Use the information reported on long-term care insurance to identify possible third-party liability (TPL) for LTC services, including waiver services, and to identify policies that may qualify as LTC Partnership policies.

- ► A future bulletin will provide instructions for determining whether a policy qualifies as a Long-Term Care Partnership policy. Until the bulletin is issued, obtain a copy of the policy and submit the policy to HealthQuest for assistance in determining whether it qualifies as a Partnership policy.

Question 22: Do you have Medicare, health or long-term care insurance now or have you had health or long-term care insurance in the last 4 months?

- ► Use information from this question to determine if other health care coverage that may have existed in the last four months was in effect during a period of retroactive eligibility.

- ► Obtain Medicare information through a TPQY response, if possible. Initiate a request via SVES/QURY. If Medicare information is unavailable through a TPQY response, follow up with the applicant to obtain the Medicare ID number and Part A and Part B start dates.

- ► Follow up to obtain details about other health insurance coverage for applicants who are eligible for Minnesota Health Care Program coverage in order to adequately enter insurance information in the TPL Resource File in MMIS and fulfill cost-effective requirements. Refer to the MMIS User Manual, TPL Resource File and HCPM 15.10.05 for additional information.

Question 23: Do you have a spouse?
This section contains information needed to determine if an asset assessment has been or needs to be completed and if a LTCF resident or Elderly Waiver applicant may be able to allocate money to his or her spouse. The spouse of the applicant may request coverage here and give additional identifying information that is not contained in the rest of the application.

- ► Require applicants who have a spouse to complete this section.

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- ► Note if an asset assessment was previously completed or if one needs to be completed prior to processing the application for individuals applying for MA payment of LTCF or EW costs (HCPM 19.45).

- ► Obtain proof of a community spouse's income if the LTC applicant wishes to allocate income to a community spouse, or is applying for coverage under a disability waiver and eligibility for a Medicare Savings Program is being considered (HCPM 03.40 and 23.40.30).

- ► Obtain missing information and verifications of a spouse who wishes to apply for coverage.

Question 24: Do you want to give money to any of the following people?
The question lists people to whom a LTCF resident or Elderly Waiver applicant may allocate income. This section also allows each eligible dependent of the applicant to request coverage.

- ► Use this information to determine if the applicant may be able to allocate money to the person or persons listed. Obtain proof of income to determine the appropriate allocation (HCPM 23.40.40).

- ► Obtain missing information and verifications of a family member who wishes to apply for coverage.

IV. System Instructions

A. MAXIS

1. Household size
   Applicants who meet the requirements for payment of long-term care or waiver services are a household of one. If others request health care coverage on the same application, establish a separate case for those individuals using appropriate household composition policy (TE02.05.38).

2. MAXIS forms and notices

   a. Complete the top portion of the STAT/AREP panel to ensure that eligibility notices are sent to both the authorized representative and the enrollee.

   b. Enter "Y" in the "Forms to AREP" field on the STAT/AREP panel to ensure that a person listed as an authorized representative receives forms on the applicant's behalf.
   c. If the enrollee is receiving cash or food support benefits, confirm that they would like all renewals, recertification and household report forms sent to the authorized representative. When a "Y" is entered, all forms are sent to the authorized representative, including forms and notices for cash and food support benefits. If the enrollee indicates they would like the forms sent to them and not their authorized representative, code the "Forms to AREP" field with an "N."

      Refer to TE02.11.35 for additional information.

3. MMIS notices
   Enter "Y" in the "MMIS Mail to AREP" field on the STAT/AREP panel to ensure that a person listed as an authorized representative receives MMIS generated notices, including Explanation of Medical Benefits (EOMBs), Pre-Paid Health Plan or Managed Care letters, Prior Authorization letters, Medical ID cards, and Designated Provider letters.

   Refer to TE02.07.359 for additional information.

B. MMIS - RREP screen

For MinnesotaCare enrollees update the RREP screen to ensure that a person listed as an authorized representative on the HCAPP receives forms and notices on the applicant's behalf.

1. Enter "Y" in the "FORMS TO AREP" field on the RREP screen to ensure that the authorized representative receives forms on the applicant's behalf. All renewal forms will be sent to the authorized representative.

2. Enter "N" in the "FORMS TO AREP" field on the RREP screen if the enrollee notifies you that he or she does not want renewal forms sent to the AREP. If "N" is entered, renewal forms will be sent to the enrollee.

3. Enter a "Y" in the "NOTICES TO AREP" field on the RREP screen to ensure that the authorized representative receives a copy of all notices. The original notice is sent to the enrollee.

4. Enter a "Y" in the "PREMIUM NOTICE TO AREP" field on the RREP screen to ensure that the authorized representative receives a copy of all premium notices. The original notice is sent to the enrollee.

Refer to the MMIS User Manual, MMIS Screen, RREP for additional information.

V. Attachments

Attachment A – Minnesota Health Care Programs Application (DHS 3417-ENG)
Attachment B – Minnesota Health Care Programs Application for Long-Term Care and Waiver Services (DHS 3531-ENG)
Attachment C – Required Questions for People Applying for Coverage to Pay for Long-Term Care or Waiver Services (DHS-4803)

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).

Minnesota Department of **Human Services**

Minnesota Health Care Programs Application

What is this application for?

Use this application to apply for health care coverage.

Do **not** use this application to apply for:

- Long-term care, such as nursing home or waiver services.
- Cash or food support.

You can find these applications on the Web at www.dhs.state.mn.us or by calling your county agency. The phone numbers are listed on pages B and C at the back of this form.

What do I need to do with this form?

1. Read the Notice of Privacy Practices and Important Information on pages D through F at the back of this form. Tear them off and keep them.
2. Answer all questions on the application. If you need more space, write the number of the question and the answer on a separate piece of paper. Include it with the application.
3. Sign and date the application.
4. Attach proofs. Proofs are listed on page A at the back of this form.
5. Mail or take the application to your county agency or MinnesotaCare State Office in St. Paul. The addresses are listed on pages B and C at the back of this form.

Send in your application right away even if you do not have all proofs. We will contact you for any additional information we need.

Questions?

If you have questions or need help, call your county agency. The phone numbers are listed on pages B and C at the back of this form. You can also call the Senior LinkAge Line® if you are 60 or older at (800) 333-2433 or the Disability Linkage Line® if you are a person with a disability at (866) 333-2466.

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 សូមសួរអ្នកការ់សំណុំរឿងរបស់អ្នក 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. ຖ້າຫາກທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປຂໍ້ຄວາມດັ່ງກ່າວນີ້ຟຣີ, ຈົ່ງຖາມນຳພນັກງານຊ່ວຍອຸກຂອງທ່ານຫຼືໂທຣ໌ ຫາຕາມເລກໂທຣ໌ 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 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.

LB #2 (10-06)

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.

DHS-3417-ENG 12-07

Minnesota Department of Human Services

Minnesota Health Care Programs Application

Office Use Only		
DATE RECEIVED	CASE NUMBER	WORKER NUMBER

- ***Answer all questions the best you can.***
- ***Return the form right away.***
- ***We will contact you for any additional information we need.***

1. Name and address

FIRST NAME	MI	LAST NAME	DATE OF BIRTH	SEX	MARITAL STATUS
				☐ M ☐ F	

STREET ADDRESS	CITY	STATE	ZIP CODE	COUNTY
MAILING ADDRESS (if different)	CITY	STATE	ZIP CODE	COUNTY

☐ Check this box if you are homeless	HOME PHONE	OTHER PHONE	Do you want us to send you a voter registration card? ☐ Yes ☐ No

What language do you speak most of the time?	Do you need an interpreter? ☐ Yes ☐ No	Are you applying for yourself? ☐ Yes ☐ No

OPTIONAL INFORMATION →	RACE ☐ Asian ☐ Black/African American ☐ American Indian/Native Alaskan ☐ Pacific Islander or Native Hawaiian ☐ White	HISPANIC OR LATINO? ☐ Yes ☐ No

2. Others living with you (List your spouse, parents/guardians, stepparents, children and step-children living in your home.)

Name (First, MI, Last)	Relationship to you	Sex	Marital status	Date of birth	Is this person applying?	OPTIONAL INFORMATION Race (Use codes below*)	OPTIONAL INFORMATION Hispanic or Latino?
		☐ M ☐ F			☐ Yes ☐ No		☐ Yes ☐ No
		☐ M ☐ F			☐ Yes ☐ No		☐ Yes ☐ No
		☐ M ☐ F			☐ Yes ☐ No		☐ Yes ☐ No
		☐ M ☐ F			☐ Yes ☐ No		☐ Yes ☐ No
		☐ M ☐ F			☐ Yes ☐ No		☐ Yes ☐ No

***Codes:** A - Asian B - Black/African American N - American Indian/Native Alaskan P - Pacific Islander or Native Hawaiian W - White

See Required Proofs on Page A

If you need more space, write the question number and the answer on a separate piece of paper.

3. Is anyone living away from home for a short time? ☐ No ☐ Yes – fill in below

FIRST NAME	MI	LAST NAME	DATE OF BIRTH	RELATIONSHIP TO YOU

Are you applying for this person? ☐ No ☐ Yes	DATE LEFT	DATE EXPECTED TO RETURN	REASON FOR NOT LIVING AT HOME

4. Applicant information (Complete for each person who is applying.)

Name of person applying	Social Security Number	If a U.S. citizen, city and state born

5. Is everyone applying a U.S. citizen or U.S. national? ☐ Yes ☐ No – fill in below

Name	Immigration status	Date entered the U.S.	Does this person have a sponsor?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

6. Does everyone plan to make Minnesota their home? ☐ Yes ☐ No – fill in below

NAME(S)	EXPLAIN

7. Has anyone lived in Minnesota for less than six months? ☐ No ☐ Yes – fill in below

NAME(S)	DATE MOVED TO MINNESOTA

See Required Proofs on Page A

If you need more space, write the question number and the answer on a separate piece of paper.

8. Do you want someone to act on your behalf as an authorized representative?

An authorized representative is a person authorized to act on your behalf as an applicant or enrollee in any of the health care programs. In most cases, authorized representatives have the same responsibilities and rights as applicants or enrollees. An authorized representative will receive forms, notices, and premium notices on your behalf. An authorized representative must be at least 18 years old and know your circumstances in order to provide necessary information.

☐ No ☐ Yes – fill in below

FIRST NAME	MI	LAST NAME	PHONE NUMBER

STREET ADDRESS	CITY	STATE	ZIP CODE

9. Additional household information

Is anyone 16 or older a student? ☐ Not Applicable (N/A) ☐ No ☐ Yes	IF YES, WHO?	
Is anyone pregnant? ☐ N/A ☐ No ☐ Yes	IF YES, WHO?	DUE DATE
Is anyone blind, have a disability, or seriously ill? ☐ No ☐ Yes	IF YES, WHO?	
Has anyone under the age of 21 ever been married, in the armed forces or have a court say they are no longer under the legal control of his or her parents? ☐ N/A ☐ No ☐ Yes	IF YES, WHO?	
Is anyone getting services from the Center for Victims of Torture? ☐ No ☐ Yes	IF YES, WHO?	
Do you want help paying for medical bills from the past three months? ☐ No ☐ Yes	IF YES, LIST MONTHS	

10. Does each child under age 18 have both parents living with them?

☐ Not Applicable (N/A) ☐ Yes ☐ No – fill in below

	First child's name	Second child's name	Third child's name
Name of parent(s) who does not live 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 or court order for paternity?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is there a court order to provide health insurance?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Does the parent provide health insurance?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Do you want help getting medical or cash child support?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

See Required Proofs on Page A

If you need more space, write the question number and the answer on a separate piece of paper.

11. Did anyone work this month or does anyone expect to work next month?

Include temporary and seasonal work.

☐ No ☐ Yes – fill in below

Name	Employer name	Start date	Monthly income (include tips)	Is this job seasonal?	Has this job ended?	
			$	☐ No ☐ Yes	☐ No ☐ Yes	IF YES, DATE ENDED
			$	☐ No ☐ Yes	☐ No ☐ Yes	IF YES, DATE ENDED
			$	☐ No ☐ Yes	☐ No ☐ Yes	IF YES, DATE ENDED
			$	☐ No ☐ Yes	☐ No ☐ Yes	IF YES, DATE ENDED

12. Is anyone self-employed this month or does anyone expect to be self-employed next month? ☐ No ☐ Yes – fill in below

Name	Business name	Start date	End date	Yearly income
				$
				$

Are the total assets of all businesses worth more than $200,000? ☐ No ☐ Yes

13. Did anyone get money this month or does anyone expect to get money next month from sources other than work?

Include Social Security, Supplemental Security Income (SSI), child or spousal support, unemployment, workers' compensation, veterans' benefits, retirement or pension payments, public assistance payments, rental income, annuities, trusts, interest, dividends, payments from a contract for deed and any other source of income.

☐ No ☐ Yes – fill in below

Name	Type of income	Start date	Amount	How often received	Has this income ended?	
			$		☐ No ☐ Yes	IF YES, DATE ENDED
			$		☐ No ☐ Yes	IF YES, DATE ENDED
			$		☐ No ☐ Yes	IF YES, DATE ENDED
			$		☐ No ☐ Yes	IF YES, DATE ENDED

14. Is anyone paying for day care for a child or adult while they work? ☐ No ☐ Yes – fill in below

NAME OF PERSON PAYING	NAMES OF CHILDREN OR ADULTS IN DAY CARE	AMOUNT PAID PER MONTH
		$

See Required Proofs on Page A

If you need more space, write the question number and the answer on a separate piece of paper.

15. Is anyone in the home court-ordered to pay child or medical support? ☐ No ☐ Yes – fill in below

NAME OF PERSON PAYING	AMOUNT PER MONTH	CURRENTLY PAYING?
	$	☐ No ☐ Yes

16. Does anyone have cash, a savings or checking account, or certificates of deposit?

☐ No ☐ Yes – fill in below

Owner(s) name	Type	Name of bank	Current balance
			$
			$
			$
			$

17. Does anyone own or co-own stocks, bonds, retirement accounts, life insurance, burial contracts, annuities, trusts, contracts for deed or other assets? ☐ No ☐ Yes – fill in below

Owner(s) name	Type of asset	Name of company, bank or funeral home	Estimated value
			$
			$
			$
			$

18. Does anyone have a vehicle?

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

☐ No ☐ Yes – fill in below

Owner(s) name	Type of vehicle	Year/Make/Model

19. Does anyone own or co-own a home, life estate, cabin, land, time share, rental property or any real estate? ☐ No ☐ Yes – fill in below

Owner(s) name	Address	Type of property	Estimated value
			$
			$

See Required Proofs on Page A

If you need more space, write the question number and the answer on a separate piece of paper.

20. Did anyone do any of the following in the last 60 months?

- Sell, trade or give away items or income for less than they were worth
- Not accept items or income they could have taken, such as an inheritance
- Buy an annuity, life estate in another person's home, a promissory note, loan or mortgage

☐ No ☐ Yes – fill in below

NAME(S)	ITEM(S) OR INCOME	DATE HAPPENED

21. Is anyone getting medical care for an accident or injury that happened in the last six years? ☐ No ☐ Yes – fill in below

NAME(S)	DATE HAPPENED	TYPE OF ACCIDENT OR INJURY	IS THERE A LAWSUIT? ☐ No ☐ Yes

22. Health insurance information

Does anyone have Medicare coverage? ☐ No ☐ Yes	IF YES, WHO?	
Can anyone get health insurance through a current employer? ☐ No ☐ Yes	IF YES, WHO?	
Did anyone turn down or drop health insurance from a current employer? ☐ No ☐ Yes	IF YES, WHO?	DATE HAPPENED
Did anyone's current employer stop offering health insurance in the last 18 months? ☐ No ☐ Yes	IF YES, WHO?	DATE STOPPED
Did anyone have health insurance that ended during the last four months? ☐ No ☐ Yes	IF YES, WHO?	DATE ENDED

23. Did anyone have health insurance this month or does anyone expect to have health insurance next month? ☐ No ☐ Yes – fill in below

COVERAGE TYPES – CHECK ALL THAT APPLY

☐ Medical ☐ Hospital only ☐ HMO ☐ Prescription drug ☐ Dental ☐ Vision ☐ Long-term care

☐ Other – list type: _____

POLICYHOLDER'S NAME	INSURANCE COMPANY NAME	START DATE	END DATE

LIST EVERYONE WHO IS COVERED BY THIS POLICY

Is this health insurance through an employer or union? ☐ No ☐ Yes – fill in below

Cost of Insurance for Employee Only		Cost of Insurance for Spouse/Dependents	
EMPLOYEE PAYS PER MONTH	EMPLOYER/UNION PAYS PER MONTH	EMPLOYEE PAYS PER MONTH	EMPLOYER/UNION PAYS PER MONTH
$	$	$	$

See Required Proofs on Page A

If you need more space, write the question number and the answer on a separate piece of paper.

Signature Page

All of the people listed must read the following information and sign:

- Adults age 18 or older who are applying
- Parents, caretakers and guardians applying for children under the age of 21
- Children under age 18 who are applying on their own behalf and not living with a parent, caretaker or guardian
- The person you have chosen to act on your behalf as an authorized representative

Authorization to Share Information for Fraud Investigation

I give permission to authorized investigators and third parties to share information about me during the course of investigations regarding fraud, fraud prevention and misrepresentation. Third parties who can share information about me with investigators 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 to share information about me remains in effect 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 payments from all other persons or entities. This assignment covers medical payments for me and anyone else for whom I apply.

It takes effect as soon as 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.

If I have Medicare Part B, I give Medicare consent to pay my health providers for the care I get while I have Minnesota Health Care Programs coverage.

Authorization for Release (Sharing) of My Medical Information

I give my consent that the following agencies or individuals may share among themselves medical information about me only for the limited purposes indicated:

- Health providers, health plans, insurance agencies, Minnesota Health Care Programs, my county case workers, and their contractors and subcontractors:
  - To determine who should pay for my health care, and
  - To provide and coordinate health care services
- Ombudspersons and county advocates for managed care to help me obtain medical care and payment of services.
- Researchers, auditors, investigators, and others who do quality of care reviews and studies or commence prosecutions or legal actions related to managing the health care programs.

This release also applies to the medical information of my minor children named in this application to the extent that I can consent to their medical treatment. Generally, I must give my written consent for the above agencies to give out the medical information. If I do not consent, it will not be released unless the law otherwise allows it. I may stop this consent with a written notice at any time, but this written notice will not affect information the agency has already released. This authorization is good while I am enrolled in Minnesota Health Care Programs, not to exceed one year, or longer if the law permits. I can refuse to sign or cancel this authorization. However, this Authorization does not expire after one year and cannot be revoked for release of records to consulting providers; or to release records to specified health payers for payment of claims, fraud investigation, or quality of care review 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. An agency or person who receives my information through this release could possibly re-disclose the information.

Over →

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.
- I agree to assign my medical benefits as stated.
- 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 are true and correct statements, to the best of my knowledge, including the identity of all persons under age 16 listed on this application. 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 of the following people must sign below:

- Adults age 18 or older who are applying
- Parents, caretakers and guardians applying for children under the age of 21
- Children under age 18 who are applying on their own behalf and not living with a parent, caretaker or guardian
- The person who you have chosen to act on your behalf as an authorized representative

You must sign this application even if you are authorizing someone to act on your behalf.

If an applicant is unable to sign, provide copies of legal documents of conservatorship or power of attorney.

YOUR SIGNATURE	DATE
SIGNATURE OF SPOUSE OR PARENT/GUARDIAN	DATE
SIGNATURE OF HOUSEHOLD MEMBER AGE 18 OR OLDER WHO IS APPLYING	DATE
SIGNATURE OF HOUSEHOLD MEMBER AGE 18 AND OLDER WHO IS APPLYING	DATE
SIGNATURE OF AUTHORIZED REPRESENTATIVE	DATE

Did you remember to:

- ☐ Sign and date this form?
- ☐ Attach the proofs you have? See page A for required proofs.
- ☐ Mail or take this form to your county or MinnesotaCare State Office in St. Paul? Do this right away even if you do not have all your proofs ready. See pages B and C at the back of this form for the address.

Required Proofs

Send these listed proofs for everyone who is applying:

- **U.S. citizenship and identity**
  U.S. passport, **or** Certificate of Naturalization, **or** Certificate of U.S. Citizenship
  OR
  One citizenship document and one identity document listed below:

  Citizenship documents:
  - U.S. birth certificate
  - Report of Birth Abroad of a U.S. citizen
  - U.S. citizen ID card
  - Hospital record of birth in one of the 50 states or U.S. territories.

  Identity documents:
  - State driver's license with picture
  - Minnesota ID card with picture
  - School ID card with picture
  - A parent, guardian, or relative caretaker's signature on the application proves identity for children under age 16.

You do not have to send proof of citizenship or identity for any person who is eligible for Medicare, receiving Supplemental Security Income (SSI), Social Security Disability, foster care or adoption assistance or a non-disabled adult under 65 without children.

- **Immigration status**
  Alien identification card (green card, I-551, I-94), visa, passport, or documentation from Immigration Services

Send these listed proofs for everyone who is:

- **Pregnant**
  Statement from a doctor, midwife, nurse, nurse practitioner or doctor's assistant that includes the date you became pregnant, number you are expecting to deliver if more than one, and the date you expect to give birth.
- **Working**
  Pay stubs from the last 30 days or a written statement of earnings from your employer.
- **Self-employed**
  Most recent income tax returns and all related schedules or business records if taxes are not filed.
- **Getting other income** (Includes any income or payments from sources other than work.)
  Copy of check, award letter, tax forms, court order, or other documents.

Send these listed proofs for everyone who is 21 or older:

- **Bank accounts**
  Recent bank statements or written statement from bank showing current balance or value of accounts.
- **Other assets** (Includes stocks, bonds, retirement accounts, annuities, trusts, property agreements, etc.)
  Copies of bonds, annuities, trusts, stock ownership statements or other documents showing value of assets. Include documents showing current loan balance owed against the asset.

Send copies of proofs. Do not send original documents.

Agency Addresses

(Effective Date: November 2, 2007)

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) 323-6046

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) 333-8300
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 Avenue 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 N Seventh Street, Suite 200
Montevideo, MN 56265-1397
(320) 269-6401 / (877) 450-6401
Fax: (320) 269-6405

Chisago County
313 North Main Street, Rm 239
Center City, MN 55012-9665
(651) 213-5640 / (888) 234-1246
Fax: (651) 213-5685

Clay County
715 North 11th Street, Suite 102
Moorhead, MN 56560-2095
(218) 299-5200 / (800) 757-3880
Fax: (218) 299-7106

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 Street, 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) 450-2691

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 Street – 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 Street 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) 596-8921

Houston County
304 S. Marshall Street, Rm 104
Caledonia, MN 55921-0310
(507) 725-5811
Fax: (507) 725-3990

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

Isanti County
1700 E Rum River Dr S, Suite A
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) 327-5548

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

Kanabec County
905 Forest Avenue East, #150
Mora, MN 55051-1316
(320) 679-6350
Fax: (320) 679-6351

Kandiyohi County
2200 23rd Street NE, Suite 1020
Willmar, MN 56201-9423
(320) 231-7800 / (877) 464-7800
Fax: (320) 231-6285

Kittson County
410 South Fifth Street, 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
206 8th Ave SE, Suite 200
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 Avenue 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

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Marshall County
208 East Colvin Avenue, 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
P.O. Box 64838
St. Paul, MN 55164-0838
(651) 297-3862 / (800) 657-3672
Fax: (651) 282-5100

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 Avenue 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
318 9th Street
P.O. 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
2116 Campus Drive SE
Rochester, MN 55904-3711
(507) 328-6600
Fax: (507) 328-6339

Otter Tail County
535 Fir Avenue W
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 Street East, Suite 1
Sandstone, MN 55072-5134
(320) 245-3020 / (800) 450-7263
Fax: (320) 216-4101

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

Polk County
223 7th Street, Suite 109
Crookston, MN 56716-1483
(218) 281-3127 / (877) 281-3127
Fax: (218) 281-7347

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

Ramsey County
160 East Kellogg Boulevard
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
208 6th Street SW
Roseau, MN 56751-1451
(218) 463-2411 / (866) 255-2932
Fax: (218) 463-3872

St. Louis County
320 West 2nd Street – Room 301
Duluth, MN 55802-1495
(218) 726-2101 / (800) 450-9777
Fax: (218) 733-2975

Or

307 1st Street South – 2nd Floor
Virginia, MN 55792-1148
(218) 749-7100
Fax: (218) 749-7123

Or

118 South 4th Ave E, Rm 12
Ely, MN 55731-1465
(218) 365-8220
Fax: (218) 365-8217

Or

1814 14th Avenue East
Hibbing, MN 55746-1314
(218) 262-6000
Fax: (218) 262-6049

Scott County For Adults
Government Center 300
200 Fourth Avenue 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) 682-7414 / (800) 362-3667
Fax: (763) 682-8920

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

Notice of Privacy Practices

Minnesota Department of Human Services

(Effective Date: August 24, 2007)

This notice tells you how medical and other private information about you may be used and disclosed and how you can get this information. **Review it carefully.**

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.

Why do we ask for your Social Security Number?

We need your social security number 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]). We also need your Social Security Number to check information you give us through matching programs that are part of an Income Eligibility Verification System (IEVS) (5 U.S.C. § 552a(o)(1)(D)).

You do not have to give us the number:

- For persons in your home who are not applying for coverage
- If you have religious objections
- If you are not a U.S. citizen and are applying for Emergency Medical only
- If you are from another country, in U.S. on a temporary basis and do not have permission from U.S. Citizenship and Immigration Services (USCIS) to live in the U.S. permanently.
- If you are living in the U.S. without the knowledge or approval of the USCIS.

Do you have to answer the questions we ask?

You do not have to give us your personal information. We need this information to tell if you can get help from us. 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 information?

Sometimes we share information about you with other agencies. We will only share information as needed and as allowed or required by law. For example, we may share your information with the following agencies or persons who need the information to do their jobs:

- Employees or volunteers with other state, county, local, federal, collaborative and non-profit agencies
- Court officials, county attorney, attorney general, other law enforcement officials, and child protection and fraud investigators
- Child support officials
- Educational institutions and organizations
- Health care providers, including mental health agencies and drug and alcohol treatment facilities
- Health care insurers, health care agencies, managed care organizations and others who pay for your care
- Guardians, conservators or persons with Power of Attorney
- Coroners and medical investigators if you die and they investigate your death
- Credit bureaus, creditors or collection agencies if you do not pay fees you owe to us for services
- Human services offices, including child support enforcement offices
- Anyone else the law says we must or can give the information

What are your rights regarding the information we have about you?

- You may see and copy medical or other private information we may have about you. You may have to pay for the copies.
- You may give other people permission to see and have copies of information about you.
- You may question if the information we have about you is correct. Send your concerns in writing. Tell us why the information is wrong or not complete. Send your own explanation of the information you do not agree with. We will attach your explanation any time information is shared with another agency.
- 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 ask us to do this in writing. If we find that your request is reasonable, we will grant it.
- You have the right to ask us to limit or restrict the way that we use or disclose your information, but we are not required to agree to this request.
- You have the right to get a record of some of the people or organizations that we have shared your health information with. This record was started on April 14, 2003. You must ask for a copy of this record in writing to our Privacy Official.
- If you do not understand the information, ask your worker to explain it to you. You can ask the Department of Human Services for another copy of this notice.

Keep this page.

What are our responsibilities?

- We must let you know our legal duties and privacy practices, which we are doing by providing you with this notice.
- We must protect the privacy of your medical and other private information according to the terms of this notice.
- We may not use your information for reasons other than the reasons listed on this form unless we get special written permission from you. We may not share your information with individuals and agencies other than those listed on this form unless we get special written permission from you.
- We are required to follow the terms of this notice, but 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 put them on our Web site at: http://edocs.dhs.state.mn.us/lfserver/Legacy/DHS-3979-ENG

What privacy rights do children have?

If you are under 18, when parental consent for medical treatment is not required, information will not be shown to parents unless the health care provider believes not sharing the information would risk your health. Parents may see other information about you and let others see this information, unless you have asked that this information not be shared with your parents. You must ask for this in writing and say what information you do not want to share 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 may be shared with your parents if they ask for it.

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 to the county agency, the organization or to the federal civil rights office at:

- 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
  Attn: Privacy Official
  PO Box 64998
  St. Paul, MN 55164-0998

Important Information

Proof of Citizenship or National Status

Certain people applying for health care must give us proof that they are U.S. citizens or nationals.

You do not have to prove you are a U.S. citizen or national if you are eligible for Medicare, receive Supplemental Security Income (SSI) or receive Social Security payments because of a disability.

Non-disabled adults under age 65 without children and children receiving foster care or adoption assistance payments are not required to give us proof that they are U.S. citizens or nationals.

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 unless you are applying for payment of long term care services.

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

- Applying for emergency medical care only
- Helping someone else apply
- A non-immigrant or undocumented person who is pregnant
- Not applying for 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 can file a complaint. You can file a complaint with any of the following places:

- 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 wrong or your application has not been processed correctly 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

Following the rules

People who are enrolled in Minnesota Health Care Programs must follow the rules listed below:

- Do not give false information or hide information to get or continue to get 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.

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. You can also be prosecuted for fraud if you break these rules. The maximum penalty is a fine of $250,000 or a jail term of 20 years, or both.

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. You may need to give information about the other parent to get medical support for your child. Your children will still get coverage if you do not help child support, but you will not get coverage unless you are pregnant. Your coverage will stop if you are already getting coverage.

If you fear the other parent may cause harm to you or your child, you can give proof to support your fears and 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.

Reviews

The State or Federal Office may look at your case. They will review the information you gave us and check to make sure we did your case correctly. They will let you know if they need to ask you questions. If you do not answer their questions, your coverage may stop.

Other Health Care

You and your household members may need to accept and keep a health insurance policy. This includes Medicare. We will review the policy and tell you if you can stop the coverage.

In some cases, if we tell you that you cannot stop it, we may help pay the premiums. If you do not 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.

Liens and Estate Claims

The state or county may try to recover the cost of medical services paid by Medical Assistance (MA) or General Assistance Medical Care (GAMC). The state may file a claim against your estate or a lien against your real property if you received:

- GAMC at any age.
- MA when you were over age 55.
- MA at any age if you lived in a long term care facility 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.

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

When you die, a lien may be set up against the portion of property you own to repay us for your medical care.

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 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. Examples of changes you need to report include:

Income:

- Starting a new job; changing jobs, or stopping a job.
- Starting to get or changes in the amount of other income you get such as Social Security, other retirement income, child support, unemployment or workers' compensation.

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:

- Starts to get health insurance or Medicare.
- 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.

Minnesota Department of **Human Services**

Minnesota Health Care Programs
Long-Term Care and Waiver Services Application

What is this application for?

Use this application to apply for health care coverage for:

- Long-term care such as a nursing home, intermediate care facility and nursing facility care in an inpatient hospital.
- Waiver programs such as Elderly Waiver (EW), Community Alternatives for Disabled Individuals (CADI), Community Alternative Care (CAC), Traumatic Brain Injury (TBI) and Developmental Disabilities Waiver (DD).

Do **not** use this application to apply for:

- Health care coverage if you do **not** live in a long-term care facility or receive waiver services.
- Cash or food support.

Call your county agency for a different application. The phone numbers are listed on pages B and C at the back of this form.

What do I need to do with this form?

1. Read the Notice of Privacy Practices and Important Information on pages D through F at the back of this form. Tear them off and keep them.
2. Answer all questions on the application. If you need more space, write the number of the question and the answer on a separate piece of paper. Include it with the application.
3. Sign and date the application.
4. Attach proofs. Proofs are listed on page A at the back of this form.
5. Mail or take the application to your county agency. The addresses are listed on pages B and C at the back of this form.

Send in your application right away even if you do not have all proofs. We will contact you for any additional information we need.

Questions?

If you have questions or need help, call your county agency. The phone numbers are listed on pages B and C at the back of this form. You can also call the Senior LinkAge Line® if you are 60 or older at (800) 333-2433 or the Disability Linkage Line® if you are a person with a disability at (866) 333-2466.

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 សូមសួរអ្នកការ់សំណុំរឿងរបស់អ្នក 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. ຖ້າຫາກທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປຂໍ້ຄວາມດັ່ງກ່າວນີ້ຟຣີ, ຈົ່ງຖາມນຳພນັກງານຊ່ວຍອຸກອງທ່ານຫຼືໂທຣ໌ ຫາຕາມເລກໂທຣ໌ 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 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.

LB #2 (10-06)

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.

Clear Form Data
FILLABLE FORM

DHS-3531-ENG 12-07

Minnesota Department of Human Services

Long-Term Care and Waiver Services Application

Office Use Only		
DATE RECEIVED	CASE NUMBER	WORKER NUMBER

- ***Answer all questions the best you can.***
- ***Return the form right away.***
- ***We will contact you for any additional information we need.***

1. Person living in or planning to live in a long-term care facility or planning to get services from a waiver program

FIRST NAME	MI	LAST NAME	DATE OF BIRTH	SEX
				☐ M ☐ F

MARITAL STATUS	SOCIAL SECURITY NUMBER	IF A U.S. CITIZEN, CITY AND STATE BORN

Are you a veteran?	Are you blind or have a disability?	Are you pregnant?	IF YES, DUE DATE
☐ No ☐ Yes	☐ No ☐ Yes	☐ N/A ☐ No ☐ Yes	

What language do you speak most of the time?	Do you need an interpreter?	Are you getting services from the Center for Victims of Torture?
	☐ No ☐ Yes	☐ No ☐ Yes

Were you in the hospital before moving to a facility or getting waiver services?	IF YES, DATE ENTERED THE HOSPITAL	IF YES, DATE LEFT THE HOSPITAL
☐ No ☐ Yes		

OPTIONAL INFORMATION →

RACE ☐ Asian ☐ Black/African American ☐ American Indian/Native Alaskan ☐ Pacific Islander or Native Hawaiian ☐ White

HISPANIC OR LATINO? ☐ No ☐ Yes

2. Address and phone number

STREET ADDRESS WHERE YOU ARE CURRENTLY LIVING	CITY	STATE	ZIP CODE	COUNTY

MAILING ADDRESS (if different)	CITY	STATE	ZIP CODE	COUNTY

PHONE NUMBER	Do you plan to make Minnesota your home?	Are you living in a long-term care facility?	IF YES, FILL IN BELOW ↓
	☐ No ☐ Yes	☐ No ☐ Yes	

LONG-TERM CARE FACILITY NAME	DATE MOVED INTO THIS FACILITY

STREET ADDRESS BEFORE MOVING TO THE FACILITY	CITY	STATE	ZIP CODE	COUNTY

Do you plan to return to your home? ☐ No ☐ Yes

See Required Proofs on Page A

If you need more space, write the question number and the answer on a separate piece of paper.

3. Are you a U.S. citizen or U.S. national? ☐ Yes ☐ No – fill in below

IMMIGRATION STATUS	DATE ENTERED THE U.S.	Do you have a sponsor? ☐ Yes ☐ No

4. Do you want someone to act on your behalf as an authorized representative?

An authorized representative is a person authorized to act on your behalf as an applicant or enrollee in any of the health care programs. In most cases, authorized representatives have the same responsibilities and rights as applicants or enrollees. An authorized representative will receive forms, notices, and premium notices on your behalf.

An authorized representative must:

- Be at least 18 years old.
- Know your circumstances in order to provide necessary information.

☐ No ☐ Yes – fill in below

FIRST NAME	MI	LAST NAME	PHONE NUMBER

STREET ADDRESS	CITY	STATE	ZIP CODE

5. Do you or a spouse have cash, a savings or checking account, or certificates of deposit?

☐ No ☐ Yes – fill in below

Owner(s) name	Type	Name of bank

6. Do you or a spouse own or have an interest in an annuity? ☐ No ☐ Yes – fill in below

OWNER(S) NAME	YOUR INTEREST
	☐ Owner ☐ Annuitant ☐ Beneficiary

7. Do you or a spouse have life insurance, a burial contract or money set aside for burial expenses? ☐ No ☐ Yes – fill in below

Owner(s) name	Name of funeral home or company that holds the contract or money

See Required Proofs on Page A

If you need more space, write the question number and the answer on a separate piece of paper.

8. Do you or a spouse own or co-own stocks, bonds, retirement accounts, trusts, contracts for deed or other assets? ☐ No ☐ Yes – fill in below

Owner(s) name	Type of asset	Name of company or bank

9. Do you or a spouse have a vehicle?

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

☐ No ☐ Yes – fill in below

Owner(s) name	Type of vehicle	Year/Make/Model

10. Do you or a spouse own or co-own a home, life estate, cabin, land, time share, rental property or any real estate? ☐ No ☐ Yes – fill in below

Owner(s) name	Address	Type	Who lives here?

11. Did you or a spouse create a trust in the last 60 months? ☐ No ☐ Yes – fill in below

NAME(S) OF WHO CREATED THE TRUST	DATE CREATED

12. Did you or a spouse buy an annuity, life estate in another person's home, a promissory note, loan or mortgage in the last 36 months? ☐ No ☐ Yes – fill in below

WHAT WAS BOUGHT?	DATE BOUGHT

13. Did you or a spouse not accept items or income you could have taken, such as an inheritance or a pension, in the last 36 months? ☐ No ☐ Yes – fill in below

Item(s) you did not take	Value of the item or income	Date happened
	$	
	$	

See Required Proofs on Page A

If you need more space, write the question number and the answer on a separate piece of paper.

14. Did you or a spouse sell, trade or give away items or income for less than they were worth in the last 36 months?

☐ No ☐ Yes – fill in below

Owner(s) name	Item or income	Value	Sold, traded or given away?	To whom?	Date	Amount you were paid
		$				$
		$				$
		$				$
		$				$
		$				$

15. Did you work this month or do you expect to work next month?

Include temporary and seasonal work.

☐ No ☐ Yes – fill in below

EMPLOYER NAME			START DATE
How often are you paid?	Is this job seasonal? ☐ No ☐ Yes	Has this job ended? ☐ No ☐ Yes	IF YES, END DATE

16. Were you self-employed this month or do you expect to be self-employed next month?

☐ No ☐ Yes – fill in below

BUSINESS NAME	START DATE	Do you plan to continue the business? ☐ Yes ☐ No	IF NO, END DATE

17. Did you get money this month or do you expect to get money next month from sources other than work?

Include Social Security, Supplemental Security Income (SSI), veterans' benefits, retirement or pension payments, rental income, annuities, trusts, interest, dividends, payments from a contract for deed, spousal support, unemployment, workers' compensation, public assistance payments and any other source of income.

☐ No ☐ Yes – fill in below

Type of income	Start date	How often received?	Has this income ended?	
			☐ No ☐ Yes	IF YES, END DATE
			☐ No ☐ Yes	IF YES, END DATE
			☐ No ☐ Yes	IF YES, END DATE
			☐ No ☐ Yes	IF YES, END DATE

WORKER NOTES

See Required Proofs on Page A

If you need more space, write the question number and the answer on a separate piece of paper.

18. Expenses

If you are blind or have a disability, do you have work expenses? ☐ Not Applicable ☐ No ☐ Yes	IF YES, TYPE OF EXPENSE(S)	MONTHLY AMOUNT $
Do you have a legal guardian, conservator or power of attorney? ☐ No ☐ Yes	IF YES, NAME	FEE PAID $
Do you have court-ordered child or medical support payments taken from your income? ☐ No ☐ Yes	IF YES, AMOUNT PER MONTH $	
Do you want help paying for medical bills from the past three months? ☐ No ☐ Yes	IF YES, LIST MONTHS	

19. Do you have medical expenses?

Include health insurance premiums, pharmacy copays and doctor office copays.

☐ No ☐ Yes – fill in below

LIST EACH MEDICAL EXPENSE

20. Are you getting medical care for an accident or injury that happened in the last six years?

☐ No ☐ Yes – fill in below

TYPE OF ACCIDENT OR INJURY	DATE HAPPENED	Is there a lawsuit? ☐ No ☐ Yes

21. Have you had long-term care insurance at any time since July 1, 2006?

☐ No ☐ Yes – fill in below

Is this policy paying benefits now? ☐ No ☐ Yes	If no, did this policy ever pay benefits? ☐ No ☐ Yes	IF YES, DATE BENEFITS STOPPED
POLICYHOLDER'S NAME	INSURANCE COMPANY NAME	

WORKER NOTES

See Required Proofs on Page A

If you need more space, write the question number and the answer on a separate piece of paper.

22. Do you have Medicare, health or long-term care insurance now or have you had health or long-term care insurance in the last 4 months? ☐ No ☐ Yes – fill in below

COVERAGE TYPES

☐ Medicare ☐ Medical ☐ Hospital only ☐ HMO ☐ Prescription drug ☐ Dental ☐ Vision
☐ Long-term care ☐ Other – List type:

POLICYHOLDER'S NAME	INSURANCE COMPANY NAME	START DATE	END DATE

LIST EVERYONE WHO IS COVERED BY THIS POLICY

Is this health insurance through an employer or union? ☐ No ☐ Yes

23. Do you have a spouse? ☐ No ☐ Yes – fill in below

NAME OF SPOUSE	Has a state or county ever reviewed all assets owned by you and your spouse (asset assessment)? ☐ No ☐ Yes	IF YES, IN WHAT STATE OR COUNTY?

Do you want to give money to your spouse? ☐ No ☐ Yes	IF YES, TYPE(S) OF INCOME YOUR SPOUSE GETS	Does your spouse pay housing costs? ☐ No ☐ Yes

Does your spouse live in a long-term care facility or get help from a waiver program? ☐ No ☐ Yes	Does your spouse want to apply? ☐ No ☐ Yes	IF YES, FILL IN BELOW ↓

DATE OF BIRTH	SOCIAL SECURITY NUMBER	Is this person a U.S. citizen or U.S. national? ☐ No ☐ Yes

24. Do you want to give money to any of the following people?

- A child under 21
- A child 21 or older whom you list as a dependent on your tax forms
- A parent or sibling whom you list as a dependent on your tax forms

☐ No ☐ Yes – fill in below

Name	Relationship	Date of birth	Type(s) of income	Living with your spouse?	Do they want to apply?
				☐ N/A ☐ No ☐ Yes	☐ No ☐ Yes
				☐ N/A ☐ No ☐ Yes	☐ No ☐ Yes

WORKER NOTES

See Required Proofs on Page A

If you need more space, write the question number and the answer on a separate piece of paper.

Signature Page

All of the people listed must read the following information and sign:

- Adults age 18 or older who are applying
- Parents, caretakers and guardians applying for children under the age of 21
- Children under age 18 who are applying on their own behalf and not living with a parent, caretaker or guardian
- The person you have chosen to act on your behalf as an authorized representative

Authorization to Share Information for Fraud Investigation

I give permission to authorized investigators and third parties to share information about me during the course of investigations regarding fraud, fraud prevention and misrepresentation. Third parties who can share information about me with investigators 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 to share information about me remains in effect 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 payments from all other persons or entities. This assignment covers medical payments for me and anyone else for whom I apply.

It takes effect as soon as 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.

If I have Medicare Part B, I give Medicare consent to pay my health providers for the care I get while I have Minnesota Health Care Programs coverage.

Authorization for Release (Sharing) of My Medical Information

I give my consent that the following agencies or individuals may share among themselves medical information about me only for the limited purposes indicated:

- Health providers, health plans, insurance agencies, Minnesota Health Care Programs, my county case workers, and their contractors and subcontractors:
  - To determine who should pay for my health care, and
  - To provide and coordinate health care services
- Ombudspersons and county advocates for managed care to help me obtain medical care and payment of services.
- Researchers, auditors, investigators, and others who do quality of care reviews and studies or commence prosecutions or legal actions related to managing the health care programs.

This release also applies to the medical information of my minor children named in this application to the extent that I can consent to their medical treatment. Generally, I must give my written consent for the above agencies to give out the medical information. If I do not consent, it will not be released unless the law otherwise allows it. I may stop this consent with a written notice at any time, but this written notice will not affect information the agency has already released. This authorization is good while I am enrolled in Minnesota Health Care Programs, not to exceed one year, or longer if the law permits. I can refuse to sign or cancel this authorization. However, this Authorization does not expire after one year and cannot be revoked for release of records to consulting providers; or to release records to specified health payers for payment of claims, fraud investigation, or quality of care review 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. An agency or person who receives my information through this release could possibly re-disclose the information.

Over →

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.
- I agree to assign my medical benefits as stated.
- 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 are true and correct statements, to the best of my knowledge, including the identity of all persons under age 16 listed on this application. 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 of the following people must sign below:

- Adults age 18 or older who are applying
- Parents, caretakers and guardians applying for children under the age of 21
- Children under age 18 who are applying on their own behalf and not living with a parent, caretaker or guardian
- The person who you have chosen to act on your behalf as an authorized representative

You must sign this application even if you are authorizing someone to act on your behalf.

If an applicant is unable to sign, provide copies of legal documents of conservatorship or power of attorney.

YOUR SIGNATURE	DATE
SIGNATURE OF SPOUSE OR PARENT/GUARDIAN	DATE
SIGNATURE OF HOUSEHOLD MEMBER AGE 18 OR OLDER WHO IS APPLYING	DATE
SIGNATURE OF HOUSEHOLD MEMBER AGE 18 AND OLDER WHO IS APPLYING	DATE
SIGNATURE OF AUTHORIZED REPRESENTATIVE	DATE

Did you remember to:

- ☐ Sign and date this form?
- ☐ Attach the proofs you have? See page A for required proofs.
- ☐ Mail or take this form to your county agency. Do this right away even if you do not have all your proofs ready. See pages B and C at the back of this form for the address.

Required Proofs

Send these listed proofs for everyone who is applying:

- **U.S. citizenship and identity**
  U.S. passport, **or** Certificate of Naturalization, **or** Certificate of U.S. Citizenship
  OR
  One citizenship document and one identity document listed below:

  Citizenship documents:
  - U.S. birth certificate
  - Report of Birth Abroad of a U.S. citizen
  - U.S. citizen ID card
  - Hospital record of birth in one of the 50 states or U.S. territories.

  Identity documents:
  - State driver's license with picture
  - Minnesota ID card with picture
  - School ID card with picture
  - A parent, guardian, or relative caretaker's signature on the application proves identity for children under age 16.

You do not have to send proof of citizenship or identity for any person who is eligible for Medicare, receiving Supplemental Security Income (SSI), Social Security Disability, foster care or adoption assistance or a non-disabled adult under 65 without children.

- **Immigration status**
  Alien identification card (green card, I-551, I-94), visa, passport, or documentation from Immigration Services

Send these listed proofs for everyone who is:

- **Working**
  Pay stubs from the last 30 days or a written statement of earnings from your employer.
- **Self-employed**
  Most recent income tax returns and all related schedules or business records if taxes are not filed.
- **Getting other income** (Includes any income or payments from sources other than work.)
  Copy of check, award letter, tax forms, court order, or other documents.

Send these listed proofs for everyone who is 21 or older:

- **Bank accounts**
  Recent bank statements or written statement from bank showing current balance or value of accounts.
- **Real estate**
  Property tax statement. Include documents showing amount owed against the property.
- **Burial contracts**
  Burial contract and statement of goods and services from the company or funeral home that holds the contract.
- **Other assets** (Includes stocks, bonds, retirement accounts, annuities, trusts, property agreements, etc.)
  Copies of bonds, annuities, trusts, stock ownership statements or other documents showing value of assets.

Send copies of proofs. Do not send original documents.

Agency Addresses

(Effective Date: November 2, 2007)

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) 323-6046

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) 333-8300
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 Avenue 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 N Seventh Street, Suite 200
Montevideo, MN 56265-1397
(320) 269-6401 / (877) 450-6401
Fax: (320) 269-6405

Chisago County
313 North Main Street, Rm 239
Center City, MN 55012-9665
(651) 213-5640 / (888) 234-1246
Fax: (651) 213-5685

Clay County
715 North 11th Street, Suite 102
Moorhead, MN 56560-2095
(218) 299-5200 / (800) 757-3880
Fax: (218) 299-7106

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 Street, 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) 450-2691

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 Street – 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 Street 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) 596-8921

Houston County
304 S. Marshall Street, Rm 104
Caledonia, MN 55921-0310
(507) 725-5811
Fax: (507) 725-3990

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

Isanti County
1700 E Rum River Dr S, Suite A
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) 327-5548

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

Kanabec County
905 Forest Avenue East, #150
Mora, MN 55051-1316
(320) 679-6350
Fax: (320) 679-6351

Kandiyohi County
2200 23rd Street NE, Suite 1020
Willmar, MN 56201-9423
(320) 231-7800 / (877) 464-7800
Fax: (320) 231-6285

Kittson County
410 South Fifth Street, 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
206 8th Ave SE, Suite 200
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 Avenue 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 Avenue, 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
P.O. Box 64838
St. Paul, MN 55164-0838
(651) 297-3862 / (800) 657-3672
Fax: (651) 282-5100

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 Avenue 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
318 9th Street
P.O. 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
2116 Campus Drive SE
Rochester, MN 55904-3711
(507) 328-6600
Fax: (507) 328-6339

Otter Tail County
535 Fir Avenue W
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 Street East, Suite 1
Sandstone, MN 55072-5134
(320) 245-3020 / (800) 450-7263
Fax: (320) 216-4101

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

Polk County
223 7th Street, Suite 109
Crookston, MN 56716-1483
(218) 281-3127 / (877) 281-3127
Fax: (218) 281-7347

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

Ramsey County
160 East Kellogg Boulevard
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
208 6th Street SW
Roseau, MN 56751-1451
(218) 463-2411 / (866) 255-2932
Fax: (218) 463-3872

St. Louis County
320 West 2nd Street – Room 301
Duluth, MN 55802-1495
(218) 726-2101 / (800) 450-9777
Fax: (218) 733-2975

Or

307 1st Street South – 2nd Floor
Virginia, MN 55792-1148
(218) 749-7100
Fax: (218) 749-7123

Or

118 South 4th Ave E, Rm 12
Ely, MN 55731-1465
(218) 365-8220
Fax: (218) 365-8217

Or

1814 14th Avenue East
Hibbing, MN 55746-1314
(218) 262-6000
Fax: (218) 262-6049

Scott County For Adults
Government Center 300
200 Fourth Avenue 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) 682-7414 / (800) 362-3667
Fax: (763) 682-8920

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

Notice of Privacy Practices

Minnesota Department of Human Services

(Effective Date: August 24, 2007)

This notice tells you how medical and other private information about you may be used and disclosed and how you can get this information. **Review it carefully.**

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.

Why do we ask for your Social Security Number?

We need your social security number 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]). We also need your Social Security Number to check information you give us through matching programs that are part of an Income Eligibility Verification System (IEVS) (5 U.S.C. § 552a(o)(1)(D)).

You do not have to give us the number:

- For persons in your home who are not applying for coverage
- If you have religious objections
- If you are not a U.S. citizen and are applying for Emergency Medical only
- If you are from another country, in U.S. on a temporary basis and do not have permission from U.S. Citizenship and Immigration Services (USCIS) to live in the U.S. permanently.
- If you are living in the U.S. without the knowledge or approval of the USCIS.

Do you have to answer the questions we ask?

You do not have to give us your personal information. We need this information to tell if you can get help from us. 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 information?

Sometimes we share information about you with other agencies. We will only share information as needed and as allowed or required by law. For example, we may share your information with the following agencies or persons who need the information to do their jobs:

- Employees or volunteers with other state, county, local, federal, collaborative and non-profit agencies
- Court officials, county attorney, attorney general, other law enforcement officials, and child protection and fraud investigators
- Child support officials
- Educational institutions and organizations
- Health care providers, including mental health agencies and drug and alcohol treatment facilities
- Health care insurers, health care agencies, managed care organizations and others who pay for your care
- Guardians, conservators or persons with Power of Attorney
- Coroners and medical investigators if you die and they investigate your death
- Credit bureaus, creditors or collection agencies if you do not pay fees you owe to us for services
- Human services offices, including child support enforcement offices
- Anyone else the law says we must or can give the information

What are your rights regarding the information we have about you?

- You may see and copy medical or other private information we may have about you. You may have to pay for the copies.
- You may give other people permission to see and have copies of information about you.
- You may question if the information we have about you is correct. Send your concerns in writing. Tell us why the information is wrong or not complete. Send your own explanation of the information you do not agree with. We will attach your explanation any time information is shared with another agency.
- 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 ask us to do this in writing. If we find that your request is reasonable, we will grant it.
- You have the right to ask us to limit or restrict the way that we use or disclose your information, but we are not required to agree to this request.
- You have the right to get a record of some of the people or organizations that we have shared your health information with. This record was started on April 14, 2003. You must ask for a copy of this record in writing to our Privacy Official.
- If you do not understand the information, ask your worker to explain it to you. You can ask the Department of Human Services for another copy of this notice.

Keep this page.

What are our responsibilities?

- We must let you know our legal duties and privacy practices, which we are doing by providing you with this notice.
- We must protect the privacy of your medical and other private information according to the terms of this notice.
- We may not use your information for reasons other than the reasons listed on this form unless we get special written permission from you. We may not share your information with individuals and agencies other than those listed on this form unless we get special written permission from you.
- We are required to follow the terms of this notice, but 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 put them on our Web site at: http://edocs.dhs.state.mn.us/lfserver/Legacy/DHS-3979-ENG

What privacy rights do children have?

If you are under 18, when parental consent for medical treatment is not required, information will not be shown to parents unless the health care provider believes not sharing the information would risk your health. Parents may see other information about you and let others see this information, unless you have asked that this information not be shared with your parents. You must ask for this in writing and say what information you do not want to share 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 may be shared with your parents if they ask for it.

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 to the county agency, the organization or to the federal civil rights office at:

- 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
  Attn: Privacy Official
  PO Box 64998
  St. Paul, MN 55164-0998

Important Information

Proof of Citizenship or National Status

Certain people applying for health care must give us proof that they are U.S. citizens or nationals.

You do not have to prove you are a U.S. citizen or national if you are eligible for Medicare, receive Supplemental Security Income (SSI) or receive Social Security payments because of a disability.

Non-disabled adults under age 65 without children and children receiving foster care or adoption assistance payments are not required to give us proof that they are U.S. citizens or nationals.

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 unless you are applying for payment of long term care services.

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

- Applying for emergency medical care only
- Helping someone else apply
- A non-immigrant or undocumented person who is pregnant
- Not applying for 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 can file a complaint. You can file a complaint with any of the following places:

- 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 wrong or your application has not been processed correctly 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

Following the rules

People who are enrolled in Minnesota Health Care Programs must follow the rules listed below:

- Do not give false information or hide information to get or continue to get 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.

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. You can also be prosecuted for fraud if you break these rules. The maximum penalty is a fine of $250,000 or a jail term of 20 years, or both.

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. You may need to give information about the other parent to get medical support for your child. Your children will still get coverage if you do not help child support, but you will not get coverage unless you are pregnant. Your coverage will stop if you are already getting coverage.

If you fear the other parent may cause harm to you or your child, you can give proof to support your fears and 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.

Reviews

The State or Federal Office may look at your case. They will review the information you gave us and check to make sure we did your case correctly. They will let you know if they need to ask you questions. If you do not answer their questions, your coverage may stop.

Other Health Care

You and your household members may need to accept and keep a health insurance policy. This includes Medicare. We will review the policy and tell you if you can stop the coverage.

In some cases, if we tell you that you cannot stop it, we may help pay the premiums. If you do not 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.

Liens and Estate Claims

The state or county may try to recover the cost of medical services paid by Medical Assistance (MA) or General Assistance Medical Care (GAMC). The state may file a claim against your estate or a lien against your real property if you received:

- GAMC at any age.
- MA when you were over age 55.
- MA at any age if you lived in a long term care facility 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.

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

When you die, a lien may be set up against the portion of property you own to repay us for your medical care.

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 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. Examples of changes you need to report include:

Income:

- Starting a new job; changing jobs, or stopping a job.
- Starting to get or changes in the amount of other income you get such as Social Security, other retirement income, child support, unemployment or workers' compensation.

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:

- Starts to get health insurance or Medicare.
- 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-4803-ENG 11-07

Minnesota Department of **Human Services**

Use Language Block Stuffer

Date: _____

Case number: _____

Worker name: _____

Worker phone number: _____

Fax number: _____

Agency name: _____

Agency address: _____

_____

Minnesota Health Care Programs
New Applicant Request for Payment of Long-Term Care Services

TO: _____

ADDRESS: _____

_____

Why did I get this form?

Someone in your household lives in a long-term care facility or gets services through a waiver program. We may be able to help pay for these services.

- Long-term care (LTC) facilities include nursing homes, intermediate care facilities 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 Disabilities Waiver (DD).

What do I have to do?

Answer the questions for _____ (NAME OF PERSON). Return the form by _____ (DUE DATE) to the address shown above. If you do not return this form, you may not get coverage for those services.

What if I need help or have questions?

Call your worker at the phone number above.

1. Person living in or planning to live in a long-term care facility or planning to get services from a waiver program

FIRST NAME	MI	LAST NAME	Is this person a veteran? ☐ No ☐ Yes

Was this person in the hospital before moving to a facility or getting waiver services? ☐ No ☐ Yes	IF YES, DATE ENTERED THE HOSPITAL	IF YES, DATE LEFT THE HOSPITAL

2. Is this person living in a long-term care facility? ☐ No ☐ Yes – fill in below

LONG-TERM CARE FACILITY NAME	PHONE NUMBER	DATE MOVED INTO THIS FACILITY

FACILITY STREET ADDRESS	CITY	STATE	ZIP CODE	COUNTY

PERSON'S STREET ADDRESS BEFORE MOVING TO THE FACILITY	CITY	STATE	ZIP CODE	COUNTY

Does this person plan to return to their home? ☐ No ☐ Yes

3. Is there a legal guardian, conservator or power of attorney? ☐ No ☐ Yes – fill in below

NAME	RELATIONSHIP	FEE PAID
		$

4. Did this person or their spouse create a trust in the last 60 months? ☐ No ☐ Yes – fill in below

NAME(S) OF WHO CREATED THE TRUST	DATE CREATED

5. Has this person had long-term care insurance at any time since July 1, 2006?
☐ No ☐ Yes – fill in below

Is this policy paying benefits now? ☐ No ☐ Yes	Did this policy ever pay benefits? ☐ No ☐ Yes	IF YES, DATE BENEFITS STOPPED

6. Does this person want to give money to a spouse? ☐ No ☐ Yes – fill in below

NAME OF SPOUSE	Does the spouse pay housing costs? ☐ No ☐ Yes

Send proof of spouse's housing costs.

7. Does this person want to give money to any of the following people?

- A child under 21
- A child 21 or older listed as a dependent on this person's tax forms
- A parent or sibling listed as a dependent on this person's tax forms.

☐ No ☐ Yes – fill in below

Name	Relationship	Date of birth

Send proof of income for any people listed above.

SIGNATURE OF APPLICANT	DATE
SIGNATURE OF SPOUSE	DATE
SIGNATURE OF AUTHORIZED REPRESENTATIVE	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.