

# Bulletin

January 22, 2008

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

**OF INTEREST TO**

- County Directors
- Financial Supervisors
- County Financial Workers
- Social Service Supervisors
- Tribal Human Services Directors
- Mille Lacs Tribal TANF
- Community Organizations

**ACTION/DUE DATE**

Please review the new Combined Application Form and process as described in this bulletin. Pilot counties will begin using the new Combined Application Form on 1/22/2008 through 3/31/08.

**EXPIRATION DATE**

1/22/2010

## Information About The New Combined Application Form And Pilot

**TOPIC**

New Combined Application Form and process.

**PURPOSE**

Inform county staff and others of the new Combined Application Form and the pilot.

**CONTACT**

Policy questions related to this bulletin should be directed to Policy Quest.

**SIGNED**

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**CHARLES E. JOHNSON**

Assistant Commissioner

Children &amp; Families Division Administration

## I. Background

During the 2007 legislative session, the following legislation was passed:

### MINNESOTA FOOD SUPPORT PROGRAM SIMPLIFIED APPLICATION.

The commissioner of human services shall implement a simplified application form and process for the food support program by January 1, 2008. The commissioner shall consult with counties and representatives of persons served by the program to develop the simplified application form and process. The application process shall:

- (1) include a simple, short form that can be completed by individuals with limited literacy skills;
- (2) include an application form for individuals without dependents;
- (3) include a process that does not require individuals to take time off work for a face-to-face interview; and
- (4) minimize demands on county staff in assisting applicants.

EFFECTIVE DATE: This section is effective January 1, 2008.

In June of 2007, DHS convened a work-group of Minnesota Department of Human Services (DHS) staff plus representatives of five counties, one Community Action Program (CAP) agency involved with Food Support application assistance, three advocacy groups, and the Saint Paul Literacy Consortium. This group reviewed current forms and processes from Minnesota and other states that have recent efforts to simplify applications in light of federal and state requirements. After extensive debate on such issues as county impacts and the relative merits of single-program vs. multiple-program applications, the group arrived at a general approach to a new form and process. New forms were drafted and a new process developed. These were presented to various county groups, fraud investigators, the Office of the Attorney General, and others for comment and input.

Two primary recommendations from this workgroup have shaped how DHS is moving forward:

- **Retain a multi-program application form.** The workgroup reached consensus almost immediately that a Food Support only application was not optimal and the multi-program application form concept should be retained. This concept was originally developed and adopted by nearly all states to help insure that eligibility for multiple programs was not overlooked when an applicant initially approached a county and expressed a desire to apply for a single program. This also means that all program applicants, not just Food Support applicants without dependents, will use the new form. Within the multi-program application concept, we agreed that all text that conveyed useful, but not required information could be removed from the form into a separate **Important Information** sheet.
- **Simplify the application and redesign the interview process.** The most important change involved both the application form and the interview process.

County representatives indicated that an adequate interview involved reviewing all of the questions asked on the current application form. In addition, they said that complex questions involving assets and income, for example, are frequently not completed adequately by clients, but must be revised in light of information gained in the interview.

The result was that in the final design, complex questions were moved from the application to the interview process, simplifying the application. Twelve pages of detailed questions were reduced to two pages of “Yes/No” questions. An **Interview Form** was developed to provide a structured format for workers to record the information developed in the interview. The final versions of the new forms are being printed for the pilot.

There was extensive discussion of the impact of this approach on the workload of county workers. Feedback from counties showed a wide variety of opinion on the impact the new process would have on the time required for an interview. One county conducted a small-scale test using a preliminary draft of the form, and found an average of seven minutes added to the process. It was agreed that this time would be reduced when workers were trained and experienced in the process. Some county representatives felt that the process would improve the quality of interviews, with the effect of reducing payment errors.

Another important issue was whether or not to require a client signature on the **Interview Form** (a signature on the application form is required). Fraud specialists suggested that the lack of a signature could interfere with the ability to prosecute fraud cases. On the other hand, requiring a signature on the **Interview Form** would complicate the process for telephone interviews – which are used in cases such as elderly, disabled, and working applicants – necessitating that the interview form would have to be mailed back to the client for a signature and then returned to the county office. The result would be delays in certification, mail losses, and non-returns. After consultation with the Office of the Attorney General and careful consideration of the arguments, DHS decided not to include a client signature on the interview form, but only on the application.

In order to evaluate workload impact, DHS and the counties decided to pilot test the new form and procedures before rolling them out to the entire state. Carver, Hennepin, Olmsted, and Ramsey counties have volunteered to conduct pilot tests simultaneously from late January through March. The pilots will comprise approximately 5,000 applications, which will provide enough data to evaluate the impact of using the new process on a wide variety of case types, and to compare the effects of the workload of using the old and the new forms. The pilot will enable DHS to evaluate improvement over time as the workers become more familiar with the process, and to determine what training will be needed.

At the end of the pilot project, final changes will be made to the forms and process, and more information will be sent to county agencies and community organizations when these forms and the process are implemented statewide.

## **II. Overview of New Combined Application (DHS-5223) Process:**

The new Combined Application Form (CAF) has several new features:

- The layout of the CAF is done in a portrait format versus the previous landscape or book format.
- The core questions from the Combined Application Form have been reformatted to Yes/No questions.

A **Worker Interview Form** (DHS-5223A) will be used by the eligibility worker to record detailed information developed during the interview with the applicant or authorized representative.

The **Combined Application Important Information** (DHS-5223B) form has been created as a handout for applicants to read and keep. This form contains the important information that is currently in the Combined Application Form.

Drafts of the new forms are attached to this bulletin. These forms are to be used only by the 4 pilot counties unless a case is transferred to your county. **Do not use the attached forms until official versions of these documents are posted on the DHS e-Doc's site.**

Another bulletin will be issued after the pilot has ended and the new Combined Application Form (DHS-5223) has been reviewed for needed changes.

DHS will not translate the new Combined Application Form into other languages until after the pilot. DHS will notify county agencies when the translated versions are available.

## **III. Transferred cases**

Some counties or agencies that are not part of the pilot may receive the new Combined Application because of case transfers. Counties should continue to follow the current policy requirements for processing applications as outlined in the Combined Manual (CM). There are no policy changes regarding processing of applications.

## **IV. Special Needs**

This information is available in other forms to people with disabilities by contacting Aaron Coonce at 651-431-4049 or through Minnesota Relay at 1-800-627-3529 (TDD), 7-1-1 or at 1-877- 627-3848, Speech-to-Speech Relay Service.

# Minnesota Department of Human Services

## Combined Application Form

### For Cash Assistance, Food Support and Health Care Programs

#### How to fill out this form

Fill out this form in black or dark blue ink.

- The general information, directions and questions are in yellow.
- List the names of all people who live with you on page 3. Include everyone, even if you are not asking for assistance for them. If a household has more than five people, page 8 has household member questions for the additional people.
- For recertifications show **all** changes in the past 12 months.
- This form will be used to decide if you can get cash, Food Support, and health care. For **each** person check **each** program that person is applying for (if unsure, talk to your county worker). Program rules require some people to get benefits together.
- If you need additional room or want to make comments, use the open space on page 8.
- If you are a family applying for cash or food assistance and have child care needs, ask your worker how to apply for the Child Care Assistance Program.
- **All adults** age 18 and older who are applying for health care programs must sign the form.
- You may need to provide proof of the information on this form. Refer to the Instructions for Completing the Combined Application Form (CAF) information sheet (DHS-2989). You cannot get help from cash, Food Support or health care programs until we get proof of this information. **Bring the proofs with you to the interview or send them to your worker as soon as you can.**
- If we require you to have an interview and you miss your interview appointment, you must reschedule. If you do not reschedule, we may stop or not approve your Cash and/or Food Support benefits.

**Tell someone if you need help filling out this form.**

**Be sure to sign and date the form on page 7.**

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 បើអ្នកចង់បានជំនួយបកប្រែព័ត៌មាននេះដោយមិនគិតថ្លៃ សូមសួរអ្នកកាន់សំណុំរឿងរបស់អ្នក ឬ ទូរស័ព្ទទៅលេខ 1-888-468-3787 ។

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

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

ໂປດຊາບ. ຖ້າຫາກທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປຂໍ້ຄວາມດັ່ງກ່າວນີ້ພຣີ, ຈົ່ງຖາມນຳພະນັກງານຊ່ວຍວຽກຂອງທ່ານຫຼືໂທ 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 này miễn phí, xin gọi nhân-viên xã-hội của quý vị hoặc gọi số 1-888-554-8759.

LB2-0001 (1-08)

This information is available in other forms to people with disabilities by calling your county worker. For TTY/TDD users, contact your county worker through the Minnesota Relay at 711 or (800) 627-3529. For the Speech-to-Speech Relay, call (877) 627-3848.

# Combined Application Form (CAF)

## Cash Assistance, Food Support and Health Care

Your application date, or the day your cash and food support benefits can start, is the date the county agency gets this page of the application form. Some health care programs may provide coverage for up to three months before the application date. We can set your application date if we have your name, address and signature (pages one and two). We must have the complete form to decide if you can get help. **Please print in black or dark blue ink.**

CASE NUMBER

1. APPLICANT'S LEGAL NAME (last/first/middle)		OTHER NAMES YOU USE (maiden name, nick name, etc.)	
ADDRESS WHERE YOU LIVE (If you do not have an address, write "homeless.")			
CITY	COUNTY	STATE	ZIP CODE
PHONE NUMBER WHERE YOU CAN BE REACHED (include area code) Home (     )     Other (     )		HOW MANY PEOPLE LIVE IN YOUR HOUSEHOLD? Adults     Children	
DO YOU LIVE ON A RESERVATION? <input type="checkbox"/> Yes <input type="checkbox"/> No     If yes, which one? _____			
DO YOU NEED AN INTERPRETER? <input type="checkbox"/> Yes <input type="checkbox"/> No	PREFERRED SPOKEN LANGUAGE?		PREFERRED WRITTEN LANGUAGE?

### Do you need help right away?

Some people can get food support benefits within 24 hours. **Questions 1-7** below will help us decide if you can get food benefits help right away.

<input type="checkbox"/> Yes <input type="checkbox"/> No	1. Has anyone in the household ever received public assistance, commodities or food support benefits before? <b>If yes:</b> When? _____ Where? _____ What? _____
<input type="checkbox"/> Yes <input type="checkbox"/> No	2a. Did all of your household <b>income recently stop</b> ? <b>If yes,</b> When? _____
	2b. How much income (cash or checks) did or will your household get <b>this month</b> ? _____
<input type="checkbox"/> Yes <input type="checkbox"/> No	3. Did anyone in your household <b>quit a job in the last 60 days</b> ? <b>If yes,</b> Employer name? _____ Dates of employment? From _____ to _____
<input type="checkbox"/> Yes <input type="checkbox"/> No	4. Does your family expect a <b>change in income</b> ? <b>If yes,</b> When? _____
	5. How much does your household (including children) have in <b>cash, checking or savings</b> ? \$ _____
	6. How much does your household pay for: <div style="display: flex; justify-content: space-between;"> <div>Rent/mortgage?</div> <div>\$ _____</div> </div> <div style="display: flex; justify-content: space-between;"> <div>Utilities?</div> <div>\$ _____</div> </div>
<input type="checkbox"/> Yes <input type="checkbox"/> No	7. Is anyone in your household a <b>migrant or seasonal farm worker</b> ?
<input type="checkbox"/> Yes <input type="checkbox"/> No	8. Is anyone in your household <b>pregnant</b> ?
<input type="checkbox"/> Yes <input type="checkbox"/> No	9. Do you need help now because of a medical or other <b>emergency</b> ?

**Read the "Your responsibilities" and "Your rights" pages on the back of this form before signing. I have looked over my answers and believe they are all true and correct to the best of my knowledge.**

SIGNATURE OF APPLICANT OR AUTHORIZED REPRESENTATIVE	DATE	AGENCY SIGNATURE	DATE RECEIVED
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**You may authorize another person to act on your behalf to help you:**

- Fill out forms and apply for help from the county agency (for example, go to an interview for you)
- Get notices and information related to your case
- Get your Food Support benefits and buy food for you through your Electronic Benefits Transfer (EBT) account.

The authorized person may be a friend, relative, conservator acting on your behalf, a person authorized by the courts, or a person with your power of attorney. This person can act for you until you notify your worker that you want this to end. Ask your worker for more information about authorized representatives.

I want the person named to:

- ☐ Fill out forms
- ☐ Get notices
- ☐ Get and use my food support benefits

NAME	RELATIONSHIP	PHONE NUMBER
ADDRESS		
CITY	STATE	ZIP CODE

- ☐ Fill out forms
- ☐ Get notices
- ☐ Get and use my food support benefits

NAME	RELATIONSHIP	PHONE NUMBER
ADDRESS		
CITY	STATE	ZIP CODE

**Legal guardian.** Do you have a legal guardian or conservator, or is there a power of attorney? ☐ Yes ☐ No

If yes, what is this person's full name (attach copies of legal documents).

NAME	DO YOU PAY A FEE? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, amount? _____	HOW OFTEN?
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**Principal Wage Earner (PWE).** Food Support households with children must designate the person they want as the PWE. Any adult in your Food Support unit can be the PWE. Talk to your worker before designating the Food Support PWE.

DESIGNATED PWE	SIGNATURE OF APPLICANT
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**Check if you need help with or information about the following areas.**

Your county worker can tell you if the county can help you with these areas or tell you where you can get help:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Personal or family problems | <input type="checkbox"/> Special needs children | <input type="checkbox"/> Applying/interviewing              |
| <input type="checkbox"/> Family/domestic violence    | <input type="checkbox"/> A language barrier     | <input type="checkbox"/> Housing assistance                 |
| <input type="checkbox"/> Chemical dependency         | <input type="checkbox"/> Child care             | <input type="checkbox"/> Veteran services                   |
| <input type="checkbox"/> Mental health issues        | <input type="checkbox"/> Transportation         | <input type="checkbox"/> Help with budgeting or bad credit  |
| <input type="checkbox"/> Family planning information | <input type="checkbox"/> Food shelves           | <input type="checkbox"/> <b>Free</b> help filing your taxes |
| <input type="checkbox"/> Learning disability         | <input type="checkbox"/> Child support          |   |
| <input type="checkbox"/> Other                       |   |   |

☐ Yes ☐ No Are you currently getting help from a **social worker or social services agency**?

☐ Yes ☐ No Are you or anyone in your household getting services from the Center for Victims of Torture?

☐ Yes ☐ No Do you want to register to vote or update your registration?

***Note:** You do not have to answer this question.*



**List all of the people living in your home** even if you are not applying for them. Include everyone, even if the person is not asking for assistance. You have to give a Social Security number **only** for people who are applying for help. If anyone in the household uses another name (maiden name, nickname, etc.) list the other name(s) in the “OTHER NAMES” boxes below.

**List in this order:** Yourself, your spouse, other adult(s), children, all other people, anyone temporarily away from home. If anyone is pregnant, list as “unborn child” and the due date. *For more than six household members go to page 8.*

Use these codes to complete MARITAL STATUS and RACE fields for each person.

**Marital Status:** (choose one): **N** = Never married **M** = Married living with spouse **S** = Separated (married, living apart)  
**L** = Legally separated **D** = Divorced **W** = Widowed  
**Race:** (choose all that apply) **N** = American Indian/ Alaska Native **A** = Asian **B** = Black or African American  
**P** = Pacific Islander/ Native Hawaiian **W** = White

<b>PERSON #1</b> APPLICANT'S LEGAL NAME (last/firs/middle)		OTHER NAMES		SEX <input type="checkbox"/> M <input type="checkbox"/> F	RELATIONSHIP TO YOU <b>SELF</b>
BIRTH DATE (mm/dd/yy)	MARITAL STATUS	SOCIAL SECURITY NUMBER	DATE MOST RECENTLY MOVED TO MINNESOTA (mm/dd/yy)		
ETHNICITY (optional) Hispanic? <input type="checkbox"/> Yes <input type="checkbox"/> No	RACE (optional)	U.S. CITIZEN OR U.S. NATIONAL? <input type="checkbox"/> Yes <input type="checkbox"/> No	LIST CITY, STATE AND COUNTRY OF BIRTH		
WHAT PROGRAMS IS THIS PERSON APPLYING FOR? <input type="checkbox"/> Cash <input type="checkbox"/> Food Support <input type="checkbox"/> Emergency help <input type="checkbox"/> Health Care <input type="checkbox"/> None					LAST SCHOOL GRADE COMPLETED

<b>PERSON #2</b> APPLICANT'S LEGAL NAME (last/firs/middle)		OTHER NAMES		SEX <input type="checkbox"/> M <input type="checkbox"/> F	RELATIONSHIP TO YOU
BIRTH DATE (mm/dd/yy)	MARITAL STATUS	SOCIAL SECURITY NUMBER	DATE MOST RECENTLY MOVED TO MINNESOTA (mm/dd/yy)		
ETHNICITY (optional) Hispanic? <input type="checkbox"/> Yes <input type="checkbox"/> No	RACE (optional)	U.S. CITIZEN OR U.S. NATIONAL? <input type="checkbox"/> Yes <input type="checkbox"/> No	LIST CITY, STATE AND COUNTRY OF BIRTH		
WHAT PROGRAMS IS THIS PERSON APPLYING FOR? <input type="checkbox"/> Cash <input type="checkbox"/> Food Support <input type="checkbox"/> Emergency help <input type="checkbox"/> Health Care <input type="checkbox"/> None					LAST SCHOOL GRADE COMPLETED

<b>PERSON #3</b> APPLICANT'S LEGAL NAME (last/firs/middle)		OTHER NAMES		SEX <input type="checkbox"/> M <input type="checkbox"/> F	RELATIONSHIP TO YOU
BIRTH DATE (mm/dd/yy)	MARITAL STATUS	SOCIAL SECURITY NUMBER	DATE MOST RECENTLY MOVED TO MINNESOTA (mm/dd/yy)		
ETHNICITY (optional) Hispanic? <input type="checkbox"/> Yes <input type="checkbox"/> No	RACE (optional)	U.S. CITIZEN OR U.S. NATIONAL? <input type="checkbox"/> Yes <input type="checkbox"/> No	LIST CITY, STATE AND COUNTRY OF BIRTH		
WHAT PROGRAMS IS THIS PERSON APPLYING FOR? <input type="checkbox"/> Cash <input type="checkbox"/> Food Support <input type="checkbox"/> Emergency help <input type="checkbox"/> Health Care <input type="checkbox"/> None					LAST SCHOOL GRADE COMPLETED

<b>PERSON #4</b> APPLICANT'S LEGAL NAME (last/firs/middle)		OTHER NAMES		SEX <input type="checkbox"/> M <input type="checkbox"/> F	RELATIONSHIP TO YOU
BIRTH DATE (mm/dd/yy)	MARITAL STATUS	SOCIAL SECURITY NUMBER	DATE MOST RECENTLY MOVED TO MINNESOTA (mm/dd/yy)		
ETHNICITY (optional) Hispanic? <input type="checkbox"/> Yes <input type="checkbox"/> No	RACE (optional)	U.S. CITIZEN OR U.S. NATIONAL? <input type="checkbox"/> Yes <input type="checkbox"/> No	LIST CITY, STATE AND COUNTRY OF BIRTH		
WHAT PROGRAMS IS THIS PERSON APPLYING FOR? <input type="checkbox"/> Cash <input type="checkbox"/> Food Support <input type="checkbox"/> Emergency help <input type="checkbox"/> Health Care <input type="checkbox"/> None					LAST SCHOOL GRADE COMPLETED

<b>PERSON #5</b> APPLICANT'S LEGAL NAME (last/firs/middle)		OTHER NAMES		SEX <input type="checkbox"/> M <input type="checkbox"/> F	RELATIONSHIP TO YOU
BIRTH DATE (mm/dd/yy)	MARITAL STATUS	SOCIAL SECURITY NUMBER	DATE MOST RECENTLY MOVED TO MINNESOTA (mm/dd/yy)		
ETHNICITY (optional) Hispanic? <input type="checkbox"/> Yes <input type="checkbox"/> No	RACE (optional)	U.S. CITIZEN OR U.S. NATIONAL? <input type="checkbox"/> Yes <input type="checkbox"/> No	LIST CITY, STATE AND COUNTRY OF BIRTH		
WHAT PROGRAMS IS THIS PERSON APPLYING FOR? <input type="checkbox"/> Cash <input type="checkbox"/> Food Support <input type="checkbox"/> Emergency help <input type="checkbox"/> Health Care <input type="checkbox"/> None					LAST SCHOOL GRADE COMPLETED

<input type="checkbox"/> Yes <input type="checkbox"/> No	1. Is there <b>anyone</b> in your household who does not buy, fix or eat food with you?
<input type="checkbox"/> Yes <input type="checkbox"/> No	2. Is <b>anyone</b> in the household, who is age 60 or over or disabled, unable to buy or fix food due to a disability?
<input type="checkbox"/> Yes <input type="checkbox"/> No	3. Is <b>anyone</b> in the household attending school?
<input type="checkbox"/> Yes <input type="checkbox"/> No	4. Is <b>anyone</b> in your household temporarily not living in your home? (for example: vacation, foster care, treatment, hospital, job search)
<input type="checkbox"/> Yes <input type="checkbox"/> No	5. Did <b>anyone</b> move in or out of your home in the past 12 months?
<input type="checkbox"/> Yes <input type="checkbox"/> No	6. Is <b>either</b> parent of any children under age 19 dead or not living in the home?
<input type="checkbox"/> Yes <input type="checkbox"/> No	7. Is <b>anyone</b> mentally or physically ill, disabled or not able to care for themselves?
<input type="checkbox"/> Yes <input type="checkbox"/> No	8. Is <b>anyone</b> unable to work for reasons other than illness or disability?
<input type="checkbox"/> Yes <input type="checkbox"/> No	9. In the last 90 days did <b>anyone</b> in the household: <ul style="list-style-type: none"> <li>• Stop working or quit a job?</li> <li>• Ask to work fewer hours?</li> <li>• Refuse a job offer?</li> <li>• Go on strike?</li> </ul>
<input type="checkbox"/> Yes <input type="checkbox"/> No	10. Has <b>anyone</b> in the household been injured or had an accident in the past 72 months?
<input type="checkbox"/> Yes <input type="checkbox"/> No	11. Is <b>anyone</b> in the household on a diet prescribed by a doctor?

## What do you own?

Check Yes or No for each item.

<input type="checkbox"/> Yes <input type="checkbox"/> No	12. Does <b>anyone</b> in the household own, or is <b>anyone</b> buying, any of the following? <table border="0"> <tr> <td><input type="checkbox"/> Yes <input type="checkbox"/> No Cash</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No Bank accounts (savings, checking, etc)</td> </tr> <tr> <td><input type="checkbox"/> Yes <input type="checkbox"/> No Life or burial insurance</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No Vehicles (cars, trucks, motorcycles, etc.)</td> </tr> <tr> <td><input type="checkbox"/> Yes <input type="checkbox"/> No Stocks, bonds, annuities, etc.</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No Real estate property (house, land, etc.)</td> </tr> <tr> <td><input type="checkbox"/> Yes <input type="checkbox"/> No Other assets (tools, boats, livestock, etc.)</td> <td></td> </tr> </table>	<input type="checkbox"/> Yes <input type="checkbox"/> No Cash	<input type="checkbox"/> Yes <input type="checkbox"/> No Bank accounts (savings, checking, etc)	<input type="checkbox"/> Yes <input type="checkbox"/> No Life or burial insurance	<input type="checkbox"/> Yes <input type="checkbox"/> No Vehicles (cars, trucks, motorcycles, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No Stocks, bonds, annuities, etc.	<input type="checkbox"/> Yes <input type="checkbox"/> No Real estate property (house, land, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No Other assets (tools, boats, livestock, etc.)	
<input type="checkbox"/> Yes <input type="checkbox"/> No Cash	<input type="checkbox"/> Yes <input type="checkbox"/> No Bank accounts (savings, checking, etc)								
<input type="checkbox"/> Yes <input type="checkbox"/> No Life or burial insurance	<input type="checkbox"/> Yes <input type="checkbox"/> No Vehicles (cars, trucks, motorcycles, etc.)								
<input type="checkbox"/> Yes <input type="checkbox"/> No Stocks, bonds, annuities, etc.	<input type="checkbox"/> Yes <input type="checkbox"/> No Real estate property (house, land, etc.)								
<input type="checkbox"/> Yes <input type="checkbox"/> No Other assets (tools, boats, livestock, etc.)									
<input type="checkbox"/> Yes <input type="checkbox"/> No	13. Has <b>anyone</b> in the household given away, sold or traded anything of value <b>in the past 60 months</b> ? (for example: Real estate property, bank accounts, annuities, vehicles, etc.) <b>Note:</b> Include any transfers made by a spouse not living with you.								

## What kinds of income do you have?

<input type="checkbox"/> Yes <input type="checkbox"/> No	14. Has <b>anyone</b> in the household had a job or been self-employed in the past 12 months?												
<input type="checkbox"/> Yes <input type="checkbox"/> No	15. Does <b>anyone</b> in the household have a job or expect to get income from a job this month or next month? <b>Note:</b> Include income from Work Study and paid internships. Include free benefits or reduced expenses received for work (shelter, food, clothing, etc.).												
<input type="checkbox"/> Yes <input type="checkbox"/> No	16. Is <b>anyone</b> in the household self-employed or does anyone expect to get income from self-employment this month or next month? Examples: <table border="0"> <tr> <td>• Product sales</td> <td>• Crop Reserve Program (CRP)</td> <td>• Personal services</td> <td>• Farming</td> </tr> <tr> <td>• Paper route</td> <td>• In-home daycare</td> <td>• Roomers/boarders</td> <td></td> </tr> <tr> <td>• Property rental</td> <td>• Taxi driver</td> <td>• Other</td> <td></td> </tr> </table>	• Product sales	• Crop Reserve Program (CRP)	• Personal services	• Farming	• Paper route	• In-home daycare	• Roomers/boarders		• Property rental	• Taxi driver	• Other	
• Product sales	• Crop Reserve Program (CRP)	• Personal services	• Farming										
• Paper route	• In-home daycare	• Roomers/boarders											
• Property rental	• Taxi driver	• Other											
<input type="checkbox"/> Yes <input type="checkbox"/> No	17. Do you expect any changes in income, expenses or work hours?												

Check Yes or No  
for each item.

**18.** Has **anyone** in the household applied for or does anyone get any of the following types of income?

- |                              |                             |                        |                              |                             |                                    |
|------------------------------|-----------------------------|------------------------|------------------------------|-----------------------------|------------------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Social Security (RSDI) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Supplemental Security Income (SSI) |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Veteran benefits (VA)  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Unemployment Insurance             |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Workers' Compensation  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Retirement benefits                |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Tribal payments        | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Child support or spousal support   |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Other unearned income  |                              |                             |                                    |

☐ Yes ☐ No

**19.** Does **anyone** in the household have or expect to get any loans, scholarships or grants for attending school?

## What kinds of expenses do you have?

Check Yes or No  
for each item.

**20.** Does **your household** have the following housing expenses?

- |                              |                             |   |
|------------------------------|-----------------------------|---|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Rent (include mobile home lot rental)               |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Mortgage/contract for deed payment                  |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Association fees                                    |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Homeowner's insurance (if not included in mortgage) |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Real estate taxes (if not included in mortgage)     |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Room and/or meals                                   |

Check Yes or No  
for each item.

**21.** Does **your household** have the following utility expenses **any time** during the year?

- |                              |                             |                          |                              |                             |                  |
|------------------------------|-----------------------------|--------------------------|------------------------------|-----------------------------|------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Heating/Air Conditioning | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Garbage removal  |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Electricity              | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Water and sewer  |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Cooking fuel             | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Phone/Cell phone |

☐ Yes ☐ No

**22.** Do **you or anyone living with you** have costs for care of a **child** or an **ill or disabled adult** because you or they were working, looking for work or going to school?

**Note:** The Child Care Fund may pay child care costs. Ask your financial worker for more information.

☐ Yes ☐ No

**23.** Does **anyone in** the household **pay** court-ordered child support, spousal support, child care support, medical support or contribute to a tax dependent who does not live in your home?

☐ Yes ☐ No

**24.** Does **anyone** in the household have expenses related to work, training or job search, such as transportation, meals or uniforms?

☐ Yes ☐ No

**25a.** Does **anyone** in your household currently have health insurance, long-term care insurance, or prescription drug coverage?

☐ Yes ☐ No

**25b.** Does **anyone** in your household have Medicare Part A, B or D?

**26.** For the following programs you will need to provide proof of your medical expenses:

**Food Support** applicants or recipients: To get a medical deduction, you must provide proof of all recurring medical bills incurred by anyone in your household **who is disabled or 60 years or older**. **Do not** bring medical bills that are being paid for by any health care program, insurance or someone not living with you.

**Health care program** applicants or recipients: Some health care programs may pay for health care you received up to three months before you apply for help. Bring proof of any medical bills you or any household member incurred in the last three months.

☐ Check here if you need someone to read or explain the information and rules on the following two pages.

## Penalty warnings and qualification questions

If you get cash or food support benefits, you must follow the rules listed below. The state may bar household members who break any of these rules from the cash or Food Support programs. The bar lasts one year for the first fraud, two years for the second fraud and is permanent for the third fraud. The maximum penalty is a fine of \$250,000 or a jail term of 20 years, or both.

- **Do not give false information** or hide information to get or continue to get cash or food support benefits.
- **Do not trade or sell** food support benefits or electronic benefits transfer (EBT) access cards.
- **Do not use food support benefits to buy ineligible items**, such as alcohol and tobacco.
- **Do not use someone else's EBT access cards** to get cash or food support benefits for your household.

If you get cash or food support benefits and give false information or hide information about your identity and/or residence to get multiple benefits for the same period of time, you may be barred for 10 years.

You can also be barred from state medical programs and the same penalties apply.

**Special Food Support penalty warning:** If a federal, state or local court finds you guilty of trading food support benefits for firearms, ammunition, explosives or controlled substances, the court will bar from the Food Support Program any household member:

- **For 12 months** for the first offense, and permanently for the second offense involving the sale of a controlled substance for food support benefits
- **Permanently** for the first offense involving the sale of firearms, ammunition or explosives for food support benefits.

*If you admit committing a drug felony after July 1, 1997, the county agency may ask you to take random drug tests. The first time you fail a drug test, the county agency will reduce your household's MFIP or Food Support by 30 percent. If you fail the test a second time, you will be permanently disqualified.*

- ☐ Yes ☐ No 1. Has a court or any other civil or administrative process in Minnesota or any other state found anyone in the household guilty or has anyone been disqualified from receiving public assistance for breaking any of the rules/above?
- ☐ Yes ☐ No 2. Has anyone in the household been convicted of making fraudulent statements about their place of residence to get cash or medical benefits since July 1, 1997?
- ☐ Yes ☐ No 3. Is anyone in your household hiding or running from the law to avoid prosecution, being taken into custody, or to avoid going to jail for a felony, attempted felony or for violating a condition of parole or probation?
- ☐ Yes ☐ No 4. Is anyone in your household a convicted drug felon?

**If you checked yes to any of the above questions, list the household member(s) and question number below:**

QUESTION #	HOUSEHOLD MEMBER	QUESTION #	HOUSEHOLD MEMBER

## Medical assignment of benefits

I assign all medical payments to the State of Minnesota. This assignment includes medical care payments from all other persons or entities. This assignment covers medical care payments for me and anyone else for whom I apply. It takes effect right away when health care coverage starts. I agree to cooperate with the State in any action to recover payment of medical expenses. If I claim good cause and good cause is approved, I may not have to cooperate.

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.

## Assignment of support

I understand that when I get MFIP, Child Care or MA for Long-Term Care (LTC), I must assign all rights to support to the State of Minnesota. This assignment includes my pre-MFIP support arrears. When I no longer receive MFIP, payments collected (except federal tax refunds) on these pre-MFIP arrears will be sent to me. For MA-LTC, this covers the total income and assets reduced by any share my spouse is allowed to keep (Minn. Stat. 256B.14, 256B.058.059). For Medical Assistance only, I understand I assign only my rights to current medical care payments.

## 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 (MHCP), my county case workers, and their contractors and subcontractors:
  - a. To determine who should pay for my health care, and
  - b. 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 disclose the information.

## Fraud investigation release

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 also understand that my permission to share information about me remains in effect for six months after my benefits stop.

## Employment services registration

Cash and Food Support applicants: I understand that signing this application registers me for employment services. I also understand that doing so automatically registers for employment services everyone in my home the county approves to receive assistance with me. I understand that I or others in my home might have to take part in employment services to receive cash assistance or food support benefits.

## Perjury and general declarations

I declare under the penalties of perjury that this application has been examined by me and to the best of my knowledge is a true and correct statement of every material point. I understand that:

- A person convicted of perjury may be sentenced to imprisonment of not more than five years or payment of a fine of not more than \$10,000, or both. (Minn. Stat. 256.984, subd. 1)
- If I give incorrect information or misuse an electronic benefits transfer card, I may be prosecuted for fraud. (Minn. Stat. 256.98 and 609.821)

Since my last application or recertification, I have received my cash and/or food support benefits directly or used my EBT card to get my cash and/or food support benefits.

### By signing below:

- I acknowledge that my worker gave me a copy of the Notice of Privacy Practices (DHS-3979), the CAF Important Information sheet (DHS-5223B) and the "Your responsibilities" and "Your rights" pages and explained them to me.
- I acknowledge that I have read and understand the "Penalty warnings and qualification questions" section on page 6.
- I agree to assign my support and medical benefits as stated above.
- I agree to the sharing of information as stated on the medical and fraud release information above and the Social Security numbers section of the "Important Information" tear-off page of this application.
- **I declare that I have looked over my answers and believe they are all true and correct to the best of my knowledge.**

SIGNATURE OF APPLICANT OR AUTHORIZED REPRESENTATIVE	DATE	SIGNATURE OF HOUSEHOLD MEMBER 18 OR OLDER APPLYING FOR HEALTH CARE	DATE
SIGNATURE OF SPOUSE OR OTHER ADULT	DATE	AGENCY SIGNATURE	DATE RECEIVED

Use this space if you need additional room.

**Complete for additional household members:**

<b>PERSON #6</b> APPLICANT'S LEGAL NAME (last/firs/middle)		OTHER NAMES		SEX <input type="checkbox"/> M <input type="checkbox"/> F	RELATIONSHIP TO YOU
BIRTH DATE (mm/dd/yy)	MARITAL STATUS	SOCIAL SECURITY NUMBER	DATE MOST RECENTLY MOVED TO MINNESOTA (mm/dd/yy)		
ETHNICITY (optional) Hispanic? <input type="checkbox"/> Yes <input type="checkbox"/> No	RACE (optional)	U.S. CITIZEN OR U.S. NATIONAL? <input type="checkbox"/> Yes <input type="checkbox"/> No	LIST CITY,STATE AND COUNTRY OF BIRTH		
WHAT PROGRAMS IS THIS PERSON APPLYING FOR? <input type="checkbox"/> Cash <input type="checkbox"/> Food Support <input type="checkbox"/> Emergency help <input type="checkbox"/> Health Care <input type="checkbox"/> None					LAST SCHOOL GRADE COMPLETED
<b>PERSON #7</b> APPLICANT'S LEGAL NAME (last/firs/middle)		OTHER NAMES		SEX <input type="checkbox"/> M <input type="checkbox"/> F	RELATIONSHIP TO YOU
BIRTH DATE (mm/dd/yy)	MARITAL STATUS	SOCIAL SECURITY NUMBER	DATE MOST RECENTLY MOVED TO MINNESOTA (mm/dd/yy)		
ETHNICITY (optional) Hispanic? <input type="checkbox"/> Yes <input type="checkbox"/> No	RACE (optional)	U.S. CITIZEN OR U.S. NATIONAL? <input type="checkbox"/> Yes <input type="checkbox"/> No	LIST CITY,STATE AND COUNTRY OF BIRTH		
WHAT PROGRAMS IS THIS PERSON APPLYING FOR? <input type="checkbox"/> Cash <input type="checkbox"/> Food Support <input type="checkbox"/> Emergency help <input type="checkbox"/> Health Care <input type="checkbox"/> None					LAST SCHOOL GRADE COMPLETED
<b>PERSON #8</b> APPLICANT'S LEGAL NAME (last/firs/middle)		OTHER NAMES		SEX <input type="checkbox"/> M <input type="checkbox"/> F	RELATIONSHIP TO YOU
BIRTH DATE (mm/dd/yy)	MARITAL STATUS	SOCIAL SECURITY NUMBER	DATE MOST RECENTLY MOVED TO MINNESOTA (mm/dd/yy)		
ETHNICITY (optional) Hispanic? <input type="checkbox"/> Yes <input type="checkbox"/> No	RACE (optional)	U.S. CITIZEN OR U.S. NATIONAL? <input type="checkbox"/> Yes <input type="checkbox"/> No	LIST CITY,STATE AND COUNTRY OF BIRTH		
WHAT PROGRAMS IS THIS PERSON APPLYING FOR? <input type="checkbox"/> Cash <input type="checkbox"/> Food Support <input type="checkbox"/> Emergency help <input type="checkbox"/> Health Care <input type="checkbox"/> None					LAST SCHOOL GRADE COMPLETED



## Your responsibilities

**Note:** If you sign this application as an Authorized Representative of a person who is requesting or receiving assistance, you are agreeing to assume all of the following responsibilities on behalf of that person.

- **You must report changes which may affect your benefits to the county agency *within 10 days*** after the change has occurred.

**Applicants** - Report these changes to your worker when the change happens.

This includes the following for everyone in your household:

- **Employment** - Start or stop a job or business; change in hours, earnings or expenses.
- **Income** - Receipt or change in child support, Social Security, Veteran benefits, Unemployment Insurance, inheritance, insurance benefits and other payments.
- **Property** - Purchase, sale or transfer of a house, car or other items of value.
- **Household** - When a person dies, moves in or out of your home or temporarily leaves; pregnancy; birth of a child.
- **Address**
- **Housing costs/rent subsidy**
- **Utility costs**
- **Filing a lawsuit**
- **Absent parent custody or visits**
- **Drug felony conviction**
- **Marriage or divorce**
- **School attendance**
- **Health insurance**
- **Each time you use your electronic benefits transfer (EBT) card or sign your check**, you state that you have informed the county agency about any changes in your situation which may affect your benefits.
- **Each time your electronic benefits transfer (EBT) card** is used we assume you have received your cash or food support benefits, unless you reported your card lost or stolen to the county agency.
- **The county, state or federal agency may check any of the information you give.** To get some information we must have your signed consent. If you don't allow the county to confirm your information, you might not get assistance.
- **If you give us information you know is untrue or we get information you did not report**, we will investigate you for fraud.
- **Cooperation requirements:**
  - If the county approves you for the Minnesota Family Investment Program (MFIP) or the Diversionary Work Program (DWP), you must cooperate with the child support enforcement unit and employment services, unless you are exempt. You must develop and sign an employment plan or your DWP application will be denied.
  - After the county approves your MFIP or DWP, if you get child support directly from the noncustodial parent, you must report it to your financial worker. You must cooperate with the child support agency in any legal action brought against a third party for payment of medical expenses, unless you claim and are granted good cause.
  - If you get health care only, you must help the child support agency pursue any person responsible for providing medical support for you and your children, unless you apply only for your children.
  - If the county approves you for health care, you must enroll in any available insurance or benefit plan offered by your employer or your spouse's employer, if the State determines it is cost-effective.
- **The State or Federal Quality Control agency** may randomly choose your case for review. They will review statements you made on forms. They will check to see if we figured your eligibility correctly. The state agency may seek information from other sources. The State or Federal Quality Control agency will tell you about any contact they intend to make. ***If you do not cooperate, your benefits may stop.***
- **Contact your financial worker** if you have any questions or are unsure about any reporting rules. If your worker is not available, leave a message so the worker can get back to you.

## Your rights

- Your right to privacy. Your private information, including your health information, is protected by state and federal laws. Your worker has given you a Notice of Privacy Practices (DHS-3979) information sheet. This sheet explains:
  - Why we are asking you to give us your private information
  - How we may use and share private information about you
  - Why we ask for your Social Security number
  - Your rights about your private information. You can:
    - Ask about how we can use information and with whom we will share this information
    - Ask to get this information in another format
    - Ask to see your information
    - Ask whom we have given your information to
  - How we must legally protect your private information
  - Whom you can contact if you think your private information has been mishandled.

Please read it carefully. For more information about your data privacy rights or a copy of the Notice of Privacy Practices, ask your worker. You can also get a copy of this notice at <http://edocs.dhs.state.mn.us/lfserver/Legacy/DHS-3979-ENG>.

- **You have the right to reapply** at any time if your benefits stop.
- **You have the right to know why, if we have not processed your application promptly.**
  - 15 days for medical care for pregnant women
  - 30 days for cash and food assistance
  - 45 days for medical care
  - 60 days for cash and medical care related to disability.
- **You have the right to know the rules of the program you are applying for** and for us to tell you how we figured your benefits.
- **You have the right to choose where and with whom you live** and, within certain limits, to choose your own doctor, hospital, etc.
- **Appeal rights.** If you are unhappy with the action taken or feel the agency did not act on your request for assistance, you may appeal. For cash, child care and health care, you may appeal **within 30 days** from the date you receive the notice by writing to the county agency, or directly to the State Appeals Office at the Minnesota Department of Human Services, PO Box 64941, St. Paul, MN 55164-0941. (If you show good cause for not appealing your cash and health care

**within 30 days**, the agency can accept your appeal **for up to 90 days** from the date you receive the notice.) For Food Support, you may appeal **within 90 days** by writing or calling the county or the State Appeals Office.

*If you wish your assistance to continue until the hearing, you must appeal before the date of the proposed action or within 10 days after the date the agency notice was mailed, whichever is later. Ask your county worker to explain how the timing of your appeal could affect your present or future assistance.*

- **Access to free legal services.** Contact your worker for information on free legal services.
- **Your right to file a complaint.** If you feel the county or the Minnesota Department of Human Services treated you differently in the handling of a public assistance application or payment because of race, color, national origin, political beliefs, religion, creed, sex, sexual orientation, public assistance status, age or disability (including access to buildings or programs), you may file a complaint with one or more of these agencies:

Minnesota Department of Human Services  
Office for Equal Opportunity  
PO Box 64997  
St. Paul, Minnesota 55164-0997  
(651) 431-3040 (Voice)

Minnesota Department of Human Rights  
190 East 5th Street, Suite 700  
St. Paul, Minnesota 55101  
(800) 657-3704 (Voice)  
(651) 296-1283 (TTY/TDD)

U.S. Department of Health and Human Services  
Office for Civil Rights, Region V  
233 North Michigan Avenue, Suite 240  
Chicago, Illinois 60601  
(312) 886-2359 (Voice)  
(312) 353-5693 (TTY/TDD)

U.S. Department of Agriculture  
Director, Office of Civil Rights  
Room 326-W, Whitten Building  
1400 Independence Avenue, SW  
Washington D.C. 20250-9410  
(800) 795-3272 (Voice)  
(202) 720-6382 (TTY/TDD)



# Worker Interview Form

APPLICANT'S LEGAL NAME		CASE NUMBER
DATE APPLICATION SIGNED	DATE OF INTERVIEW	INTERVIEWER NAME
INTERPRETER USED? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, <input type="checkbox"/> Client provided <input type="checkbox"/> County provided		WORKER NAME

<b>Applicant eligible for Expedited Food Support benefits?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
Comments/verification: <i>Same day interview offered?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Client declined?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No	

## Household composition:

NAME	PROGRAMS APPLYING FOR	INTENDS TO RESIDE IN MN	MEMB, MEMI TYPE, PROG, SPON,	
			IMMIGRATION STATUS	SPONSOR
PERSON #1	<input type="checkbox"/> None <input type="checkbox"/> Cash <input type="checkbox"/> Food support <input type="checkbox"/> Emergency <input type="checkbox"/> Health care	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
PERSON #2	<input type="checkbox"/> None <input type="checkbox"/> Cash <input type="checkbox"/> Food support <input type="checkbox"/> Emergency <input type="checkbox"/> Health care	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
PERSON #3	<input type="checkbox"/> None <input type="checkbox"/> Cash <input type="checkbox"/> Food support <input type="checkbox"/> Emergency <input type="checkbox"/> Health care	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
PERSON #4	<input type="checkbox"/> None <input type="checkbox"/> Cash <input type="checkbox"/> Food support <input type="checkbox"/> Emergency <input type="checkbox"/> Health care	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
PERSON #5	<input type="checkbox"/> None <input type="checkbox"/> Cash <input type="checkbox"/> Food support <input type="checkbox"/> Emergency <input type="checkbox"/> Health care	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
PERSON #6	<input type="checkbox"/> None <input type="checkbox"/> Cash <input type="checkbox"/> Food support <input type="checkbox"/> Emergency <input type="checkbox"/> Health care	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
PERSON #7	<input type="checkbox"/> None <input type="checkbox"/> Cash <input type="checkbox"/> Food support <input type="checkbox"/> Emergency <input type="checkbox"/> Health care	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
PERSON #8	<input type="checkbox"/> None <input type="checkbox"/> Cash <input type="checkbox"/> Food support <input type="checkbox"/> Emergency <input type="checkbox"/> Health care	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No

SPONSOR	
NAME	ADDRESS
NAME	ADDRESS

Comments/verification:
------------------------

**Instructions:** If client answered “Yes” to any of the corresponding questions on the application, request the information listed under the question on the interview form and record any pertinent information in the “Comments/verification” section. If client answered “No” on the application, you do not have to complete the corresponding section on the interview form. Follow-up and document any inconsistent information in the comments/verification sections.

**1. Is there anyone in your household who does not buy, fix or eat food with you?**

If Yes, complete:

**EATS**

NAME	NAME

Comments/verification:

**2. Is anyone in the household, who is age 60 or over or disabled, unable to buy or fix food due to a disability?**

If Yes, complete:

**EATS**

NAME	NAME

Comments/verification:

**3. Is anyone in the household attending school?**

If Yes, complete:

**SCHL**

NAME	GRADE	NAME OF SCHOOL	STUDENT STATUS
			<input type="checkbox"/> Part time <input type="checkbox"/> Full time
			<input type="checkbox"/> Part time <input type="checkbox"/> Full time
			<input type="checkbox"/> Part time <input type="checkbox"/> Full time
			<input type="checkbox"/> Part time <input type="checkbox"/> Full time
			<input type="checkbox"/> Part time <input type="checkbox"/> Full time
			<input type="checkbox"/> Part time <input type="checkbox"/> Full time

Comments/verification:

**4. Is anyone temporarily not living in your home?**

If Yes, complete:

**REMO**

NAME	DATE	PLACE/ADDRESS WHILE OUT OF HOME	EXPECTED DATE OF RETURN

Comments/verification:

5. Did **anyone** move in or out of your home in the past 12 months?

If Yes, complete:

**ADME, REMO**

NAME	RELATIONSHIP TO YOU OR YOUR CHILDREN	DATE MOVED IN	DATE MOVED OUT

Comments/verification:

6. Is **either** parent of any children under age 19 dead, or not living in the home?

If Yes, complete:

**INFC/CSIA, ABPS**

ABSENT PARENT'S NAME	CHILD'S NAME	DOES PARENT VISIT OR SHARE CUSTODY
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No

Comments/verification:

*Referral made to Child Support and Collections?*

☐ Yes ☐ No

7. Is **anyone** mentally or physically ill, disabled or not able to care for themselves?

If Yes, complete:

**DISA**

NAME	MEDICAL PROBLEM	DATE MEDICAL PROBLEM STARTED

Comments/verification:

Verification: ☐ requested ☐ attached

8. Is **anyone** unable to work for reasons other than illness or disability?

If Yes, complete:

**WREG, EMPS**

NAME	REASON

Comments/verification:

Verification: ☐ requested ☐ attached

9. Is the last 90 days did **anyone** in the household quit a job or stop working, refuse a job offer, ask to work fewer hours, or go on strike?

If Yes, complete:

**STWK, STRK**

PERSON'S NAME	REASON	DATE OF ACTION

Comments/verification:

Verification: ☐ requested ☐ attached

10. Has **anyone** in the household been injured or had an accident in the past 72 months?

If Yes, complete:

**ACCI**

PERSON'S NAME	DATE OF ACCIDENT OR INJURY	TYPE OF ACCIDENT/INJURY

Comments/verification:

Verification: ☐ requested ☐ attached

11. Is **anyone** in the household on a diet prescribed by a doctor?

If Yes, complete:

**DIET**

NAME	TYPE OF DIET

Comments/verification:

Verification: ☐ requested ☐ attached

## Assets

**12.** Does **anyone** in the household own, or is anyone buying, any of the following types of assets? If Yes, complete:

TYPE OF PROPERTY		OWNER(S) NAME	TOTAL VALUE
Cash	<b>CASH</b>		
Accounts such as checking, savings, debit cards, money market, trust funds, annuities, certificates of deposit (CD), retirement funds <b>ACCT</b>	Type(s):		
Stocks, bonds, annuities, contracts for deed or other securities <b>SECU</b>			
Life insurance or burial accounts <b>SECU, OTHR</b>			
Vehicles such as cars, trucks, campers, motorcycles (specify make/model/year) <b>CARS</b>			
Other assets such as tools, livestock, boats, motors, trailers, farm implements, snowmobiles <b>OTHR</b>			
Land, buildings, life estates, houses, mobile homes <b>REST</b>			
Sponsor's assets (if client is not a U.S. citizen) <b>SPON</b>			

Comments/verification: Verification: ☐ requested ☐ attached

**13.** Has **anyone** in the household given away, sold or traded anything of value **in the past 60 months?** If Yes, complete:

					TRAN
TYPE(S) OF PROPERTY	ITEM(S) TRANSFERRED	PERSON WHO TRANSFERRED PROPERTY	PERSON WHO RECEIVED PROPERTY	VALUE OF PROPERTY	DATE OF TRANSFER
Land, buildings, mobile homes, life estates, waived right to an inheritance					
Cash, bank accounts, stocks, bonds, contracts for deed, annuities, trust funds					
Property such as burial funds, vehicles or other assets					

Comments/verification (Question 13):

Verification: ☐ requested ☐ attached

## Income

14. Has **anyone** in the household had a job in the past 12 months?

If Yes, complete:

### JOBS

NAME	EMPLOYER	DATE STARTED	DATE STOPPED

Comments/verification:

Verification: ☐ requested ☐ attached

15. Does **anyone** in the household have a job or expect to get income from a job this month or next month? (Request verification or complete table below.)

If Yes, complete:

### JOBS, STIN

#1 This month's work income	NAME		JOB BEGIN DATE	
EMPLOYER NAME	EMPLOYER ADDRESS			
HOW OFTEN PAID? <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Biweekly <input type="checkbox"/> Semimonthly <input type="checkbox"/> Other _____		PAY RATE	# HOURS PER WEEK	DATE LAST CHECK REC'D
DATE CHECK RECEIVED	GROSS AMOUNT	TIPS/COMMISSION	HOURS WORKED	
1st				
2nd				
3rd				
4th				
5th				
Next month's expected work income	GROSS INCOME	EXPECTED TIPS/COMMISSION	TOTAL INCOME	EXPECTED HOURS

Comments/verification (Question 15):

Verification: ☐ requested ☐ attached

#2 This month's work income	NAME		JOB BEGIN DATE	
EMPLOYER NAME		EMPLOYER ADDRESS		
HOW OFTEN PAID? <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Biweekly <input type="checkbox"/> Semimonthly <input type="checkbox"/> Other _____		PAY RATE	# HOURS PER WEEK	DATE LAST CHECK REC'D
DATE CHECK RECEIVED	GROSS AMOUNT	TIPS/COMMISSION	HOURS WORKED	
1st				
2nd				
3rd				
4th				
5th				
Next month's expected work income	GROSS INCOME	EXPECTED TIPS/COMMISSION	TOTAL INCOME	EXPECTED HOURS

Does the household have other sources of income from a job? ☐ Yes ☐ No

Comments/verification:

Verification: ☐ requested ☐ attached

**16. Does anyone in the household self-employed or does anyone expect to get income from self-employment this month or next month?**

If Yes, complete:

**BUSI, RBIC**

PERSON'S NAME		DATE SELF-EMPLOYMENT BEGAN	HOURS WORKED PER MONTH
KIND OF BUSINESS		OWNERSHIP <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation	
This month	GROSS INCOME	AMOUNT OF EXPENSES	
Last calendar year	GROSS INCOME	AMOUNT OF EXPENSES	

Does the client have other sources of self-employment income? ☐ Yes ☐ No

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

Comments/verification (Question 16):

Verification: ☐ requested ☐ attached

17. Do you expect any changes in income, expenses or work hours?

EXPLAIN:

18. Has **anyone** in the household applied for or does anyone get any unearned income?

If Yes, complete:

PBEN, UNEA

TYPE OF UNEARNED INCOME		AMOUNT OF LAST CHECK RECEIVED	PERSON WHO RECEIVED CHECK	DATE STARTED	DATE STOPPED
Social Security (RSDI)					
Supplemental Security Income (SSI)					
Veteran benefits (VA)					
Unemployment Insurance					
Workers' Compensation					
Retirement benefits					
Child support or spousal support					
Other unearned income such as: contract for deed, interest/dividends, rental, gifts or loans, sponsor's income (for non-citizens), lump sums, gambling winnings, annuities, trusts	(list type of other income)				

Comments/verification:

Verification: ☐ requested ☐ attached



19. Does **anyone** in the household have or expect to get any loans, scholarships or grants for attending school?

If Yes, complete:

STIN

Comments/verification:

Verification: ☐ requested ☐ attached

## Expenses

20. Does **your household** have the following housing expenses?

If Yes, complete:

SHEL, EATS

TYPE OF HOUSING EXPENSE	AMOUNT OF HOUSING EXPENSE	PERSON BILLED	IF SHARED, HOW MUCH DOES EACH PERSON PAY?
Rent (include mobile home lot rental)			
Mortgage/contract for deed payment			
Association fees			
Homeowner's insurance (if not included in mortgage)			
Real estate taxes (if not included in mortgage)			
Room and/or meals			

Is the client billed for garage rent? ☐ Yes ☐ No

Does the client live in **subsidized** housing? ☐ Yes ☐ No

Does the client expect a change in housing costs? ☐ Yes ☐ No

When? \_\_\_\_\_ What? \_\_\_\_\_

Are housing costs shared with anyone? ☐ Yes ☐ No

Who? \_\_\_\_\_ What cost(s)? \_\_\_\_\_

Comments/verification:

Verification: ☐ requested ☐ attached

**21. Does your household** have the following utility expenses **any time** during the year?

If Yes, complete:

**ACUT, HEST**

TYPE OF UTILITY EXPENSE	AMOUNT OF BILL	PERSON BILLED	HOW MUCH DOES EACH PERSON PAY?
Heating and/or A/C			
Electricity			
Cooking fuel			
Garbage removal			
Water and sewer			
Phone			

Does the client have central or window air conditioning in their home?

☐ Yes ☐ No

If yes, do they ever use it?

☐ Yes ☐ No

Is household responsible to pay A/C costs?

☐ Yes ☐ No

Does the client want Food Support benefits figured using the standard or actual utility amounts?

☐ Standard utility amount **or** ☐ Actual utility costs

Does client get Low Income Home Energy Assistance Program (LIHEAP) funds?

☐ Yes ☐ No

Comments/verification:

Verification: ☐ requested ☐ attached

**22. Child or adult care: Do you or anyone living with you** have costs for care of a child or an ill or disabled adult because you or they were working, looking for work or going to school? If Yes, complete:

**DCEX**

NAME OF PERSON GETTING CARE	AMOUNT CLIENT PAID FOR CURRENT MONTH	AMOUNT PAID BY SOMEONE ELSE FOR CURRENT MONTH	NAME OF PERSON GIVING CARE
1.			
2.			
3.			
4.			

Comments/verification:

Verification: ☐ requested ☐ attached

**23. Does anyone in the household pay court-ordered child support, spousal support, child care support, medical support or contribute to a tax dependent who does not live in your home?**

If Yes, complete:

**COEX**

NAME OF PERSON MAKING PAYMENT	TYPE OF PAYMENT	MONTHLY AMOUNT

Comments/verification:

Verification: ☐ requested ☐ attached

**24. Does anyone in the household have expenses related to work, training or job search, such as transportation, meals or uniforms?**

If Yes, complete:

**WKEX**

Comments/verification:	Verification: <input type="checkbox"/> requested <input type="checkbox"/> attached
------------------------	--

**25a. Does anyone in your household currently have health insurance or prescription drug coverage?**

If Yes, complete:

**INSA**

Has anyone had coverage in the past 4 months?

☐ Yes ☐ No If yes:

NAME	KIND OF COVERAGE

Does anyone in client's household work for an employer who currently offers health insurance or has offered health insurance in the past?

☐ Yes ☐ No If yes:

NAME	KIND OF COVERAGE

If any member of the household is a college student, can they get health insurance through their parents or through the school?

☐ Yes ☐ No If yes:

NAME	KIND OF COVERAGE

Comments/verification:

**25b.** Does **anyone in** your household have Medicare Part A, B or D?

If Yes, complete:

**MEDI**

NAME	MEDICARE ID NUMBER	START DATE

Comments/verification:

**26.** Proof of medical expenses:

**FMED, BILS**

**Food Support** applicants or recipients: Before allowing a medical deduction, request proof of all recurring medical bills incurred by anyone in client's household who is disabled or 60 years or older. Do not count medical bills that are being paid for by any health care program, insurance or someone not living in client's household.

**Health care program** applicants or recipients: Some health care programs may pay for health care the client received up to three months before client applied for help. Request proof of any medical bills the client or any household member incurred in the last three months.

What month would client like health care coverage to start?

Comments/verification:

Verification: ☐ requested ☐ attached

Client given:

☐ R & R (tear off page on CAF)

☐ Notice of Privacy Practices (DHS-3979)

☐ ADA brochure (DHS-4133)

☐ Family Violence Referral (DHS-3323)

☐ Change Report Form (DHS-2402)

☐ Important Information sheet (DHS 5223B)

☐ Domestic Violence Information Brochure (DHS-3477)

### Program eligibility summary

PERSON #	CASH	FOOD SUPPORT	HEALTH CARE	OTHER	COMMENTS
1					
2					
3					
4					
5					
6					
7					
8					

# Combined Application Form

## Important Information

### Social Security numbers

You must provide a Social Security number (SSN) for each household member applying for benefits.\* If you need a SSN we can help you apply for one. The State uses your SSN:

- To check identity, prevent duplicate participation and to make mass changes
- To determine eligibility and benefit levels for programs such as Food Support, family cash assistance, health care programs and the school lunch program
- For program reviews and audits to determine household eligibility, including fraud investigations
- To coordinate with other programs or state agencies to provide more effective and meaningful services to you.

If you are not a U.S. citizen and are applying for emergency health care coverage only, you do not have to provide a SSN.

\* (Food Stamp Act of 1977 as amended by PL 97-98 and the Social Security Act of 1935 [section 1137] as amended by PL 98-369)

### Family cap information

If you or someone else in your family has a child while getting cash assistance, your family may not get more cash for that child. If you have questions, talk to your worker.

### Important information for non-citizen applicants

To get help from most public assistance programs, you must be in the United States (U.S.) legally. Members of your household who are not citizens and are applying for help must show proof of their immigration status. Give a copy of both sides of immigration cards or other documents that show immigration status for every household member who is not a U.S. citizen and is applying for help. (If you are applying only for emergency health care services, you do not need to give us information about your immigration status. Non-immigrant or undocumented people who are pregnant, under age 18, age 65 and older or people with disabilities, may also be eligible without providing immigration information.) You can apply and get help for eligible household members, even if your household includes other members who are not eligible because of immigration status.

For members of your household who apply and are eligible for help, your worker may do a computer match with the U.S. Citizenship and Immigration Services (USCIS) to confirm their immigration status.

Federal law allows the county agency to give information about your immigration status to the USCIS. We will only share information with the USCIS about people in your household who apply for help.

If you get cash or long-term care institutional benefits (e.g., nursing home care), it may affect changes to your immigration status. If you would like more information about this or would like to know what the county might tell or ask the USCIS, talk to your worker.

### Immigration

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

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

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

### Proof of citizenship or national status

(Required for health care programs)

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.

Proof can be one of the following:

- U.S. passport
- Certificate of Naturalization
- Certificate of U.S. Citizenship If you do not have or cannot get these items, ask your worker for help right away.

## Family/domestic violence

Domestic violence is what someone says or does over and over again to make you feel afraid or to control you. The following are some examples of domestic violence:

- Swearing or screaming at you
- Threatening to hurt you or others you care about
- Calling you names
- Not letting you leave your house
- Forcing you to have sex
- Stalking you
- Choking, grabbing, hitting, pushing or kicking you.

For more information on domestic violence, ask your worker for the Domestic Violence Information brochure (DHS-3477). **If domestic violence makes it hard for you to follow program rules, talk to your worker.** If you are in danger from domestic violence and need help, call the National Domestic Abuse hotline at (800) 799-7233 (TTY/TDD: (800) 787-3224) or Minnesota Coalition for Battered Women at (800) 289-6177.

## Liens and estate claims

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

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

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

Liens can be set up against:

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

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

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

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

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

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

## Denial or changes

The State may deny or change your cash assistance, Food Support and/or health care because of information you give on this form. The State may make changes without giving you 10 days advance notice. The State will send you written notice no later than the effective date of the change for cash assistance and health care or no later than the date you receive or would receive your food support benefits.

## Interim aid programs

General Assistance (GA) and/or Group Residential Housing (GRH) are interim aid programs. In order to receive aid you must apply for other benefits for which you may be eligible, such as Social Security or Worker's Compensation. If you receive other aid for the same period of time that you received GA or GRH, you must repay the GA or GRH.

## Food Support Nutrition Education Program

The University of Minnesota Extension Food Support Nutrition Education Program can help you with ideas to:

- Make quick and healthy meals for you and your family
- Save money at the grocery store
- Get your kids to eat more fruits and vegetables.

Your local county extension service provides nutrition classes or home visits. Call (612) 625-8260 or visit [www.extension.umn.edu](http://www.extension.umn.edu) for the contact person and programs in your county.

## Minnesota's WorkForce centers

Minnesota's WorkForce centers are "one-stop shops" for all employment and training needs. Job seekers, employers, and those with special needs can visit any one of the WorkForce centers across the state. Call the office nearest you: (888) GET JOBS/(888) 438-5627.

## Tax refund Information

Your worker can tell you where you can get free help to file your tax forms for this year and prior years. There are different types of tax refunds you may be able to get. For example, if you worked and had low income, you may qualify for the Earned Income Tax Credit (EITC). If you are a renter, you do not have to have worked to qualify for a renter's credit. **Getting a tax refund will not affect your eligibility for public assistance benefits.**