Clear Form Data

FILLABLE FORM

DHS-5223A-ENG 1-08

Minnesota Department of Human Services

Worker Interview Form

APPLICANT'S LEGAL NAME		CASE NUMBER
DATE APPLICATION SIGNED	DATE OF INTERVIEW	INTERVIEWER NAME
INTERPRETER USED? ☐ Yes ☐ No If yes, ☐ Client provided ☐ County provided		WORKER NAME

Applicant eligible for Expedited Food Support benefits? ☐ Yes ☐ No

Comments/verification: *Same day interview offered?* ☐ *Yes* ☐ *No* *Client declined?* ☐ *Yes* ☐ *No*

Household composition:

MEMB, MEMI TYPE, PROG, SPON,

NAME	PROGRAMS APPLYING FOR	INTENDS TO RESIDE IN MN	IF NOT A UNITED STATES CITIZEN	
			IMMIGRATION STATUS	SPONSOR
PERSON #1	☐ None ☐ Cash ☐ Food support ☐ Emergency ☐ Health care	☐ Yes ☐ No		☐ Yes ☐ No
PERSON #2	☐ None ☐ Cash ☐ Food support ☐ Emergency ☐ Health care	☐ Yes ☐ No		☐ Yes ☐ No
PERSON #3	☐ None ☐ Cash ☐ Food support ☐ Emergency ☐ Health care	☐ Yes ☐ No		☐ Yes ☐ No
PERSON #4	☐ None ☐ Cash ☐ Food support ☐ Emergency ☐ Health care	☐ Yes ☐ No		☐ Yes ☐ No
PERSON #5	☐ None ☐ Cash ☐ Food support ☐ Emergency ☐ Health care	☐ Yes ☐ No		☐ Yes ☐ No
PERSON #6	☐ None ☐ Cash ☐ Food support ☐ Emergency ☐ Health care	☐ Yes ☐ No		☐ Yes ☐ No
PERSON #7	☐ None ☐ Cash ☐ Food support ☐ Emergency ☐ Health care	☐ Yes ☐ No		☐ Yes ☐ No
PERSON #8	☐ None ☐ Cash ☐ Food support ☐ Emergency ☐ Health care	☐ Yes ☐ No		☐ Yes ☐ 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
			☐ Part time ☐ Full time
			☐ Part time ☐ Full time
			☐ Part time ☐ Full time
			☐ Part time ☐ Full time
			☐ Part time ☐ Full time
			☐ Part time ☐ 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
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ 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 **CASH**			
Accounts such as checking, savings, debit cards, money market, trust funds, annuities, certificates of deposit (CD), retirement funds **ACCT**	*Type(s):*		
Stocks, bonds, annuities, contracts for deed or other securities **SECU**			
Life insurance or burial accounts **SECU, OTHR**			
Vehicles such as cars, trucks, campers, motorcycles *(specify make/model/year)* **CARS**			
Other assets such as tools, livestock, boats, motors, trailers, farm implements, snowmobiles **OTHR**			
Land, buildings, life estates, houses, mobile homes **REST**			
Sponsor's assets (if client is not a U.S. citizen) **SPON**			

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? ☐ Daily ☐ Weekly ☐ Biweekly ☐ Semimonthly ☐ 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? ☐ Daily ☐ Weekly ☐ Biweekly ☐ Semimonthly ☐ 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 ☐ Individual ☐ Partnership ☐ 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:* ☐ *requested* ☐ *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					