#08-01-02

Bulletin

May 28, 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
- MinnesotaCare Operations

ACTION/DUE DATE

June 2, 2008

EXPIRATION DATE

May 28, 2010

DHS Issues New Combined Application and Procedures

TOPIC

A new Combined Application Form (CAF) and procedures to comply with state statute.

PURPOSE

To describe the new CAF and explain application processing procedures.

CONTACT

Questions related to this bulletin should be directed to Policy Quest. Questions related to Health Care programs should be directed to HealthQuest.

SIGNED

CHARLES E. JOHNSON
Assistant Commissioner
Children and Family Services

BRIAN J. OSBERG
Assistant Commissioner
Health Care Administration

I. Background:

In 2007, the Minnesota Legislature passed a law requiring the Department of Human Services, in consultation with counties and advocates, to develop a new application form and process for the Food Support program. The aim was to reduce the size and complexity of the form for applicants.

A work group consisting of DHS staff, advocates, county supervisors and managers, and literacy experts decided to retain the Combined Application concept, and designed a new, simplified Combined Application Form (CAF) (DHS-5223.) The group also developed a Worker Information Form (WIF) (DHS-5223A) for recording information gathered in client interviews, and a Combined Application Form Important Information sheet (DHS-5223B.) These forms will be used for all of the programs that the current CAF is used for. The new forms and process were tested in four counties in February and March, 2008. The results of the test and feedback from financial workers were used to revise and finalize the forms.

Along with the development of a new Combined Application Form a new CAF Addendum (DHS-5223C) and the CAF Child Care Addendum (DHS-5223D) have been developed that are laid out consistently with the DHS-5223 format.

Copies of the new forms are attached to this bulletin.

II. Organization of the forms and process:

The new CAF is 12 pages long (vs. 24 pages). Essential questions about emergency needs, authorized representatives, and household composition information are on pages 1 to 3 of the CAF. The primary questions from the old CAF (DHS-3469) that can be answered with a "yes/no" response are included on pages 4 and 5. The remainder of the pages include required information, warnings, and signature blocks. Additional useful information from the old CAF has been moved to a separate two-sided CAF Important Information sheet that must be given to the applicant in the application packet. The Worker Interview Form (WIF) is a twelve-page document designed for use by financial workers to record information gathered in the application interviews. Each numbered question on the CAF has a corresponding question on the WIF with structured spaces and open writing space to record information.

The client fills out the information on the CAF (DHS-5223), and is then interviewed for cash and food programs using procedures established by each county for its own financial workers. Health Care programs do not require in-person interviews. (Do not delay eligibility determinations for health care programs to schedule in-person interviews required by cash or food programs.) Information from the interview must be recorded on the WIF in sufficient detail for other workers, supervisors, and other reviewers to follow the application process and the accuracy of worker decisions. Supervisors should establish agency standards, requirements, and guidelines they deem necessary for workers to achieve an accurate determination of eligibility and benefits. For questions to which the client has responded "no" on the CAF, workers only

need to ask sufficient questions to confirm the client's responses. If a question on income is answered "yes, and there is verification in the file, it is sufficient to check the box provided labeled "verification attached," or to write in "see attached."

Documents listed in the "Client given" blue space on the last page of the WIF must given to the applicant at the interview.

If the application is transferred to another county agency or to state MinnesotaCare Operations, send both the CAF and the WIF.

III. Pilot tests:

DHS conducted a pilot test in four counties in February and March, comprising about 1300 interviews, to track the time required for interviews using the old and new CAFs, and to solicit feedback and suggestions for improvement of the forms and process. Interviews using the new forms did take longer than those using the old forms, but the pilot demonstrated that there was substantial improvement with practice. By the end of the pilot, workers who used both old and new forms took only about three minutes longer for interviews using the new forms.

Participants in the pilot tests provided many valuable suggestions and comments which were incorporated into the forms.

IV. Rollout:

The new forms will be printed by late May, and initial supplies shipped to all counties by June. The Issuance Operations Center (IOC) will send out recertification packets in June using the DHS-3469 (old CAF) in order to use up existing supplies. Subsequent mailings from the IOC will send out the new form. Also in the interest of avoiding waste, counties may, at their discretion, use up existing supplies of the old forms.

Any application made using the old forms must be accepted. Under no circumstances may a client be required to fill a new DHS-5223 in addition to an old DHS-3469.

The new forms will be available on E-docs by June 1. The DHS-3469 will be removed from eDocs in June, after the new DHS-5223/5223A/5223B are posted. The forms will be fillable on-line, and workers will be able to save the completed form to their computers/county networks if they have Adobe Reader 7.0 or a later version. This is especially important for workers who choose to complete the WIF on-line as a part of the interview so they do not lose what they have completed if there is a power issue during the interview process. Workers can maintain the completed WIF electronically and/or as a printed form in the clients file as long as the form is available to anyone who needs access to review the case.

The new forms are now being translated into Spanish, Somali, Russian, and Vietnamese, the four most frequently used non-English languages. Translations of the old CAF (DHS-3469) will

remain on eDocs until the new translations are available.
When the new forms are added to eDocs, they will be available at the following links:

Combined Application Form (DHS-5223)
http://edocs.dhs.state.mn.us/lfserver/Legacy/DHS-5223-ENG

Worker Interview Form (DHS-5223A)
http://edocs.dhs.state.mn.us/lfserver/Legacy/DHS-5223A-ENG

CAF Important Information sheet (DHS-5223B)
http://edocs.dhs.state.mn.us/lfserver/Legacy/DHS-5223B-ENG

Combined Application - Addendum (DHS-5223C)
http://edocs.dhs.state.mn.us/lfserver/Legacy/DHS-5223C-ENG

Combined Application - Child Care Addendum (DHS-5223D)
http://edocs.dhs.state.mn.us/lfserver/Legacy/DHS-5223D-ENG

Special Needs
This information is available in other forms to people with disabilities by contacting Aaron Coonce at (651)431-4049 (voice). TDD users can call the Minnesota Relay at 711 or (800) 627-3529. For the Speech-to-Speech Relay, call (877) 627-3848.

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, instructions 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 additional people.
- For recertifications report **all** changes in the past 12 months.
- The county human services agency will use this form 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 បើអ្នកចង់បានជំនួយបកប្រែពត៌មាននេះដោយមិនគិតថ្លៃ សូមសួរអ្នកកាន់សំណុំរឿងរបស់អ្នក ឬ ទូរស័ព្ទទៅលេខ 1-888-468-3787 ។

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

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

ໂປດຊາບ. ຖ້າຫາກທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປຂໍ້ຄວາມດັ່ງກ່າວນີ້ຟຣີ, ຈົ່ງຖາມນຳພນັກງານຊ່ວຍວຽກຂອງທ່ານຫຼືໂທຣ ຫາຕາມເລກໂທຣ 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.

LB2-0009 (1-08)

This information is available in alternative formats to individuals with disabilities by calling your county worker. TTY users can call through Minnesota Relay at (800) 627-3529. For Speech-to-Speech, call (877) 627-3848. For additional assistance with legal rights and protections for equal access to human services benefits, contact your agency's ADA coordinator.

Clear Form Data
FILLABLE FORM

(Tear off here)

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 1 and 2). We must have the complete form to decide if you can get help. **Print in black or dark blue ink.**

CASE NUMBER

1. APPLICANT'S LEGAL NAME (last/first/middle)	OTHER NAMES YOU USE (maiden name, nickname, etc.)
ADDRESS WHERE YOU LIVE (If you do not have an address, write "homeless.")	SOCIAL SECURITY NUMBER

CITY	COUNTY	STATE	ZIP CODE

PHONE NUMBER WHERE YOU CAN BE REACHED (include area code)	HOW MANY PEOPLE LIVE IN YOUR HOUSEHOLD?
Home Other	Adults _____ Children _____

DO YOU LIVE ON A RESERVATION?
☐ Yes ☐ No If yes, which one?_____

DO YOU NEED AN INTERPRETER?	WHAT IS YOUR PREFERRED SPOKEN LANGUAGE?	WHAT IS YOUR PREFERRED WRITTEN LANGUAGE?
☐ Yes ☐ No		

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.

☐ Yes ☐ No **1.** Has anyone in the household ever received public assistance, commodities or food support benefits before? **If yes:**
When? Where? What?

☐ Yes ☐ No **2a.** Did all of your household **income recently stop? If yes,**
When?

2b. How much income (cash or checks) did or will your household get **this month?**

☐ Yes ☐ No **3.** Did anyone in your household **quit a job in the last 60 days**? **If yes,**
Employer name?
Dates of employment? From to

☐ Yes ☐ No **4.** Does your family expect a **change in income**? **If yes,**
When?

5. How much does your household (including children) have in **cash, checking or savings**?
$

6. How much does your household pay for: **Rent/mortgage?** $
Utilities? $

☐ Yes ☐ No **7.** Is anyone in your household a **migrant or seasonal farm worker**?

☐ Yes ☐ No **8.** Is anyone in your household **pregnant**?

☐ Yes ☐ No **9.** Do you need help now because of a medical or other **emergency?**

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

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?	HOW OFTEN?
	☐ Yes ☐ No If yes, amount? _____	

Principal Wage Earner (PWE). Food Support households with children must designate the person they want as the PWE. Any adult in your Food Support household can be the PWE. Talk to your worker before designating the Food Support PWE.

DESIGNATED PWE	SIGATURE OF APPLICANT

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:

☐ Personal or family problems
☐ Family/domestic violence
☐ Chemical dependency
☐ Mental health issues
☐ Family planning information
☐ Learning disability
☐ Special needs children
☐ A language barrier
☐ Child care
☐ Transportation
☐ Food shelves
☐ Child support
☐ Applying/interviewing for programs
☐ Housing assistance
☐ Veteran services
☐ Help with budgeting or bad credit
☐ **Free** help filing your taxes
☐ 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 and/or 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 fetus as "unborn child" and the due date. *For more than five 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

PERSON 1 APPLICANT'S LEGAL NAME (last/first/middle) | OTHER NAMES | SEX ☐ M ☐ F | RELATIONSHIP TO YOU **SELF**

BIRTH DATE (mm/dd/yy) | MARITAL STATUS | SOCIAL SECURITY NUMBER | DATE MOST RECENTLY MOVED TO MINNESOTA (mm/dd/yy)

ETHNICITY (optional) Hispanic? ☐ Yes ☐ No | RACE (optional) | U.S. CITIZEN OR U.S. NATIONAL? ☐ Yes ☐ No | LIST CITY, STATE AND COUNTRY OF BIRTH

WHAT PROGRAMS IS THIS PERSON APPLYING FOR? ☐ Cash ☐ Food Support ☐ Emergency help ☐ Health care ☐ None | LAST SCHOOL GRADE COMPLETED

PERSON 2 LEGAL NAME (last/first/middle) | OTHER NAMES | SEX ☐ M ☐ 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? ☐ Yes ☐ No | RACE (optional) | U.S. CITIZEN OR U.S. NATIONAL? ☐ Yes ☐ No | LIST CITY, STATE AND COUNTRY OF BIRTH

WHAT PROGRAMS IS THIS PERSON APPLYING FOR? ☐ Cash ☐ Food Support ☐ Emergency help ☐ Health care ☐ None | LAST SCHOOL GRADE COMPLETED

PERSON 3 LEGAL NAME (last/first/middle) | OTHER NAMES | SEX ☐ M ☐ 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? ☐ Yes ☐ No | RACE (optional) | U.S. CITIZEN OR U.S. NATIONAL? ☐ Yes ☐ No | LIST CITY, STATE AND COUNTRY OF BIRTH

WHAT PROGRAMS IS THIS PERSON APPLYING FOR? ☐ Cash ☐ Food Support ☐ Emergency help ☐ Health care ☐ None | LAST SCHOOL GRADE COMPLETED

PERSON 4 LEGAL NAME (last/first/middle) | OTHER NAMES | SEX ☐ M ☐ 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? ☐ Yes ☐ No | RACE (optional) | U.S. CITIZEN OR U.S. NATIONAL? ☐ Yes ☐ No | LIST CITY, STATE AND COUNTRY OF BIRTH

WHAT PROGRAMS IS THIS PERSON APPLYING FOR? ☐ Cash ☐ Food Support ☐ Emergency help ☐ Health care ☐ None | LAST SCHOOL GRADE COMPLETED

PERSON 5 LEGAL NAME (last/first/middle) | OTHER NAMES | SEX ☐ M ☐ 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? ☐ Yes ☐ No | RACE (optional) | U.S. CITIZEN OR U.S. NATIONAL? ☐ Yes ☐ No | LIST CITY, STATE AND COUNTRY OF BIRTH

WHAT PROGRAMS IS THIS PERSON APPLYING FOR? ☐ Cash ☐ Food Support ☐ Emergency help ☐ Health care ☐ None | LAST SCHOOL GRADE COMPLETED

☐ Yes ☐ No **1.** Is there **anyone** in your household who does not buy, fix or eat food with you?

☐ Yes ☐ No **2.** Is **anyone** in the household, who is age 60 or over or disabled, unable to buy or fix food due to a disability?

☐ Yes ☐ No **3.** Is **anyone** in the household attending school?

☐ Yes ☐ No **4.** Is **anyone** in your household temporarily not living in your home? (for example: vacation, foster care, treatment, hospital, job search)

☐ Yes ☐ No **5.** Did **anyone** move in or out of your home in the past 12 months?

☐ Yes ☐ No **6.** Is **either** parent of any child under age 19 dead or not living in the home?

☐ Yes ☐ No **7.** Is **anyone** mentally or physically ill, disabled or not able to care for themselves?

☐ Yes ☐ No **8.** Is **anyone** unable to work for reasons other than illness or disability?

☐ Yes ☐ No **9.** In the last 90 days did **anyone** in the household:
- Stop working or quit a job?
- Ask to work fewer hours?
- Refuse a job offer?
- Go on strike?

☐ Yes ☐ No **10.** Has **anyone** in the household been injured or had an accident in the past 72 months?

☐ Yes ☐ No **11.** Is **anyone** in the household on a diet prescribed by a doctor?

What do you own?

Check yes or no for each item.

12. Does **anyone** in the household own, or is **anyone** buying, any of the following?

☐ Yes ☐ No Cash
☐ Yes ☐ No Bank accounts (savings, checking, etc.)
☐ Yes ☐ No Life or burial insurance
☐ Yes ☐ No Vehicles (cars, trucks, motorcycles, etc.)
☐ Yes ☐ No Stocks, bonds, annuities, etc.
☐ Yes ☐ No Real estate property (house, land, etc.)
☐ Yes ☐ No Other assets (tools, boats, livestock, etc.)

☐ Yes ☐ No **13.** Has **anyone** in the household given away, sold or traded anything of value **in the past 60 months?** (for example: real estate property, bank accounts, annuities, vehicles, etc.)
Note: Include any transfers made by a spouse not living with you.

What kinds of income do you have?

☐ Yes ☐ No **14.** Has **anyone** in the household had a job or been self-employed in the past 12 months?

☐ Yes ☐ No **15.** Does **anyone** in the household have a job or expect to get income from a job this month or next month?
Note: Include income from Work Study and paid internships.
Include free benefits or reduced expenses received for work (shelter, food, clothing, etc.).

☐ Yes ☐ No **16.** Is **anyone** in the household self-employed or does anyone expect to get income from self-employment this month or next month? Examples:
- Product sales
- Paper route
- Property rental
- Crop Reserve Program (CRP)
- In-home day care
- Taxi driver
- Personal services
- Roomers/boarders
- Other
- Farming

☐ Yes ☐ 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?

☐ Yes	☐ No	Social Security (RSDI)	☐ Yes	☐ No	Supplemental Security Income (SSI)
☐ Yes	☐ No	Veteran benefits (VA)	☐ Yes	☐ No	Unemployment Insurance
☐ Yes	☐ No	Workers' Compensation	☐ Yes	☐ No	Retirement benefits
☐ Yes	☐ No	Tribal payments	☐ Yes	☐ No	Child support or spousal support
☐ Yes	☐ 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?

- ☐ Yes ☐ No Rent (include mobile home lot rental)
- ☐ Yes ☐ No Mortgage/contract for deed payment
- ☐ Yes ☐ No Association fees
- ☐ Yes ☐ No Homeowner's insurance (if not included in mortgage)
- ☐ Yes ☐ No Real estate taxes (if not included in mortgage)
- ☐ Yes ☐ 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?

☐ Yes	☐ No	Heating/air conditioning	☐ Yes	☐ No	Garbage removal
☐ Yes	☐ No	Electricity	☐ Yes	☐ No	Water and sewer
☐ Yes	☐ No	Cooking fuel	☐ Yes	☐ 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?

Bring proof of medical expenses.

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, food support or health care benefits, you must follow the rules listed below. The state may bar household members who break any of these rules from the cash, Food Support or Minnesota Health Care programs. The bar lasts one year for the first fraud, two years for the second fraud and is permanent for the third fraud. The months you are barred from MFIP for breaking the rules may count toward your 60-month lifetime limit.

- **Do not give false information** or hide information to get or continue to get cash, food support or medical benefits. 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.
- **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 help others get medical services** that you know they should not get.
- **Do not use someone else's EBT access cards or health care membership cards** to get cash, food support or medical benefits for your household.

The maximum penalty is a fine of $250,000 or a jail term of 20 years, or both.

Special Food Support penalty warning: If a federal, state or local court finds you or any household member guilty of giving or receiving food support benefits in exchange for:

- **Controlled substances,** that household member will be barred from getting Food Support for 12 months for the first offense and permanently for the second offense.
- **Firearms, ammunition or explosives,** that household member will be barred from getting Food Support permanently.

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 NO.	HOUSEHOLD MEMBER	QUESTION NO.	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 redisclose the information.

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 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)

By signing below:

- I understand if I give incorrect information or misuse an electronic benefits transfer (EBT) card, I may be prosecuted for fraud. (Minn. Stat. 256.98 and 609.821)
- I acknowledge that 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.
- 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" sheet (DHS-5223B) given with this application.

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:

PERSON 6 LEGAL NAME (last/first/middle)	OTHER NAMES	SEX ☐ M ☐ 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? ☐ Yes ☐ No / RACE (optional)	U.S. CITIZEN OR U.S. NATIONAL? ☐ Yes ☐ No	LIST CITY, STATE AND COUNTRY OF BIRTH	
WHAT PROGRAMS IS THIS PERSON APPLYING FOR? ☐ Cash ☐ Food Support ☐ Emergency help ☐ Health care ☐ None			LAST SCHOOL GRADE COMPLETED

PERSON 7 LEGAL NAME (last/first/middle)	OTHER NAMES	SEX ☐ M ☐ 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? ☐ Yes ☐ No / RACE (optional)	U.S. CITIZEN OR U.S. NATIONAL? ☐ Yes ☐ No	LIST CITY, STATE AND COUNTRY OF BIRTH	
WHAT PROGRAMS IS THIS PERSON APPLYING FOR? ☐ Cash ☐ Food Support ☐ Emergency help ☐ Health care ☐ None			LAST SCHOOL GRADE COMPLETED

PERSON 8 LEGAL NAME (last/first/middle)	OTHER NAMES	SEX ☐ M ☐ 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? ☐ Yes ☐ No / RACE (optional)	U.S. CITIZEN OR U.S. NATIONAL? ☐ Yes ☐ No	LIST CITY, STATE AND COUNTRY OF BIRTH	
WHAT PROGRAMS IS THIS PERSON APPLYING FOR? ☐ Cash ☐ Food Support ☐ Emergency help ☐ Health care ☐ None			LAST SCHOOL GRADE COMPLETED

(Tear off here)

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 file a privacy complaint.
  - 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 your public assistance application or benefits because of race, color, national origin, political beliefs, religion, creed, sex, sexual orientation, public assistance status, age or disability, including physical access to government buildings, you may file a complaint with your county agency or any of the following agencies.

Minnesota Department of Human Services
Office for Equal Opportunity
PO Box 64997
St. Paul, MN 55164-0997
(651) 431-3040 (Voice)
(866) 786-3945 (TTY)

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

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)
(312) 353-5693 (TTY)

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

Clear Form Data
FILLABLE FORM

DHS-5223A-ENG 5-08

Minnesota Department of Human Services

Worker Interview Form

APPLICANT'S LEGAL NAME		CASE NUMBER
DATE APPLICATION RECEIVED	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: *Verification:* ☐ *requested* ☐ *attached*

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: *Verification:* ☐ *requested* ☐ *attached*

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: *Verification:* ☐ *requested* ☐ *attached*

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: *Verification:* ☐ *requested* ☐ *attached*

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: *Verification:* ☐ *requested* ☐ *attached*

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: *Verification:* ☐ *requested* ☐ *attached*

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. In 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, 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

First job: This month's work income	NAME			JOB START DATE
EMPLOYER NAME	EMPLOYER ADDRESS			
HOW OFTEN PAID? ☐ Daily ☐ Weekly ☐ Biweekly ☐ Semimonthly ☐ Other _____	PAY RATE	NO. 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*

Second job: This month's work income	NAME		JOB START DATE
EMPLOYER NAME	EMPLOYER ADDRESS		
HOW OFTEN PAID? ☐ Daily ☐ Weekly ☐ Biweekly ☐ Semimonthly ☐ Other _____	PAY RATE	NO. 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. Is **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? If yes, complete:

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 air conditioning			
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 air conditioning 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, complete:

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, complete:

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, complete:

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 the 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 the client like health care coverage to start?

Comments/verification: *Verification:* ☐ *requested* ☒ *attached*

Client given:
- ☐ R and R (tear off page on CAF)
- ☐ Family Violence Referral (DHS-3323)
- ☐ Domestic Violence Information brochure (DHS-3477)
- ☐ Notice of Privacy Practices (DHS-3979)
- ☐ Change Report Form (DHS-2402)
- ☐ ADA brochure (DHS-4133)
- ☐ Important Information sheet (DHS-5223B)

Program eligibility summary

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

Minnesota Department of Human Services

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 an 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 might 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: (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 children 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 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.**

Combined Application - Addendum
(Cash, Food Support and Health Care)

CASE NAME	FINANCIAL WORKER NAME
CASE NUMBER	FINANCIAL WORKER PHONE NUMBER

Instructions: Use this form to add people to existing cash, Food Support and health care assistance units after the initial application has been processed. **All questions refer to the person(s) being added.**

- If you are not applying for help for a person, you do not have to give a Social Security number for that person.
- Use these codes to complete MARITAL STATUS and RACE fields for each person.

Marital Status: (choose one) **N** = Never married **M** = Marred 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

Person 1:

NAME *(Last, first, middle)*			OTHER NAMES
SEX ☐ M ☐ F	BIRTH DATE	RELATIONSHIP TO YOU	MARITAL STATUS *(see codes above)* ☐ N ☐ M ☐ S ☐ L ☐ D ☐ W
ETHNICITY *(optional)* Hispanic? ☐ Yes ☒ No	RACE *(optional) (see codes above)* ☐ N ☐ A ☐ B ☐ P ☐ W		LIST CITY, STATE AND COUNTRY OF BIRTH
DATE MOST RECENTLY MOVED INTO YOUR HOME *(mm/dd/yy)*	SOCIAL SECURITY NUMBER		LAST SCHOOL GRADE COMPLETED

WHAT PROGRAMS IS THIS PERSON APPLYING FOR?
☐ Cash ☐ Food Support ☐ Emergency help ☐ Health care ☐ None

Does this person(s) buy, fix *or* eat food with you? ☐ Yes ☐ No
Note: Answer yes for minor children unless they have children of their own.

Person 2:

NAME (LAST, FIRST, MIDDLE)			OTHER NAMES
SEX ☐ M ☐ F	BIRTH DATE	RELATIONSHIP TO YOU	MARITAL STATUS *(see codes above)* ☐ N ☐ M ☐ S ☐ L ☐ D ☐ W
ETHNICITY *(optional)* Hispanic? ☐ Yes ☐ No	RACE *(optional) (see codes above)* ☐ N ☐ A ☐ B ☐ P ☐ W		LIST CITY, STATE AND COUNTRY OF BIRTH
DATE MOST RECENTLY MOVED INTO YOUR HOME *(mm/dd/yy)*	SOCIAL SECURITY NUMBER		LAST SCHOOL GRADE COMPLETED

WHAT PROGRAMS IS THIS PERSON APPLYING FOR?
☐ Cash ☐ Food Support ☐ Emergency help ☐ Health care ☐ None

Does this person(s) buy, fix *or* eat food with you? ☐ Yes ☐ No
Note: Answer yes for minor children unless they have children of their own.

1. Is this person a U.S. citizen or U.S. national? ☐ Yes ☐ No
If no, complete the section below for that person.
Note: Read the "Important Information for Non-Citizen Applicants" on page 4.

	DATE OF ENTRY INTO U. S.	NATIONALITY *(optional)*	IMMIGRATION STATUS	SPONSOR'S NAME
Person 1				
	SPONSOR'S ADDRESS			SPONSOR'S PHONE NUMBER
Person 2	DATE OF ENTRY INTO U.S.	NATIONALITY *(optional)*	IMMIGRATION STATUS	SPONSOR'S NAME
	SPONSOR'S ADDRESS			SPONSOR'S PHONE NUMBER

2. When did this person most recently move to Minnesota? **If less than 12 months ago,** list where the person lived before moving to Minnesota.

	DATE *(mm/dd/yy)*	CITY	STATE	DATES *(to/from)*
Per 1				
Per 2				

3. Is this person mentally or physically ill, incapacitated or disabled? ☐ Yes ☐ No
If yes, complete the section below for that person.

	MEDICAL PROBLEM	
Person 1		
	DOCTOR'S NAME	DOCTOR'S ADDRESS
Person 2	MEDICAL PROBLEM	
	DOCTOR'S NAME	DOCTOR'S ADDRESS

4. Is this person unable to work for reasons *other than* illness, incapacity or disability? ☐ Yes ☐ No
If yes, complete the section below for that person.

	REASON
Per 1	
Per 2	

5. Is this person under age 19? ☐ Yes ☐ No
If yes, complete the section below if both parents do not live with the child.
Note: You may also have to fill out additional child support forms.

Absent parent data

	Name of *absent* parent	Current address of *absent* parent	Does parent visit or share custody?
Per 1			☐ Yes ☐ No
Per 2			☐ Yes ☐ No

6. Is this person currently going to school? ☐ Yes ☐ No
If yes, complete the section below for that person.
Note: Answer yes if not attending classes due to school holidays or breaks (including summer break).

	NAME OF SCHOOL	ADDRESS
Per 1		
Per 2		

7. Does this person have any property or assets such as cash, checking, savings, life insurance, retirement accounts, burial accounts, stocks, bonds, car, land, house or mobile home? ☐ Yes ☐ No
If yes, complete the section below for that person *and send proof.* (Check yes even if bank balance is zero.)

	TYPE OF ASSETS	VALUE	AMOUNT OWED
Person 1		$	$
	TYPE OF ASSETS	$	$
Person 2	TYPE OF ASSETS	VALUE $	AMOUNT OWED $
	TYPE OF ASSETS	$	$

8. Does this person get money from Social Security, Supplemental Security Income, Unemployment Insurance, Workers' Compensation, annuities, trust funds, school loans or grants, child support? ☐ Yes ☐ No
If yes, complete the section below for that person and send proof.

	TYPE OF INCOME	AMOUNT	HOW OFTEN RECEIVED
Per 1		$	
Per 2	TYPE OF INCOME	AMOUNT $	HOW OFTEN RECEIVED

9. Is this person currently employed or self-employed? ☐ Yes ☐ No
If yes, complete the section below for that person and send proof.

	EMPLOYER	AMOUNT EARNED	HOW OFTEN RECEIVED
Person 1		$	
	EMPLOYER	$	$
Person 2	EMPLOYER	AMOUNT EARNED $	HOW OFTEN RECEIVED
	EMPLOYER	$	$

10. Does this person have any expenses such as dependent care, meals, transportation or court-ordered child support? ☐ Yes ☐ No
If yes, complete the section below for that person.

	TYPE OF EXPENSE	MONTHLY AMOUNT $
Per 1		
Per 2	TYPE OF EXPENSE	MONTHLY AMOUNT $

11. Does this person want help paying for medical bills from the past three months? ☐ Yes ☐ No
If yes, attach copies of those bills.

	WHAT MONTHS?
Per 1	
Per 2	WHAT MONTHS?

12. Is this person covered by or has this person been covered in the past four months by Medicare, health insurance, dental insurance or long-term care insurance? ☐ Yes ☐ No
If yes, complete the section below for that person.

	NAME OF INSURANCE COMPANY
Per 1	
Per 2	NAME OF INSURANCE COMPANY

Penalty warnings and qualification questions

If you get cash, food support or health care benefits, you must follow the rules listed below. The state may bar household members who break any of these rules from the cash, Food Support or Minnesota Health Care programs. The bar lasts one year for the first fraud, two years for the second fraud and is permanent for the third fraud. The months you are barred from MFIP for breaking the rules may count toward your 60-month lifetime limit.

- **Do not give false information or hide information** to get or continue to get cash, food support or medical benefits. 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.
- **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 help others get medical services** that you know they should not get.
- **Do not use someone else's EBT access cards or health care membership cards** to get cash, food support or medical benefits for your household.

The maximum penalty is a fine of $250,000 or a jail term of 20 years, or both.

Special Food Support penalty warning: If a federal, state or local court finds you or any household member guilty of giving or receiving food support benefits in exchange for:

- **Controlled substances,** that household member will be barred from getting Food Support for 12 months for the first offense and permanently for the second offense.
- **Firearms, ammunition or explosives,** that household member will be barred from getting Food Support permanently.

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.

1. Has a court or any other civil or administrative process in Minnesota or any other state found anyone in the household guilty of 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? ☐ Yes ☐ No

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

QUESTION NO.	HOUSEHOLD MEMBER	QUESTION NO.	HOUSEHOLD MEMBER

Important Information for Non-Citizen Applicants

To get most public assistance help, you must be in the United States 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 (such as, 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.

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 redisclose the information.

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 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)

By signing below:

- I acknowledge that my worker gave me a copy of the Notice of Privacy Practices (DHS-3979) and the Client Responsibilities Rights (DHS-4163) and explained them to me.
- I acknowledge that I have read and understand the "Penalty warnings and qualification questions" section on page 3.
- I agree to the sharing of information as stated in the medical and fraud authorization information above.

SIGNATURE OF APPLICANT OR AUTHORIZED REPRESENTANTIVE	DATE	SIGNATURE OF SPOUSE OR SECOND APPLICANT	DATE
AGENCY SIGNATURE	DATE	☐ R & R (DHS-4163) ☐ Notice of Privacy Practices (DHS-3979) ☐ ADA brochure (DHS-4133) ☐ Family Violence Referral (DHS-3323) ☐ Change Report Form (DHS-2402)	

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

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

ចំណាប់អារម្មណ៍ 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.

ໂປຼດຊາບ. ຖ້າຫາກທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປຂໍ້ຄວາມດັ່ງກ່າວນີ້ຟຣີ, ຈົ່ງຖາມນຳພນັກງານຊ່ວຍວຽກຂອງທ່ານຫຼືໂທຣ໌ຫາຕາມເລກໂທຣ໌ 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.

LB2-0009 (1-08)

This information is available in alternative formats to individuals with disabilities by calling your county worker. TTY users can call through Minnesota Relay at (800) 627-3529. For Speech-to-Speech, call (877) 627-3848. For additional assistance with legal rights and protections for equal access to human services benefits, contact your agency's ADA coordinator.

(Tear off here)

Client Responsibilities and Rights

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 file a privacy complaint.
  - 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 your public assistance application or benefits because of race, color, national origin, political beliefs, religion, creed, sex, sexual orientation, public assistance status, age or disability, including physical access to government buildings, you may file a complaint with your county agency or any of the following agencies.

Minnesota Department of Human Services
Office for Equal Opportunity
PO Box 64997
St. Paul, Minnesota 55164-0997
(651) 431-3040 (Voice)
(866) 786-3945 (TTY)

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

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)

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

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Clear Form Data
FILLABLE FORM

Minnesota Department of Human Services

Combined Application - Child Care Addendum

Purpose: This form is used to apply for the Minnesota Child Care Assistance Programs (CCAP) if you are applying for cash assistance, Food Support or health care and have completed a Combined Application Form (CAF). You may be eligible to get help for your child care expenses so you can work, look for work or attend school.

To qualify for CCAP, your family must:

- Be income eligible
- Meet employment and training requirements:
  - Work at least an average of 20 hours per week (10 hours per week if a full-time student) at minimum wage, or
  - Participate in job search, attend school or training classes, or
  - Comply with the activities in your approved Minnesota Family Investment Program (MFIP) employment plan.
- Cooperate with child support enforcement for all children in the family
- Use a legal child care provider. (Legal providers include licensed and unlicensed providers, 18 years of age or older, who are registered with a county to provide care.)

CASE NAME (LAST, FIRST, MI)	WORKER NAME	WORKER PHONE NUMBER

Have you ever received or requested CCAP in Minnesota? ☐ Yes ☐ No

If yes, what county?_____

Read these instructions before you fill out the application.

We have included the CCAP Program booklet Do you need help paying for child care? (DHS-3551) to give you information about the CCAP Program and choosing a child care provider.

Please follow these instructions as you complete your application.

- Print your answers using black ink.
- Read all instructions carefully and answer all questions completely.
- Attach additional sheets of paper if you need more space.
- Include proof of all requested information.
- Sign and date the application.

If you have questions about completing this application or have problems getting the information, talk to your worker.

A child care worker will write or call you if we need more information. Once we receive all information you will receive a written notice about your eligibility.

Child Care Assistance staff only:

Case number	_____	MFIP begin date	_____
MAXIS number	_____	MFIP end date	_____
CCAP worker name	_____	ESP agency	_____
MFIP worker name	_____	ESP worker name	_____

Complete for all children who are attending or are in need of child care.

- Child care assistance is available for children under age 13 and for children with disabilities under age 15.
- Call the number on the front of the application if your child has special needs and requires specialized care.

Include proof of citizenship status for each child in need of child care assistance, such as a birth certificate, an adoption record or an BCIS card.

Child 1

CHILD'S NAME

Indicate the days and the hours each day child care is needed below.

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

Complete the provider information if you currently use or have chosen a child care provider for this child.

CHILD CARE PROVIDER'S NAME	PROVIDER'S TELEPHONE NUMBER	START DATE

ADDRESS	CITY	STATE	ZIP CODE

Is provider related to the child? ☐ Yes ☐ No If yes, relationship _____

Where is care provided? ☐ Provider's home ☐ Child care center ☐ Child's home

Complete the days and times student attends school below if this child is now in school or plans to go to school within the next six months. Start date if not currently attending (mm/dd/yy) _____

Monday	Tuesday	Wednesday	Thursday	Friday

If the child has a parent who does not live in your home, does the child live in your home full-time or part time? ☐ Full-time ☐ Part-time

Child 2

CHILD'S NAME

Indicate the days and the hours each day child care is needed below.

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

Complete the provider information if you currently use or have chosen a child care provider for this child.

CHILD CARE PROVIDER'S NAME	PROVIDER'S TELEPHONE NUMBER	START DATE

ADDRESS	CITY	STATE	ZIP CODE

Is provider related to the child? ☐ Yes ☐ No If yes, relationship _____

Where is care provided? ☐ Provider's home ☐ Child care center ☐ Child's home

Complete the days and times student attends school below if this child is now in school or plans to go to school within the next six months. Start date if not currently attending (mm/dd/yy) _____

Monday	Tuesday	Wednesday	Thursday	Friday

If the child has a parent who does not live in your home, does the child live in your home full-time or part time? ☐ Full-time ☐ Part-time

Child 3

CHILD'S NAME

Indicate the days and the hours each day child care is needed below.

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

Complete the provider information if you currently use or have chosen a child care provider for this child.

CHILD CARE PROVIDER'S NAME	PROVIDER'S TELEPHONE NUMBER	START DATE

ADDRESS	CITY	STATE	ZIP CODE

Is provider related to the child? ☐ Yes ☐ No If yes, relationship _____

Where is care provided? ☐ Provider's home ☐ Child care center ☐ Child's home

Complete the days and times student attends school below if this child is now in school or plans to go to school within the next six months. Start date if not currently attending (mm/dd/yy) _____

Monday	Tuesday	Wednesday	Thursday	Friday

If the child has a parent who does not live in your home, does the child live in your home full-time or part time? ☐ Full-time ☐ Part-time

Child 4

CHILD'S NAME

Indicate the days and the hours each day child care is needed below.

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

Complete the provider information if you currently use or have chosen a child care provider for this child.

CHILD CARE PROVIDER'S NAME	PROVIDER'S TELEPHONE NUMBER	START DATE

ADDRESS	CITY	STATE	ZIP CODE

Is provider related to the child? ☐ Yes ☐ No If yes, relationship _____

Where is care provided? ☐ Provider's home ☐ Child care center ☐ Child's home

Complete the days and times student attends school below if this child is now in school or plans to go to school within the next six months. Start date if not currently attending (mm/dd/yy) _____

Monday	Tuesday	Wednesday	Thursday	Friday

If the child has a parent who does not live in your home, does the child live in your home full-time or part time? ☐ Full-time ☐ Part-time

Agency use

Child 5

CHILD'S NAME

Indicate the days and the hours each day child care is needed below.

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

Complete the provider information if you currently use or have chosen a child care provider for this child.

CHILD CARE PROVIDER'S NAME	PROVIDER'S TELEPHONE NUMBER	START DATE

ADDRESS	CITY	STATE	ZIP CODE

Is provider related to the child? ☐ Yes ☐ No If yes, relationship _____

Where is care provided? ☐ Provider's home ☐ Child care center ☐ Child's home

Complete the days and times student attends school below if this child is now in school or plans to go to school within the next six months. Start date if not currently attending (mm/dd/yy) ☐

Monday	Tuesday	Wednesday	Thursday	Friday

If the child has a parent who does not live in your home, does the child live in your home full-time or part time? ☐ Full-time ☐ Part-time

List any **other** children who live with you that are:

- Eighteen years old or older and
- Attend school and
- For whom you provide 50% or more of their financial support.

NAME	NAME
NAME	NAME

The state and federal governments require CCAP to report data on families who receive CCAP. **This information will not affect your eligibility for CCAP.**

Do any children in your household attend Head Start? ☐ Yes ☐ No

Does your family attend Early Childhood Family Education (ECFE) classes? ☐ Yes ☐ No

Does any member of your family participate in the School Readiness Program? ☐ Yes ☐ No

Agency use

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

Provider release

State and federal privacy laws protect my information. If I am eligible for child care assistance, CCAP staff can share information about the hours and amount of child care assistance I get with my child care provider(s). I understand:

- This information must be shared so that my child care provider knows how much CCAP will pay for the child care provided.
- This information can be shared only if I give my written permission or if the law allows it.
- I can refuse to sign or cancel this release, but if I do, CCAP may not be able to pay my provider for the child care provided.
- I may cancel this authorization with written notice anytime. This written notice will not affect information already released.
- The person or agency who gets my information may be able to pass it on to others.
- If my information is passed on to others by DHS, it may no longer be protected by this authorization.

This authorization will end one year from the date I sign it. Minnesota Data Privacy Act (Minn. Stat., Ch. 13).

If I get CCAP I understand:

- I must cooperate with child support enforcement and assign my child care support portion to the Department of Human Services. I have the right to claim "good cause" for not cooperating with child support enforcement.
- I may be required to pay a co-payment fee.
- If my child care provider charges more than the maximum rate paid in my county, I will pay the additional costs, as well as my co-payment fee.
- I must report all changes to the information I have given within 10 calendar days from the date the change occurred. These include changes in employment, school and training schedules, marital status, income, address or residence, or anyone moving in or out of my household.
- I must give the county agency and my child care provider 15 calendar days' notice before changing my child care provider(s). This notice is not needed in cases of alleged abuse by a provider or when the health and safety of a child in care is in immediate danger.
- My eligibility for CCAP must be redetermined at least every six (6) months.
- I have the right to choose any legal child care provider, including licensed child care centers, licensed family child care providers and legally unlicensed family child care providers that meet program requirements.
- If I choose a provider to provide child care in my home, I am considered the employer of the provider and have legal and tax responsibilities.

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)

By signing below:

- I acknowledge that my worker gave me a copy of the Notice of Privacy Practices (DHS-3979) and the "Your Responsibilities", "Your Rights" and "Penalty Warning" sections from this form and explained them to me.
- I agree to assign my child support as stated above.
- I agree to the sharing of information as stated in the provider and fraud authorization information above.

SIGNATURE OF APPLICANT OR AUTHORIZED REPRESENTANTIVE	DATE	AGENCY SIGNATURE	DATE
SIGNATURE OF SPOUSE OR SECOND APPLICANT	DATE	**Client given:** ☐ R & R (DHS-4163) ☐ ADA brochure (DHS-4133) ☐ Notice of Privacy Practices (DHS-3979)	

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

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

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

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

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

ໂປດຊາບ. ຖ້າຫາກທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປຂໍ້ຄວາມດັ່ງກ່າວນີ້ຟຣີ, ຈົ່ງຖາມນຳພນັກງານຊ່ວຍວຽກຂອງທ່ານຫຼືໂທຣ໌ 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.

LB22-0009 (1-08)

This information is available in alternative formats to individuals with disabilities by calling your county worker. TTY users can call through Minnesota Relay at (800) 627-3529. For Speech-to-Speech, call (877) 627-3848. For additional assistance with legal rights and protections for equal access to human services benefits, contact your agency’s ADA coordinator.

Tear off here

Child Care Responsibilities and Rights

Penalty warning

If you get child care assistance benefits, you must follow these rules. Do not give false information or hide information:

- To get or continue to get child care assistance benefits
- To help someone else to get or to continue to get child care assistance payments.

The state may bar a family with a member who breaks either of these rules from the Child Care Assistance Program. The bar lasts three months for the first fraud, six months for the second fraud, two years for the third fraud and is permanent for the fourth fraud. The maximum penalty is a fine of $100,000 or a jail term of 20 years, or both.

Your responsibilities

- *You* **may be required to pay a co-payment fee.** If you do not pay the fee, your Child Care Assistance will be terminated until fees are paid in full or satisfactory payment agreements have been made with the county and your child care provider. Your Child Care Assistance worker will tell you whether to pay this fee to your child care provider or to the county agency.
- You may be required to pay additional costs when your child care provider charges a rate that is more than the maximum rate in your county.
- **You must document** the immigration or citizenship status of the children in your family for whom you are applying for child care assistance.
- **You must cooperate with child support enforcement** for all children in your household. You must assign the child care portion of your child support to the State of Minnesota for all children receiving Child Care Assistance. If you do not cooperate or assign your child care support, Child Care Assistance will be denied or terminated. You have the right to claim "good cause' for not cooperating with child support enforcement. Ask your child care worker to help you.
- **You must report the following changes** for each family member to your Child Care Assistance worker within 10 calendar days.

  Failure to report these changes within 10 days may result in an overpayment, termination of your Child Care Assistance, a fraud investigation and/or possible criminal charges.

  - Employment status
  - Names of family members who move in or out of your household
  - Marriages, separations, divorces
  - Income, wage or salary increases and receipt or changes in child support, social security, MFIP, GA, unemployment insurance, insurance benefits and other cash payments
  - Child support paid by you to someone who does not live with you
  - Address or residence
  - Health and dental insurance premiums
  - Work, school or job search hours
  - Child custody arrangements

  Note: If *you* receive other types of assistance from your local county agency ***and*** your Child Care Assistance worker is not your worker for these programs, report changes to your Child Care Assistance worker to avoid possible overpayment.
- **If you change providers,** you must tell your child care worker and provider at least 15 days before the change goes into effect.

You must sign the application to acknowledge that you have read and understand your rights and responsibilities under the CCAP. Please keep these pages for your records.

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
    - File a privacy complaint.
  - 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 within 30 days.**
- **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.
- **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. 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 child care within 30 days, the agency can accept your appeal for up to 90 days from the date you receive the notice.)

  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.** You may 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 your public assistance application or benefits because of race, color, national origin, political beliefs, religion, creed, sex, sexual orientation, public assistance status, age or disability, including physical access to government buildings, you may file a complaint with your county agency or any of the following agencies.

  Minnesota Department of Human Services
  Office for Equal Opportunity
  PO Box 64997
  St. Paul, MN 55164-0997
  (651) 431-3040 (Voice)
  (866) 786-3945 (TTY))

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

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