Clear Form Data
FILLABLE FORM

Attachment B

DHS-5337-ENG 2-08

Minnesota Department of **Human Services**

Permission to Share Information with Agencies Assisting with Applications

COUNTY OR STATE AGENCY			
MAILING ADDRESS	CITY	STATE	ZIP CODE

APPLICATION ASSISTOR AGENCY		MNCAA ID NUMBER	
MAILING ADDRESS	CITY	STATE	ZIP CODE

APPLICANT/ENROLLEE'S NAME		SOCIAL SECURITY NUMBER	DATE OF BIRTH
STREET ADDRESS	CITY	STATE	ZIP CODE

I give permission to the agencies listed above to share information about me as indicated below:

- ☐ Outstanding information or proofs needed to complete my application for Minnesota Health Care Programs.
- ☐ The status of my application for Minnesota Health Care Programs coverage including the program(s) I am enrolled in and the effective date of enrollment.
- ☐ The reason I am not eligible for Minnesota Health Care Programs coverage if my request for coverage is denied or my coverage ends.
- ☐ The effective date(s) of my renewal(s) for coverage and any outstanding information or verifications needed to complete my renewal.

This information will be used to help me with my enrollment and continued eligibility in Minnesota Health Care Programs.

I know that state and federal privacy laws protect my records. I know:

- Why I am being asked to release this information.
- I do not have to give permission to release this information.
- That, generally, I must give my written permission for the agencies listed above to give out this information.
- If I do not give my permission, the information will not be released unless the law otherwise allows it.
- I may stop this permission to share information with a written notice at any time but this written notice will not affect information the agencies have already released.
- The agency that gets my information may be able to pass it on to others.
- If my information is passed on to others, it may no longer be protected by this permission form.
- This permission form will end one year from the date I sign it unless the law allows for a longer period.

APPLICANT OR ENROLLEE SIGNATURE	DATE
SIGNATURE OF PARENT/GUARDIAN/AUTHORIZED REPRESENTATIVE	DATE

This information is available in other forms to people with disabilities by contacting us at (651) 431-2670 (voice) or toll free at (800) 657-3739. TTY/TDD users can call the Minnesota Relay at 711 or (800) 627-3529. For Speech-to-Speech Relay, call (877) 627-3848.

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.

LB2-00001 (1-08)