Clear Form Data
FILLABLE FORM

Attachment C
DHS-5203-ENG 3-08

Minnesota Department of **Human Services**

Date: _____

Worker name: _____

Worker phone number: _____

Fax number: _____

Agency name: _____

Agency address: _____

_____

To: _____

_____

_____

_____

Minnesota Health Care Programs

Request for Income Verification

Why am I getting this letter?

We are writing to you about your income. Your health care application or renewal states your household has $0 income.

What do I need to do?

Call your worker at the above number and tell us how you are paying your expenses or check the box(es) below that applies to your household. Send this form and the proof listed, if needed, to the agency listed above by

_____.
DATE

☐ One or more members of my family are now working.
Proof: Send pay stubs from the last 30 days or a written statement of earnings from your employer. If self employed, send your most recent income tax returns and all related schedules or business records if taxes are not filed.

☐ One or more members of my family get money from sources other than work such as child support, Social Security, Supplemental Security Income (SSI), spousal support or other sources.
Proof: Send copy of check, award letter, tax forms, court order or other documents.

☐ My family gets money from a friend, relative or organization.
Proof: Send a written statement from the person or organization showing how much money they give you and how often you get it. If the money is a loan, send a copy of the loan statement or the written agreement to repay the money.

☐ A relative, friend or organization pays all of my bills and expenses.

☐ I pay bills from the sale of personal items or money in a savings or checking account.

What will happen if I do not give you this information?

You will not get coverage or your coverage will end.

Questions

If you have questions, call your worker.

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.

កំណាត់សំគាល់ 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, ຈົ່ງຖາມນຳພນັກງານຊ່ວຍອຽກຂອງທ່ານຫຼືໂທຣ໌ຫາຕາມເລກໂທຣ໌ 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.

LEP-0001 (1-08)

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