



## *Minnesota Health Care Programs*

# **Application for Certain Populations**

## **What is this application for?**

Use this application to apply for health care coverage, if everyone in the household:

- Is 65 years of age or older.
- Is only requesting help with Medicare costs.
- Is a child in foster care.
- Is over 21 years of age with no dependents and has Medicare coverage.
- Receives SSI income.
- Is applying for Medical Assistance for Employed Person with Disabilities (MA-EPD).
- If you are a person who lives in or may need to move to a nursing home use the Minnesota Health Care Programs Application for Payment of Long-Term Care Services (DHS-3531) or the online application, ApplyMN, at [applymn.dhs.mn.gov](http://applymn.dhs.mn.gov).
- If you are a person with a disability or age 65 or older who would like services to help you stay in your home use the Minnesota Health Care Programs Application for Payment of Long-Term Care Services (DHS-3531). Also ask your county agency about a Long-Term Care Consultation.
- People who are not described above should apply for health care coverage through MNsure, Minnesota's health insurance marketplace. Use the online application at [www.mnsure.org](http://www.mnsure.org), or the Application for Health Coverage and Help Paying Costs (DHS-6696).

You can find these applications on the web at [www.dhs.state.mn.us/healthcare](http://www.dhs.state.mn.us/healthcare) or have one mailed to you by calling your county agency. The phone numbers are listed on pages B and C at the back of this form.

## **What do I need to do with this form?**

1. Read the Notice of Privacy Practices and Rights and Responsibilities on pages D through F at the back of this form. Tear them off and keep them.
2. Answer all questions on the application. If you need more space, write the number of the question and the answer on a separate piece of paper. Include it with the application.
3. Sign and date the application.
4. Attach proofs. Proofs are listed on page A at the back of this form.
5. Mail or take the application to your county agency. The addresses are listed on pages B and C at the back of this form.
6. Send in your application right away even if you do not have all proofs. We will contact you for any additional information we need.

## **Questions?**

If you have questions or need help, call your county agency. The phone numbers are listed on pages B and C at the back of this form. You can also call the Senior LinkAge Line® if you are 60 or older at 800-333-2433 or the Disability LinkAge Line® if you are a person with a disability at 866-333-2466.

# The information below can help you decide which health care program is best for you.

## Medical Assistance

- Coverage can begin three months before the month we get your application.
- Most health care services are covered including doctor visits, lab and x-ray services, prescriptions, and hospital stays.
- Income limits (the amount of money you can have and still be eligible) may be lower than for a Medicare Savings Program.
- You may have copays for certain services.
- You can have other health insurance, even if it is through an employer. Help with payment of other health insurance may be possible.
- A claim may be placed against your estate for benefits paid.
- You may be required to choose a health plan and get all your health care services from providers in that plan.

## Medicare Savings Programs

- Helps pay for Medicare costs such as Part A or Part B premiums.
- Payment of your Part B premiums can begin three months before the month we get your application.
- You may qualify for payment of your Medicare deductibles and copays.
- Income and asset limits are higher than Medical Assistance.
- No claim is placed against your estate for benefits paid.

## Medical Assistance for Employed Persons with a Disability (MA-EPD)

- Must have earnings and pay FICA taxes.
- You must pay a monthly premium. The premium may be less than another type of health care coverage.
- Contact the Disability Linkage Line 866-333-2466 for help deciding the best program to meet your health care needs.

## For more information:

- Call your county human services office. The phone numbers are listed in this application on pages B and C.
- Go to [www.dhs.state.mn.us/healthcare](http://www.dhs.state.mn.us/healthcare) for further information.

Attention. If you need free help interpreting this document, ask your worker or call the number below for your language.

ملاحظة: إذا أردت مساعدة مجانية لترجمة هذه الوثيقة، اطلب ذلك من مشرفك أو اتصل على الرقم 1-800-358-0377.

កំណត់សំគាល់ ៖ បើអ្នកត្រូវការជំនួយក្នុងការបកប្រែឯកសារនេះដោយឥតគិតថ្លៃ សូមសួរអ្នកកាន់សំណុំរឿង របស់អ្នក ឬហៅទូរស័ព្ទមកលេខ 1-888-468-3787 ។

Pažnja. Ako vam treba besplatna pomoć za tumačenje ovog dokumenta, pitajte vašeg radnika ili nazovite 1-888-234-3785.

Thov ua twb zoo nyeem. Yog hais tias koj xav tau kev pab txhais lus rau tsab ntaub ntawv no pub dawb, ces nug koj tus neeg lis dej num los sis hu rau 1-888-486-8377.

ໂປຣດຊາບ. ຖ້າທາກ ທ່ານຕ້ອງການ ການຊ່ວຍເຫຼືອໃນການແປເອກະສານນີ້ຟຣີ, ຈົ່ງຖາມ ພະນັກງານກຳກັບການຊ່ວຍເຫຼືອຂອງທ່ານ ຫຼື ໂທໂປທີ່ 1-888-487-8251.

Hubachiisa. Dokumentiin kun bilisa akka siif hiikamu gargaarsa hoo feete, hojjetoota kee gaafadhu ykn afaan ati dubbattuuf bilbilli 1-888-234-3798.

Внимание: если вам нужна бесплатная помощь в устном переводе данного документа, обратитесь к своему социальному работнику или позвоните по телефону 1-888-562-5877.

Digniin. Haddii aad u baahantahay caawimaad lacag-la'aan ah ee tarjumaadda qoraalkan, hawlwadeenkaaga weydiiso ama wac lambarka 1-888-547-8829.

Atención. Si desea recibir asistencia gratuita para interpretar este documento, comuníquese con su trabajador o llame al 1-888-428-3438.

Chú ý. Nếu quý vị cần được giúp đỡ dịch tài liệu này miễn phí, xin gọi nhân viên xã hội của quý vị hoặc gọi số 1-888-554-8759.

LB1-0003 (3-13)

ADA1 (12-12)

This information is available in accessible formats for individuals with disabilities by calling 651-431-2670, toll-free 800-657-3739, or by using your preferred relay service. For other information on disability rights and protections, contact the agency's ADA coordinator.



# Minnesota Health Care Programs Application for Certain Populations

Office Use Only		
DATE RECEIVED	CASE NUMBER	WORKER NUMBER

- Answer all questions the best you can.
- Return the form right away.
- We will contact you for any additional information we need.

**1. If you have dependents under the age of 19, apply online at [www.mnsure.org](http://www.mnsure.org). Do not use this application form.**

If you only want to apply for a Medicare Savings Program, check the box below.

I only want to apply for Medicare Savings Programs. I do not want to apply for other health care programs.

**1a. Name and address**

FIRST NAME	MI	LAST NAME	DATE OF BIRTH	SEX M F
SOCIAL SECURITY NUMBER*	MARITAL STATUS		HOME PHONE	OTHER PHONE
STREET ADDRESS	CITY	STATE	ZIP CODE	COUNTY
MAILING ADDRESS (if different)	CITY	STATE	ZIP CODE	COUNTY
Check this box if you are homeless	Are you applying for yourself? Yes No		Do you want us to send you a voter registration card? Yes No	
What language do you speak most of the time?			Do you need an interpreter? Yes No	
OPTIONAL INFORMATION				
RACE (check all that apply) Asian Black/African American American Indian/Native Alaskan Pacific Islander or Native Hawaiian White				HISPANIC OR LATINO? Yes No
American Indians: Some applicants are limited to the amount of assets they can own. If you are an American Indian, certain assets do not count. Note: If you are an American Indian who has provided verification of American Indian status, you are exempt from paying a premium for MA-EPD.				
Check this box if you are an American Indian living on a reservation.				
Some American Indians living on a reservation have the option to not receive their health care services through a health plan.				

\*See Notice of Privacy Practices for information about Social Security numbers.

**2. Others living with you** (List your spouse, parents/guardians of children under 21, stepparents, children and stepchildren living in your home.)

OPTIONAL  
INFORMATION

NAME (First, MI, Last)	SOCIAL SECURITY NUMBER*	RELATIONSHIP TO YOU	SEX	MARITAL STATUS	DATE OF BIRTH	IS THIS PERSON APPLYING?	RACE (Use codes below**)	HISPANIC OR LATINO?
			M F			Yes No		Yes No
			M F			Yes No		Yes No
			M F			Yes No		Yes No
			M F			Yes No		Yes No
			M F			Yes No		Yes No

\*\*Codes: (choose all that apply)

A-Asian B-Black/African American N-American Indian/Native Alaskan P-Pacific Islander or Native Hawaiian W-White

**3. Is anyone living away from home for a short time?**

No

Yes – fill in below

FIRST NAME	MI	LAST NAME	SOCIAL SECURITY NUMBER*	DATE OF BIRTH	RELATIONSHIP TO YOU
Are you applying for this person? Yes No		DATE LEFT	DATE EXPECTED TO RETURN	REASON FOR NOT LIVING AT HOME	

**4. Is everyone applying a U.S. Citizen or U.S. National?**

No – fill in below

Yes

NAME	IMMIGRATION STATUS	DATE ENTERED THE U.S.	DOES THIS PERSON HAVE A SPONSOR?
			Yes No
			Yes No
			Yes No
			Yes No
Is anyone getting services from the Center for Victims of Torture? Yes No	IF YES, WHO?		
Does anyone need help paying for a medical emergency? Yes No	IF YES, WHO?		

\*See Notice of Privacy Practices for information about Social Security numbers.

## 5. Do you want someone to act on your behalf as an authorized representative?

No

Yes – fill in below

An authorized representative is a person authorized to act on your behalf as an applicant or enrollee in any of the health care programs. In most cases, authorized representatives have the same responsibilities and rights as applicants or enrollees. An authorized representative will receive forms, notices, and premium notices on your behalf. An authorized representative must be at least 18 years old and know your circumstances in order to provide necessary information. This person must sign the application.

FIRST NAME	MI	LAST NAME	PHONE NUMBER
STREET ADDRESS		CITY	STATE ZIP CODE

## 6. Additional household information

Does everyone plan to make Minnesota their home?    Yes    No	IF NO, WHO?	EXPLAIN
Is anyone 16 or older a student? Yes    No	IF YES, WHO?	
Is anyone pregnant? Yes    No    Not Applicable (N/A)	IF YES, WHO?	DUE DATE
Is anyone blind, or does anyone have a physical or mental health condition that limits the ability to work or perform daily activities? Yes    No	IF YES, WHO?	
Has anyone ever been in the United States military?    Yes    No	IF YES, WHO?	
Do you want help paying for medical bills from the past three months?    Yes    No	IF YES, LIST MONTHS	
Does anyone currently have medical benefits from another state?    Yes    No	IF YES, WHO?	

## 7. Is anyone self-employed or does anyone expect to be self-employed?

No

Yes – fill in below

NAME	BUSINESS NAME	START DATE	END DATE	YEARLY INCOME
				\$
				\$

## 8. Did anyone work in the last 30 days or does anyone expect to work next month?

No

Yes – fill in below

Include temporary work. Include all seasonal work during the last year.

- If seasonally employed, enter original start date for the listed employer.
- Enter gross income per pay period (before taxes and deductions)

NAME	EMPLOYER NAME	START DATE	GROSS INCOME PER PAY PERIOD (include tips)	HOW OFTEN PAID?	IS THIS JOB SEASONAL?	HAS THIS JOB ENDED?
			\$		Yes No	Yes No IF YES, DATE ENDED
			\$		Yes No	Yes No IF YES, DATE ENDED
			\$		Yes No	Yes No IF YES, DATE ENDED
			\$		Yes No	Yes No IF YES, DATE ENDED

## 9. Did anyone get money this month or does anyone expect to get money next month from sources other than work?

No

Yes – fill in below

Include:

- Social Security
- Supplemental Security Income (SSI)
- Retirement or pension payments
- Payments from a contract for deed
- Any other payments
- Child or spousal support
- Workers' compensation
- Public assistance payments
- Annuities
- Unemployment
- Veterans' benefits
- Rental income
- Student grants, loans or scholarships
- Interest
- Dividends
- Trusts

NAME	TYPE OF INCOME	START DATE	GROSS AMOUNT	HOW OFTEN RECEIVED?	HAS THIS INCOME ENDED?
			\$		Yes No IF YES, DATE ENDED
			\$		Yes No IF YES, DATE ENDED
			\$		Yes No IF YES, DATE ENDED
			\$		Yes No IF YES, DATE ENDED

**10. Does anyone have cash, a savings or checking account, or certificates of deposit?**

No

Yes – fill in below

Do not include business accounts.

OWNER(S) NAME	TYPE	NAME OF BANK	CURRENT BALANCE
			\$
			\$
			\$
			\$

**11. Does anyone own or co-own stocks, bonds, retirement accounts, life insurance, burial contracts, annuities, trusts, contracts for deed or other assets?**

No

Yes – fill in below

OWNER(S) NAME	TYPE OF TRUST	NAME OF COMPANY, BANK OR FUNERAL HOME	ESTIMATED VALUE
			\$
			\$
			\$
			\$

**12. Does anyone own a vehicle?**

No

Yes – fill in below

Include cars, trucks, snowmobiles, four-wheelers, motorcycles, boats and motors, trailers, campers and motor homes.

OWNER(S) NAME	TYPE OF VEHICLE	YEAR/MAKE/MODEL	ESTIMATED VALUE	AMOUNT OWED
			\$	\$
			\$	\$
			\$	\$
			\$	\$
			\$	\$

**13. Does anyone own or co-own a home, life estate, cabin, land, time share, rental property or any real estate?**

No

Yes – fill in below

OWNER(S) NAME	ADDRESS	TYPE OF PROPERTY	ESTIMATED VALUE
			\$
			\$

**14. Is anyone getting medical care for an accident or injury that happened in the last six years?**

No

Yes – fill in below

NAME(S)	DATE HAPPENED	TYPE OF ACCIDENT OR INJURY	Is there a lawsuit? Yes      No
---------	---------------	----------------------------	------------------------------------

**15. Did you have Medicare or health insurance this month or does anyone expect to have Medicare or health insurance next month?**

No

Yes – fill in below

COVERAGE TYPES – CHECK ALL THAT APPLY				
Medicare	Medicare Part D	Medicare Advantage Plan	Medical	Hospital only
HMO	Prescription drug	Dental	Vision	Long-term care
Other – list type: _____				
POLICYHOLDER'S NAME		INSURANCE COMPANY NAME	START DATE	END DATE
POLICY NUMBER	LIST EVERYONE WHO IS COVERED BY THIS POLICY			
MEDICARE COVERAGE: Policy holder has: (check all coverage)				
Part A      Part B      Part D – list name of plan: _____				
Start date: Part A _____ Part B _____ Part D _____				

**15a. Does anyone else have Medicare or health insurance or expect to have Medicare or health insurance next month?**

No

Yes – fill in below

COVERAGE TYPES – CHECK ALL THAT APPLY				
Medicare	Medicare Part D	Medicare Advantage Plan	Medical	Hospital only
HMO	Prescription drug	Dental	Vision	Long-term care
Other – list type: _____				
POLICYHOLDER'S NAME		INSURANCE COMPANY NAME	START DATE	END DATE
POLICY NUMBER	LIST EVERYONE WHO IS COVERED BY THIS POLICY			
MEDICARE COVERAGE: Policy holder has: (check all coverage)				
Part A      Part B      Part D – list name of plan: _____				
Start date: Part A _____ Part B _____ Part D _____				



## Signature Page

(Effective Date: March 1, 2014)

*Read the following information and sign.*

### Authorization to Share Information for Fraud Investigation and Audits

I agree that third parties may share information about me with persons investigating fraud and completing federal or state audits. This may include, but is not limited to:

- Employers and schools,
- Landlords and utility companies,
- Financial and insurance agencies, and
- Other government offices.

If I am enrolled in MinnesotaCare, the Minnesota Department of Revenue may share copies of my income tax returns with investigators.

I understand this consent is good for six months after my benefits stop.

### Authorization for Release (Sharing) of My Medical Information

I give my consent to the following agencies or individuals to share between them medical information about me only for the limited purposes indicated:

- Health providers including school districts, health plans, insurance agencies, Minnesota Health Care Programs, county advocates, my county or state case workers, and their contractors and subcontractors:
  - To determine who should pay for my health care, and
  - To provide, manage, and coordinate health care services.
- All other agencies or persons as listed on the Notice of Privacy Practices.

This consent applies to medical information about my minor children I applied for on this application. I understand the school district needs a separate consent to share information about my children with private insurance plans. I can stop this consent at any time by asking in writing for it to end. The written notice to stop this consent will not affect information the agency has already given to others. This consent is good while I am enrolled in Minnesota Health Care Programs, up to one year, or longer if the law permits. However, it does not end after one year for records given to consulting providers, records given for payment of my bills, fraud investigations, or quality of care review and studies. An agency or person who gets my information through this consent could give the information to others.

If I do not sign or I end this consent, I cannot enroll or stay enrolled in Minnesota Health Care Programs.

### Medical Assignment of Benefits

I give my rights to all medical payments for me and anyone else I apply for to the State of Minnesota. This includes medical payments from all other persons or companies. For MA for Long-Term Care, this includes my right to support from my spouse under Minnesota Statutes, section 256B.14, subdivision 3. This begins as soon as health care coverage starts.

I agree to help the state to get paid back for medical expenses that should have been paid by others. I may not have to help the state if I have a good reason for not doing so and the state approves the reason.

If I have Medicare Part B, Medicare can pay my health providers for the care I get while I am on a Minnesota Health Care Program.

**By signing below:**

- I agree that I have reviewed and understand my options for choosing the health care program I want to apply for.
- I agree that I have read and understand the Notice of Privacy Practices and the list of my responsibilities in that Notice.
- I agree that I have read and understand the Rights and Responsibilities section including Following the rules, Changes and Liens and Estate Claims.
- I agree and understand that my information will be released to the parties listed in the Notice of Privacy Practices in order to verify eligibility for Minnesota Health Care Programs.
- I agree and understand that my information will be shared for fraud investigations and audits as stated in the Authorization to Share Information for Fraud Investigations and Audits section.
- I agree to assign my medical benefits as stated in the Medical Assignment of Benefits.
- I agree to the release of my Minnesota Health Care Programs health records to the parties listed in the Authorization for Release (Sharing) of My Medical Information section.
- I declare that, under penalty of perjury, all parts of this application and any updates to information on this application I give during the year are true and correct statements, to the best of my knowledge. I understand what happens to people convicted of perjury (not telling the truth). They may be sentenced to prison for up to five years, a fine up to \$10,000, or both.

You must sign this application even if you are authorizing someone to act on your behalf.

If an applicant is unable to sign, provide copies of legal documents of conservatorship or power of attorney.

YOUR SIGNATURE	DATE
SIGNATURE OF AUTHORIZED REPRESENTATIVE	DATE

**Did you remember to:**

Sign and date this form?

Attach the proofs you have? See page A for required proofs.

Mail or take this form to your county office? Do this right away even if you do not have all your proofs ready. See pages B and C at the back of this form for the address.

## Required Proofs

### **Send one of the listed proofs for everyone applying who is:**

- An immigrant  
Alien identification card (green card, I-551, I-94), visa, passport, or documentation from Immigration Services

### **Send these listed proofs for everyone who is:**

- An American Indian  
A document issued by an American Indian/Alaska Native tribe such as an enrollment or membership card, document from Indian Health Services (IHS) showing the person may get IHS services as an American Indian, or a document from the Bureau of Indian Affairs (BIA) that says the person is an American Indian.
- Working  
Pay stubs from the last 30 days and from each month prior to the last 30 days for which you want coverage or a written statement of earnings from your employer if you do not have pay stubs.
- Self-employed  
Most recent income tax returns and all related schedules or business records if taxes are not filed.
- Getting other income (Includes any income or payments from sources other than work.)  
A statement from the person or company that sends the income, copy of checks, award letter, student financial aid award letter, tax forms, court order, or other documents from the last 30 days.

### **Send these listed proofs for everyone who is 21 or older:**

- Bank accounts  
Recent bank statements or written statement from bank showing current balance or value of accounts.
- Other assets (Includes stocks, bonds, retirement accounts, annuities, trusts, property agreements, etc.)  
Copies of bonds, annuities, trusts, stock ownership statements or other documents showing value of assets. Include documents showing current loan balance owed against the asset.

***Send copies of proofs. Do not send original documents.***

# Agency Addresses

(Effective Date: February 2015)

## Aitkin County

204 First Street NW  
Aitkin, MN 56431-1291  
218-927-7200 / 800-328-3744  
Fax: 218-927-7210

## Anoka County

2100 Third Avenue  
Anoka, MN 55303-5047  
763-422-7200  
Fax: 763-712-2318

## Becker County

712 Minnesota Avenue  
Detroit Lakes, MN 56501  
218-847-5628  
Fax: 218-847-6738

## Beltrami County

616 America Ave NW, Suite 270  
Bemidji, MN 56601-3802  
218-333-8300  
Fax: 218-333-4150

## Benton County

531 Dewey Street  
Foley, MN 56329-0740  
320-968-5087 / 800-530-6254  
Fax: 320-968-5330

## Big Stone County

340 2<sup>nd</sup> Street NW  
PO Box 338  
Ortonville, MN 56278-1413  
320-839-2555  
Fax: 320-839-3966

## Blue Earth County

410 S 5th Street  
Mankato, MN 56002-3526  
507-304-4335  
Fax: 507-304-4336

## Brown County

1117 Center Street  
New Ulm, MN 56073-0788  
507-354-8246 / 800-450-8246  
Fax: 507-359-6542

## Carlton County

14 N. 11th Street  
Cloquet, MN 55720-1610  
218-879-4583 / 800-642-9082  
Fax: 218-878-2500

## Carver County

602 East Fourth Street  
Chaska, MN 55318-2102  
952-361-1600  
Fax: 952-361-1660

## Cass County

400 Michigan Avenue W  
Walker, MN 56484-0519  
218-547-1340  
Fax: 218-547-1448

## Chippewa County

719 N Seventh Street, Suite 200  
Montevideo, MN 56265-1397  
320-269-6401 / 877-450-6401  
Fax: 320-269-6405

## Chisago County

313 North Main Street, Rm 239  
Center City, MN 55012-9665  
651-213-5640 / 888-234-1246  
Fax: 651-213-5685

## Clay County

715 North 11<sup>th</sup> Street, Suite 102  
Moorhead, MN 56560-2095  
218-299-5200 / 800-757-3880  
Fax: 218-299-7106

## Clearwater County

216 Park Avenue NW  
Bagley, MN 56621-0682  
218-694-6164 / 800-245-6064  
Fax: 218-694-3535

## Cook County

411 West Second Street  
Grand Marais, MN 55604-2307  
218-387-3620  
Fax: 218-387-3020

## Cottonwood County

11 Fourth Street  
Windom, MN 56101-0009  
507-831-1891  
Fax: 507-831-0126

## Crow Wing County

204 Laurel Street, Suite 22  
Brainerd, MN 56401-0686  
218-824-1250 / 888-772-8212  
Fax: 218-824-1141

## Dakota County

1 Mendota Road West, #100  
West St. Paul, MN 55118-4773  
651-554-5611  
Fax: 651-554-5709

## Dodge County

**MnPrairie**  
22 Sixth Street East – Dept. 401  
Mantorville, MN 55955  
507-635-6170 / 888-600-5169  
Fax: 507-635-6186

## Douglas County

809 Elm Street, Suite 1186  
Alexandria, MN 56308  
320-762-2302  
Fax: 320-762-3833

## Faribault County

412 N Nicollet  
Blue Earth, MN 56013-0217  
507-526-3265  
Fax: 507-526-2039

## Fillmore County

902 Houston Street NW, #1  
Preston, MN 55965-1080  
507-765-2175  
Fax: 507-765-3895

## Freeborn County

203 W Clark Street  
Albert Lea, MN 56007-1246  
507-377-5400  
Fax: 507-377-5498

## Goodhue County

469 12th Street  
Red Wing, MN 55066-0031  
651-385-3200  
Fax: 651-385-3205

## Grant County

28 Central S  
Elbow Lake, MN 56531-1006  
218-685-8200 / 800-291-2827  
Fax: 218-685-4978

## Hennepin County

330 South 12<sup>th</sup> Street  
Minneapolis, MN 55404-9760  
612-596-1300  
Fax: 612-466-9923

## Houston County

304 S. Marshall Street, Rm 104  
Caledonia, MN 55921-0310  
507-725-5811  
Fax: 507-725-3990

## Hubbard County

205 Court Avenue  
Park Rapids, MN 56470-1483  
218-732-1451 / 877-450-1451  
Fax: 218-732-3231

## Isanti County

1700 E Rum River Dr S, Suite A  
Cambridge, MN 55008-9386  
763-689-1711  
Fax: 763-689-9877

## Itasca County

1209 Second Avenue SE  
Grand Rapids, MN 55744-3983  
218-327-2941 / 800-422-0312  
Fax: 218-327-5548

## Jackson County

407 5th Street  
Jackson, MN 56143-0067  
507-847-4000  
Fax: 507-847-5616

## Kanabec County

905 Forest Avenue East, #150  
Mora, MN 55051-1316  
320-679-6350  
Fax: 320-679-6351

## Kandiyohi County

2200 23<sup>rd</sup> Street NE, Suite 1020  
Willmar, MN 56201-9423  
320-231-7800 / 877-464-7800  
Fax: 320-231-6285

## Kittson County

410 South Fifth Street, Suite 100  
Hallock, MN 56728  
218-843-2689 / 800-672-8026  
Fax: 218-843-2607

## Koochiching County

1000 Fifth Street  
Int'l Falls, MN 56649-2485  
218-283-7000 / 800-950-4630  
Fax: 218-283-7013

## Lac Qui Parle County

930 First Avenue N  
Madison, MN 56256-0007  
320-598-7594  
Fax: 320-598-7597

## Lake County

616 Third Avenue  
Two Harbors, MN 55616-1560  
218-834-8400  
Fax: 218-834-8412

## Lake of the Woods County

206 8<sup>th</sup> Avenue SE, Suite 200  
Baudette, MN 56623-0200  
218-634-2642  
Fax: 218-634-4520

## Le Sueur County

88 South Park Avenue  
Le Center, MN 56057-1646  
507-357-8288  
Fax: 507-357-6122

## Lincoln County

SWHHS  
319 Rebecca Street N  
Ivanhoe, MN 56142-0044  
507-694-1452 / 800-657-3781  
Fax: 507-694-1859

## Lyon County

SWHHS  
607 West Main  
Marshall, MN 56258-3099  
507-537-6747 / 800-657-3760  
Fax: 507-537-6088

## McLeod County

1805 Ford Avenue North, #100  
Glencoe, MN 55336  
320-864-3144 / 800-247-1756  
Fax: 320-864-5265

## Mahnomen County

311 N Main Street  
Mahnomen, MN 56557-0460  
218-935-2568  
Fax: 218-935-5459

## Marshall County

208 East Colvin Avenue, Suite 14  
Warren, MN 56762-1695  
218-745-5124 / 800-642-5444  
Fax: 218-745-5260

## Martin County

115 West First Street  
Fairmont, MN 56031-1815  
507-238-4757  
Fax: 507-238-1574

## Meeker County

114 North Holcombe Ave, #180  
Litchfield, MN 55355-2273  
320-693-5300 / 877-915-5300  
Fax: 320-693-5344

**Mille Lacs County**

525 Second Street SE  
Milaca, MN 56353  
320-983-8208/888-270-8208  
Fax: 320-983-8306

**MinnesotaCare Operations**

540 Cedar Street  
PO Box 64252  
St. Paul, MN 55164-0252  
651-297-3862/800-657-3672  
Fax: 651-431-7750

**Morrison County**

213 SE First Avenue  
Little Falls, MN 56345-3196  
320-632-2951/800-269-1464  
Fax: 320-632-0225

**Mower County**

201 1st Street NE  
PO Box 537  
Austin, MN 55912-3317  
507-437-9700  
Fax: 507-437-9774

**Murray County**

SWHHS  
3001 Maple Road, Suite 100  
Slayton, MN 56172-1493  
507-836-6144/800-657-3811  
Fax: 507-836-8841

**Nicollet County**

108 South Minnesota Ave, #200  
St. Peter, MN 56082-2516  
507-934-8559  
Fax: 507-931-9562

**Nobles County**

318 9th Street  
PO Box 189  
Worthington, MN 56187-0189  
507-295-5213  
Fax: 507-372-5094

**Norman County**

15 Second Avenue East, Room 108  
Ada, MN 56510-1389  
218-784-5400  
Fax: 218-784-7142

**Olmsted County**

2117 Campus Drive SE, Suite 100  
Rochester, MN 55904-4825  
507-328-6600  
Fax: 507-328-6339

**Otter Tail County**

535 Fir Avenue W  
Fergus Falls, MN 56537-2703  
218-998-8230  
Fax: 218-998-8270

**Pennington County**

318 N Knight Avenue  
Thief River Falls, MN 56701-0340  
218-681-2880  
Fax: 218-683-7013

**Pine County**

130 Oriole Street East, Suite 1  
Sandstone, MN 55072-5134  
320-216-4100/800-450-7263  
Fax: 320-216-4101

**Pipestone County****SWHHS**

1091 North Hiawatha Avenue  
Pipestone, MN 56164-0157  
507-825-6720/888-632-4325  
Fax: 507-825-6727

**Polk County**

612 N Broadway, Room 302  
Crookston, MN 56716-1483  
218-281-3127/877-281-3127  
Fax: 218-281-7347

**Or**

1424 Central Avenue NE  
East Grand Forks, MN 56721  
218-773-2431  
Fax: 218-773-3602

**Or**

104 N. Kaiser Avenue  
Fosston, MN 56542  
218-435-1585  
Fax: 218-435-1552

**Pope County**

211 East MN Avenue, Suite 200  
Glenwood, MN 56334-1628  
320-634-5750  
Fax: 320-634-0164

**Ramsey County**

160 East Kellogg Boulevard  
St. Paul, MN 55101-1494  
651-266-4444  
Fax: 651-266-3708

**Red Lake County**

125 Edward Avenue  
Red Lake Falls, MN 56750-0356  
218-253-4131/877-294-0846  
Fax: 218-253-2926

**Redwood County**

SWHHS  
302 E Third Street  
Redwood Falls, MN 56283  
507-637-4050/888-234-1292  
Fax: 507-637-4055

**Renville County**

105 S 5th Street, Suite 203H  
Olivia, MN 56277-1301  
320-523-2202  
Fax: 320-523-3565

**Rice County**

320 Third Street NW, #2  
Faribault, MN 55021-0718  
507-332-6115  
Fax: 507-332-6247

**Rock County**

SWHHS  
2 Roundwind Road  
Luverne, MN 56156-0715  
507-283-5070  
Fax: 507-283-5074

**Roseau County**

208 6th Street SW  
Roseau, MN 56751-1451  
218-463-2411/866-255-2932  
Fax: 218-463-3872

**St. Louis County**

320 West 2nd Street, Room 301  
Duluth, MN 55802-1495  
218-726-2101/800-450-9777  
Fax: 218-733-2975

**Or**

307 1st Street S – PO Box 1148  
Virginia, MN 55792-1148  
218-749-7137  
Fax: 218-749-7123

**Or**

320 Miners Dr. E  
Ely, MN 55731-1465  
218-365-8220  
Fax: 218-365-8217

**Or**

1814 14th Avenue East  
Hibbing, MN 55746-1314  
218-262-6000  
Fax: 218-262-6049

**Scott County For Adults**

792 Canterbury Road S  
Shakopee, MN 55379-1375  
952-496-8686  
Fax: 952-496-8685

**Or****Scott County for Families**

Workforce Center  
752 Canterbury Road  
Shakopee, MN 55379-1375  
952-496-8686  
Fax: 952-496-8685

**Sherburne County**

13880 Business Center Drive  
Elk River, MN 55330-4600  
763-765-4000/800-433-5239  
Fax: 763-765-4096

**Sibley County**

111 8th Street  
Gaylord, MN 55334-0237  
507-237-4000  
Fax: 507-237-4031

**Stearns County**

705 Courthouse Square  
St. Cloud, MN 56302-1107  
320-656-6000/800-450-3663  
Fax: 320-656-6447

**Steele County****MnPrairie**

630 Florence Avenue  
Owatonna, MN 55060-0890  
507-444-7500  
Fax: 507-451-5947

**Stevens County**

400 Colorado Avenue, Suite 104  
Morris, MN 56267  
320-208-6600/800-950-4429  
Fax: 320-589-3972

**Swift County**

410 21st Street South  
Benson, MN 56215-0208  
320-843-3160  
Fax: 320-843-4582

**Todd County**

212 Second Avenue South  
Long Prairie, MN 56347-1640  
320-732-4500/888-838-4066  
Fax: 320-732-4540

**Traverse County**

202 8th Street North  
Wheaton, MN 56296  
320-422-7777/855-735-8916  
Fax: 320-563-4230

**Wabasha County**

625 Jefferson Avenue  
Wabasha, MN 55981-1589  
651-565-3351/888-315-8815  
Fax: 651-565-3084

**Wadena County**

124 First Street SE  
Wadena, MN 56482-1553  
218-631-7605/888-662-2737  
Fax: 218-631-7616

**Waseca County****MnPrairie**

299 Johnson Avenue SW, Suite 160  
Waseca, MN 56093-2498  
507-835-0560  
Fax: 507-835-0566

**Washington County**

14949 62nd Street North  
PO Box 30  
Stillwater, MN 55082-0030  
651-430-6459  
Fax: 651-430-6605

**Watsonwan County**

715 Second Avenue S  
St. James, MN 56081-0031  
507-375-3294/888-299-5941  
Fax: 507-375-7359

**Wilkin County**

300 S Fifth Street  
Breckenridge, MN 56520-0369  
218-643-7161  
Fax: 218-643-7175

**Winona County**

202 West Third Street  
Winona, MN 55987-3146  
507-457-6200  
Fax: 507-454-9382

**Wright County**

1004 Commercial Drive  
Buffalo, MN 55313-1736  
763-682-7414/800-362-3667  
Fax: 763-682-8920

**Yellow Medicine County**

930 4th Street, #4  
Granite Falls, MN 56241-1367  
320-564-2211  
Fax: 320-564-4165

# **Notice of Privacy Practices**

## **Minnesota Department of Human Services**

(Effective Date: March 2014)

**This notice tells how medical and other private information about you may be used and disclosed and how you can get this information. Please review it carefully.**

### **Why do we ask for this information?**

- To tell you apart from other people with the same or similar name
- To decide what you are eligible for
- To help you get medical, mental health, financial or social services and decide if you can pay for some services
- To make reports, do research, do audits, and evaluate our programs
- To investigate reports of people who may lie about the help they need
- To decide about out-of-home care and in-home care for you or your children
- To collect money from other agencies, like insurance companies, if they should pay for your care
- To decide if you or your family need protective services
- To collect money from the state or federal government for help we give you.

### **Why do we ask you for your Social Security number?**

We need your Social Security number (SSN) to give you medical assistance, some kinds of financial help, or child support enforcement services (42 CFR 435.910 [2006]; Minn. Stat. 256D.03, subd.3(h); Minn. Stat.256L.04, subd. 1a; 45 CFR 205.52 [2001]; 42 USC 666; 45 CFR 303.30 [2001]). We also need your SSN to verify identity and prevent duplication of state and federal benefits. Additionally, your SSN is used to conduct computer data matches with collaborative, nonprofit and private agencies to verify income, resources, or other information that may affect your eligibility and/or benefits.

You do not have to give us the SSN:

- For persons in your home who are not applying for coverage
- If you have religious objections
- If you are not a U.S. citizen and are applying for Emergency Medical Assistance only
- If you are from another country, in the U.S. on a temporary basis and do not have permission from the U.S. Citizenship and Immigration Services (USCIS) to live in the U.S. permanently
- If you are living in the U.S. without the knowledge or approval of the USCIS.

### **Do you have to answer the questions we ask?**

You do not have to give us your personal information. Without the information, we may not be able to help you. If you give us wrong information on purpose, you can be investigated and charged with fraud.

### **With whom may we share information?**

We will only share information about you as needed and as allowed or required by law. We may share your information with the following agencies or persons who need the information to do their jobs:

- Employees or volunteers with other state, county, local, federal, collaborative, nonprofit and private agencies
- Researchers, auditors, investigators, and others who do quality of care reviews and studies or commence prosecutions or legal actions related to managing the human services programs.
- Court officials, county attorney, attorney general, other law enforcement officials, child support officials, and child protection and fraud investigators
- Human services offices, including child support enforcement offices
- Governmental agencies in other states administering public benefits programs
- Health care providers, including mental health agencies and drug and alcohol treatment facilities
- Health care insurers, health care agencies, managed care organizations and others who pay for your care
- Guardians, conservators or persons with power of attorney
- Coroners and medical investigators if you die and they investigate your death
- Credit bureaus, creditors or collection agencies if you do not pay fees you owe to us for services
- Anyone else to whom the law says we must or can give the information.

We may disclose your health information to a record locator service. This can help health care providers find health plans and other health care providers that have health information about you. The health care provider can then get that information to help make better decisions about your treatment. If you prefer not to be included in the record locator service, you may “opt out” by contacting the Community Health Information Collaborative (CHIC) service desk at 877-411-CHIC (toll free), 218-625-5515 (voice), 218-625-5518 (fax).

### **What are your rights regarding the information we have about you?**

- You and people you have given permission to may see and copy medical or other private information we have about you. You may have to pay for the copies.
- You may question if the information we have about you is correct. Send your concerns in writing. Tell us why the information is wrong or not complete. Send your own explanation of the information you do not agree with. We will attach your explanation any time information is shared with another agency.
- You have the right to ask us in writing to share health information with you in a certain way or in a certain place.

For example, you may ask us to send health information to your work address instead of your home address. If we find that your request is reasonable, we will grant it.

- You have the right to ask us to limit or restrict the way that we use or disclose your information, but we are not required to agree to this request.
- You have the right to get a record of some of the people or organizations with whom we have shared your information. This record was started on April 14, 2003. You must ask for a copy of this record in writing to our Privacy Official.
- If you do not understand the information, ask your worker to explain it to you. You can ask the Minnesota Department of Human Services for another copy of this notice.

## What are our responsibilities?

- We must protect the privacy of your medical and other private information according to the terms of this notice.
- We may not use your information for reasons other than the reasons listed on this form or share your information with individuals and agencies other than those listed on this form unless you tell us in writing that we can.
- We will not sell any data collected, created, or maintained as part of this application.
- We must follow the terms of this notice, but we may change our privacy policy because privacy laws change. We will put changes to our privacy rules on our website at:  
<http://edocs.dhs.state.mn.us/lfserver/Public/DHS-3979-ENG>

## What privacy rights do children have?

If you are under 18, when parental consent for medical treatment is not required, information will not be shown to parents unless the health care provider believes not sharing the information would risk your health. Parents may see other information about you and let others see this information, unless you have asked that this information not be shared with your parents. You must ask for this in writing and say what information you do not want to share and why. If the agency agrees that sharing the information is not in your best interest, the information will not be shared with your parents. If the agency does not agree, the information may be shared with your parents if they ask for it.

## What if you believe your privacy rights have been violated?

You may complain if you believe your privacy rights have been violated. You cannot be denied service or treated badly because you have made a complaint. If you believe that your medical privacy was violated by your doctor or clinic, a health insurer, a health plan, or a pharmacy, you may send a written complaint either to the county agency, the organization or to the federal civil rights office at:

- 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) or  
toll free 800-368-1019  
800-537-7697 (TTY)  
312-886-1807 (Fax)

If you think that the Minnesota Department of Human Services has violated your privacy rights, you may send a written complaint to the U.S. Department of Health and Human Services at the address above or to:

- Minnesota Department of Human Services  
Attn: Privacy Official  
PO Box 64998  
St. Paul, MN 55164-0998

# Rights and Responsibilities

## Immigration

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 unless you are applying for payment of long term care services.

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

- Applying for emergency medical care only.
- Helping someone else apply.
- Living in the United States without the knowledge or approval of the United States Citizenship and Immigration Services (USCIS) and are pregnant.
- Not applying for yourself.

## You Have the Right to Fair Treatment

Discrimination is against the law. The U.S. Department of Health and Human Services' Office for Civil Rights prohibits discrimination in its programs because of race, color, national origin, age, disability and sex, including sex stereotypes and gender identity. If you believe you have been discriminated against, you have the right to file a complaint directly with the federal agency.

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)  
800-368-1019 (Toll Free)  
312-353-5693 (TTY)

In Minnesota, if you believe you have been discriminated against because of race, color, national origin, religion, creed, sex, sexual orientation, public assistance status, age, or disability, you have the right to file a complaint with:

- Minnesota Department of Human Services  
Equal Opportunity and Access  
PO Box 64997  
St. Paul, MN 55164-0997  
651-431-3040 (Voice)  
711 or 800-627-3529 (MN Relay)
- Minnesota Department of Human Rights  
Freeman Building  
625 Robert St. N.  
St. Paul, MN 55155  
651-539-1100 (Voice)  
800-657-3704 (Toll-Free)  
651-296-1283 (TTY)

## You Have the Right to Ask for a Hearing

If you feel your benefits are wrong or your application has not been processed correctly, you may ask for a fair hearing. You can ask for a hearing by telling your worker or by writing to:

- Minnesota Department of Human Services  
Appeals and Regulations  
PO Box 64941  
St. Paul, MN 55164-0941

## Following the rules

People who are enrolled in Minnesota Health Care Programs must follow the rules listed below:

- Do not give false information or hide information to get or continue to get coverage.
- Do not trade or sell your membership cards.
- Do not help others get medical services that you know they should not get.
- Do not use someone else's membership card for yourself or other household members.

If you break the rules you may not be able to keep your coverage. Some adults without children who get their coverage through MinnesotaCare and break the rules, may have their coverage stop for one year the first time; for two years the second time; and forever after the third time. You can also be prosecuted for fraud if you break the rules. Additional fines and penalties may apply.

## Child Support

If you are applying for yourself and your children and you do not live with the other parent, the law says you may have to give information to child support staff. This includes helping the state prove who the father of your children is and getting the other parent to help pay the children's medical expenses. Your children will still get coverage if you do not help child support, but you may not get coverage unless you are pregnant.

If you are afraid the other parent may cause harm to you or your child, you can give proof to support your fears. We will review your proof and tell you if you still need to give information about the other parent.

## Reviews

The state or federal office may look at your case. They will review the information you gave us and check to make sure we did your case correctly. They will let you know if they need to ask you questions. If you do not answer their questions, your coverage may stop.

## Other Health Care

You and your household members may need to accept and keep a health insurance policy. This includes Medicare. If you do not give us information about your policy, you may not get coverage.

## Liens and Estate Claims

The state or county may try to recover the cost of medical services paid by Medical Assistance (MA) or General Assistance Medical Care (GAMC). The state may file a claim against your estate, against the estate of your surviving spouse or file a lien against your ownership interest in real property if you received:

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

Liens can be filed against:

- Your life estate interest in real property.
- Real property you own by yourself.
- Real property you own with someone else. If you own property with another person, the lien is only against your share.

You should talk to your lawyer or advisor if you have questions.

## Changes

You must report changes to your worker within 10 days of the change happening. If you do not report changes, you may have to pay money back to the State for what we paid if you were not eligible.

If you are not sure if you should report a change, call your worker and explain what is happening. Examples of changes you need to report include:

### Income:

- Starting a new job, changing jobs or stopping a job.
- Starting to get or changes in the amount of other income you get such as Social Security, other retirement income, child support, unemployment or workers' compensation.

### When you:

- Sell your home.
- Move to a new address.
- Get an inheritance or a settlement.
- Transfer or give away assets or income.

### When someone in your household:

- Starts to get health insurance or Medicare.
- Becomes pregnant or has a baby.
- Moves in or out of your home.
- Dies, gets married or gets a divorce.
- Becomes disabled.
- Starts or stops school.