Attached is a new Combined Application

Confirmation #

Applicant Summary:

BASIC INFO

Name

Date of Birth

Sex

Phone

Email

Communication Opt-In

EMPLOYMENT, INCOME & OTHER

Total # of Jobs

Job Searching?

Additional Info

JOBS

Employer/Business Name	Employer/Business Name	Employer/Business Name	Employer/Business Name
Self-employed?	Self-employed?	Self-employed?	Self-employed?
Gross Monthly Earnings	Gross Monthly Earnings	Gross Monthly Earnings	Gross Monthly Earnings
Pay Period	Pay Period	Pay Period	Pay Period
Wage Per Pay Period	Wage Per Pay Period	Wage Per Pay Period	Wage Per Pay Period

DEPARTMENT OF HUMAN SERVICES

Combined Application Form

Apply online at www.applymn.dhs.mn.gov

This application can be used to apply for any of the following programs:

Supplemental Nutrition Assistance Program (SNAP)

SNAP helps low income Minnesotans get the food they need for good nutrition and well-balanced meals. If you are age 60 and older and are applying for SNAP only, please use the "Supplemental Nutrition Assistance Program (SNAP) Application for Seniors" (DHS-5223F).

Cash assistance programs

Cash assistance programs are provided to help families and individuals meet their basic needs until they can support themselves. Cash assistance programs include:

- Diversionary Work Program (DWP)
- Emergency Assistance (EA)*
- General Assistance (GA)
- Group Residential Housing (GRH)
- Minnesota Family Investment Program (MFIP)
- Minnesota Supplemental Aid (MSA)
- Refugee Cash Assistance (RCA).

If you need help paying for child care, ask your worker how to apply for the Child Care Assistance Program.

Need to apply for Health Care coverage?
Apply for free or low-cost coverage at MNsure, Minnesota's online health insurance marketplace. Go to www.mnsure.org or call 855-366-7873.

How to fill out this application

Read all of the information in this application. Tell someone if you need help filling out this application. Complete and turn in pages 1–9 as soon as possible to your agency. We can set your application date if we have your name, address and signature (page 1), but we must have the complete application to decide if you can get help.

For your application to be complete, you must answer all questions and have certain information verified. SNAP and cash programs require an interview with a worker. For SNAP, this can be a phone interview.

If you miss your interview appointment, you must reschedule. If you do not reschedule, we may stop or not approve your benefits.

You may need to provide proof of the information you report on this application. Your worker may ask for additional proofs. You may not get help until we get proof of this information. Bring the required information with you to the interview or send the information to your worker as soon as you can.

Recertifications

Report all changes in the past 12 months on this application. You may need to provide proof of the reported information.

Required Information	Cash Programs	SNAP
Identity of applicant or authorized representative (driver's license, state ID, passport, etc.)	✓	✓
Social Security numbers of all people applying for help	✓	✓
Residency in Minnesota (state ID, lease agreement, etc.)	✓	✓
Income** (paystubs, pension, etc.) or any other money coming into your household (unemployment, sponsor income, etc.). The agency will verify Social Security income.	✓	✓
Housing costs*** (rent/house payment receipt, mortgage, lease, etc.)	✓	✓
Medical costs*** (prescription and medical bills, etc.)		✓
Relationship to other household members (birth certificates, marriage licenses, court documents, etc.)	✓	
Checking and savings accounts (bank statement, etc.)	✓	
Value of vehicles (cars, trucks, motorcycles, trailers, campers)	✓	
Current value of stocks/bonds, certificates of deposit, trusts (statement, etc.)	✓	
Utility costs (utility statement, phone bill, etc.)	✓	
Proof of illness or disability (doctor's statement, etc.)	✓	

* Before applying for Emergency Assistance, check with your agency regarding funding and specific eligibility criteria.

** Proof of income from the last 30 days or federal income tax records if you are self-employed.

*** Your SNAP benefits may increase if you also provide proof of these expenses: child support paid for children not living with you; housing costs; medical expenses (including prescriptions) for people with disabilities or who are age 60 or older. Your DWP benefits may increase if you provide proof of your housing and utility costs.

Important Information

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.

Denial or changes
The state may deny or change your cash or SNAP assistance because of information you give on the application. The state may make changes without giving you 10 days advance notice for cash assistance and SNAP. The state will send you written notice no later than the effective date of the change for cash assistance and no later than the date you receive or would receive your SNAP benefits.

For SNAP only
Household members may choose not to apply. The amount of SNAP benefits will depend on the number of people who apply. The Social Security number and citizenship or immigration questions do not need to be completed for those who do not apply. Household members who do apply must provide this information. Household members who are not applying must give information on their income and, in some cases, assets because this information is needed to see if the persons who are applying can get help.

Interim Assistance Programs
GA and GRH are "interim assistance programs." That means they will help you while you apply for other benefits. To get GA or GRH you have to apply for other benefits you may be eligible for, like Social Security or Worker's Compensation. If you get other benefits for the same period of time that you got GA or GRH, you will have to pay GA and GRH back.

Social Security numbers (SSN)
For most programs, 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 for programs such as SNAP, family cash assistance, 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 Refugee Cash Assistance you do not have to provide an SSN.

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 who is applying for help. You can apply and get help for other household members, even if you are not applying or if you are not eligible because of immigration status.

For non-citizen 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 the immigration status documents you give us are valid.

We will not share information about you with the USCIS without your permission. If you get cash it may affect changes to your immigration status. If you would like more information or would like to know what the agency 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 help. We only share it when the law allows it or requires it. In most cases, applying will not affect your immigration status.

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

- Only helping someone else apply
- Applying for your children or other household members, but not yourself.

Domestic violence and vulnerable adults
Violence or abuse is what someone says or does to make you feel afraid or to control you. People who are elderly, frail, have a disability, or who depend on others for assistance may not be able to protect themselves from domestic violence or abuse. Minnesota has a law to protect and assist adults who are vulnerable to abuse or who are not able to care for themselves. The law can help vulnerable adults get the protection and safety that they need.

Domestic violence
For more information on domestic violence, read 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 Violence hotline at 800-799-7233; 800-787-3224 (TTY) or Minnesota Coalition for Battered Women at 866-223-1111.

Vulnerable adults
To report suspected maltreatment of a vulnerable adult call the Minnesota Adult Abuse Reporting Center at 844-880-1574.

* The collection of this information, including the social security number (SSN) of each household member, is authorized under the Food Stamp Act of 1977, as amended, 7 U.S.C. 2011-2036. The information will be used to determine whether your household is eligible or continues to be eligible to participate in the Food Stamp Program. We will verify this information through computer matching programs. This information will also be used to monitor compliance with program regulations and for program management. This information may be disclosed to other Federal and State agencies for official examination, and to law enforcement officials for the purpose of apprehending persons fleeing to avoid the law. If a food stamp claim arises against your household, the information on this application, including all SSNs, may be referred to Federal and State agencies, as well as private claims collection agencies, for claims collection action. Providing the requested information, including the SSN of each household member, is voluntary. However, failure to provide an SSN will result in the denial of food stamp benefits to each individual failing to provide an SSN. Any SSNs provided will be used and disclosed in the same manner as SSNs of eligible household members.

DEPARTMENT OF HUMAN SERVICES

DHS-5223-ENG 11-16

Combined Application Form

Apply online at: www.applymn.dhs.mn.gov

Do not use this application to apply for health care coverage. The application date or the day your SNAP (food) or cash benefits can start is the date the agency gets your application. We can set your application date if we have your name, address and signature on page 1. For your application to be complete, answer all questions on the application. **Tell someone if you need help filling out this application. Be sure to sign and date the application on pages 1 and 9.**

CASE NUMBER

PERSON 1

APPLICANT'S LEGAL NAME – LAST	FIRST NAME	MIDDLE NAME	OTHER NAMES YOU USE (maiden name, nickname, etc.)

SOCIAL SECURITY NUMBER	DATE OF BIRTH	GENDER	MARITAL STATUS*
		◯ Male ◯ Female	◯ N ◯ M ◯ S ◯ L ◯ D ◯ W

ADDRESS WHERE YOU LIVE (if you do not have an address, write "homeless")	APT. NUMBER	CITY	STATE	ZIP CODE

MAILING ADDRESS (If different from address where you live)	APT. NUMBER	CITY	STATE	ZIP CODE

HOME PHONE NUMBER	OTHER PHONE NUMBER	DO YOU LIVE ON A RESERVATION?
		◯ No ◯ Yes – which one?

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

LAST SCHOOL GRADE COMPLETED	MOST RECENTLY MOVED TO MINNESOTA (mm/dd/yyyy)	U.S. CITIZEN OR U.S. NATIONAL?
	Date: From:	◯ Yes ◯ No

WHAT PROGRAM(S) ARE YOU APPLYING FOR?	ETHNICITY *(optional)*	RACE* *(optional)*
☐ SNAP (food) ☐ Cash programs ☐ Emergency Assistance** ☐ None	Hispanic? ◯ Yes ◯ No	☐ A ☐ B ☐ N ☐ P ☐ W

* **See MARITAL and RACE codes on the top of page 2.**

** Before applying for Emergency Assistance, check with your agency regarding funding and specific eligibility criteria.

Do you need help right away? Questions 1-4 below will help us decide if you can get help with food right away.

1. How much income (cash or checks) did or will your household get **this month**? $
2. How much does your household (including children) have in **cash, checking or savings**? $
3. How much does your household pay for **rent/mortgage per month**? $
   What **utilities** do you pay? ☐ Heat ☐ Air conditioning ☐ Electricity ☐ Phone ☐ None
4. Is anyone in your household a **migrant or seasonal farm worker**? ◯ Yes ◯ No
5. Has anyone in your household ever received cash assistance, commodities or SNAP benefits before? ◯ Yes ◯ No
   If yes, When? Where? What?
6. Is anyone in your household pregnant? ◯ Yes ◯ No If yes, Who?

AGENCY USE: **MEMB, MEMI, TYPE, PROG, IMIG, SPON**

Eligible for expedited SNAP? ◯ Yes ◯ No Same-day interview offered? ◯ Yes ◯ No Declined? ◯ Yes ◯ No Next-day interview offered? ◯ Yes ◯ No Declined? ◯ Yes ◯ No children adults	Intends to reside in MN? ◯ Yes ◯ No Has sponsor? ◯ Yes ◯ No Immigration status *Verification:* ◯ *requested* ◯ *attached*

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

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. Program rules require some people to get benefits together. 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:** Your spouse, other adult(s), children, all other people, anyone temporarily away from home. The ETHNICITY and RACE questions are optional and will not affect your eligibility or level of benefits. The reason we ask for this information is to assure that program benefits are distributed without regard to race, color, or national origin.

***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:** *(list all that apply)*
A = Asian **B** = Black or African American **N** = American Indian or Alaska Native **P** = Pacific Islander or Native Hawaiian **W** = White

Living situation: *(optional, choose one)*
◯ Own housing; lease, mortgage or roommate ◯ Family/friends due to economic hardship ◯ Emergency shelter
◯ Service provider - foster care, group home ◯ Hospital, treatment facility, detox center or nursing home ◯ Unknown
◯ Jail, prison or juvenile detention facility ◯ Hotel or motel ◯ Declined
◯ Place not meant for housing (anywhere outside, a vehicle, an abandoned building, or bus/train/airport)

PERSON 2

LEGAL NAME - LAST	FIRST NAME	MIDDLE NAME	OTHER NAMES

SOCIAL SECURITY NUMBER	DATE OF BIRTH	GENDER	RELATIONSHIP TO YOU	MARITAL STATUS*
		◯ Male ◯ Female		◯ N ◯ M ◯ S ◯ L ◯ D ◯ W

LAST SCHOOL GRADE COMPLETED	MOST RECENTLY MOVED TO MINNESOTA (mm/dd/yyyy)	U.S. CITIZEN or U.S. NATIONAL?
	Date: _____ From: _____	◯ Yes ◯ No

WHAT PROGRAM(S) IS THIS PERSON APPLYING FOR?	ETHNICITY *(optional)*	RACE *(optional)*
☐ SNAP (food) ☐ Cash programs ☐ Emergency Assistance** ☐ None	Hispanic? ◯ Yes ◯ No	☐ A ☐ B ☐ N ☐ P ☐ W

** Before applying for Emergency Assistance, check with your agency regarding funding and specific eligibility criteria.

***AGENCY USE:* MEMB, MEMI, TYPE, PROG, IMIG, SPON**

	IMMIGRATION STATUS	*VERIFICATION*
Intends to reside in MN? ◯ Yes ◯ No Has sponsor? ◯ Yes ◯ No		◯ *requested* ◯ *attached*

PERSON 3

LEGAL NAME - LAST	FIRST NAME	MIDDLE NAME	OTHER NAMES

SOCIAL SECURITY NUMBER	DATE OF BIRTH	GENDER	RELATIONSHIP TO YOU	MARITAL STATUS*
		◯ Male ◯ Female		◯ N ◯ M ◯ S ◯ L ◯ D ◯ W

LAST SCHOOL GRADE COMPLETED	MOST RECENTLY MOVED TO MINNESOTA (mm/dd/yyyy)	U.S. CITIZEN or U.S. NATIONAL?
	Date: _____ From: _____	◯ Yes ◯ No

WHAT PROGRAM(S) IS THIS PERSON APPLYING FOR?	ETHNICITY *(optional)*	RACE *(optional)*
☐ SNAP (food) ☐ Cash programs ☐ Emergency Assistance** ☐ None	Hispanic? ◯ Yes ◯ No	☐ A ☐ B ☐ N ☐ P ☐ W

** Before applying for Emergency Assistance, check with your agency regarding funding and specific eligibility criteria.

***AGENCY USE:* MEMB, MEMI, TYPE, PROG, IMIG, SPON**

	IMMIGRATION STATUS	*VERIFICATION*
Intends to reside in MN? ◯ Yes ◯ No Has sponsor? ◯ Yes ◯ No		◯ *requested* ◯ *attached*

PERSON 4

LEGAL NAME - LAST	FIRST NAME	MIDDLE NAME	OTHER NAMES

SOCIAL SECURITY NUMBER	DATE OF BIRTH	GENDER	RELATIONSHIP TO YOU	MARITAL STATUS*
		◯ Male ◯ Female		◯ N ◯ M ◯ S ◯ L ◯ D ◯ W

LAST SCHOOL GRADE COMPLETED	MOST RECENTLY MOVED TO MINNESOTA (mm/dd/yyyy)	U.S. CITIZEN or U.S. NATIONAL?
	Date: _____ From: _____	◯ Yes ◯ No

WHAT PROGRAM(S) IS THIS PERSON APPLYING FOR?	ETHNICITY *(optional)*	RACE *(optional)*
☐ SNAP (food) ☐ Cash programs ☐ Emergency Assistance** ☐ None	Hispanic? ◯ Yes ◯ No	☐ A ☐ B ☐ N ☐ P ☐ W

** Before applying for Emergency Assistance, check with your agency regarding funding and specific eligibility criteria.

AGENCY USE: **MEMB, MEMI, TYPE, PROG, IMIG, SPON**		
Intends to reside in MN? ◯ Yes ◯ No Has sponsor? ◯ Yes ◯ No	IMMIGRATION STATUS	*VERIFICATION* ◯ *requested* ◯ *attached*

PERSON 5

LEGAL NAME - LAST	FIRST NAME	MIDDLE NAME	OTHER NAMES

SOCIAL SECURITY NUMBER	DATE OF BIRTH	GENDER	RELATIONSHIP TO YOU	MARITAL STATUS*
		◯ Male ◯ Female		◯ N ◯ M ◯ S ◯ L ◯ D ◯ W

LAST SCHOOL GRADE COMPLETED	MOST RECENTLY MOVED TO MINNESOTA (mm/dd/yyyy)	U.S. CITIZEN or U.S. NATIONAL?
	Date: _____ From: _____	◯ Yes ◯ No

WHAT PROGRAM(S) IS THIS PERSON APPLYING FOR?	ETHNICITY *(optional)*	RACE *(optional)*
☐ SNAP (food) ☐ Cash programs ☐ Emergency Assistance** ☐ None	Hispanic? ◯ Yes ◯ No	☐ A ☐ B ☐ N ☐ P ☐ W

** Before applying for Emergency Assistance, check with your agency regarding funding and specific eligibility criteria.

AGENCY USE: **MEMB, MEMI, TYPE, PROG, IMIG, SPON**		
Intends to reside in MN? ◯ Yes ◯ No Has sponsor? ◯ Yes ◯ No	IMMIGRATION STATUS	*VERIFICATION* ◯ *requested* ◯ *attached*

If more than 5 people, complete DHS-5223S or use back page of application.

Tell us about your household. **(Answer all questions below.)**

◯ Yes ◯ No **1.** Does **everyone** in your household buy, fix **or** eat food with you?

AGENCY USE: **EATS**	
☐ *Confirmed response*	*VERIFICATION:* ◯ *requested* ◯ *attached*

◯ 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?

AGENCY USE: **EATS**	
☐ *Confirmed response*	*VERIFICATION:* ◯ *requested* ◯ *attached*

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

AGENCY USE: **SCHL**	
☐ *Confirmed response*	*VERIFICATION:* ◯ *requested* ◯ *attached*

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

AGENCY USE: **REMO**	
☐ *Confirmed response*	*VERIFICATION:* ◯ *requested* ◯ *attached*

◯ Yes ◯ No **5.** Is **anyone** blind, or does anyone have a physical or mental health condition that limits the ability to work or perform daily activities?

AGENCY USE: DISA, EMPS, PBEN, UNEA, WREG	
☐ *Confirmed response*	*VERIFICATION:* ◯ *requested* ◯ *attached*

◯ Yes ◯ No **6.** Is **anyone** unable to work for reasons other than illness or disability?

AGENCY USE: EMPS, WREG	
☐ *Confirmed response*	*VERIFICATION:* ◯ *requested* ◯ *attached*

◯ Yes ◯ No **7.** In the last 60 days did **anyone** in the household:
• Stop working or quit a job? • Refuse a job offer? • Ask to work fewer hours? • Go on strike?

AGENCY USE: STWK, STRK		
☐ *Confirmed response*	*ELIGIBLE FOR GOOD CAUSE:* ◯ Yes ◯ No	*VERIFICATION:* ◯ *requested* ◯ *attached*

What kinds of income do you have? (Answer all questions below.)

◯ Yes ◯ No **8.** Has **anyone** in the household had a job or been self-employed in the past 12 months?

◯ Yes ◯ No **a. For SNAP only:** Has anyone in the household had a job or been self-employed in the past 36 months?

AGENCY USE: JOBS	
☐ *Confirmed response*	*VERIFICATION:* ◯ *requested* ◯ *attached*

◯ Yes ◯ No **9.** Does **anyone** in the household have a job or expect to get income from a job this month or next month? **Bring or send proof.**

If yes:

EMPLOYEE NAME	HOURLY WAGE *(optional)*	GROSS MONTHLY EARNINGS
EMPLOYER/BUSINESS NAME		PAY FREQUENCY
EMPLOYEE NAME	HOURLY WAGE *(optional)*	GROSS MONTHLY EARNINGS
EMPLOYER/BUSINESS NAME		PAY FREQUENCY

Note: Include income from Work Study and paid internships. Include free benefits or reduced expenses received for work (shelter, food, clothing, etc.).

AGENCY USE: JOBS, STIN	
☐ *Confirmed response*	*VERIFICATION:* ◯ *requested* ◯ *attached*
HOW OFTEN PAID: ☐ *Daily* ☐ *Weekly* ☐ *Biweekly* ☐ *Semi-monthly* ☐ *Other*	

◯ Yes ◯ No **10.** Is **anyone** in the household self-employed or does anyone expect to get income from self-employment this month or next month? **Bring or send proof.**

If yes:

GROSS MONTHLY EARNINGS

Examples:
• Product sales • Conservation Reserve Program (CRP) • Personal services
• Farming • Paper route • In-home day care • Roomers/boarders
• Property rental • Taxi driver • Other

AGENCY USE: BUSI, RBIC	
☐ *Confirmed response*	*VERIFICATION:* ◯ *requested* ◯ *attached*

◯ Yes ◯ No **11.** Do you expect any changes in income, expenses or work hours?

AGENCY USE: **BUSI, JOBS, WKEX**	
☐ *Confirmed response*	*VERIFICATION:* ◯ *requested* ◯ *attached*

Principal Wage Earner (PWE)

SNAP (food) households with children must designate the person they want as the PWE. Any adult in your SNAP household can be the PWE. Talk to your worker before designating the SNAP PWE.

DESIGNATED PWE	SIGNATURE OF APPLICANT

12. Has **anyone** in the household applied for or does anyone get any of the following types of income each month? Check yes or no for each item. **Bring or send proof.**

◯ 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 (trusts, gifts, gambling, etc.) $ _____

*** The agency will verify this income for you.

AGENCY USE: **PBEN, UNEA**	
☐ *Confirmed response*	*VERIFICATION:* ◯ *requested* ◯ *attached*

◯ Yes ◯ No **13.** Does **anyone** in the household have or expect to get any loans, scholarships or grants for attending school?

AGENCY USE: **STIN**	
☐ *Confirmed response*	*VERIFICATION:* ◯ *requested* ◯ *attached*

What kinds of expenses do you have? (Answer all questions below.)

14. Does your household have the following housing expenses? Check yes or no for each item. **Bring or send proof.**

◯ Yes ◯ No Rent (include mobile home lot rental)

◯ Yes ◯ No Mortgage/contract for deed payment

◯ Yes ◯ No Homeowner's insurance (if not included in mortgage)

◯ Yes ◯ No Real estate taxes (if not included in mortgage)

◯ Yes ◯ No Rent or Section 8 subsidy

◯ Yes ◯ No Association fees

◯ Yes ◯ No Room and/or board

AGENCY USE: **SHEL, EATS**	
☐ *Confirmed response*	*VERIFICATION:* ◯ *requested* ◯ *attached*

15. Does **your household** have the following utility expenses **any time** during the year? Check yes or no for each item. **Bring or send proof.**

◯ Yes ◯ No Heating/air conditioning

◯ Yes ◯ No Water and sewer

◯ Yes ◯ No Electricity

◯ Yes ◯ No Garbage removal

◯ Yes ◯ No Cooking fuel

◯ Yes ◯ No Phone/cell phone

◯ Yes ◯ No Did you or anyone in your household receive LIHEAP (energy assistance) of more than $20 in the past 12 months?

AGENCY USE: **ACUT, HEST**	
☐ *Confirmed response*	*VERIFICATION:* ◯ *requested* ◯ *attached*

◯ Yes ◯ No **16.** Do **you or anyone living with you** have costs for care of a **child(ren)** because you or they are working, looking for work or going to school? The Child Care Assistance Program may help pay child care costs. Ask your worker how to apply for the Child Care Assistance Program.

AGENCY USE: **DCEX**	
☐ *Confirmed response*	*VERIFICATION:* ◯ *requested* ◯ *attached*

◯ Yes ◯ No **17.** Do **you or anyone living with you** have costs for care of an **ill or disabled adult** because you or they are working, looking for work or going to school?

AGENCY USE: **DCEX**	
☐ *Confirmed response*	*VERIFICATION:* ◯ *requested* ◯ *attached*

◯ Yes ◯ No **18.** 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?

AGENCY USE: **COEX**	
☐ *Confirmed response*	*VERIFICATION:* ◯ *requested* ◯ *attached*

◯ Yes ◯ No **19. For SNAP only:** Does **anyone** in the household have medical expenses?
To get a medical deduction you must provide proof of all 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.

AGENCY USE: **FMED**	
☐ *Confirmed response*	*VERIFICATION:* ◯ *requested* ◯ *attached*

What do you own? (Answer all questions below.)

20. Does **anyone** in the household own, or is **anyone** buying, any of the following? Check yes or no for each item.
Bring or send proof.

◯ Yes ◯ No Cash

◯ Yes ◯ No Bank accounts (savings, checking, debit card, etc.)

◯ Yes ◯ No Stocks, bonds, annuities, 401K, etc.

◯ Yes ◯ No Vehicles (cars, trucks, motorcycles, campers, trailers)

AGENCY USE: **CASH, CARS, ACCT, REST, SECU, SPON**		
☐ *Confirmed response*	*EFT OFFERED?* ◯ Yes ◯ No	*VERIFICATION:* ◯ *requested* ◯ *attached*

◯ Yes ◯ No **21. For Cash programs only:** Has **anyone** in the household given away, sold or traded anything of value **in the past 12 months**? (For example: Cash, Bank accounts, Stocks, Bonds, Vehicles)

AGENCY USE: **TRAN**	
☐ *Confirmed response*	*VERIFICATION:* ◯ *requested* ◯ *attached*

Other information (Answer questions below.)

◯ Yes ◯ No **22. For recertifications only:** Did **anyone** move in or out of your home in the past 12 months?

AGENCY USE: **ADME, REMO**	
☐ *Confirmed response*	*VERIFICATION:* ◯ *requested* ◯ *attached*

◯ Yes ◯ No **23.** For children under the age of 19, are **both** parents living in the home?

AGENCY USE: **INFC/CSIA, ABPS**	
☐ *Confirmed response*	*VERIFICATION:* ◯ *requested* ◯ *attached*

24. For MSA recipients only: Does **anyone** in the household have any of the following expenses?

◯ Yes ◯ No Representative Payee fees ◯ Yes ◯ No Guardian or Conservator fees

◯ Yes ◯ No Physician-prescribed special diet ◯ Yes ◯ No High housing costs

AGENCY USE: **DIET**	
☐ *Confirmed response*	*VERIFICATION:* ◯ *requested* ◯ *attached*

You may authorize another person(s) to act on your behalf to help you:

- **Fill out forms and apply for help from the agency** (for example, go to an interview for you, talk to or work with Employment services provider(s))
- **Get notices and information related to your case**
- **Get your SNAP benefits and buy food for you through your Electronic Benefit Transfer (EBT) account.**

You can ask more than one person(s) to help you with the items listed above. The authorized person(s) 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(s) can act for you until you notify your worker that you want this to end. Ask your worker for more information about authorized representatives. **All authorized person(s) must sign and date the last page of this application.**

AUTHORIZED PERSON 1

I WANT THE PERSON NAMED TO:	NAME	RELATIONSHIP		PHONE NUMBER
☐ Fill out forms ☐ Get notices ☐ Get and use my SNAP benefits	ADDRESS	CITY	STATE	ZIP CODE

AUTHORIZED PERSON 2

I WANT THE PERSON NAMED TO:	NAME	RELATIONSHIP		PHONE NUMBER
☐ Fill out forms ☐ Get notices ☐ Get and use my SNAP benefits	ADDRESS	CITY	STATE	ZIP CODE

AUTHORIZED PERSON 3

I WANT THE PERSON NAMED TO:	NAME	RELATIONSHIP		PHONE NUMBER
☐ Fill out forms ☐ Get notices ☐ Get and use my SNAP benefits	ADDRESS	CITY	STATE	ZIP CODE

Legal guardian

◯ Yes ◯ No Do you have a legal guardian or conservator, or is there a power of attorney?

If yes:

PERSON'S FULL NAME	DO YOU PAY A FEE? ◯ Yes ◯ No	IF YES, AMOUNT	HOW OFTEN?

Attach copies of legal documents.

Other help

◯ Yes ◯ No Are you currently getting help from a social worker or social services agency?

◯ Yes ◯ No Do you need help with referrals for other areas (for example, food shelves, housing, transportation)?

◯ Yes ◯ No Do you want to register to vote or update your registration?

COMMENTS

Penalty warnings and qualification questions

If you get cash or SNAP benefits, you must follow the rules listed below.

- **Do not give false information** or hide information to get or continue to get benefits. If you get cash or SNAP benefits and give false information or hide information about your **identity** and **residency** to get multiple benefits for the same period of time, you may be barred for 10 years.
- **Do not trade or sell SNAP benefits** or Electronic Benefit Transfer (EBT) access cards. **The trade or sale of benefits valued at over $500 may result in permanent ineligibility.**
- **Do not use cash or SNAP benefits to buy ineligible items**, such as alcohol and tobacco.
- **Do not use someone else's EBT access card(s)** to get cash or SNAP benefits for your household.

The state may bar household members who break any of these rules. 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.

You can also be prosecuted for fraud if you break the rules and additional fines and penalties may apply. The maximum penalty is a fine of $250,000 or a jail term of 20 years, or both.

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

- **Controlled substances**, that household member will be barred from getting SNAP for 24 months for the first offense and permanently for the second offense.
- **Firearms, ammunition or explosives**, that household member will be barred from getting SNAP permanently.

If you admit committing a drug felony in the past 10 years, the agency may ask you to take random drug tests. The first time you fail a drug test, the agency will reduce your household's MFIP or SNAP benefits 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 SNAP benefits from more than one state?
◯ 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?
◯ Yes ◯ No	4. Has anyone in your household been convicted of a drug felony in the past 10 years?
◯ Yes ◯ No	5. Is anyone in your household currently violating a condition of parole, probation or supervised release?

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

Employment services registration

I understand that signing this application registers me for employment services. I also understand that doing so automatically registers everyone in my home whom the agency approves to receive assistance with me for employment services. I understand that I or others in my home might have to take part in employment services to receive cash assistance or SNAP benefits.

Assignments

I understand that when I get MFIP I must assign my rights to child support and maintenance to the state of Minnesota.

Perjury and general declarations

I declare under the penalties of perjury that I have examined this application and to the best of my knowledge, it 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. [Minnesota Statutes, section 256.984, subd. 1]

Authorization to share information for fraud investigation and audits

I agree that third parties may share information about me with persons investigating fraud and conducting 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.

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

By signing:

- I understand cash assistance is provided to help eligible families meet their basic needs.
- I understand if I give incorrect information or misuse an electronic benefit transfer (EBT) card, I may be investigated and disqualified or prosecuted for fraud. [Minnesota Statute, sections 256.98 and 609.821]
- I acknowledge that since my last application or recertification, I have received my cash and/or SNAP benefits directly or used my EBT card to get my cash and/or SNAP benefits.
- I acknowledge that I have read and understand the "Penalty warnings and qualification questions" section on page 8.
- I acknowledge that my worker reviewed and explained the attached "Notice of Privacy Practices" (DHS-3979) and "Client Responsibilities and Rights" (DHS-4163).
- I agree to assign my child support as stated above.
- I agree to the sharing of information as stated on the fraud release information section above.
- I agree to the sharing of information as stated in the Social Security numbers section on page ii.

SIGNATURE OF APPLICANT OR AUTHORIZED REPRESENTATIVE	DATE	SIGNATURE OF SPOUSE OR OTHER ADULT	DATE
SIGNATURE OF AUTHORIZED REPRESENTATIVE	DATE	SIGNATURE OF AUTHORIZED REPRESENTATIVE	DATE

AGENCY USE

PROVIDED APPLICANT WITH THE FOLLOWING DOCUMENTS:

- ☐ Program information brochure (DHS-2920)
- ☐ Domestic Violence Information brochure (DHS-3477)
- ☐ Notice of Privacy Practices (DHS-3979) *(attached)*
- ☐ Responsibilities and Rights (DHS-4163) *(attached)*
- ☐ Important Information (DHS-3353) *(attached)*
- ☐ Notice About Income and Eligibility Verification System and Work Reporting System (DHS-2759) *(attached)*
- ☐ Do you have a disability? (DHS-4133)
- ☐ How to Use Your Minnesota EBT Card (DHS-3315A)
- ☐ Reviewed all pages of application with client

AGENCY SIGNATURE	INTERVIEW DATE	CASE NUMBER

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

ያስተውሉ: ይህንን ዶኩመንት ለመተርጎም እርዳታ የሚፈልጉ ከሆነ: የጉዳዮን ሰራተኛ ይጠይቁ ወይም በሰልክ ቁጥር 1-844-217-3547 ይደውሉ።

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

သတိ။ ဤစာရွက်စာတမ်းအားအခမဲ့ဘာသာပြန်ပေးခြင်း အကူအညီလိုအပ်ပါက၊ သင့်လူမှုရေးအလုပ်သမား အားမေးမြန်း ခြင်းသို့ မဟုတ် 1-844-217-3563 ကိုခေါ်ဆိုပါ။

កំណាត់សំគាល់ ។ បើអ្នកត្រូវការជំនួយក្នុងការបកប្រែឯកសារនេះដោយឥតគិតថ្លៃ សូមសួរអ្នកកាន់សំណុំរឿង របស់អ្នក ឬហៅទូរស័ព្ទមកលេខ 1-888-468-3787 ។

請注意，如果您需要免費協助傳譯這份文件，請告訴您的工作人員或撥打 1-844-217-3564。

Attention. Si vous avez besoin d’une aide gratuite pour interpréter le présent document, demandez à votre agent chargé du traitement de cas ou appelez le 1-844-217-3548.

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.

ဟ်သူဉ်ဟ်သးဘဉ်တက့်. ဖဲနမ့်လိဉ်ဘဉ်တ်မၤစၢၤကလီလၢတ်ကကျိးထံဝဲဒဉ်လ်ာ် တီလ်ာ်မီတခါအံၤန္ဉ်,သံကွါဘဉ်ပှၤဂ့ၢ်ဝီအပှၤမၤစၢၤတ်လၢနဂီၢ်မ့တမ့်ကီးဘဉ် 1-844-217-3549 တက့်.

알려드립니다. 이 문서에 대한 이해를 돕기 위해 무료로 제공되는 도움을 받으시려면 담당자에게 문의하시거나 1-844-217-3565으로 연락하십시오.

ໂປຣດຊາບ. ຖ້າຫາກ ທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປເອກະສານນີ້ຟຣີ, ຈົ່ງຖາມພະນັກງານກ່ຽວກັບການຊ່ວຍເຫຼືອ ຂອງທ່ານ ຫຼື ໂທຣໄປທີ່ 1-888-487-8251.

Hubachiisa. Dokumentiin kun bilisa akka siif hiikamu gargaarsa hoo feete, hojjettoota 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 (8-16)

ADA Advisory

For accessible formats of this information, ask your county worker. For assistance with additional equal access to human services, contact your county's ADA coordinator. ADA4 (2-18)

Notice of Privacy Practices

(Effective Date: November 2016)

This notice tells how 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?

- In order to determine whether and how we can help you, we collect 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 decide if you or your family need protective services
  - To decide about out-of-home care and in-home care for you or your children
  - To investigate the accuracy of the information in your application
- After we have begun to provide services or support to you, we may collect additional information:
  - 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 collect money from other agencies, like insurance companies, if they should pay for your care
  - To collect money from the state or federal government for help we give you.
  - When your or your family's circumstances change and you are required to report the change (see Client Responsibilities and Rights – DHS-4163)

Why do we ask you for your Social Security number?

We need your Social Security number 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 Social Security Number to verify identity and prevent duplication of state and federal benefits. Additionally, your Social Security Number 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 Social Security Number:

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

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.

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

- You and people you have given permission to may see and copy 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 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.
- 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 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 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?

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 to the address below:

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

DEPARTMENT OF HUMAN SERVICES

Client Responsibilities and Rights

Note: Cash on an Electronic Benefit Transfer (EBT) card is provided to help families meet their basic needs, including: food, shelter, clothing, utilities and transportation. These funds are provided until families can support themselves. It is illegal for an EBT user to buy or attempt to buy tobacco products or alcohol with the EBT card. If you do, it is fraud and you will be removed from the program. Do not use an EBT card at a gambling establishment or retail establishment, which provides adult-orientated entertainment in which performers disrobe or perform in an unclothed state for entertainment.

Your responsibilities

- **If you receive cash assistance and/or child care assistance,** you must report changes which may affect your benefits to the county agency within 10 days after the change has occurred. If you receive Supplemental Nutrition Assistance Program (SNAP) benefits, report changes by the 10th of the month following the month of the change. Each program may have different requirements for reporting changes. Talk to your caseworker about what you must report.

  You may be required to report changes in:
  - **Employment** – starting or stopping a job or business; change in hours, earnings or expenses
  - **Income –** receipt or change in child support, Social Security, veteran benefits, unemployment insurance, inheritance or insurance benefits
  - **Property –** purchase, sale or transfer of a house, car or other items of value, or if you receive an inheritance or settlement
  - **Household –** When a person dies or becomes disabled, moves in or out of your home or temporarily leaves; pregnancy; birth of a child.
  - **Citizenship or immigration status**
  - **Address**
  - **Housing costs and/or rent subsidy**
  - **Utility costs**
  - **Filing a lawsuit**
  - **Absent parent custody or visits**
  - **Drug felony conviction**
  - **Marriage, separation or divorce**
  - **School attendance**
  - **Health insurance coverage and premiums**

  Note: If you change child care providers, you must tell your child care worker and provider at least 15 days before the change goes into effect.

  If you have any questions or are unsure about any reporting rules, contact your worker. If your worker is not available, leave a message so the worker can get back to you.

- **The county, state or federal agency may check any of the information you provide.** To obtain some forms of information we must have your signed consent. If you don't allow the county to confirm your information, you might not receive assistance.

- **If you give us information you know is untrue, withhold information or do not report as required, or we discover your information is untrue,** you **may** be investigated for fraud. **This may result in you being disqualified from receiving benefits, charged criminally, or both.**

- **The state or federal quality control agency** may randomly choose your case for review. They will review statements you provided and will check to see if your eligibility was figured correctly. The state may seek information from other sources and will inform you about any contact they intend to make. **If you do not cooperate, your benefits may stop.**

- **Cooperation requirements:**
  - If the county approves you for the Minnesota Family Investment Program (MFIP) or the Diversionary Work Program (DWP), you must cooperate with employment services, unless you are exempt. You must develop and sign an employment plan or your DWP application will be denied.
  - To receive MFIP, DWP, and/or child care assistance, you must cooperate with child support enforcement for all children in your household. You have the right to claim "good cause" for not cooperating with child support enforcement. You must assign your child support to the state of Minnesota for all eligible children. If you do not cooperate or assign your child support, benefits will be denied or terminated.

  After the county approves your MFIP or DWP, if you receive child support directly from the noncustodial parent, you must report it to your worker.

For Cash and Supplemental Nutrition Assistance Program (SNAP) benefits:

- **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 EBT** card is used we assume you have received your cash or SNAP benefits, unless you reported your card lost or stolen to the county agency.

For Child Care Assistance:

- **You may be required to pay a co-payment fee to your child care provider.** 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.
- **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.

Note: If you sign the application as an authorized representative of a person who is requesting or receiving assistance, you are agreeing to assume all of the responsibilities listed above on behalf of that person.

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 explaining these rights.
- **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 for cash, SNAP and child care assistance
  - 60 days for cash related to disability.
- **You have the right to know the rules of the program you are applying for** and for the agency to tell you how your benefit amount was figured.
- **You have the right to choose where and with whom you live.**
- **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 assistance 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 SNAP, you may appeal **within 90 days** by writing or calling the county or the State Appeals Office. You may represent yourself at the hearing, or you may have someone (an attorney, relative, friend or another person) speak for you.

  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.

DEPARTMENT OF HUMAN SERVICES

Appeal rights

- **Appeal rights.** An appeal is a legal process where a human services judge reviews a decision made by the agency. You may appeal a decision if:
  - You feel the agency did not act on your request for assistance.
  - You do not agree with the action taken.

  You may represent yourself at the hearing, or you may have someone (an attorney, relative, friend or another person) speak for you.

  - **For emergency help**, when your case is about an emergency and you need a faster decision on your appeal, you can ask for an emergency hearing in your appeal request. You can also request it by calling the Department of Human Services Appeals Division.
  - **For cash, child care and health care**, you may appeal **within 30 days** from the date you received this notice by sending a written appeal request saying you do not agree with the decision. You can send this letter to the agency, or directly to the Appeals Division. If you show good cause for not appealing your cash, child care and health care **within 30 days**, the agency can accept your appeal for **up to 90 days** from the date of the notice. Good cause is when you have a good reason for not appealing on time. The Appeals Division will decide if your reason is a good cause reason. You can ask to meet informally with agency staff to try to solve the problem, but this meeting will not delay or replace your right to an appeal.
  - **For the Supplemental Nutrition Assistance Program**, you may appeal **within 90 days** by writing or calling the agency or the Appeals Division.
  - Submit your appeal request:
    - **Online:** https://edocs.dhs.state.mn.us/lfserver/Public/DHS-0033-ENG
    - **Write:** Minnesota Department of Human Services Appeals Division
P.O. Box 64941
St. Paul, MN 55164-0941
    - **Fax:** 651-431-7523
    - **Call:** Metro: 651-431-3600
Greater Minnesota: 800-657-3510
or use your preferred relay service
  - **If you want to keep receiving your benefits until the hearing,** you must appeal within 10 days of the date on the agency's notice of action letter or before the proposed action takes place in order to keep benefits in place. For most programs, if you file your appeal on time, you will get your benefits until the Appeals Division decides your appeal. If you lose your appeal, you may have to pay back the benefits you got while your appeal was pending. You can ask the agency to end your benefits until the decision. If you end your benefits and then win your appeal, you will be paid back for benefits that you should have received or, for child care assistance, your provider will be reimbursed for eligible costs that you paid or incurred. Ask your agency worker to explain how the timing of your appeal could affect your present or future assistance.

- **You have the right to reapply** at any time if your benefits stop.
- **Access to free legal services.** You may be able to get legal advice or help with an appeal from your local legal aid office. To find your local legal aid office, visit www.LawHelpMN.org or call 888-354-5522.

DEPARTMENT OF HUMAN SERVICES

Notice About Income and Eligibility Verification System and Work Reporting System

Read this if you are asking for or get:

- Cash Assistance:
  - Diversionary Work Program
  - Minnesota Family Investment Program
  - Refugee Cash Assistance
  - Minnesota Supplemental Aid
  - General Assistance
  - Emergency Assistance
- Supplemental Nutrition Assistance Program
- Minnesota Health Care Programs

What is the Income and Eligibility Verification System (IEVS)?

The government has a way to check income. It is the "Income and Eligibility Verification System" (IEVS).

The law has us check your income with other agencies. We have to check income for all who ask for or get cash assistance, Supplemental Nutrition Assistance Program (SNAP) benefits or Medical Assistance (MA). This includes your children.

We need Social Security Numbers (SSN) for anyone wanting help. If you have no SSN, you must apply for one. Apply with your county human services agency. You must report all SSNs to your worker.

What facts will we get? How will we use them?

We check with other agencies about your income, assets and health insurance. If you didn't tell us about all of your income or assets, we will refigure your aid. Your aid might go lower or stop. If you get aid you should not be getting, we may use these facts in civil or criminal lawsuits.

We will tell you if facts from other agencies are not the same as the facts you gave us. We will tell you what facts we got, the kind of income or assets, and the amount. We give you 10 days to respond in writing to prove if our facts are wrong.

We will ask you to show proof of income, assets, or health insurance you did not report or that we could not verify. You may need to give us permission to check the facts with the source of data. We will tell you what happens if you do not sign for permission or do not help us.

Agencies we get information from

We must trade facts with these agencies:

- United States Social Security Administration (SSA) - We get records of self-employment earnings, retirement income, survivor's benefits, disability payments, Social Security (RSDI), Supplemental Security Income (SSI).
- United States Internal Revenue Service (IRS) - We get records of unearned income (like interest and dividends).
- Minnesota Department of Employment and Economic Development (DEED) - We get records of wages and pay and facts on Unemployment Insurance.
- Minnesota Office of Child Support Division
- Agencies in other states that manage:
  - Unemployment Insurance
  - Cash assistance
  - Medical Assistance (MA)
  - SNAP
  - Child support
  - SSI state supplements

These agencies have the right to get certain facts from us about you. They have to use those facts for programs like RSDI, child support, cash assistance, SNAP, MA, Unemployment Insurance, and SSI.

What is the Work Reporting System?

Minnesota employers must tell us when they hire someone. This information is used by the Child Support Program. We also use this information to see if a new employee is getting help from any of the programs listed above.

How do we use it?

If the employee is getting help from any of these programs, the county worker gets a notice. If the client did not report the new job, the county worker will contact the client. The county worker may ask the client to show proof about the job. The client may need to give the county permission to check the facts with the employer. If a client does not help us check the information, they will lose benefits.

The law limits who gets facts about you

The law limits the facts about you that we get from other agencies and the facts we give them. Contracts with the Minnesota Department of Human Services and those agencies also protect you. Only those agencies, the state, and the county agency where you apply for and get program benefits can use the facts about you. No one else can get the facts about you without your written permission.

Your duty to report

You **must report** all of your income and assets.

- **If you receive cash assistance**, report any changes within 10 days of the change, **or**, if you report on a Household Report Form (DHS-2120), complete the form and return it by the 8th of the month.
- **If you receive SNAP**, report required changes by the 10th of the month following the month of the change. For example, if a change happens in March, you must report the change by April 10.

You **must** still report all of your income, assets and other information on redetermination forms we send you.

You **must** help the county agency check your income, assets and health insurance. IEVS is one way of proving your income, assets and health insurance amounts.

What if you do not help

You must help us check your income, assets and health insurance to get cash assistance, SNAP and MA. **If you don't, you and your family will not get help.**

Legal Authority

IEVS - 7 CFR, parts 271, 272, 273, 275; 42 CFR, parts 431, 435; 45 CFR, parts 205, 206, 233

Work Reporting - Minnesota Statutes Section 256.998, Subd. 10

Civil Rights Notice

Discrimination is against the law. The Minnesota Department of Human Services (DHS) does not discriminate on the basis of any of the following:

- race
- color
- national origin
- creed
- religion
- sexual orientation
- public assistance status
- marital status
- age
- disability
- sex
- political beliefs

Civil Rights Complaints

You have the right to file a discrimination complaint if you believe you were treated in a discriminatory way by a human services agency.

Contact **DHS** directly only if you have a discrimination complaint:

Civil Rights Coordinator
Minnesota Department of Human Services
Equal Opportunity and Access Division
P.O. Box 64997
St. Paul, MN 55164-0997
651-431-3040 (voice) or use your preferred relay service

Minnesota Department of Human Rights (MDHR)

In Minnesota, you have the right to file a complaint with the MDHR if you believe you have been discriminated against because of any of the following:

- race
- color
- national origin
- religion
- creed
- sex
- sexual orientation
- marital status
- public assistance status
- disability

Contact the **MDHR** directly to file a complaint:

Minnesota Department of Human Rights
Freeman Building, 625 North Robert Street
St. Paul, MN 55155
651-539-1100 (voice)
1-800-657-3704 (toll free)
711 or 1-800-627-3529 (MN Relay)
651-296-9042 (fax)
Info.MDHR@state.mn.us (email)

U.S. Department of Health and Human Services' Office for Civil Rights (OCR)

You have the right to file a complaint with the OCR, a federal agency, if you believe you have been discriminated against because of any of the following:

- race
- color
- national origin
- age
- disability
- sex
- religion

Contact the **OCR** directly to file a complaint:

Director, U.S. Department of Health and Human Services' Office for Civil Rights
200 Independence Avenue SW, Room 509F
HHH Building
Washington, DC 20201
1-800-368-1019 (voice)
1-800-537-7697 (TDD)
Complaint Portal:
https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

In accordance with Federal civil rights law and **U.S. Department of Agriculture (USDA)** civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at 1-800-877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call 1-866- 632-9992. Submit your completed form or letter to USDA by:

(1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, DC 20250-9410;
(2) fax: 202-690-7442; or
(3) email: program.intake@usda.gov

This institution is an equal opportunity provider.