DEPARTMENT OF HUMAN SERVICES

MINNESOTA HEALTH CARE PROGRAMS (MHCP)

Application for Certain Populations

■ What is this application for?

Use this application if everyone in the household who wants to apply for health care coverage meets at least one of these criteria:

- Is 65 years old or older
- Is blind or has a disability
- Is only requesting help with Medicare costs
- Is 21 years old or older, has no dependents, and has Medicare coverage
- Receives Supplemental Security Income (SSI)
- Is applying for Medical Assistance for Employed Persons with Disabilities (MA-EPD)

Use other applications for these purposes:

- 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 Medical Assistance for Long-Term-Care Services (MA-LTC) (DHS-3531).
- If you have a disability or are 65 years old or older and would like services to help you stay in your home, use the Minnesota Health Care Programs Application for Medical Assistance for Long-Term-Care Services (MA-LTC) (DHS-3531). Also ask your county or tribal agency about a long-term-care consultation.

People who don't meet any of these criteria should apply for health care coverage through MNsure, Minnesota's health insurance marketplace. These include adults who are applying for coverage and have dependents under the age of 19, even if the adults otherwise meet the criteria for using this application. Use the online application at www.mnsure.org, or the Application for Health Coverage and Help Paying Costs (DHS-6696). Individual members of the household who are 65 years old or older, are blind, have a disability, or need access to home and community-based services will then receive a referral with a supplemental form to complete.

You can find these applications on the web at https://mn.gov/dhs/health-care/paper-applications/ or have one mailed to you by calling your county or tribal agency. The phone numbers are listed in Attachment C.

■ What do I need to do with this form?

1. Read the Notice of Privacy Practices and Notice of Rights and Responsibilities in Attachment A. 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. **Send copies of proofs. Do not send original documents.**
5. Mail or take the application to your county or tribal agency. The addresses are listed in Attachment C.

Send in your application right away even if you do not have all proofs. We will contact you if we need more information.

■ Questions?

If you have questions or need help, call your county or tribal agency. The phone numbers are listed in Attachment C. If you are 60 years old or older, you can also call the Senior LinkAge Line® at 800-333-2433. If you have a disability, you can also call Disability Hub MN™ at 866-333-2466.

The information on this page can help you decide whether you want to apply for Medical Assistance, Medicare Savings Programs, or both.

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 certain benefits you receive from this program.
- You may be required to choose a health plan and get all your health care services from providers in that plan.

Medical Assistance for Employed Persons with Disabilities (MA-EPD)

- If you have a disability and work, you may be eligible for MA-EPD.
- To be eligible for MA-EPD, applicants 65 years old or older must have been determined disabled before age 65.
- MA-EPD has unique financial eligibility policies that may be beneficial for people nearing age 63.
- To be eligible, you must have earnings and pay FICA taxes.
- You must pay a monthly premium. The premium may cost less than other types of health care coverage.
- If you have retirement assets, you can keep and accumulate more of those assets.
- Contact Disability Hub MN at 866-333-2466 for help deciding the best program to meet your health care needs.

Medicare Savings Programs

- These programs help pay for some Medicare costs. Three programs all pay for Medicare Part B premiums: Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), and Qualified Individual (QI).
- Payment of your Part B premiums can begin three months before the month we get your application.
- If you have income at or below 100 percent of the federal poverty guidelines (FPG), you may qualify for payment of both Medicare Part A and Part B premiums, and for payment of your Medicare deductibles and copays.
- If you are a qualified working and disabled individual with income no greater than 200 percent of the FPG, you qualify for the Qualified Working Disabled (QWD) program, which pays for the Medicare Part A premium.
- These programs allow you to have more assets than may be allowed by the Medical Assistance program.
- No claim is placed against your estate for benefits received from this program.
- You may be eligible for both Medical Assistance and the QMB, SLMB or QWD Medicare Savings Program.

Medical Assistance and Medicare Savings Programs

- You may be eligible for both Medical Assistance and a Medicare Savings Program.
- Medicare Savings Programs pay only some expenses related to Medicare coverage.
- Medical Assistance members may be subject to Minnesota's estate recovery and lien program, but only for Medical Assistance services.

For more information:

- Call your county or tribal agency. The phone numbers are listed in Attachment C.
- Go to https://mn.gov/dhs/people-we-serve/ for more information.

Clear Form

DEPARTMENT OF HUMAN SERVICES

DHS-3876-ENG 11-19

MINNESOTA HEALTH CARE PROGRAMS (MHCP)

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 if we need more information.***

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

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

Information about the person applying

FIRST NAME	MI	LAST NAME	DATE OF BIRTH

GENDER ◯ Rather not say ◯ Male ◯ Female

MARITAL STATUS ◯ Legally separated ◯ Divorced ◯ Never married ◯ Married ◯ Widowed

Do you have a Social Security number (SSN)*? ◯ Yes ◯ No

*See the Notice of Privacy Practices and Notice of Rights and Responsibilities (Attachment A) for information about Social Security numbers.

IF YES, WHAT IS YOUR SSN?

IF NO, HAVE YOU APPLIED FOR AN SSN? ◯ Yes ◯ No

IF YOU HAVE NOT APPLIED, WHY NOT? (Choose a reason code from the list on Attachment B)

Do you have a guardian or conservator? ◯ Yes – fill in the following ◯ No

NAME OF GUARDIAN OR CONSERVATOR	PHONE NUMBER

STREET ADDRESS	CITY	STATE	ZIP CODE

Have you ever been in the U.S. military? ◯ Yes ◯ No

Are you a student? ◯ Yes ◯ No

Are you blind? ◯ Yes ◯ No

Do you have a physical, mental, or emotional health condition that limits your activities (like bathing, dressing, daily chores, etc.)? ◯ Yes ◯ No

If yes, have you been determined disabled by the Social Security Administration (SSA) or the State Medical Review Team (SMRT)? ◯ Yes ◯ No

Do you need help staying in your home or help paying for care in a long-term-care facility, such as a nursing home? ◯ Yes ◯ No

Are you pregnant? ◯ Yes ◯ No ◯ Not applicable

IF YES, HOW MANY BABIES ARE EXPECTED?

DUE DATE (MM/DD/YYYY)

What language do you speak most of the time?

Do you need an interpreter? ◯ Yes ◯ No

OPTIONAL INFORMATION →

RACE (Choose one or more race codes from the list on Attachment B, or write in your race if it is not on the list.)

2. If you or anyone in your family is an American Indian or Alaska Native, some income and assets might not count toward your eligibility and you might not be required to pay premiums or copays. Do you want to apply for these exceptions?

◯ Yes – you need to complete and include Appendix A ◯ No

3. Address and phone number

STREET ADDRESS WHERE YOU ARE CURRENTLY LIVING	CITY	STATE	ZIP CODE	COUNTY
MAILING STREET ADDRESS (if different)	CITY	STATE	ZIP CODE	COUNTY

PHONE NUMBER	Do you plan to make Minnesota your home? ◯ Yes ◯ No	Do you currently have medical benefits from another state? ◯ Yes ◯ No

OPTIONAL INFORMATION ↓

What is your living situation? *(choose one)*

◯ I have my own housing (rent, pay a mortgage or share housing costs with a roommate).
◯ I live with family or friends because of economic hardship.
◯ I live in an emergency shelter.
◯ I live in a service provider's housing (foster home, group home or assisted living).
◯ I live in a hospital, nursing home, treatment facility or detox center.
◯ I live in a jail, prison or juvenile detention facility.
◯ I live in a hotel or motel.
◯ I live in a place not meant for housing (anywhere outside, a vehicle, an abandoned building, a bus or train station, or an airport). In which county do you live? _____
◯ Unknown
◯ I decline to answer.

4. Others living with you

(List your spouse, parents or guardians of children under 21, stepparents, children and stepchildren living in your home. Include people who are living away from home for a short time.) Do not include yourself. For people not seeking health care coverage, only name, date of birth and relationship are required.

Person 1

Does this person want health care coverage? ◯ Yes ◯ No

FIRST NAME	MI	LAST NAME	DATE OF BIRTH

RELATIONSHIP TO YOU	GENDER	MARITAL STATUS
	◯ Male ◯ Female	◯ Legally separated ◯ Divorced ◯ Never married ◯ Married ◯ Widowed

Does this person have a Social Security number (SSN)*? ◯ Yes ◯ No	IF YES, WHAT IS THE SSN?	IF NO, HAS THIS PERSON APPLIED FOR AN SSN? ◯ Yes ◯ No
*See the Notice of Privacy Practices and Notice of Rights and Responsibilities (Attachment A) for information about Social Security numbers.	IF PERSON HAS NOT APPLIED, WHY NOT? (Choose a reason code from the list on Attachment B)	

Does this person plan to make Minnesota his or her home? ◯ Yes ◯ No	Is this person a student? ◯ Yes ◯ No	Is this person blind? ◯ Yes ◯ No

Does this person have a physical, mental, or emotional health condition that limits activities (like bathing, dressing, daily chores, etc.)? ◯ Yes ◯ No	If yes, has this person been determined disabled by the Social Security Administration (SSA) or the State Medical Review Team (SMRT)? ◯ Yes ◯ No
Does this person need help staying in his or her home or help paying for care in a long-term-care facility, such as a nursing home? ◯ Yes ◯ No	
Has this person ever been in the U.S. military? ◯ Yes ◯ No	Does this person currently have medical benefits from another state? ◯ Yes ◯ No

Is this person pregnant? ◯ Yes ◯ No ◯ Not applicable	IF YES, HOW MANY BABIES ARE EXPECTED?	DUE DATE (MM/DD/YYYY)
OPTIONAL INFORMATION →	RACE (Choose one or more race codes from the list on Attachment B, or write in this person's race if it is not on the list.)	

Person 2

Does this person want health care coverage? ◯ Yes ◯ No

FIRST NAME	MI	LAST NAME	DATE OF BIRTH

RELATIONSHIP TO YOU	GENDER	MARITAL STATUS
	◯ Male ◯ Female	◯ Legally separated ◯ Divorced ◯ Never married ◯ Married ◯ Widowed

Does this person have a Social Security number (SSA)*? ◯ Yes ◯ No *See the Notice of Privacy Practices and Notice of Rights and Responsibilities (Attachment A) for information about Social Security numbers.	IF YES, WHAT IS THE SSN?	IF NO, HAS THIS PERSON APPLIED FOR AN SSN? ◯ Yes ◯ No
	IF PERSON HAS NOT APPLIED, WHY NOT? (Choose a reason code from the list on Attachment B)	

Does this person plan to make Minnesota his or her home? ◯ Yes ◯ No	Is this person a student? ◯ Yes ◯ No	Is this person blind? ◯ Yes ◯ No
Does this person have a physical, mental, or emotional health condition that limits activities (like bathing, dressing, daily chores, etc.)? ◯ Yes ◯ No	If yes, has this person been determined disabled by the Social Security Administration (SSA) or the State Medical Review Team (SMRT)? ◯ Yes ◯ No	
Does this person need help staying in his or her home or help paying for care in a long-term-care facility, such as a nursing home? ◯ Yes ◯ No		
Has this person ever been in the U.S. military? ◯ Yes ◯ No	Does this person currently have medical benefits from another state? ◯ Yes ◯ No	

Is this person pregnant? ◯ Yes ◯ No ◯ Not applicable	IF YES, HOW MANY BABIES ARE EXPECTED?	DUE DATE (MM/DD/YYYY)
OPTIONAL INFORMATION →	RACE (Choose one or more race codes from the list on Attachment B, or write in this person's race if it is not on the list.)	

5. Is anyone listed in Question 4 living away from home for a short time?

◯ Yes – fill in the information ◯ No

FIRST NAME	MI	LAST NAME	DATE LEFT	DATE EXPECTED TO RETURN

REASON FOR NOT LIVING AT HOME

6. Is everyone applying a U.S. citizen or U.S. national?

◯ Yes ◯ No – fill in the information

Person 1

NAME

What is this person's current immigration status? (Choose a status code from the list on Attachment B, or write in the status below if it is not on the list.)

a. IMMIGRATION DOCUMENT TYPE	b. ALIEN ID NUMBER	c. CARD NUMBER

d. Did this person enter the United States before August 22, 1996? ◯ Yes ◯ No

e. Has this person lived in the United States for five years or more in a qualified status? (See Attachment B to determine whether a status is qualified.) ◯ Yes ◯ No

f. DATE OF ENTRY (MM/DD/YYYY)

g. Does this person have a sponsor? ◯ Yes ◯ No

h. Is this person, or the person's spouse or parent, a veteran or active-duty member of the military? ◯ Yes ◯ No

i. Does this person want help paying for a medical emergency? ◯ Yes ◯ No

j. Is this person getting services from the Center for Victims of Torture? ◯ Yes ◯ No

k. Did this person ever have an immigration status different from his or her current status (example, refugee or asylee)?

◯ Yes – fill in the following ◯ No

What is this person's previous immigration status? (Choose a status code from the list on Attachment B, or write in the status below if it is not on the list.)

ORIGINAL DATE OF ENTRY (MM/DD/YYYY)

Person 2

NAME

What is this person's current immigration status? (Choose a status code from the list on Attachment B, or write in the status below if it is not on the list.)

a. IMMIGRATION DOCUMENT TYPE	b. ALIEN ID NUMBER	c. CARD NUMBER

d. Did this person enter the United States before August 22, 1996? ◯ Yes ◯ No

e. Has this person lived in the United States for five years or more in a qualified status? (See Attachment B to determine whether a status is qualified.) ◯ Yes ◯ No

f. DATE OF ENTRY (MM/DD/YYYY)

g. Does this person have a sponsor? ◯ Yes ◯ No

h. Is this person, or the person's spouse or parent, a veteran or active-duty member of the military? ◯ Yes ◯ No

i. Does this person want help paying for a medical emergency? ◯ Yes ◯ No

j. Is this person getting services from the Center for Victims of Torture? ◯ Yes ◯ No

k. Did this person ever have an immigration status different from his or her current status (example, refugee or asylee)?

◯ Yes – fill in the following ◯ No

What is this person's previous immigration status? (Choose a status code from the list on Attachment B, or write in the status below if it is not on the list.)

ORIGINAL DATE OF ENTRY (MM/DD/YYYY)

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

◯ Yes – complete Appendix B ◯ No

(You can give a trusted person permission to talk about this application with us, see your information and act for you on matters related to this application, including getting information about your application and signing your application on your behalf.)

8. Does anyone applying for health care on this application want help from MA to pay for medical bills from the past three months?

(The start date for MA can go back up to three months. You must have medical bills and meet the MA requirements for each month you want coverage.)

◯ Yes – fill in the information ◯ No

WHICH PERSON? (First, MI, Last)	HOW MANY MONTHS?
	◯ One ◯ Two ◯ Three
WHICH PERSON? (First, MI, Last)	HOW MANY MONTHS?
	◯ One ◯ Two ◯ Three

You must provide proof of your medical expenses, income and assets in each of the months for which you are requesting coverage. Refer to the types of proof listed after each of the following questions for examples of acceptable proof for the income and assets you had.

9. Is anyone self-employed, or does anyone expect to be self-employed next month?

◉ Yes – fill in the information ◉ No

Name	Type of work	Monthly income	Monthly expenses	Start date (MM/DD/YYYY)
		$	$	
		$	$	

You must provide proof of this income. Proof may be most recent income tax returns and all related schedules, or business records if taxes are not filed.

10. Is anyone working, or does anyone expect to work in the next month?

◯ Yes – fill in the information ◯ No

Person 1

NAME		
EMPLOYER NAME		START DATE (MM/DD/YYYY)
Is this job seasonal? ◯ Yes ◯ No	Has this job ended? ◯ Yes ◯ No	IF YES, END DATE (MM/DD/YYYY)

Wages and tips before taxes (Choose one and fill in the dollar amount and your hours per week.)

◯ Hourly	$ _____ per hour	Hours per week: _____
◯ Weekly	$ _____	Hours per week: _____
◯ Every two weeks	$ _____	Hours per week: _____
◯ Twice a month	$ _____	Hours per week: _____
◯ Monthly	$ _____	Hours per week: _____
◯ Yearly	$ _____	Hours per week: _____

Person 2

NAME

EMPLOYER NAME	START DATE (MM/DD/YYYY)

Is this job seasonal?	Has this job ended?	IF YES, END DATE (MM/DD/YYYY)
◯ Yes ◯ No	◯ Yes ◯ No	

Wages and tips before taxes (Choose one and fill in the dollar amount and your hours per week.)

◯ Hourly	$ _____ per hour	Hours per week: _____
◯ Weekly	$ _____	Hours per week: _____
◯ Every two weeks	$ _____	Hours per week: _____
◯ Twice a month	$ _____	Hours per week: _____
◯ Monthly	$ _____	Hours per week: _____
◯ Yearly	$ _____	Hours per week: _____

You must provide proof of this income. Proof may be paystubs or a written statement of earnings from your employer if you do not have paystubs.

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

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

◯ Yes – fill in the information ◯ No

Person 1

NAME

Type of income	Amount	How often received?	Has this income ended?
	$		◯ Yes – END DATE: _____ ◯ No
	$		◯ Yes – END DATE: _____ ◯ No
	$		◯ Yes – END DATE: _____ ◯ No
	$		◯ Yes – END DATE: _____ ◯ No

Person 2

NAME

Type of income	Amount	How often received?	Has this income ended?
	$		◯ Yes – END DATE: _____ ◯ No
	$		◯ Yes – END DATE: _____ ◯ No
	$		◯ Yes – END DATE: _____ ◯ No
	$		◯ Yes – END DATE: _____ ◯ No

You must provide proof of this income. Proof may be award letters, copies of checks, tax forms, court orders, or other documents.

12. Is anyone in the household blind, or does anyone have a disability?

◯ Yes – fill in the information ◯ No

Name	Does this person have work expenses?	If yes, type of expenses	Monthly amount
	◯ Yes ◯ No ◯ Not applicable		$
	◯ Yes ◯ No ◯ Not applicable		$

You must provide proof of these work expenses.

Questions 13–24 are for only those household members who are 21 years old or older.

13. How much cash do you or your spouse have on hand, in a safety deposit box, at home and at the facility where you live?	$

14. Do you or your spouse have savings or checking accounts, money market accounts or certificates of deposit?

◯ Yes – fill in the information ◯ No

Owner name(s)	Type of account	Bank name and address	Account number

You must provide proof of these assets. Proof may be recent account statements or a written statement from your bank, credit union, or other financial institution showing the current balance or value of accounts.

15. Do you or your spouse have stocks, bonds or retirement accounts?

◯ Yes – fill in the information ◯ No

Owner name(s)	Type of investment	Company or bank name and address	Account number

You must provide proof of these assets. Proof may be copies of bonds, stock ownership, retirement accounts, or documents showing current loan balance owed against the asset.

16. Do you or your spouse own or co-own houses, condominiums, summer or winter homes, cabins, mobile homes, time-shares, rental properties, any other real estate, or life estate interests or remainder interests in real property?

◯ Yes – fill in the information ◯ No

Owner name(s)	Type of property	Property address	Do you or your spouse live here all year?
			◯ Yes ◯ No
			◯ Yes ◯ No
			◯ Yes ◯ No
			◯ Yes ◯ No

You must provide proof of these assets. Proof may be real property tax statements, warranty deeds, quit claim deeds, life estate or other real property agreements or documents showing the amounts owed against the property.

17. Do you or your spouse own or co-own promissory notes, contracts for deed or other property agreements?

◯ Yes – fill in the information ◯ No

Owner name(s)	Type of property

You must provide proof of these assets. Proof may be copies of the contract for deed, mortgage, loan contract, or promissory note.

18. Do you or your spouse have any vehicles in your name?

Include cars, trucks, vans, motorcycles, motor homes, campers, boats, snowmobiles, all-terrain vehicles, etc.

◯ Yes – fill in the information ◯ No

Owner name(s)	Type of vehicle	Year, make, model

You must provide proof of these asset. Proof may be copies of your vehicle title.

19. Do you or your spouse have an interest in a trust or annuity?

◯ Yes – fill in the information ◯ No

Owner name(s)	Type

You must provide proof of these assets. Proof may be copies of the annuity contract, other documents showing the value of the annuity or copies of the entire trust document.

20. Do you or your spouse have life insurance?

◯ Yes – fill in the information ◯ No

Owner name(s)	Policy number	Insurance company name and address

You must provide proof of the current cash surrender value of all policies. You must provide copies of the life insurance policy.

21. Do you or your spouse have a prepaid burial account or burial trust?

Include revocable and irrevocable accounts, insurance-funded burials, annuity-funded burials, Cremation Society agreements, burial spaces, burial space items and other funds designated for burial.

◯ Yes – fill in the information ◯ No

Owner name(s)	Type of burial asset	Company or bank name and address

You must provide proof of these assets. Proof may be copies of the life insurance policy, burial contracts or other documents showing the current value of the assets.

22. Do you or your spouse have assets currently used for self-employment or in a business in which you or your spouse has an interest?

◯ Yes – fill in the information ◯ No

Owner name(s)	Type of asset

You must provide proof of these assets. Proof may be current tax documents, business ledgers, or account statements.

23. Do you or your spouse own or co-own any other assets you have not listed?

◯ Yes – fill in the information ◯ No

Owner name(s)	Type of asset

You must provide proof of these assets.

24. Do you or your spouse live in a continuing care retirement community?

◯ Yes ◯ No

You must provide proof of the entrance fee.

25. Is anyone applying for health care on this application getting medical care for an accident or injury that happened in the last six years?

◯ Yes – fill in the information ◯ No

Name	Type of accident of injury	Date happened (MM/DD/YYYY)	Is there a lawsuit?
			◯ Yes ◯ No
			◯ Yes ◯ No

You must provide proof of your medical injury. Proof may be information about your injury; third-party insurance claims, including automobile insurance claims; or workers' compensation payments or benefits.

26. Does anyone have Medicare, other health coverage or long-term-care insurance now, or has anyone had coverage in the last three months?

◯ Yes – fill in the information ◯ No

Person 1

NAME

COVERAGE TYPES

☐ Medicare ☐ Medicare supplemental policy ☐ Medical insurance ☐ Hospital only ☐ HMO ☐ Prescription drug
☐ Dental ☐ Vision ☐ Long-term care ☐ Other (list type) _____

POLICYHOLDER'S NAME	INSURANCE COMPANY NAME	START DATE (MM/DD/YYYY)	END DATE (MM/DD/YYYY)

POLICY NUMBER	LIST EVERYONE WHO IS COVERED BY THIS POLICY	MONTHLY PREMIUM
		$

Is this health insurance through an employer or union? ◯ Yes ◯ No

Person 2

NAME

COVERAGE TYPES

☐ Medicare ☐ Medicare supplemental policy ☐ Medical insurance ☐ Hospital only ☐ HMO ☐ Prescription drug
☐ Dental ☐ Vision ☐ Long-term care ☐ Other (list type) _____

POLICYHOLDER'S NAME	INSURANCE COMPANY NAME	START DATE (MM/DD/YYYY)	END DATE (MM/DD/YYYY)

POLICY NUMBER	LIST EVERYONE WHO IS COVERED BY THIS POLICY	MONTHLY PREMIUM
		$

Is this health insurance through an employer or union? ◯ Yes ◯ No

You must provide proof of your health care coverage. Proof may be front and back copies of your health insurance cards, documentation of monthly premium amounts, written documentation of coverage from the health insurance provider or copies of paid medical bills.

WORKER NOTES

Signature Page

(Effective Date: February 2020)

Read the following information and sign.

Please complete this page and read the attached Notice of Privacy Practices and Notice of Rights and Responsibilities (Attachment A) before signing this page.

By signing this page:

I received and reviewed the Notice of Privacy Practices and the Notice of Rights and Responsibilities (Attachment A). I know that I must report changes to the information listed on this application.

I declare under the penalties of perjury that this application has been examined by me and to the best of my knowledge is a true and correct statement of every material point. I understand that a person convicted of perjury may be sentenced to imprisonment of not more than five years or payment of a fine of not more than $10,000, or both. I understand that there may be other penalties for not telling the truth.

Additional agreements for Medical Assistance

I consent to the release of my Minnesota Health Care Programs health records to the parties listed in the Consent for Sharing of Medical Information section of the Notice of Rights and Responsibilities.

- I give the Medical Assistance agency our rights to pursue and get any money from other health insurance, legal settlements, or other third parties.
- I have read and understand that the state may claim repayment for the cost of medical care, or the cost of the premiums paid for care, from my estate or my spouse's estate.
- I understand that my information, and information about me shared from third parties, will be shared for fraud prevention investigations as stated in the Notice of Privacy Practices.
- If I am a parent that is eligible for Medical Assistance, I understand I may be asked to cooperate with the agency that collects medical support from an absent parent. If I think that cooperating to collect medical support will harm me or my children, I can tell the agency, and I may not have to cooperate. I give to the Medical Assistance agency the rights to medical support paid for my children.
- I understand that the assets owned by me in the last month I am eligible for MA-EPD, and, if allowed under law, the assets of my spouse, will be designated to my Employment Incentive Asset Account (EIAA). The assets designated to my EIAA will be disregarded if I continue my MA eligibility under the basis of a person age 65 or older if I have been enrolled in MA-EPD for 24 consecutive months and did not become ineligible for MA for a calendar month or more before my 65th birthday.

YOUR SIGNATURE	DATE
AUTHORIZED REPRESENTATIVE SIGNATURE, IF APPLICABLE	DATE

Submit your completed and signed application

Submit your completed and signed application and your proofs in one of these three ways:

- Fax your application for faster processing.
- Mail your application.
- Submit your application in person.

Mail, fax, or bring your application and proofs to your county or tribal agency. Send copies of proofs. Do not send original documents. Note: Ask your worker if you need help getting proofs. Some required proofs, such as certification of disability, citizenship and identity, will first be requested electronically from other government agencies.

If you want to register to vote in Minnesota, you can complete a voter registration form at sos.state.mn.us.

Attachment A

MINNESOTA DEPARTMENT OF HUMAN SERVICES

Notice of Privacy Practices and Notice of Rights and Responsibilities

(Effective Date: November 2018)

Notice of Privacy Practices

This part of the notice describes how private or confidential information about you may be used and disclosed. 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 and mental health services and decide whether you can pay for some services
- To decide whether you or your family need protective services
- To decide about out-of-home care and in-home care for you or your children
- To make reports, do research, do audits, and evaluate our programs
- To investigate reports of people that may lie about the help they need or to get assistance they may not be entitled to receive
- 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

Why do we ask you for your Social Security number?

We need your Social Security number (SSN) to give you Medical Assistance (MA), some kinds of financial help, and child support enforcement services (42 USC 666; Minn. Stat. 256L.04, subd. 1a; 42 CFR 435.910).

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 our partner nonprofit and private agencies to verify income, resources, and other information that may affect your eligibility or benefits.

You do not have to give us the SSN for people in your home who are not applying for coverage. You also do not have to give us your SSN:

- 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, are 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

Why do we ask you for your financial information?

We use this information only for the purposes authorized by law, such as verifying eligibility or determining the amount of a premium. We will not share this information with any other person or entity.

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 could be investigated and then charged with a crime.

With whom may we share information?

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

- Employees or volunteers with other state, county, local, federal, and partner nonprofit and private agencies
- Researchers, auditors, investigators, and others that do quality-of-care reviews and studies or begin prosecutions or legal actions related to managing the human services programs
- Court officials, county attorneys, attorneys general, other law enforcement officials, child support officials, child protection and fraud investigators, and fraud prevention 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 that pay for your care
- Guardians, conservators or people with power of attorney who are authorized representatives
- 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, in limited situations
- Certified application counselors, in-person assisters, and navigators and anyone else the law says we must or can give the information to

What are our responsibilities?

- We must protect the privacy of your personal, health care 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 people 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 and give you a copy of it, but we may change our privacy policy. Those changes will apply to all information we have about you. The new notice will be available on request, and we will put changes to it on our website at https://edocs.dhs.state.mn.us/lfserver/Public/DHS-4839E-ENG.
- The law requires us to keep your private information private and secure.
- If something happens that causes your private information to no longer be private and secure, we will let you know right away.

This part of the notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

We can use and share your health care information to

- **Help manage the health care treatment you receive**
  - We can use your health information and share it with professionals who are treating you. *Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.*
  - We can also share your information with guardians, conservators or people with power of attorney who are authorized representatives
- **Run our organization**
  - We can use and share your information to run our organization and contact you when necessary. This includes sharing your information with employees or volunteers with other state, county, local, federal, and partner nonprofit and private agencies, including child support offices.
  - We can share your information with these people and groups:
    - Auditors, investigators, and others that do quality-of-care reviews and studies
    - Credit bureaus, creditors or collection agencies if you do not pay fees you owe to us for services, in limited situations
    - Certified application counselors, in-person assisters, and navigators and anyone else the law says we must or can give the information to
  - We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long-term-care plans. *Example: We use health information about you to develop better services for you.*
- **Pay for your health services**
  - We can use and share your health information as we pay for your health services. *Example: We share information about you with your dental plan to coordinate payment for your dental work.*
- **Help with public health and safety issues**
  - We can share health information about you for purposes such as:
    - Preventing disease
    - Helping with product recalls
    - Reporting adverse reactions to medications
    - Reporting suspected abuse, neglect, or domestic violence
    - Preventing or reducing a serious threat to anyone's health or safety
- **Do research**
  - We can use or share your information for health research.
- **Comply with the law**
  - We will share information about you if state or federal laws require it. This includes sharing information with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
- **Respond to organ and tissue donation requests and work with a medical examiner or funeral director**
  - We can share health information about you with organ procurement organizations.
  - We can share health information with a coroner, medical examiner, or funeral director when a person dies.
- **Address workers' compensation, law enforcement, and other government requests**
  - For workers' compensation claims
  - For law enforcement purposes or with a law enforcement official
  - With health oversight agencies for activities authorized by law
  - With governmental agencies in other states administering public benefits programs
  - For special government functions, such as military, national security, and presidential protective services
- **Respond to lawsuits and legal actions**
  - We can share health information about you in response to a court order. We may share the information with court officials, county attorneys, attorneys general, other law enforcement officials, child support officials, child protection and fraud investigators, and fraud prevention investigators.

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

Get a copy of health and claims records

- You and people you have given permission to may see and copy private information we have about you, such as health and claims records. You may have to pay for the copies.
- You can choose someone to act for you with a medical power of attorney or as a legal guardian. That person can exercise your rights and make choices about your information.

Ask us to correct health and claims records

- You may question whether the information we have about you is correct. Send your concerns in writing. Tell us why the information is wrong or incomplete. Send your own explanation of the information you do not agree with. We will attach your explanation anytime information is shared.

Request confidential communications

- You have the right to ask us in writing to share health information with you in a certain way or in a certain place.
- We will consider all reasonable requests. We must say yes if you tell us you would be in danger if we did not. 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.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request and we may say no if it would affect your care.

Get a list of those with whom we've shared information

- This list will not include disclosures for treatment, payment, and health care operations. It will also not include certain other disclosures, such as any you asked us to make.
- We'll provide one list a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

If you do not understand the information, ask your worker to explain it to you. You may ask the Minnesota Department of Human Services for another copy of this notice.

What are your choices?

For certain health information, you can tell us your choices about what we share.

You have both the right and choice to tell us to:

- Share health information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

Tell us what you want us to do, and we will follow your instructions. If you are not able to tell us your preference, for example, if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

What privacy rights do children have?

If you are under 18, when parental consent for medical treatment is not required, information will be provided to parents only when the medical provider believes that your health is at risk if the information is not shared. 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 to either the county agency, the organization or 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)
800-368-1019 (toll free)
800-537-7697 (TTY)
312-886-1807 (fax)

If you believe the Minnesota Department of Human Services violated your privacy rights, you may also contact:

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

Whom do you contact if you need more information about privacy practices?

If you need more information about privacy practices, call the Minnesota Health Care Programs (MHCP) Member Help Desk at 800-657-3739 or 651-431-2670.

Notice of Rights and Responsibilities

Changes

If you have MA, you must report a change within 10 days of the change happening. Call your county or tribal agency to report the change.

If you do not report changes, you may have to pay money back to the state or federal government for benefits that you received but were not eligible for. If you are not sure whether to report a change, call and explain what is happening. Examples of changes you need to report include the following:

Income changes when you

- Start a new job, change jobs or stop a job
- Start to get, or receive changes in the amount of, other income like Social Security, other retirement income and unemployment

Residence changes when you

- Move to a new address

Life changes in your household when someone

- Starts or stops other health insurance or Medicare
- Becomes pregnant or has a baby
- Moves in or out of your home
- Changes tax filing status
- Loses Minnesota residency
- Changes citizenship or lawful presence status
- Changes incarceration status
- Dies, gets married or gets a divorce
- Becomes disabled

Reviews

The state or federal agency's health care program auditors may look at your case. They will review the information you gave us and check to make sure we processed your case correctly. They will let you know if they need to ask you questions.

Consent for Sharing of Medical Information

In your application for Minnesota Health Care Program coverage, you have given your written and signed consent to the following agencies and people to share between them medical information about you only for the limited purposes indicated:

- Health providers, including health plans, insurance agencies, Minnesota Health Care Programs, county advocates, school districts, your county or state case workers, and their contractors and subcontractors, for these purposes:
  - To determine who should pay for your health care
  - To provide, manage and coordinate health care services
- All other agencies or people listed on this Notice of Privacy Practices and Notice of Rights and Responsibilities, for this purpose:
  - To administer Minnesota Health Care Programs, pay for services, and conduct research and investigations

This consent applies to medical information about your minor children you applied for on this application.

You 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 you are 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 or for payment of your bills, fraud investigations or quality-of-care review and studies.

An agency or person who gets your information through this consent could give the information to others.

If you end this consent, you cannot enroll or stay enrolled in Minnesota Health Care Programs.

Other Health Care

You and your household members enrolled in MA must tell us about any other health insurance that you have or that is available to you, including employer-sponsored coverage, private health insurance, long-term-care insurance, and any limited health coverage, such as dental or accident coverage. You must tell us whether your employer offers insurance and whether you accepted it.

You and your household members enrolled in MA may need to accept and keep a health insurance policy when the policy is found to be cost effective. If you have a good reason for not doing that, you may ask the state to approve the reason. If you do not give us information about your health insurance policy, you may not get coverage.

You must also tell us when you become eligible for Medicare. MA pays for the Medicare premiums of some low-income people. Once you are eligible for Medicare Part B and Part D, MA will no longer pay for services that could be covered by a Medicare program.

MA Medical 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 if both you and your child are eligible for MA. This includes helping the state prove who the father of your children is and helping the state to get the other parent to help pay the children's medical expenses. If you do not help child support staff, your children will still get coverage, but your coverage will end, unless you are pregnant.

If you are afraid the other parent may cause harm to you or your child, you can give your county or tribal agency proof to support your fears. The agency will review your proof and tell you whether you still must give information to child support staff.

Assignment of Medical Payments

By accepting MA, you give your rights to all medical payments for yourself and anyone else you apply for to the state of Minnesota. These include medical payments from all other people or companies, including medical support payments from an absent parent. This assignment of medical payments begins as soon as health care coverage starts. For MA for Long-Term Care, this includes your right to support from your spouse under Minnesota Statutes, section 256B.14, subdivision 3.

You also agree to help the state get paid back for medical expenses that should have been paid by others. You may not have to help the state if you have a good reason for not helping and the state approves the reason.

MA Estate Claims and Liens

In certain circumstances, federal and state law require the Minnesota Department of Human Services and local agencies to recover costs that the MA program paid for its members health care services. This recovery process is done through Minnesota's MA estate recovery and lien program.

If you are enrolled in MA when you are 55 years old or older, then, after you die, Minnesota must try to recover certain payments the MA program made for your health care, including:

- Nursing home services
- Home and community-based services
- Related hospital and prescription drug costs

If you permanently live in a medical institution, Minnesota must also try to recover the costs of all MA services you receive at any age while living in a medical institution. If you are permanently living in a medical institution and you do not have a spouse or disabled child living on your homesteaded real property, the state may file an MA lien against your real property to recover MA costs before your death. However, MA members who qualify for services under modified adjusted gross income (MAGI) eligibility criteria are not subject to recovery for services received before the age of 55.

After you die, the state also may file a notice of potential claim, which is a form of lien, against real property to recover MA costs. Liens to recover MA costs may be filed against the following:

- Your life estate or joint tenancy interest in real property
- Your real property that you own solely
- Your real property that you own with someone else

Minnesota cannot start recovery of these costs while your spouse is still living or if you have a child under 21 years old or a child who is permanently disabled. Once your spouse dies, Minnesota must try to recover your MA costs from your spouse's estate. However, recovery is further delayed if you still have a child who is under 21 or permanently disabled.

Your children do not have to use their assets to reimburse the state for any MA services you received.

You have the right to speak with a legal-aid group or a private attorney if you have specific questions about how MA estate recovery and liens may affect your circumstance and estate planning. The Minnesota Department of Human Services cannot provide you with legal advice. For more information, go to http://mn.gov/dhs/ma-estate-recovery/.

You Have the Right to Ask for a Hearing

If you feel your health care eligibility or benefits are wrong or your application was not processed correctly, you may ask for an appeal hearing. By requesting an appeal hearing, you are requesting a fair review of your case. You can represent yourself or use an attorney, advocate, authorized representative, relative, friend or other person. You will find specific appeal instructions on all eligibility notices that you receive. Learn more about the appeals process and how to ask for a hearing at www.dhs.state.mn.us/appeals/faqs.

You can complete and submit an appeal request online at https://edocs.dhs.state.mn.us/lfserver/Public/DHS-0033-ENG.

You can also print the form that is available at the address above and submit the completed form by fax to 651-431-7523 or by mail to this address:

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

Immigration

Immigration information you give to us is private. We use it to see whether you can get coverage. We share it only when the law allows it or requires it, such as to verify identity. 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 a pregnant woman living in the United States without the knowledge or approval of the United States Citizenship and Immigration Services (USCIS). You also do not have to give us your immigration information if you are:

- Applying for emergency medical care only
- Helping someone else apply
- Not applying for yourself

Genetic Information

DHS does not collect, maintain or use genetic information for purposes of eligibility.

Record Retention

Information provided in an application for coverage through DHS is subject to the False Claims Act and may be kept for up to 10 years. DHS follows the general records retention schedules for state agencies and for the Department of Human Services and maintains data according to state and federal law. After the appropriate time period, DHS destroys the data in a way that prevents their contents from being determined, including by shredding paper files and permanently removing electronic data so as to prevent recovery.

Instructions for completing this application

Social Security number

Choose a reason for not applying for a Social Security number (SSN) and place your letter choice in the proper question.

Reasons for not applying for an SSN:

A. Not eligible for an SSN
B. Can be issued for nonwork reason only
C. No SSN because of religious objections
D. No SSN as newborn or newly adopted
E. Other

Immigration status

Choose an immigration status from this list and place your letter choice in the proper question. The immigration statuses with an asterisk (*) are qualified statuses.

A. American Indian born in Canada (Immigration and Nationality Act [INA], section 289)*
B. Amerasian noncitizen*
C. Asylee*
D. Conditional entrant*
E. Cuban or Haitian entrant*
F. Deportation being withheld under section 243(h) or 231(b)(3) of the INA
G. Refugee*
H. Special Iraqi or Afghani immigrant*
I. Victim of severe trafficking (LPR or T Visa)*
J. Withholding of removal*
K. Battered noncitizen*
L. Lawful permanent resident (LPR)*
M. Paroled for at least one year*
N. Temporary nonimmigrant
O. Deferred action for childhood arrivals

Race (optional)

If you choose to answer the question about race, choose a race or races from this list and place your letter choice(s) in the proper question.

A. White
B. Black or African American
C. American Indian or Alaska Native
D. Asian Indian
E. Chinese
F. Filipino
G. Japanese
H. Korean
I. Vietnamese
J. Other Asian
K. Native Hawaiian
L. Guamanian or Chamorro
M. Samoan
N. Other Pacific Islander
O. Other (please write in the race)

Attachment C

Agency Addresses

(Effective Date: September 2021)

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

Anoka County
Economic Assistance Department
1201 89th Ave NE, Suite 400
Blaine, MN 55434
763-422-7200
Fax: 763-324-3620

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

Beltrami County
616 America Ave NW
Bemidji, MN 56601
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 2nd Street NW
P.O. Box 338
Ortonville, MN 56278-0338
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, Suite 100
Cloquet, MN 55720-0660
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 11th Street, Suite 502
Moorhead, MN 56560-2095
218-299-5200 / 800-757-3880
Fax: 218-299-7106

Clearwater County
216 Park Avenue NW
Bagley, MN 56621-9500
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
DVHHS
11 Fourth Street
Windom, MN 56101-0009
507-831-1891
Fax: 507-831-0126

Crow Wing County
204 Laurel Street
Brainerd, MN 56401-0686
218-824-1250 / 888-772-8212
Fax: 218-824-1305

Dakota County
1 Mendota Road West, #100
West St. Paul, MN 55118-4765
651-554-5611
Fax: 651-554-5748

Dept of Human Services
Health Care Consumer Support
540 Cedar Street, PO Box 64252
St. Paul, MN 55164-0252
651-297-3862 / 800-657-3672
Fax: 651-431-7750

Dodge County
MnPrairie
22 Sixth Street East, Dept. 401
Mantorville, MN 55955
507-923-2900 / 888-850-9419
Fax: 507-635-6186

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

Faribault County
FMCHS
412 Nicollet Street North
Blue Earth, MN 56013
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
426 West Avenue
Red Wing, MN 55066
651-385-3200
Fax: 651-267-4879

Grant County
15 Central Avenue N, PO Box 1006
Elbow Lake, MN 56531-1006
218-685-8200 / 800-291-2827
Fax: 218-685-4978

Hennepin County
PO Box 107
Minneapolis, MN 55440-0107
612-596-1300
Fax: 612-288-2981
Call if you need office hours and office location information.

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
218-732-1451 / 877-450-1451
Fax: 218-732-3231

Isanti County
1700 E Rum River Dr S, Suite A
Cambridge, MN 55008-2547
763-689-1711
Fax: 763-689-9877

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

Jackson County
DVHHS
407 5th Street, PO Box 67
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 23rd 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
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 8th Avenue SE, Suite 200
Baudette, MN 56623
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
SWMHHS
319 N Rebecca Street
Ivanhoe, MN 56142
507-694-1452 / 800-657-3781
Fax: 507-694-1859

Lyon County
SWMHHS
607 West Main Street, Suite 100
Marshall, MN 56258
507-537-6747 / 800-657-3760
Fax: 507-537-6088

McLeod County
520 Chandler Avenue North
Glencoe, MN 55336
320-864-3144 / 800-247-1756
Fax: 320-864-5265

Mahnomen County
PO Box 460
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

Attachment - Keep this page.

Martin County
FMCHS
115 West First Street
Fairmont, MN 56031
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

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, Suite 18
Austin, MN 55912-3405
507-437-9700
Fax: 507-437-9721

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

Nicollet County
622 South Front Street
St. Peter, MN 56082-2106
507-934-8559
Fax: 507-934-8552

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 200
Rochester, MN 55904
507-328-6500
Fax: 507-328-7956

Otter Tail County
535 Fir Avenue W
Fergus Falls, MN 56537
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
315 Main Street S, Suite 200
Pine City, MN 55063
320-591-1570
Fax: 320-591-1601

Or

1602 Highway 23 N
Sandstone, MN 55072-5009
320-216-4100
Fax: 320-216-4101

Pipestone County
SWMHHS
1091 North Hiawatha Avenue
Pipestone, MN 56164
507-825-6720 / 888-632-4325
Fax: 507-825-5649

Polk County
612 N Broadway, Room 302
Crookston, MN 56716
218-281-3127 / 877-281-3127
Fax: 218-281-3926

Or

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

Or

250 SW Cleveland Avenue
PO Box 100
McIntosh, MN 56556
21-435-1585 / 877-281-3127
Fax: 218-435-1552

Pope County
211 East MN Avenue, Suite 200
Glenwood, MN 56334-1629
320-634-7755
Fax: 320-634-0164

Ramsey County
160 East Kellogg Boulevard
St. Paul, MN 55101-1494
651-266-4444
Fax: 651-266-3942

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

Redwood County
SWMHHS
266 E Bridge 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
320-523-2202
Fax: 320-523-3565

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

Rock County
SWMHHS
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
Duluth, MN 55802-1495
218-726-2101 / 800-450-9777
Fax: 218-726-2163

Or

307 S 1st Street – PO Box 1148
Virginia, MN 55792-1148
218-471-7137
Fax: 218-471-7123

Or

320 Miners Drive E
Ely, MN 55731-1402
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
752 Canterbury Rd S
Shakopee, MN 55379
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
PO Box 237
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
507-431-5600
Fax: 507-635-6186

Stevens County
400 Colorado Avenue, Suite 104
Morris, MN 56267-1235
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, PO Box 46
Wheaton, MN 56296
320-422-7777 / 855-735-8916
Fax: 320-563-4230

Wabasha County
411 Hiawatha Drive E
Wabasha, MN 55981-1573
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
507-837-6600
Fax: 507-635-6186

Washington County
14949 62nd Street North
PO Box 30
Stillwater, MN 55082-0030
651-430-6455
Fax: 651-430-6605

Watonwan County
715 Second Avenue S
St. James, MN 56081-1741
507-375-3294 / 888-299-5941
Fax: 507-375-7359

Wilkin County
227 6th Street North
PO Box 369
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: 507-454-9381

Wright County
1004 Commercial Drive
Buffalo, MN 55313-1736
763-682-7400 / 800-362-3667
Fax: 763-682-7701

Yellow Medicine County
415 9th Avenue, Suite 202
Granite Falls, MN 56241
320-564-2211
Fax: 320-564-4165

White Earth Financial Services
PO Box 100
Nay-tah-waush, MN 56566
218-935-5554

Attachment - Keep this page.

Appendix A – American Indian or Alaska Native Family Member (AI or AN)

American Indians and Alaska Natives (AI and AN) have certain health coverage benefits and protections. If you or your family members qualify, some income and assets might not count toward your eligibility, and you may not be required to pay co-pays, deductibles, or monthly premiums for some programs. Complete this appendix and submit it with your application if you want to apply for these exceptions.

You must provide proof of AI or AN status. Proof can be a document issued by an AI or AN tribe, such as an enrollment or membership card; a document from the Indian Health Service (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.

Note: If you have more people to include, make copies of this page and attach them.

	AI or AN PERSON 1	AI or AN PERSON 2
1. Name (First Name, Middle Name, Last Name)	First _____ Middle _____ Last _____	First _____ Middle _____ Last _____
2. Is this person receiving or has this person ever received a service from the Indian Health Service, a tribal health program or an urban Indian health program or through a referral from one of these programs?	◯ Yes ◯ No	◯ Yes ◯ No

3. Certain money received may not be counted for Medical Assistance (MA). Some assets also may not be counted for MA or are excluded as an asset for up to one year after receipt. List any income and assets (amount and how often received) reported on your application that include money from these sources:
• For income:
  • Per capita payments from a tribe that come from natural resources, usage rights, rent, leases or royalties
  • Cobell Settlement payments for American Indians or Alaska Claims Settlement Act payments
  • Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (Including reservations and former reservations)
  • Money from selling things that have cultural significance
• For assets:
  • Money that you still have from any of the income sources listed previously
  • Real property located on Indian land or land held in a trust
  • Ownership interests in rents, leases, royalties, or usage rights related to natural resources or things that have cultural significance.
	Income $ _____
	Type _____
	How often? _____
	
	Assets $ _____
	Type _____
		Income $ _____
		Type _____
		How often? _____
		
		Assets $ _____
		Type _____

4. Does this person live on a reservation?	◯ Yes ◯ No	◯ Yes ◯ No

Appendix B – Authorized Representative Designation

You can choose an authorized representative.

You can give a trusted person permission to talk about this application with us, see your information and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an "authorized representative." If you ever need to change your authorized representative, contact your county or tribal agency. Contact information is listed in Attachment C.

A legally appointed representative for someone on this application must submit proof with the application.

1. NAME OF AUTHORIZED REPRESENTATIVE (First Name, Middle Name, Last Name)		RELATIONSHIP TO YOU, IF ANY	
2. ADDRESS		3. APARTMENT OR SUITE NUMBER	
4. CITY		5. STATE	6. ZIP CODE
7. PHONE NUMBER	8. ORGANIZATION NAME	9. ID NUMBER (if applicable)	

By signing, you allow this person to sign your application, get official information about this application and act for you on all future matters with this agency.

10. YOUR SIGNATURE	11. DATE (MM/DD/YYYY)

Authorized Representative Signature

By signing, I agree to be an authorized representative for this household. I understand my responsibilities including keeping information about the people applying on this application private.

☐ I would like to get information by email at: _____

AUTHORIZED REPRESENTATIVE SIGNATURE	DATE (MM/DD/YYYY)

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 (including sex stereotypes and gender identity)
- political beliefs

Auxiliary Aids and Services: DHS provides auxiliary aids and services, like qualified interpreters or information in accessible formats, free of charge and in a timely manner to ensure an equal opportunity to participate in our health care programs. Call 651-431-2670 or 800-657-3739 or use your preferred relay service.

Language Assistance Services: DHS provides translated documents and spoken language interpreting, free of charge and in a timely manner, when language assistance services are necessary to ensure limited English speakers have meaningful access to our information and services. Call 651-431-2670 or 800-657-3739 or use your preferred relay service.

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. You may contact any of the following three agencies directly to file a discrimination complaint.

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

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

Office for Civil Rights
U.S. Department of Health and Human Services
Midwest Region
233 N. Michigan Avenue, Suite 240
Chicago, IL 60601
Customer Response Center:
Toll-free: 1-800-368-1019
TDD Toll-free: 1-800-537-7697
Email: ocrmail@hhs.gov

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
540 Fairview Avenue North, Suite 201
St. Paul, MN 55104
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)

DHS

You have the right to file a complaint with DHS if you believe you have been discriminated against in our health care programs because of any of the following:

- race
- color
- national origin
- creed
- religion
- sexual orientation
- public assistance status
- marital status
- age
- disability
- sex (including sex stereotypes and gender identity)
- political beliefs

Complaints must be in writing and filed within 180 days of the date you discovered the alleged discrimination. The complaint must contain your name and address and describe the discrimination you are complaining about. After we get your complaint, we will review it and notify you in writing about whether we have authority to investigate. If we do, we will investigate the complaint.

DHS will notify you in writing of the investigation's outcome. You have the right to appeal the outcome if you disagree with the decision. To appeal, you must send a written request to have DHS review the investigation outcome. Be brief and state why you disagree with the decision. Include additional information you think is important.

If you file a complaint in this way, the people who work for the agency named in the complaint cannot retaliate against you. This means they cannot punish you in any way for filing a complaint. Filing a complaint in this way does not stop you from seeking out other legal or administrative actions.

Contact **DHS** directly to file 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

651-431-2670 or 800-657-3739

Attention. If you need free help interpreting this document, call the above number.

ያስተውሉ፡ ካለምንም ክፍያ ይህንን ዶኩመንት የሚተረጉምሎ አስተርጓሚ ከፈለጉ ከላይ ወደተጻፈው የስልክ ቁጥር ይደውሉ።

ملاحظة: إذا أردت مساعدة مجانية لترجمة هذه الوثيقة، اتصل على الرقم أعلاه.

သတိ။ ဤစာရက်စာတမ်းအားအခမဲ့ဘာသာပြန်ပေးခြင်း အကူအညီလိုအပ်ပါက၊ အထက်ပါဖုန်းနံပါတ်ကိုခေါ်ဆိုပါ။

កំណត់សំគាល់ ។ បើអ្នកត្រូវការជំនួយក្នុងការបកប្រែឯកសារនេះដោយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទតាមលេខខាងលើ ។

請注意，如果您需要免費協助傳譯這份文件，請撥打上面的電話號碼。

Attention. Si vous avez besoin d’une aide gratuite pour interpréter le présent document, veuillez appeler au numéro ci-dessus.

Thov ua twb zoo nyeem. Yog hais tias koj xav tau kev pab txhais lus rau tsab ntaub ntawv no pub dawb, ces hu rau tus najnpawb xov tooj saum toj no.

ဟ်သူဉ်ဟ်သးဘဉ်တက့်၊ ဖဲနမ့်၊လိဉ်ဘဉ်တ်မၤစၢၤကလီလၢတ်ကကျိုးထံဝဲဒဉ်လံာ်တီလံာ်မီတခါအံၤနူဉ်,ကိးဘဉ်လီတဲစိနီ၊ဂံ၊လၢထးအံၤနူဉ်တက့်၊.

알려드립니다. 이 문서에 대한 이해를 돕기 위해 무료로 제공되는 도움을 받으시려면 위의 전화번호로 연락하십시오.

ໂປຣດຊາບ. ຖ້າຫາກ ທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປເອກະສານນີ້ຟຣີ, ຈົ່ງໂທຣໄປທີ່ໝາຍເລກຂ້າງເທິງນີ້.

Hubachiisa. Dokumentiin kun tola akka siif hiikamu gargaarsa hoo feete, lakkoobsa gubbatti kenname bilbili.

Внимание: если вам нужна бесплатная помощь в устном переводе данного документа, позвоните по указанному выше телефону.

Digniin. Haddii aad u baahantahay caawimaad lacag-la’aan ah ee tarjumaadda (afcelinta) qoraalkan, lambarka kore wac.

Atención. Si desea recibir asistencia gratuita para interpretar este documento, llame al número indicado arriba.

Chú ý. Nếu quý vị cần được giúp đỡ dịch tài liệu này miễn phí, xin gọi số bên trên.

LB2 (10-20)

ADA Advisory

For accessible formats of this information or assistance with additional equal access to human services, write to DHS.info@state.mn.us, call 800-657-3739, or use your preferred relay service. ADA1 (2-18)