



## 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](http://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.

MINNESOTA HEALTH CARE PROGRAMS (MHCP)

# Application for Certain Populations

**Office Use Only**

DATE RECEIVED	CASE NUMBER	WORKER NUMBER
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- **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	MARITAL STATUS			
<input type="radio"/> Male	<input type="radio"/> Female	<input type="radio"/> Legally separated <input type="radio"/> Divorced <input type="radio"/> Never married <input type="radio"/> Married <input type="radio"/> Widowed			
Do you have a Social Security number (SSN)*? <input type="radio"/> Yes <input type="radio"/> No		IF YES, WHAT IS YOUR SSN?		IF NO, HAVE YOU APPLIED FOR AN SSN? <input type="radio"/> Yes <input type="radio"/> No	
*See the Notice of Privacy Practices and Notice of Rights and Responsibilities (Attachment A) for information about Social Security numbers.		IF YOU HAVE NOT APPLIED, WHY NOT? (Choose a reason code from the list on Attachment B) 			
Do you have a guardian or conservator? <input type="radio"/> Yes – fill in the following <input type="radio"/> No					
NAME OF GUARDIAN OR CONSERVATOR					PHONE NUMBER
STREET ADDRESS		CITY		STATE	ZIP CODE
Have you ever been in the U.S. military? <input type="radio"/> Yes <input type="radio"/> No		Are you a student? <input type="radio"/> Yes <input type="radio"/> No		Are you blind? <input type="radio"/> Yes <input type="radio"/> No	
Do you have a physical, mental, or emotional health condition that limits your activities (like bathing, dressing, daily chores, etc.)? <input type="radio"/> Yes <input type="radio"/> No		If yes, have you been determined disabled by the Social Security Administration (SSA) or the State Medical Review Team (SMRT)? <input type="radio"/> Yes <input type="radio"/> 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? <input type="radio"/> Yes <input type="radio"/> No					
Are you pregnant? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> 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? <input type="radio"/> Yes <input type="radio"/> 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? <input type="radio"/> Yes <input type="radio"/> No		Do you currently have medical benefits from another state? <input type="radio"/> Yes <input type="radio"/> 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 <input type="radio"/> Male <input type="radio"/> Female		MARITAL STATUS <input type="radio"/> Legally separated <input type="radio"/> Divorced <input type="radio"/> Never married <input type="radio"/> Married <input type="radio"/> Widowed		
Does this person have a Social Security number (SSN)*? <input type="radio"/> Yes <input type="radio"/> No		IF YES, WHAT IS THE SSN?		IF NO, HAS THIS PERSON APPLIED FOR AN SSN? <input type="radio"/> Yes <input type="radio"/> 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? <input type="radio"/> Yes <input type="radio"/> No		Is this person a student? <input type="radio"/> Yes <input type="radio"/> No		Is this person blind? <input type="radio"/> Yes <input type="radio"/> No	

Does this person have a physical, mental, or emotional health condition that limits activities (like bathing, dressing, daily chores, etc.)? <input type="radio"/> Yes <input type="radio"/> No		If yes, has this person been determined disabled by the Social Security Administration (SSA) or the State Medical Review Team (SMRT)? <input type="radio"/> Yes <input type="radio"/> 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? <input type="radio"/> Yes <input type="radio"/> No			
Has this person ever been in the U.S. military? <input type="radio"/> Yes <input type="radio"/> No		Does this person currently have medical benefits from another state? <input type="radio"/> Yes <input type="radio"/> No	
Is this person pregnant? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> 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? <input type="radio"/> Yes <input type="radio"/> No			
FIRST NAME	MI	LAST NAME	DATE OF BIRTH
RELATIONSHIP TO YOU	GENDER <input type="radio"/> Male <input type="radio"/> Female	MARITAL STATUS <input type="radio"/> Legally separated <input type="radio"/> Divorced <input type="radio"/> Never married <input type="radio"/> Married <input type="radio"/> Widowed	
Does this person have a Social Security number (SSN)*? <input type="radio"/> Yes <input type="radio"/> No	IF YES, WHAT IS THE SSN?	IF NO, HAS THIS PERSON APPLIED FOR AN SSN? <input type="radio"/> Yes <input type="radio"/> 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? <input type="radio"/> Yes <input type="radio"/> No	Is this person a student? <input type="radio"/> Yes <input type="radio"/> No	Is this person blind? <input type="radio"/> Yes <input type="radio"/> No	
Does this person have a physical, mental, or emotional health condition that limits activities (like bathing, dressing, daily chores, etc.)? <input type="radio"/> Yes <input type="radio"/> No	If yes, has this person been determined disabled by the Social Security Administration (SSA) or the State Medical Review Team (SMRT)? <input type="radio"/> Yes <input type="radio"/> 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? <input type="radio"/> Yes <input type="radio"/> No			
Has this person ever been in the U.S. military? <input type="radio"/> Yes <input type="radio"/> No		Does this person currently have medical benefits from another state? <input type="radio"/> Yes <input type="radio"/> No	
Is this person pregnant? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> 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 ☐ Noe. 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 ☐ Noh. Is this person, or the person's spouse or parent, a veteran or active-duty member of the military? ☐ Yes ☐ Noi. Does this person want help paying for a medical emergency? ☐ Yes ☐ Noj. Is this person getting services from the Center for Victims of Torture? ☐ Yes ☐ Nok. 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 ☐ Noe. 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 ☐ Noh. Is this person, or the person's spouse or parent, a veteran or active-duty member of the military? ☐ Yes ☐ Noi. Does this person want help paying for a medical emergency? ☐ Yes ☐ Noj. Is this person getting services from the Center for Victims of Torture? ☐ Yes ☐ Nok. 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)	<input type="button" value="v"/>	HOW MANY MONTHS?
		<input type="radio"/> One <input type="radio"/> Two <input type="radio"/> Three
WHICH PERSON? (First, MI, Last)	<input type="button" value="v"/>	HOW MANY MONTHS?
		<input type="radio"/> One <input type="radio"/> Two <input type="radio"/> 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? <input type="radio"/> Yes <input type="radio"/> No	Has this job ended? <input type="radio"/> Yes <input type="radio"/> 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.)

<input type="radio"/> Hourly	\$ _____ per hour	Hours per week: _____
<input type="radio"/> Weekly	\$ _____	Hours per week: _____
<input type="radio"/> Every two weeks	\$ _____	Hours per week: _____
<input type="radio"/> Twice a month	\$ _____	Hours per week: _____
<input type="radio"/> Monthly	\$ _____	Hours per week: _____
<input type="radio"/> Yearly	\$ _____	Hours per week: _____

<b>Person 2</b>		
NAME		
EMPLOYER NAME		START DATE (MM/DD/YYYY)
Is this job seasonal? <input type="radio"/> Yes <input type="radio"/> No	Has this job ended? <input type="radio"/> Yes <input type="radio"/> No	IF YES, END DATE (MM/DD/YYYY)
<b>Wages and tips before taxes</b> (Choose one and fill in the dollar amount and your hours per week.) <input type="radio"/> Hourly      \$ _____ per hour      Hours per week: _____ <input type="radio"/> Weekly      \$ _____      Hours per week: _____ <input type="radio"/> Every two weeks      \$ _____      Hours per week: _____ <input type="radio"/> Twice a month      \$ _____      Hours per week: _____ <input type="radio"/> Monthly      \$ _____      Hours per week: _____ <input type="radio"/> 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.

<b>11. Did anyone get money this month or does anyone expect to get money next month from sources other than work?</b>			
Include:	<ul style="list-style-type: none"> <li>Social Security</li> <li>Supplemental Security Income (SSI)</li> <li>Retirement or pension payments</li> <li>Payments from a contract for deed</li> </ul>	<ul style="list-style-type: none"> <li>Child or spousal support</li> <li>Workers' compensation</li> <li>Public assistance payments</li> <li>Annuities</li> </ul>	<ul style="list-style-type: none"> <li>Unemployment</li> <li>Veterans' benefits</li> <li>Rental income</li> <li>Any other payments</li> <li>Interest</li> <li>Dividends</li> <li>Trusts</li> </ul>
<input type="radio"/> Yes – fill in the information <input type="radio"/> No			

<b>Person 1</b>			
NAME			
Type of income	Amount	How often received?	Has this income ended?
	\$ _____		<input type="radio"/> Yes – END DATE: _____ <input type="radio"/> No
	\$ _____		<input type="radio"/> Yes – END DATE: _____ <input type="radio"/> No
	\$ _____		<input type="radio"/> Yes – END DATE: _____ <input type="radio"/> No
	\$ _____		<input type="radio"/> Yes – END DATE: _____ <input type="radio"/> No

<b>Person 2</b>			
NAME			
Type of income	Amount	How often received?	Has this income ended?
	\$ _____		<input type="radio"/> Yes – END DATE: _____ <input type="radio"/> No
	\$ _____		<input type="radio"/> Yes – END DATE: _____ <input type="radio"/> No
	\$ _____		<input type="radio"/> Yes – END DATE: _____ <input type="radio"/> No
	\$ _____		<input type="radio"/> Yes – END DATE: _____ <input type="radio"/> 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
	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not applicable		\$
	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> 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?
			<input type="radio"/> Yes <input type="radio"/> No
			<input type="radio"/> Yes <input type="radio"/> No
			<input type="radio"/> Yes <input type="radio"/> No
			<input type="radio"/> Yes <input type="radio"/> 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 or injury	Date happened (MM/DD/YYYY)	Is there a lawsuit?
			<input type="radio"/> Yes <input type="radio"/> No
			<input type="radio"/> Yes <input type="radio"/> 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](https://sos.state.mn.us).

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](http://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)* | H. Special Iraqi or Afghani immigrant*           |
| B. Amerasian noncitizen*  | I. Victim of severe trafficking (LPR or T Visa)* |
| C. Asylee*  | J. Withholding of removal*                       |
| D. Conditional entrant*   | K. Battered noncitizen*                          |
| E. Cuban or Haitian entrant*  | L. Lawful permanent resident (LPR)*              |
| F. Deportation being withheld under section 243(h) or 231(b)(3) of the INA              | M. Paroled for at least one year*                |
| G. Refugee*   | 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                            | F. Filipino    | K. Native Hawaiian                  |
| B. Black or African American        | G. Japanese    | L. Guamanian or Chamorro            |
| C. American Indian or Alaska Native | H. Korean      | M. Samoan                           |
| D. Asian Indian                     | I. Vietnamese  | N. Other Pacific Islander           |
| E. Chinese                          | J. Other Asian | 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

**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

**Watsonwan 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

## 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?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> 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: <ul style="list-style-type: none"> <li>For income:               <ul style="list-style-type: none"> <li>Per capita payments from a tribe that come from natural resources, usage rights, rent, leases or royalties</li> <li>Cobell Settlement payments for American Indians or Alaska Claims Settlement Act payments</li> <li>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)</li> <li>Money from selling things that have cultural significance</li> </ul> </li> <li>For assets:               <ul style="list-style-type: none"> <li>Money that you still have from any of the income sources listed previously</li> <li>Real property located on Indian land or land held in a trust</li> <li>Ownership interests in rents, leases, royalties, or usage rights related to natural resources or things that have cultural significance.</li> </ul> </li> </ul>	Income \$ _____ Type _____ How often? _____          Assets \$ _____ Type _____	Income \$ _____ Type _____ How often? _____          Assets \$ _____ Type _____
4. Does this person live on a reservation?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> 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](mailto: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](mailto: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 ዶክመንት የሚተረጎም ለሕተርዳሚ 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.

ဟ်သုဂ်ဟ်သးဘဉ်တက့ၢ်.ဖဲန့ၢ်လိာ်ဘဉ်တၢ်မၤစၢၤကလိလၢတၢ်ကကျိးထံဝဲဒၣ်လိာ်တိလိာ်မိတခါအံၤန့ၣ်,ကိးဘဉ်လိာ်တဲစီၣ်ဂံၢ်လၢထးအံၤန့ၣ်တက့ၢ်.

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

ໂປຣດຊາບ. ຖ້າຫາກ ທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປເອກະສານນີ້ພຣີ, ຈົ່ງໂທໂປທີ່ໝາຍເລກຂ້າງເທິງນີ້.

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)



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