DEPARTMENT OF HUMAN SERVICES

Minnesota Child Care Assistance Program Application

This is the Minnesota Child Care Assistance Program (CCAP) Application. You may be eligible to get help for your child care expenses so you can work, look for work, or attend school. CCAP can pay any legal child care provider who registers for payments including licensed, certified, and unlicensed providers, 18 years of age or older. If you do not have a child care provider, you can apply for CCAP and ask for help finding a child care provider.

To qualify, your family must:

- Be income eligible;
- Meet employment and training requirements:
  - Work at least an average of 20 hours per week (10 hours per week if a full-time student) at minimum wage, *or*
  - Participate in job search, attend school or training classes, *or*
  - Comply with the activities of an approved Minnesota Family Investment Program (MFIP)/Diversionary Work Program (DWP) employment plan.
- Cooperate with child support enforcement for all children in the family who have an absent parent.

Read these instructions before you fill out the application.

The Child Care Assistance Program booklet Do you need help paying for child care? (DHS-3551) gives you information about the Child Care Assistance Program and choosing a child care provider.

Please follow these instructions as you complete your application.

- Print using black ink.
- Read all instructions and answer all questions completely.
- If you need more room, use space on page 17 or attach additional sheets of paper.
- **Provide proof of all requested information.** This includes proof of:
  - Identity for each adult in your family
  - Residence/Address
  - Age and relationship to you for each child in your family
  - Citizenship or immigration status for each child in your family who needs child care
  - School schedule and program completion date for each adult in your family
  - All counted earned and unearned income and work schedules
  - Allowable deductions such as insurance premiums and child/spousal support paid
- The county or tribe must ask for your Social Security number. You are not required to provide this to be eligible for assistance.
- Read the "Penalty warning" section of this form.
- Read Client Responsibilities and Rights (DHS-4163), Notice of Privacy Practices (DHS-3979), and The Child Care Assistance Program and fraud: Questions and answers for families (DHS-3943B) at the end of this form. These documents are on tear-off pages for you to keep.
- Sign and date the application.
- Mail, fax or bring the completed application and all other needed items to the address listed below.
- **If you have questions or have problems getting the information you need, contact the county or tribal human services office where you live.**

Once your application is received, you will receive a written notice about your eligibility within 30 calendar days, or 45 days if needed.

A child care worker will write or call you if more information is needed.

Mail application to: →

If you want help, please call this phone number.

AFFIX COUNTY LABEL HERE

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

LB1 (8-16)

ADA Advisory

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

DEPARTMENT OF HUMAN SERVICES

DHS-3550-ENG 8-19

Minnesota Child Care Assistance Program Application

Child care assistance staff only				
CASE NUMBER	CCAP WORKER NAME		MFIP WORKER NAME	COUNTY DATE STAMP
MFIP BEGIN DATE	MFIP END DATE	EMPLOYMENT SERVICES AGENCY	EMPLOYMENT SERVICES WORKER	

1. Applicant

Tell us about you and where you live.

- Include *proof of your identity*, such as a copy of your driver's license, state identification card, passport, school identification card, or birth certificate.
- Include *proof of your residence/address*, such as one of the items listed above or a copy of a recent utility bill, rental lease, or mortgage document.

PERSON 1				
LAST NAME	FIRST NAME	MIDDLE NAME		
OTHER NAMES YOU MIGHT BE KNOWN AS	GENDER ◯ Male ◯ Female	DATE OF BIRTH	SOCIAL SECURITY NUMBER	
ADDRESS	CITY		STATE	ZIP CODE
MAILING ADDRESS *(if different)*	CITY		STATE	ZIP CODE
HOME PHONE NUMBER	WORK PHONE NUMBER	OTHER PHONE NUMBER	MARITAL STATUS ◯ Married ◯ Divorced ◯ Separated ◯ Single	
What is your preferred spoken language?	What is your preferred written language?	Do you need an interpreter? ◯ Yes ◯ No		
ETHNICITY *(optional)* Hispanic? ◯ Yes ◯ No	RACE *(optional)* ☐ Asian ☐ Black or African American ☐ American Indian or Alaska Native ☐ Pacific Islander or Native Hawaiian ☐ White			
Have you ever received or requested child care assistance? ◯ Yes ◯ No				
IF YES, WHEN?	WHERE? (MN CITY)	MN COUNTY		
Do you get a housing or Section 8 subsidy? ◯ Yes ◯ No				

Living situation: *(optional, choose one)*

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

2. Family members

Tell us about all the other people living in your home.

Include all household members, both adults and children. Include family members who do not live with you, but are expected to return to your home.

Adults:

- Include your spouse, the parents of children in your family who live with you, and all other adults living with you whether or not they are family members.
- Include proof of identity for each adult in your family, such as a copy of a driver's license, state identification card, passport, school identification card, or birth certificate.

Children:

- List all children under the age of 18 who live with you. List children in order from oldest to youngest.
- Include children 18 or older if they are full-time students and you provide 50% or more of their financial support.
- Include proof of each child's relationship to you, such as a birth certificate, adoption record, legal guardianship statement or baptismal record.
- Include proof of each child's age, such as one of the items listed above or a school or immunization record.
- Include proof of citizenship or immigration status for each child in need of child care assistance, such as a birth certificate, an adoption record or a USCIS (United States Citizenship and Immigration Services) card.

Note: Proof of citizenship or immigration status will not be used for immigration purposes.

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

PERSON 2				
LAST NAME		FIRST NAME		MIDDLE NAME
DATE OF BIRTH	GENDER ◯ Male ◯ Female	SOCIAL SECURITY NUMBER	ETHNICITY *(optional)* Hispanic? ◯ Yes ◯ No	RACE *(optional)* ☐ A ☐ B ☐ N ☐ P ☐ W
RELATIONSHIP TO YOU		CITIZENSHIP If this person is a child who needs child care, is the child a U.S. citizen? ◯ Yes ◯ No		
Do you need an interpreter? ◯ Yes ◯ No	What is your preferred spoken language?	What is your preferred written language?		

PERSON 3				
LAST NAME		FIRST NAME		MIDDLE NAME
DATE OF BIRTH	GENDER ◯ Male ◯ Female	SOCIAL SECURITY NUMBER	ETHNICITY *(optional)* Hispanic? ◯ Yes ◯ No	RACE *(optional)* ☐ A ☐ B ☐ N ☐ P ☐ W
RELATIONSHIP TO YOU		CITIZENSHIP If this person is a child who needs child care, is the child a U.S. citizen? ◯ Yes ◯ No		
Do you need an interpreter? ◯ Yes ◯ No	What is your preferred spoken language?	What is your preferred written language?		

PERSON 4

LAST NAME	FIRST NAME	MIDDLE NAME

DATE OF BIRTH	GENDER	SOCIAL SECURITY NUMBER	ETHNICITY *(optional)*	RACE *(optional)*
	◯ Male ◯ Female		Hispanic? ◯ Yes ◯ No	☐ A ☐ B ☐ N ☐ P ☐ W

RELATIONSHIP TO YOU	CITIZENSHIP
	If this person is a child who needs child care, is the child a U.S. citizen? ◯ Yes ◯ No

Do you need an interpreter?	What is your preferred spoken language?	What is your preferred written language?
◯ Yes ◯ No		

PERSON 5

LAST NAME	FIRST NAME	MIDDLE NAME

DATE OF BIRTH	GENDER	SOCIAL SECURITY NUMBER	ETHNICITY *(optional)*	RACE *(optional)*
	◯ Male ◯ Female		Hispanic? ◯ Yes ◯ No	☐ A ☐ B ☐ N ☐ P ☐ W

RELATIONSHIP TO YOU	CITIZENSHIP
	If this person is a child who needs child care, is the child a U.S. citizen? ◯ Yes ◯ No

Do you need an interpreter?	What is your preferred spoken language?	What is your preferred written language?
◯ Yes ◯ No		

PERSON 6

LAST NAME	FIRST NAME	MIDDLE NAME

DATE OF BIRTH	GENDER	SOCIAL SECURITY NUMBER	ETHNICITY *(optional)*	RACE *(optional)*
	◯ Male ◯ Female		Hispanic? ◯ Yes ◯ No	☐ A ☐ B ☐ N ☐ P ☐ W

RELATIONSHIP TO YOU	CITIZENSHIP
	If this person is a child who needs child care, is the child a U.S. citizen? ◯ Yes ◯ No

Do you need an interpreter?	What is your preferred spoken language?	What is your preferred written language?
◯ Yes ◯ No		

For additional household members, use the blank page at the end of the application.

3. Child Support and custody arrangement

List all children in your family who have a parent who does not live in your home. If your child spends time with his or her other parent, please describe the schedule or shared custody arrangements.

CHILD 1

CHILD'S NAME	NAME OF PARENT NOT LIVING IN YOUR HOME	Do you receive child support? ◯ Yes ◯ No

Shared Custody/Visitation Schedule – List time child spends with parent who is not in the home.

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
START TIME							
END TIME							

CHILD 2

CHILD'S NAME	NAME OF PARENT NOT LIVING IN YOUR HOME	Do you receive child support? ◯ Yes ◯ No

Shared Custody/Visitation Schedule – List time child spends with parent who is not in the home.

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
START TIME							
END TIME							

CHILD 3

CHILD'S NAME	NAME OF PARENT NOT LIVING IN YOUR HOME	Do you receive child support? ◯ Yes ◯ No

Shared Custody/Visitation Schedule – List time child spends with parent who is not in the home.

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
START TIME							
END TIME							

CHILD 4

CHILD'S NAME	NAME OF PARENT NOT LIVING IN YOUR HOME	Do you receive child support? ◯ Yes ◯ No

Shared Custody/Visitation Schedule – List time child spends with parent who is not in the home.

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
START TIME							
END TIME							

CHILD 5

CHILD'S NAME	NAME OF PARENT NOT LIVING IN YOUR HOME	Do you receive child support? ◯ Yes ◯ No

Shared Custody/Visitation Schedule – List time child spends with parent who is not in the home.

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
START TIME							
END TIME							

4. Student information – children

Complete this section for all children in your family who are **now in school or plan to go to school within the next 12 months**.

- Include start date if not currently in school.
- Include children 18 or older if they are full-time students and you provide 50% or more of their financial support. Include proof of their school status, such as a fee statement or registration confirmation, the expected completion date of their program, and your financial support.
- For preschool age children: Indicate "Head Start" or "preschool" in the "GRADE" field if child attends one of those programs.
- Include proof of school enrollment status for children with earned income.

STUDENT 1

STUDENT NAME	START DATE	END DATE	SCHOOL NAME	GRADE

Days and times student attends school

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
START TIME							
END TIME							

STUDENT 2

STUDENT NAME	START DATE	END DATE	SCHOOL NAME	GRADE

Days and times student attends school

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
START TIME							
END TIME							

STUDENT 3

STUDENT NAME	START DATE	END DATE	SCHOOL NAME	GRADE

Days and times student attends school

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
START TIME							
END TIME							

STUDENT 4

STUDENT NAME	START DATE	END DATE	SCHOOL NAME	GRADE

Days and times student attends school

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
START TIME							
END TIME							

STUDENT 5

STUDENT NAME	START DATE	END DATE	SCHOOL NAME	GRADE

Days and times student attends school

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
START TIME							
END TIME							

5. Income

List all income received by you and all members of your family.

- Include income received by family members temporarily absent from your home.
- Report self-employment income in question *5.B. Self-employment income*.
- Include proof of work schedule and all income for the most current 30 days, such as wages, tips, commissions and bonuses.

A. Earned income (wages)

Income #1			
EMPLOYEE'S NAME	EMPLOYER NAME		EMPLOYER PHONE NUMBER
EMPLOYER ADDRESS	CITY	STATE	ZIP CODE
WORK ADDRESS (if different)	CITY	STATE	ZIP CODE
HOURLY PAY RATE	NUMBER OF HOURS PER WEEK	HOW OFTEN PAID? ◯ Daily ◯ Weekly ◯ Every other week ◯ Two times a month ◯ Other _____	
TOTAL AMOUNT PAID BEFORE DEDUCTIONS	WORK START DATE	DATE OF FIRST PAY CHECK	DATE OF LAST PAY CHECK

Income #2			
EMPLOYEE'S NAME	EMPLOYER NAME		EMPLOYER PHONE NUMBER
EMPLOYER ADDRESS	CITY	STATE	ZIP CODE
WORK ADDRESS (if different)	CITY	STATE	ZIP CODE
HOURLY PAY RATE	NUMBER OF HOURS PER WEEK	HOW OFTEN PAID? ◯ Daily ◯ Weekly ◯ Every other week ◯ Two times a month ◯ Other _____	
TOTAL AMOUNT PAID BEFORE DEDUCTIONS	WORK START DATE	DATE OF FIRST PAY CHECK	DATE OF LAST PAY CHECK

B. Self-employment income

Complete this section if you or someone in your family is **self-employed**. Examples of self-employment income include product sales, real estate sales, personal services, farming, in-home child care, and rental property.

Include proof of:

- All self-employment income and expenses, such as federal tax returns or business ledgers.
- Work schedule, such as a calendar with work hours.

Income #1			
ADULT'S NAME		TYPE OF BUSINESS	
START DATE	NUMBER OF HOURS WORKED PER WEEK	MONTHLY INCOME BEFORE EXPENSES	MONTHLY EXPENSES

Income #2			
ADULT'S NAME		TYPE OF BUSINESS	
START DATE	NUMBER OF HOURS WORKED PER WEEK	MONTHLY INCOME BEFORE EXPENSES	MONTHLY EXPENSES

C. Unearned income

Complete this section for each type of **unearned income** you or someone in your family receives.

- Include proof of all unearned income, such as a check stub, an award letter, a financial aid form, or a written statement from the source of the income for the most current 30 days.

Type	Yes	No	Name of person receiving income	How often received	Amount
Public assistance (MFIP, DWP, GA, Tribal TANF)	◯	◯			
Child support/Spousal support	◯	◯			
Unemployment Insurance	◯	◯			
Insurance payments (settlements, short- or long-term disability, etc.)	◯	◯			
RSDI (Retirement, Survivors, Disability Insurance)	◯	◯			
Supplemental Security Income (SSI)	◯	◯			
Veteran benefits (VA)	◯	◯			
Contract for deed	◯	◯			
Trust income	◯	◯			
Interest/dividends	◯	◯			
Tribal payments	◯	◯			
Cost-effective health care reimbursement	◯	◯			
Other (lottery or gambling winnings, inheritance, capital gains, etc.) - list below:	◯	◯			

D. Do you expect any changes to work hours or income listed in A, B, or C above?

◯ Yes ◯ No

IF YES, DESCRIBE IN DETAIL

6. Deductions

Complete this section if you or someone in your family has any of the expenses listed for which you are not reimbursed.

- These expenses may be deducted from your gross income in determining your co-payment.
- Include proof of deductions, such as check stubs, benefit statements or premium statements.

Expense	How often do you pay?	Amount
Medical insurance premiums		
Dental insurance premiums		
Vision insurance premiums		
Child support paid for a child not living in the home		
Court ordered spousal support		

7. Assets

Assets include cash, bank accounts, vehicles, investments, and real estate (other than your home). Do not include the home you live in, personal belongings, or self-employment assets. How much are your family's assets?

◯ My family's assets are **LESS THAN $1 million** (or equal to $1 million), **OR**

◯ My family's assets are **MORE THAN $1 million** (your worker will contact you for more information)

8. Request for child care assistance

Complete the sections that apply to adult members of your family.

A. List all *adult* family members who need help paying for child care to attend school or training classes.

- Include family members participating in GED or ESL classes.
- Include proof of school schedules that show the days and times classes meet, including school breaks.

ADULT 1							
ADULT'S NAME			NAME OF SCHOOL OR TRAINING SITE				
SCHOOL PROGRAM ATTENDING						START DATE	
Days and times this adult attends school or training							
	MONDAY	**TUESDAY**	**WEDNESDAY**	**THURSDAY**	**FRIDAY**	**SATURDAY**	**SUNDAY**
START TIME							
END TIME							

ADULT 2							
ADULT'S NAME			NAME OF SCHOOL OR TRAINING SITE				
SCHOOL PROGRAM ATTENDING						START DATE	
Days and times this adult attends school or training							
	MONDAY	**TUESDAY**	**WEDNESDAY**	**THURSDAY**	**FRIDAY**	**SATURDAY**	**SUNDAY**
START TIME							
END TIME							

B. List all *adult* family members who need help paying for child care to be able to work.

- Include proof of all work schedules, such as a time card or a letter from employer.
  If the work schedule varies, please provide this information for the past two months.

ADULT 1							
ADULT'S NAME			EMPLOYER'S NAME				
Days and times this adult works							
	MONDAY	**TUESDAY**	**WEDNESDAY**	**THURSDAY**	**FRIDAY**	**SATURDAY**	**SUNDAY**
START TIME							
END TIME							

ADULT 2							
ADULT'S NAME			EMPLOYER'S NAME				
Days and times this adult works							
	MONDAY	**TUESDAY**	**WEDNESDAY**	**THURSDAY**	**FRIDAY**	**SATURDAY**	**SUNDAY**
START TIME							
END TIME							

C. List all *adult* family members who need help paying for child care to look for work.

ADULT'S NAME	NUMBER OF HOURS PER WEEK REQUESTED (up to 20)
ADULT'S NAME	NUMBER OF HOURS PER WEEK REQUESTED (up to 20)

D. List all *adult* family members who need help paying for child care to attend MFIP orientations or other MFIP/DWP activities in an approved employment plan.

ADULT'S NAME	JOB COUNSELOR ASSIGNED?	JOB COUNSELOR'S NAME	JOB COUNSELOR'S PHONE NUMBER
ADULT'S NAME	JOB COUNSELOR ASSIGNED? ◯ Yes ◯ No	JOB COUNSELOR'S NAME	JOB COUNSELOR'S PHONE NUMBER

9. Child care needs

List all children who are attending or are in need of child care.

- Child care assistance is available for children under age 13 and for children with disabilities under age 15.
- Complete the provider questions if you currently use or have chosen a child care provider(s) for your child.
- Contact your county or tribal human services office if your child has special needs and needs specialized care.
- Child care assistance can only pay two providers per child, one primary and one secondary provider.

CHILD 1

CHILD'S NAME

Days and hours child care is needed with child's primary provider

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
START TIME							
END TIME							

PRIMARY CHILD CARE PROVIDER'S NAME	PHONE NUMBER	START DATE

PRIMARY CHILD CARE PROVIDER'S ADDRESS	CITY	STATE	ZIP CODE

WHERE IS CARE PROVIDED?

◯ Provider's home ◯ Child care center ◯ Child's home

IS PROVIDER RELATED TO THE CHILD?

◯ Yes ◯ No

IF RELATED, PROVIDER IS CHILD'S:

◯ Sibling ◯ Aunt/Uncle ◯ Grandparent ◯ Other: _____

Days and hours child care is needed with child's secondary provider

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
START TIME							
END TIME							

SECONDARY CHILD CARE PROVIDER'S NAME	PHONE NUMBER	START DATE

SECONDARY CHILD CARE PROVIDER'S ADDRESS	CITY	STATE	ZIP CODE

WHERE IS CARE PROVIDED?

◯ Provider's home ◯ Child care center ◯ Child's home

IS PROVIDER RELATED TO THE CHILD?

◯ Yes ◯ No

IF RELATED, PROVIDER IS CHILD'S:

◯ Sibling ◯ Aunt/Uncle ◯ Grandparent ◯ Other: _____

CHILD 2

CHILD'S NAME

Days and hours child care is needed with child's primary provider

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
START TIME							
END TIME							

PRIMARY CHILD CARE PROVIDER'S NAME	PHONE NUMBER	START DATE

PRIMARY CHILD CARE PROVIDER'S ADDRESS	CITY	STATE	ZIP CODE

WHERE IS CARE PROVIDED?

◯ Provider's home ◯ Child care center ◯ Child's home

IS PROVIDER RELATED TO THE CHILD?

◯ Yes ◯ No

IF RELATED, PROVIDER IS CHILD'S:

◯ Sibling ◯ Aunt/Uncle ◯ Grandparent ◯ Other: _____

Days and hours child care is needed with child's secondary provider

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
START TIME							
END TIME							

SECONDARY CHILD CARE PROVIDER'S NAME	PHONE NUMBER	START DATE

SECONDARY CHILD CARE PROVIDER'S ADDRESS	CITY	STATE	ZIP CODE

WHERE IS CARE PROVIDED?

◯ Provider's home ◯ Child care center ◯ Child's home

IS PROVIDER RELATED TO THE CHILD?

◯ Yes ◯ No

IF RELATED, PROVIDER IS CHILD'S:

◯ Sibling ◯ Aunt/Uncle ◯ Grandparent ◯ Other: _____

CHILD 3

CHILD'S NAME

Days and hours child care is needed with child's primary provider

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
START TIME							
END TIME							

PRIMARY CHILD CARE PROVIDER'S NAME	PHONE NUMBER	START DATE

PRIMARY CHILD CARE PROVIDER'S ADDRESS	CITY	STATE	ZIP CODE

WHERE IS CARE PROVIDED?

◯ Provider's home ◯ Child care center ◯ Child's home

IS PROVIDER RELATED TO THE CHILD?

◯ Yes ◯ No

IF RELATED, PROVIDER IS CHILD'S:

◯ Sibling ◯ Aunt/Uncle ◯ Grandparent ◯ Other: _____

Days and hours child care is needed with child's secondary provider

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
START TIME							
END TIME							

SECONDARY CHILD CARE PROVIDER'S NAME	PHONE NUMBER	START DATE

SECONDARY CHILD CARE PROVIDER'S ADDRESS	CITY	STATE	ZIP CODE

WHERE IS CARE PROVIDED?

◯ Provider's home ◯ Child care center ◯ Child's home

IS PROVIDER RELATED TO THE CHILD?

◯ Yes ◯ No

IF RELATED, PROVIDER IS CHILD'S:

◯ Sibling ◯ Aunt/Uncle ◯ Grandparent ◯ Other: _____

CHILD 4

CHILD'S NAME

Days and hours child care is needed with child's primary provider

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
START TIME							
END TIME							

PRIMARY CHILD CARE PROVIDER'S NAME	PHONE NUMBER	START DATE

PRIMARY CHILD CARE PROVIDER'S ADDRESS	CITY	STATE	ZIP CODE

WHERE IS CARE PROVIDED?

◯ Provider's home ◯ Child care center ◯ Child's home

IS PROVIDER RELATED TO THE CHILD?

◯ Yes ◯ No

IF RELATED, PROVIDER IS CHILD'S:

◯ Sibling ◯ Aunt/Uncle ◯ Grandparent ◯ Other: _____

Days and hours child care is needed with child's secondary provider

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
START TIME							
END TIME							

SECONDARY CHILD CARE PROVIDER'S NAME	PHONE NUMBER	START DATE

SECONDARY CHILD CARE PROVIDER'S ADDRESS	CITY	STATE	ZIP CODE

WHERE IS CARE PROVIDED?

◯ Provider's home ◯ Child care center ◯ Child's home

IS PROVIDER RELATED TO THE CHILD?

◯ Yes ◯ No

IF RELATED, PROVIDER IS CHILD'S:

◯ Sibling ◯ Aunt/Uncle ◯ Grandparent ◯ Other: _____

CHILD 5

CHILD'S NAME

Days and hours child care is needed with child's primary provider

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
START TIME							
END TIME							

PRIMARY CHILD CARE PROVIDER'S NAME	PHONE NUMBER	START DATE

PRIMARY CHILD CARE PROVIDER'S ADDRESS	CITY	STATE	ZIP CODE

WHERE IS CARE PROVIDED?

◯ Provider's home ◯ Child care center ◯ Child's home

IS PROVIDER RELATED TO THE CHILD?

◯ Yes ◯ No

IF RELATED, PROVIDER IS CHILD'S:

◯ Sibling ◯ Aunt/Uncle ◯ Grandparent ◯ Other: _____

Days and hours child care is needed with child's secondary provider

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
START TIME							
END TIME							

SECONDARY CHILD CARE PROVIDER'S NAME	PHONE NUMBER	START DATE

SECONDARY CHILD CARE PROVIDER'S ADDRESS	CITY	STATE	ZIP CODE

WHERE IS CARE PROVIDED?

◯ Provider's home ◯ Child care center ◯ Child's home

IS PROVIDER RELATED TO THE CHILD?

◯ Yes ◯ No

IF RELATED, PROVIDER IS CHILD'S:

◯ Sibling ◯ Aunt/Uncle ◯ Grandparent ◯ Other: _____

Important! Please read and sign this application.

Authorization to share information for fraud investigation and audits.

I give permission to authorized investigators and third parties to share information about me during the course of investigations regarding fraud, fraud prevention and misrepresentation, and conducting federal or state audits. Third parties who can share information about me with investigators include but are not limited to financial institutions, credit reporting agencies, landlords, public housing agencies, schools, utility companies, insurance agencies, employers, other government agencies and others as they apply. I also understand that my permission to share information about me remains in effect for six months after my benefits stop.

Provider release.

State and federal privacy laws protect my information. If I am eligible for child care assistance, CCAP staff can share information about the hours and amount of child care assistance I get with my child care provider(s). My provider will be notified when my redetermination is due. I understand:

- This information must be shared so that my child care provider knows how much CCAP will pay for the child care provided.
- This information can be shared only if I give my written permission or if the law allows it.
- I can refuse to sign or cancel this release, but if I do, CCAP may not be able to pay my provider for the child care provided.
- I may cancel this authorization with written notice anytime. This written notice will not affect information already released.
- The person or agency who gets my information may be able to pass it on to others.
- If my information is passed on to others by DHS, it may no longer be protected by this authorization.

This authorization will end one year from the date I sign it. Minnesota Data Privacy Act (Minn. Stat., Ch. 13).

Penalty warning.

If you get child care assistance benefits, do not give false information or hide information:

- To get or continue to get child care assistance benefits
- To help someone else to get or to continue to get child care assistance payments.

The state may bar a family with a member who breaks either of these rules from the Child Care Assistance Program. The bar lasts one year for the first fraud, two years for the second fraud, and is permanent for the third fraud. A person who supplies false information in order for them or someone else to receive Child Care Assistance may also be prosecuted criminally.

If I get child care assistance I understand:

- I must cooperate with child support enforcement and assign my child care support portion to the Minnesota Department of Human Services. I have the right to claim "good cause" for not cooperating with child support enforcement.
- I may be required to pay a co-payment fee.
- If my child care provider charges more than the maximum rate paid in my county, I will pay the additional costs, as well as my co-payment fee.
- I must report changes to the information I have given within 10 calendar days from the date the change occurred. These include changes in employment and activity status and schedules, family status, significant income changes, address or residence, or anyone moving in or out of my household. Refer to Reporting Responsibilities for CCAP families (DHS-6953) for specific requirements.
- I must give the county agency and my child care provider 15 calendar days' notice before changing my child care provider(s). This notice is not needed in cases when:
  - A provider's Minnesota child care license has been temporarily immediately suspended or
  - There is an imminent risk of harm to the health, safety, or rights of a child in the care of a provider not licensed by Minnesota.
- My eligibility for child care assistance will be redetermined every 12 months.
- I have the right to choose any legal child care provider, including certified licensed child care centers, licensed family child care providers and legally nonlicensed child care providers that meet program requirements.
- If I choose a provider to provide child care in my home, I am considered the employer of the provider and have legal and tax responsibilities. This care must be approved by DHS before child care assistance can be paid.

Perjury and general declarations

I declare under the penalties of perjury that I have reviewed this form 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. [Minnesota Statute, section 256.984, subd. 1]

By signing below:

- I have received a copy of the Notice of Privacy Practices (DHS-3979), the Client Responsibilities and Rights (DHS-4163), and The Child Care Assistance Program and Fraud - Questions and Answerers for Families (DHS-3943B). I have read, and understand this information. If I have questions about this information, I will ask a worker to explain them to me.
- I agree to continue to assign my child care support to the state of Minnesota. I understand that I have the right to claim good cause for not cooperating with child support enforcement.
- I agree to the sharing of information as stated in the provider release and fraud investigation authorization information above.

SIGNATURE OF APPLICANT OR AUTHORIZED REPRESENTATIVE	DATE
SIGNATURE OF SPOUSE OR SECOND APPLICANT	DATE

AGENCY SIGNATURE	DATE	CLIENT GIVEN:
		☐ Client Responsibilities and Rights (DHS-4163) ☐ Notice of Privacy Practices (DHS-3979) ☐ The Child Care Assistance Program and fraud: Questions and answers for parents (DHS-3943B)

AGENCY NOTES

Use this space if you need additional room

Use this space if you need additional room

DEPARTMENT OF HUMAN SERVICES

The Child Care Assistance Program and fraud: Questions and answers for families

What is the Child Care Assistance Program?

The Child Care Assistance Program, sometimes called CCAP, helps parents with low incomes pay for child care so they can work, go to school, or look for a job, and it helps make sure children are well cared for and prepared to enter school ready to learn.

What are the Child Care Assistance Program laws?

You do not need to use child care assistance, but if you do, you and your child care provider must follow the law. Failure to follow child care assistance laws could result in serious consequences. Some of these laws are listed below. If you have questions about these laws, contact your child care assistance worker.

What do I need to tell my worker?

If you use child care assistance, you must report certain changes to your child care worker within 10 calendar days of the change. For more information, see Reporting responsibilities for Child Care Assistance Program families (DHS-6953).

If you do not report required changes within 10 calendar days, you may have to pay back the money provided for your child care assistance.

When requested, you must submit proof of your actual income to your child care assistance worker. It is against the law to submit pay stubs that are different from what you actually earned to your child care assistance worker, employment counselor, and/or the county/tribe where you receive benefits.

Can the program pay for days when my child does not attend child care?

Yes, but there are limits to what child care assistance can pay. You should bring your child to child care when they are scheduled to be there. If your child stops attending their provider or needs less child care, tell your child care assistance worker. **It is against the law for child care providers to bill the Child Care Assistance Program for days when your child does not attend unless the provider bills those days as absent days or holidays.**

Absent days

The Child Care Assistance Program will pay for up to 25 total absent days per child, per calendar year (or 10 days in a row). The program will not make absent day payments to legal non-licensed (LNL) child care providers.

Children with verified medical conditions, or illnesses that cause more frequent absences, may exceed the 25 absent day limit and the 10 consecutive day limit. Such medical conditions or illnesses must be documented on the CCAP Medical Condition Documentation Form (DHS-4602).

When absent days are all used for the year:

- Your family can continue getting child care assistance
- Child care assistance will pay for days when your child attends child care
- Child care assistance will not pay for days when your child does not go to child care
- Your family is responsible to pay for any absent days that child care assistance does not pay.

If a child is absent for part of a day, the payment for that day will be for the amount of care that is scheduled for that day, and the day will not count toward the 25 absent day limit.

Holidays

The Child Care Assistance Program will pay for up to 10 holidays per year if:

- Your child care provider is **closed** AND
- The holiday falls on a day when your child is authorized and scheduled to attend child care.

Attendance records

Attendance records must be a true record of the days and times each child arrives at and leaves their child care provider. Records must include the date of service, each child's first and last name, and sign in and out times. Each day a child attends, the person picking up or dropping off the child should be the one to sign the child in and out.

Can I get child care assistance if I'm self-employed?

Yes, child care assistance can help parents who are self-employed or who own their own businesses as long as:

- The family meets all other Child Care Assistance Program requirements, including income requirements, AND
- The parents need child care during the time they are working.

Can I get child care assistance if I work at a child care center?

Yes, but the Child Care Assistance Program cannot pay for more than 25 employees' children to attend a child care center where their parents work. This law applies to both licensed and license exempt centers. Parents may work at a child care center where their children do not attend. For more information about this law, see Child Care Assistance Program Payments for Children of Center Employees – Questions and Answers for Parents (DHS-6960C).

What if I don't follow the law?

Failure to follow Child Care Assistance Program rules could result in serious consequences, such as:

- A loss of child care assistance
- The need to pay back money paid by the Child Care Assistance Program, and/or
- A fraud determination (see below for more information).

What is fraud?

Fraud is knowingly giving the government false information to get public assistance for yourself or someone else. Public assistance includes programs like child care assistance, cash assistance, SNAP and Medical Assistance.

It's very important that you provide **true, complete and current information** about everyone in your household. This information will be used to determine the amount of benefits you should receive. If your worker discovers any information you gave is not true, you risk losing future public assistance benefits and face other serious penalties.

Know what you are signing

Before you sign your name on an application or form, read it carefully. Be sure that you are giving true information about yourself, your situation and all changes in your life.

Fraud penalties

If you commit fraud, you may lose your right to get any future benefits. You may also have to:

- Pay back the money or public assistance benefits that you wrongfully received
- Pay additional fines to the court
- Go to jail or prison.

How can I report fraud?

People who are dishonest about information related to public assistance benefits cause serious trouble for themselves and others. If you think someone is cheating or breaking the law, please help by reporting it. To report suspected fraud, contact the Department of Human Services Fraud Hotline:

- 800-627-9977 toll-free outside the Twin Cities metropolitan area
- 651-431-3968 in the Twin Cities metropolitan
- Online at https://fraudhotline.dhs.mn.gov

You do not have to give your name when you report fraud.

Notice of Privacy Practices

(Effective Date: November 2016)

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

Why do we ask for this information?

- In order to determine whether and how we can help you, we collect information:
  - To tell you apart from other people with the same or similar name
  - To decide what you are eligible for
  - To help you get medical, mental health, financial or social services and decide if you can pay for some services
  - To decide if you or your family need protective services
  - To decide about out-of-home care and in-home care for you or your children
  - To investigate the accuracy of the information in your application
- After we have begun to provide services or support to you, we may collect additional information:
  - To make reports, do research, do audits, and evaluate our programs
  - To investigate reports of people who may lie about the help they need
  - To collect money from other agencies, like insurance companies, if they should pay for your care
  - To collect money from the state or federal government for help we give you.
  - When your or your family's circumstances change and you are required to report the change (see Client Responsibilities and Rights – DHS-4163)

Why do we ask you for your Social Security number?

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

You do not have to give us the Social Security Number:

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

Do you have to answer the questions we ask?

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

With whom may we share information?

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

- Employees or volunteers with other state, county, local, federal, collaborative, nonprofit and private agencies
- Researchers, auditors, investigators, and others who do quality of care reviews and studies or commence prosecutions or legal actions related to managing the human services programs.
- Court officials, county attorney, attorney general, other law enforcement officials, child support officials, and child protection and fraud investigators
- Human services offices, including child support enforcement offices
- Governmental agencies in other states administering public benefits programs
- Health care providers, including mental health agencies and drug and alcohol treatment facilities
- Health care insurers, health care agencies, managed care organizations and others who pay for your care

- Guardians, conservators or persons with power of attorney
- Coroners and medical investigators if you die and they investigate your death
- Credit bureaus, creditors or collection agencies if you do not pay fees you owe to us for services
- Anyone else to whom the law says we must or can give the information.

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

- You and people you have given permission to may see and copy private information we have about you. You may have to pay for the copies.
- You may question if the information we have about you is correct. Send your concerns in writing. Tell us why the information is wrong or not complete. Send your own explanation of the information you do not agree with. We will attach your explanation any time information is shared with another agency.
- You have the right to ask us in writing to share information with you in a certain way or in a certain place. For example, you may ask us to send health information to your work address instead of your home address. If we find that your request is reasonable, we will grant it.
- You have the right to ask us to limit or restrict the way that we use or disclose your information, but we are not required to agree to this request.
- If you do not understand the information, ask your worker to explain it to you. You can ask the Minnesota Department of Human Services for another copy of this notice.

What are our responsibilities?

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

What privacy rights do children have?

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

What if you believe your privacy rights have been violated?

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

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

DEPARTMENT OF HUMAN SERVICES

Client Responsibilities and Rights

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

Your responsibilities

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

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

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

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

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

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

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

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

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

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

- **Each time you use your Electronic Benefits Transfer (EBT) card or sign your check**, you state that you have informed the county agency about any changes in your situation which may affect your benefits.
- **Each time your EBT** card is used we assume you have received your cash or SNAP benefits, unless you reported your card lost or stolen to the county agency.

For Child Care Assistance:

- **You may be required to pay a co-payment fee to your child care provider.** If you do not pay the fee, your child care assistance will be terminated until fees are paid in full or satisfactory payment agreements have been made with the county and your child care provider.
- **You may be required to pay additional costs** when your child care provider charges a rate that is more than the maximum rate in your county.
- **You must document** the immigration or citizenship status of the children in your family for whom you are applying for child care assistance.

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

Your rights

- **Your right to privacy.** Your private information, including your health information, is protected by state and federal laws. Your worker has given you a Notice of Privacy Practices (DHS-3979) information sheet explaining these rights.
- **You have the right to reapply** at any time if your benefits stop.
- **You have the right to know why, if we have not processed your application within:**
  - 30 days for cash, SNAP and child care assistance
  - 60 days for cash related to disability.
- **You have the right to know the rules of the program you are applying for** and for the agency to tell you how your benefit amount was figured.
- **You have the right to choose where and with whom you live.**
- **Appeal rights.** If you are unhappy with the action taken or feel the agency did not act on your request for assistance, you may appeal. For cash, child care assistance and health care, you may appeal **within 30 days** from the date you receive the notice by writing to the county agency, or directly to the State Appeals Office at the Minnesota Department of Human Services, PO Box 64941, St. Paul, MN 55164-0941. (If you show good cause for not appealing your cash and health care **within 30 days**, the agency can accept your appeal **for up to 90 days** from the date you receive the notice.)

  For SNAP, you may appeal **within 90 days** by writing or calling the county or the State Appeals Office. You may represent yourself at the hearing, or you may have someone (an attorney, relative, friend or another person) speak for you.

  If you wish your assistance to continue until the hearing, you must appeal before the date of the proposed action or within 10 days after the date the agency notice was mailed, whichever is later. Ask your county worker to explain how the timing of your appeal could affect your present or future assistance.
- **Access to free legal services.** Contact your worker for information on free legal services.

Civil Rights Notice

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

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

Civil Rights Complaints

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

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

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

Minnesota Department of Human Rights (MDHR)

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

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

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

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

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

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

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

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

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

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

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