Minnesota Health Care Programs Application

Fill out this application to apply for health care coverage for the following people:

- **Families**
- **Children**
- **Married couples**
- **People who are single**
- **People who are blind or disabled**
- **People who live in a nursing home or other facility**
- **People who are applying to get help from a waiver services program.**

  Waiver programs include: Elderly Waiver (EW), Community Alternatives for Disabled Individuals (CADI), Community Alternative Care (CAC), Traumatic Brain Injury (TBI), Mental Retardation and Related Conditions (MR/RC)

Attention. If you want free help translating this information, ask your worker or call the number below for your language.

ملاحظة: إذا أردت مساعدة مجانية في ترجمة هذه المعلومات، فاسأل مساعدك في مكتب الخدمة الاجتماعية أو اتصل على الرقم 1-800-358-0377.

កំណត់សំគាល់ បើអ្នកចង់បានជំនួយបកប្រែពត៌មាននេះដោយមិនគិតថ្លៃ សូមសួរអ្នកកាន់សំណុំរឿងរបស់អ្នក ឬ ទូរស័ព្ទទៅលេខ 1-888-468-3787 ។

Pažnja. Ako vam je potrebna besplatna pomoć za prevod ove informacije, pitajte vašeg radnika ili nazovite 1-888-234-3785.

Ceeb toom. Yog koj xav tau kev pab txhais cov xov no rau koj dawb, nug koj tus neeg lis dej num (worker) lossis hu 1-888-486-8377.

ໂປຼດຊາບ. ຖ້າຫາກທ່ານຕ້ອງການ ການຊ່ວຍເຫຼືອໃນການແປຂໍ້ຄວາມດັ່ງກ່າວນີ້ຟຣີ, ຈົ່ງຖາມນໍາພນັກງານຊ່ວຍວຽກ ຂອງທ່ານ ຫຼືໂທຣຫາ ຕາມເລກໂທຣ 1-888-487-8251.

Hubaddhu. Yoo akka odeeffannoon kun sii hiikamu gargaarsa tolaa feeta ta'e, hojjataa kee gaafaddhu ykn lakkoofsa kana bilbili 1-888-234-3798.

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

Ogow. Haddii aad dooneyso in lagaa kaalmeeyo tarjamadda macluumaadkani oo lacag la'aan ah, weydii hawl-wadeenkaaga ama wac lambarkan 1-888-547-8829.

Atención. Si desea recibir asistencia gratuita para traducir esta información, consulte a su trabajador o llame al 1-888-428-3438.

Chú Ý. Nếu quý vị cần dịch thông-tin nầy miễn phí, xin gọi nhân-viên xã-hội của quý vị hoặc gọi số 1-888-554-8759.

LB #2 (12-03)

This information is available in other forms to people with disabilities by contacting us at (651) 431-2670 (voice) or toll free at (800) 657-3739. TTY/TDD users can call the Minnesota Relay at 711 or (800) 627-3529. For the Speech-to-Speech Relay, call (877) 627-3848.

Minnesota Health Care Programs Application – Part A

Read and keep Part A of this application.

How do I apply for health care coverage?

- Answer all of the questions on the white pages (Part B) of the application.
- Make sure that the application is signed and dated by each person age 18 and older who wants health care coverage.
- Find all the proofs you need and include them with your application. Each question tells you if you need proof. Proof includes items such as pay stubs, bank statements and car titles. Proof also includes information you write on Form A at the back of the application. You may not get coverage if we do not get proofs. Tell us if you need help getting proofs.
- Read the information on the green pages, Part A, (A through I) at the beginning of the application. **Tear off the green pages (Part A) and keep them.** This will save you postage money if you mail the application.
- To apply for all Minnesota health care programs, take or mail your application to the human service office in the county where you live.
- To apply for MinnesotaCare only, either:
  - Take or mail your application to the state office or
  - Ask your county office if they accept applications for MinnesotaCare.
- County and state mailing addresses, phone numbers and fax numbers are listed on the next two pages. Add extra postage if you mail the application.

If you want to apply for cash benefits or Food Support, ask your county office for a different application to fill out. Do not wait for that application if you want health care. Fill out this health care application right away or you may lose some months of coverage.

How soon should I apply for health care?

Turn in your application as soon as you fill it out, sign it and date it. In some cases, coverage may start three months before you turn in your application. In other cases, coverage can only begin on the day you turn in the application.

For most people who have a monthly payment for health care, coverage will start on the first day of the month after we get the payment. For example, if we get your payment in May, your coverage will start on June 1.

What if I need help or have questions?

Call your county human services office. The list of county offices and the state office is on the next two pages of this application.

If you are disabled or age 65 or older, you may also call the Linkage Line at (800) 333-2433.

Agency Addresses

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

Anoka County
2100 Third Avenue
Anoka, MN 55303-2264
763-422-7246
Fax: 763-323-6046

Becker County
P.O. Box 1637
Detroit Lakes, MN 56502-1637
218-847-5628
Fax: 218-847-6738

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

Benton County
P.O. Box 740
Foley, MN 56329-0740
320-968-5087 / 800-530-6254
Fax: 320-968-5330

Big Stone County
P.O. Box 338
Ortonville, MN 56278-0338
320-839-2555
Fax: 320-839-3966

Blue Earth County
P.O. Box 3526
Mankato, MN 56002-3526
507-304-4335
Fax: 507-304-4336

Brown County
P.O. Box 788
New Ulm, MN 56073-0788
507-354-8246 / 800-450-8246
Fax: 507-359-6542

Carlton County
1215 Avenue C
Cloquet, MN 55720-1610
218-879-4583 / 800-642-9082
Fax: 218-878-2500

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

Cass County
P.O. Box 519
Walker, MN 56484-0519
218-547-1340
Fax: 218-547-1448

Chippewa County
719 North Seventh St – Suite 200
Montevideo, MN 56265-1397
320-269-6401 / 877-450-6401
Fax: 320-269-6405

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

Clay County
715 North 11th St – Suite 102
Moorhead, MN 56560-2095
218-299-5200 / 800-757-3880
Fax: 218-299-7515

Clearwater County
P.O. Box X
Bagley, MN 56621-0682
218-694-6164 / 800-245-6064
Fax: 218-694-3535

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

Cottonwood County
P.O. Box 9
Windom, MN 56101-0009
507-831-1891
Fax: 507-831-0126

Crow Wing County
P.O. Box 686
204 Laurel St – Suite 22
Brainerd, MN 56401-0686
218-824-1250 / 888-772-8212
Fax: 218-824-1141

Dakota County
1 Mendota Road West – #100
West St. Paul, MN 55118-4773
651-554-5611
Fax: 651-554-5793

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

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

Faribault County
P.O. Box 217
Blue Earth, MN 56013-0217
507-526-3265
Fax: 507-526-2039

Fillmore County
902 Houston St NW – #1
Preston, MN 55965-1080
507-765-2175
Fax: 507-765-3895

Freeborn County
P.O. Box 1246
Albert Lea, MN 56007-1246
507-377-5400
Fax: 507-377-5498

Goodhue County
426 West Avenue
Red Wing, MN 55066-0031
651-385-3200
Fax: 651-385-3205

Grant County
P.O. Box 1006
Elbow Lake, MN 56531-1006
218-685-4417 / 800-291-2827
Fax: 218-685-4978

Hennepin County
330 South 12th Street
Minneapolis, MN 55404-9760
612-596-1300
Fax: 612-596-8921

Houston County
P.O. Box 310
Caledonia, MN 55921-0310
507-725-5811
Fax: 507-725-3990

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

Isanti County
553 18th Avenue SW
Cambridge, MN 55008-9386
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
P.O. 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 St NE
Willmar, MN 56201-9423
320-231-7800 / 877-464-7800
Fax: 320-231-6285

Kittson County
410 South Fifth St – 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
P.O. Box 7
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
P.O. Box 158
Baudette, MN 56623-0200
218-634-2642
Fax: 218-634-4520

LeSueur County
88 South Park Avenue
LeCenter, MN 56057-1646
507-357-8288
Fax: 507-357-6122

Lincoln County
P.O. Box 44
Ivanhoe, MN 56142-0044
507-694-1452 / 800-657-3781
Fax: 507-694-1859

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

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

Mahnomen County
P.O. Box 460
Mahnomen, MN 56557-0460
218-935-2568
Fax: 218-935-5459

Keep this page.

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

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

Meeker County
114 North Holcombe Ave – #180
Litchfield, MN 55355-2273
320-693-5300 / 800-915-5300
Fax: 320-693-5344

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

MinnesotaCare State Office
PO Box 64838
St. Paul, MN 55164-0838
651-297-3862 / 800-657-3672

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

Mower County
1301 18th Avenue NW – Suite A
Austin, MN 55912-3317
507-437-9700
Fax: 507-437-9774

Murray County
3095 20th Street
Slayton, MN 56172-1493
507-836-6144 / 800-657-3811
Fax: 507-836-8841

Nicollet County
108 South Minnesota Ave – #200
St. Peter, MN 56082-2516
507-934-8559 / 800-247-5044
Fax: 507-931-9562

Nobles County
901 Fourth Avenue
318 9th Street
PO Box 189
Worthington, MN 56187-0189
507-372-2157
Fax: 507-372-5094

Norman County
15 Second Ave East – Room 108
Ada, MN 56510-1389
218-784-5400
Fax: 218-784-7142

Olmsted County
151 Fourth Street SE
Rochester, MN 55904-3711
507-285-8382
Fax: 507-287-7118

Otter Tail County
535 West Fir
Fergus Falls, MN 56537-2703
218-998-8230
Fax: 218-998-8270

Pennington County
P.O. Box 340
Thief River Falls, MN 56701-0340
218-681-2880
Fax: 218-683-7013

Pine County
130 Oriole St East – Suite 1
Sandstone, MN 55072-5134
320-245-3020 / 800-450-7263
Fax: 320-245-3060

Pipestone County
P.O. Box 157
Pipestone, MN 56164-0157
507-825-6720 / 888-632-4325
Fax: 507-825-6727

Polk County
223 7th St – Suite 109
Crookston, MN 56716-1474
218-281-3127 / 800-281-3127
Fax: 218-281-7347

Pope County
211 East MN Ave – Suite 200
Glenwood, MN 56334-1628
320-634-5750
Fax: 320-634-0164

Ramsey County
160 East Kellogg Boulevard
St. Paul, MN 55101-1494
651-266-4444
Fax: 651-266-4439

Red Lake County
P.O. Box 356
Red Lake Falls, MN 56750-0356
218-253-4131 / 877-294-0846
Fax: 218-253-2926

Redwood County
P.O. Box 510
Redwood Falls, MN 56283
507-637-4050 / 888-234-1292
Fax: 507-637-4055

Renville County
301 South Seventh Street
Olivia, MN 56277-1301
320-523-2202
Fax: 320-523-3565

Rice County
P.O. Box 718
Faribault, MN 55021-0718
507-332-6115
Fax: 507-332-6247

Rock County
P.O. Box 715
Luverne, MN 56156-0715
507-283-5070
Fax: 507-283-5074

Roseau County
300 Sixth Street SW
Roseau, MN 56751-1451
218-463-2411 / 866-255-2932
Fax: 218-463-3872

St. Louis County
320 W 2nd Street – Room 301
Duluth, MN 55802-1495
218-726-2101 / 800-450-9777
Fax: 218-733-2975
Or
307 1st St S – 2nd Floor
Virginia, MN 55792-1148
218-749-7100
Fax: 218-749-7123
Or
118 S 4th Ave E
Ely, MN 55731-1465
218-365-8210
Fax: 218-365-3217
Or
1814 14th Ave E
Hibbing, MN 55746-1314
218-262-6000
Fax: 218-262-6049

Scott County For Adults
Government Center 300
200 Fourth Ave West
Shakopee, MN 55379-1375
952-445-7751
Fax: 952-496-8551
Or
Scott County for Families
Workforce Center
752 Canterbury Road
Shakopee, MN 55379-1375
952-496-8686
Fax: 952-496-8685

Sherburne County
13880 Highway 10
Elk River, MN 55330-4600
763-241-2600 / 800-433-5239
Fax: 763-241-2698

Sibley County
P.O. Box 237
Gaylord, MN 55334-0237
507-237-4000
Fax: 507-237-4031

Stearns County
P.O. Box 1107
St. Cloud, MN 56302-1107
320-656-6000 / 800-450-3663
Fax: 320-656-6447

Steele County
P.O. Box 890
Owatonna, MN 55060-0890
507-444-7500
Fax: 507-451-5947

Stevens County
10 East Highway 28
Morris, MN 56267
320-589-7400 / 800-950-4429
Fax: 320-589-3972

Swift County
P.O. Box 208
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
P.O. Box 46
Wheaton, MN 56296
320-563-8255 / 800-721-8277
Fax: 320-563-4230

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

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

Waseca County
123 Third Avenue NW
Waseca, MN 56093-2498
507-835-0560
Fax: 507-835-0566

Washington County
14949 62nd Street North
P.O. Box 30
Stillwater, MN 55082-0030
651-430-6459
Fax: 651-430-6636

Watonwan County
P.O. Box 31
St. James, MN 56081-0031
507-375-3294 / 888-299-5941
Fax: 507-375-7359

Wilkin County
P.O. 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: 507-454-9382

Wright County
10 2nd Street NW – Room 300
Buffalo, MN 55313-1736
763-682-8920 / 800-362-3667
Fax: 763-682-7701

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

Keep this page.

Notice of Privacy Practices

Minnesota Department of Human Services

(Effective Date: April 14, 2003)

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

You have privacy rights under the Minnesota Government Data Practices Act and the federal Health Insurance Portability and Accountability Act (HIPAA). These laws protect your privacy, but also let us give information about you to others if a law requires it.

Why do we ask for this information?

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

Do you have to answer the questions we ask?

Generally, the law does not say you have to give us this information. We need your social security number in order to give you some kinds of financial help or child support enforcement services (45 CFR 205.52 [2001]; 42 USC 666; 45 CFR 303.30 [2001]).

What will happen if you do not answer the questions we ask?

We need information about you to tell if you can get help from any program. 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 the information about you?

We may give information about you to the following agencies if they need it for investigations, or to help you, or to help us help you.

We don't always share information about you with these people, but the law says we may share information with them. If you have questions about when we give these people information, ask your worker.

- U.S. Department of Agriculture
- U.S. Department of Health and Human Services
- U.S. Department of Labor
- United States Citizenship and Immigration Services
- Internal Revenue Service
- Social Security Administration
- Minnesota Department of Employment and Economic Development
- Minnesota Department of Education
- Minnesota Department of Human Rights
- Minnesota Department of Human Services
- Minnesota Department of Labor and Industry
- Minnesota Department of Public Safety
- Minnesota Department of Revenue
- Minnesota Department of Veterans Affairs
- Minnesota Historical Society
- American Indian tribes, if your household is in need of human services at a tribal reservation
- Higher education coordinating board
- State hospitals or long-term care facilities
- State and federal auditors
- Court officials

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- Anyone under contract with the Minnesota Department of Human Services or U.S. Department of Health and Human Services, or the county social services agency
- Local and state health departments
- County human services boards
- Child or adult protection teams
- People who investigate child or adult protection
- Other human services offices, including child support enforcement offices
- Fraud prevention and control units
- Employees or volunteers of any welfare agency who need the information to do their jobs
- County attorney, attorney general or other law enforcement officials
- Mental health centers
- Ombudsman for families
- Ombudsman for mental health and mental retardation
- County advocates for Minnesota Managed Health Care Programs
- Guardian, conservator or person who has power of attorney for you
- Local collaborative agencies
- Community food shelves or surplus food programs
- Health care providers
- School districts
- Schools and other institutions of higher education
- Coroner/medical examiner if you die and they investigate your death
- Hospitals if you, a friend, or relative has an emergency and we need to contact someone
- Others who may pay for your care
- Insurance companies to check health care benefits you or your children may get
- Managed care organizations about your health care or benefits
- Credit bureaus
- Creditors
- Collection agencies, if you do not pay fees you owe to us for services
- Minnesota Board on Aging
- Anyone else to whom the law says we can give the information

You have the right to information we have about you.

- You may ask if we have any information about you and get copies. You may have to pay for the copies.
- You may give other people permission to see and have copies of private information about you.
- Unless we get special written permission from you, we will only use your health information for the purposes listed on this form.
- You may question the accuracy of any information we have about you.
- You have the right to ask us to share health information with you in a certain way or in a certain place. For example, you may ask us to send health information to your work address instead of your home address. You must make this request in writing. You do not have to explain the basis for your request. If we find that your request is reasonable, we will grant it.
- You can ask us to restrict uses or disclosures of your health information. Your request must be in writing. You must explain what information you want to restrict from being disclosed and to whom you want these restrictions to apply. You can request to end these restrictions at any time by calling us or by writing to us. We are not required to agree to your restrictions.
- You have the right to receive a record of the people or organizations that we have shared your health information with. We must keep a record of each time we share your health information for six years from the date it was shared. This record will be started on April 14, 2003.
  It will NOT include those times when we have shared your information in order to treat you, pay or bill for your health care services or to run our programs. If you want a copy of this record, you must send a request in writing to our Privacy Official.
- If you do not understand the information, ask your worker to explain it to you. You can ask DHS for another copy of this notice.

Keep this page.

What are our responsibilities under this notice?

We may change our privacy policy in the future. We might do this, for example, because privacy laws change and require us to change our practices.

When we change our privacy rules we will publish them on our Web site at:

http://edocs.dhs.state.mn.us/lfserver/Legacy/DHS-3979-ENG

Until we publish new privacy rules, we will abide by the terms of this notice.

What if you believe the information we have about you is wrong?

Send your concerns in writing, telling us why the information is not accurate or complete. You may send your own explanation of the facts you disagree with. Your explanation will be attached any time that information is shared with another agency.

What privacy rights do children have?

If you are under 18, parents may see information about you and allow others to see this information, unless you have asked that this information not be shared with your parents or it involved medical treatment for which parental consent was not required. You must make this request in writing and say what information you want withheld 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 will be shared with your parents if they ask for it.

When parental consent for medical treatment is not required, information will not be shown to parents unless the health care provider believes failing to share the information would jeopardize your health.

What if you believe your privacy rights have been violated?

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

- U.S. Department of Health and Human Services
  Office for Civil Rights, Region V
  233 N. Michigan Avenue, Suite 240
  Chicago, IL 60601
  (312) 886-2359 (Voice) or
  toll free (800) 368-1019 or (866) 282-0659
  (312) 353-5693 (TTY/TDD)
  (312) 886-1807 (Fax)

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

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

Important Information

Proof of Citizenship or National Status

Parents and caretakers, children, pregnant women, people with disabilities and people age 65 or over must give us proof that they are U.S. Citizens or Nationals. National status includes people from American Samoa and Swains Island.

If you are eligible for Medicare, you do not have to prove you are a U.S. Citizen. If you receive SSI (Supplemental Security Income) or received SSI in the past, your worker will contact the Social Security Office to document you are a U.S. Citizen.

Adults without children are not required to give us proof that they are U.S. Citizens or Nationals.

Proof can be one of the following:

1. U.S. passport
2. Certificate of Naturalization
3. Certificate of U.S. Citizenship

If you do not have one of the above documents, you must give us one item from List #1 and one from List #2 below. If you do not have or cannot get these items, ask your worker for help right away.

Keep this page.

List #1

1. U.S. birth certificate
2. Report of Birth Abroad of a U.S. Citizen
3. U.S. Citizen ID card
4. Hospital record of birth in one of the 50 states, the District of Columbia, Puerto Rico, Guam, the U.S. Virgin Islands, American Samoa, Swains Island or the Northern Mariana Islands.

List #2

1. State driver's license with picture
2. Minnesota ID card with picture
3. School ID card with picture.
4. Nursery or day care records for children under 16.
5. A parent or guardian's signature on the application proves identity for children under age 16.

Immigration

All immigration information you give to us is private. We use it to see if you can get coverage. We only share it when the law allows it or requires it. In most cases, applying will not affect your immigration status. However, it may if you are applying to pay for long-term care services.

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

- Applying only for emergency medical care.
- Only helping someone else apply.
- A non-immigrant or undocumented person who is pregnant.
- Applying for your children or other household members, but not yourself.

You Have the Right to Fair Treatment

We cannot treat you different because of your race, color, national origin, religion, sex, marital status, sexual orientation or political beliefs. We cannot treat you different because you have a physical, mental or emotional disability. If you feel the State or local agency did not treat you fairly, you may file a complaint. You can contact any of the following places to file a complaint:

- Minnesota Department of Human Services
  Office for Equal Opportunity
  PO Box 64997, St. Paul, MN 55164-0997
- Minnesota Department of Human Rights
  190 E. Fifth Street, Suite 700
  St. Paul, MN 55101
- U.S. Department of Health and Human Services
  Office of Civil Rights - Region V
  233 N. Michigan Avenue, Suite 240
  Chicago, IL 60601

You Have the Right to Ask for a Hearing

If you feel that your benefits are not right you may ask for a fair hearing. You can ask for a hearing by telling your worker or by writing to the:

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

A person from the State office will check the facts of your case. They will tell you if your benefits are correct or not according to the laws.

You must ask for a hearing within 30 days from the day you get a notice. You must say that you feel a decision is wrong. If you cannot ask for a hearing within 30 days, you can ask for more time. You will need to show that you have a good reason for not asking for hearing on time. If a person from the State office decides you had a good reason, they will accept your appeal up to 90 days after you received the notice of action on your case.

If you ask for a hearing after 30 days, you will not be able to have your health care continue until the hearing. If you want your health care to continue, you must ask for a hearing before the date your coverage will be reduced or within 10 days from the date of the notice, whichever is later.

Breaking the Rules

The below rules apply to some people who are enrolled in certain health care programs. If the rules apply to you, it explains what will happen if you break the rules.

What are the rules?

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

What happens if I break these rules?

If you break the rules you may not be able to keep your coverage. The first time you break the rules, your coverage will stop for one year. The second time you break the rules you will not get coverage for two years. If you break the rules a third time, you will not get coverage forever. Also, if you break these rules we can prosecute you for fraud. The maximum penalty is a fine of $250,000 or a jail term of 20 years, or both.

Social Security Numbers

Most people who apply for coverage must give a Social Security Number. We use them to check who you are, for system matches, and for reviews and audits to make sure your case is correct.

You do not have to give us a number if you:

- Do not want coverage
- Have religious objections
- Are not a U.S. Citizen and are applying for Emergency Medical only
- Are a non-immigrant or a person without documentation.

Child Support

If you are applying for yourself and your children and you do not live with the other parent, the law says that you may have to give information to child support staff.

If you were not married to the other parent when your child was born, you may also have to help child support staff prove who the father is. This means that you may need to give information to get medical support for your child. If you do not help child support, your children will still get coverage. You will not get coverage unless you are pregnant. Your coverage will stop if you are already getting coverage.

Do you have fear that the other parent may cause harm to you or your child? If you do, and you can give proof to support your fears, you may not have to give information to child support staff. A group of people at the county or state office will review your proof. After the review, they will tell you if you still need to give information about the other parent.

If you are already getting child support services, they will stop during the review. If they make a decision that you must give information about the other parent, child support services will start again.

A law says that the State of Minnesota gets to keep medical support payments for the person who is applying for or getting coverage. The State can not keep more than it pays out. This is also true even if you are applying only for a child.

Reviews

The State or Federal Office may pull your case at random to review. They will review the information you put on your application and renewal forms. They will also check to make sure we did your case correctly. They will let you know if they will need to ask you questions. If you refuse to answer their questions, your coverage may stop.

Reporting Systems

The State uses systems to check the information you give. If we get information that does not match yours, we will write to you. You will need to give us proof or give us permission to check your information. If you refuse, your coverage may stop. If you want more information, ask your worker for the "Notice About Income and Eligibility Verification System and Work Reporting System" (DHS-Form #2759).

Other Health Care

You and your household members may need to accept and keep a health insurance policy that is good. This includes Medicare. We will review your policy. We will tell you if you can or cannot cancel it.

In some cases, if we tell you that you cannot cancel it, we may help pay the premiums. If you refuse to give us information about your policy, you may not get coverage.

Keep this page.

State As Annuity Beneficiary

The state becomes a remainder beneficiary of some annuities when we pay for long-term care services.

Liens and Estate Claims

The state or county may try to recover the cost of medical services that MA or GAMC paid for you. They do this by filing a claim against your estate or by filing a lien against your real property.

The state may file a claim against your estate if you received:

- General Assistance Medical Care (GAMC) at any age.
- MA when you were over age 55.
- MA when you were under 55 and lived in a long-term care facility (LTCF) for six months or more.

Liens can be set up against:

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

The state will not file a lien against your property if you are in a long-term care facility and will be returning home.

Before you die, the State can file a Notice of Potential Claim (Notice). The Notice must:

- List the real property you own.
- Note if you have a life estate.
- State if other people own any real property with you.

When you die, a lien is set up against your portion of the property that was listed in the Notice. Your interest in real property that is part of your estate may be used to pay that claim.

Note that this is a very general explanation of the rights that the state and counties have regarding claims and liens. You should talk to your lawyer or advisor if you have questions about how these laws apply to your property.

Changes

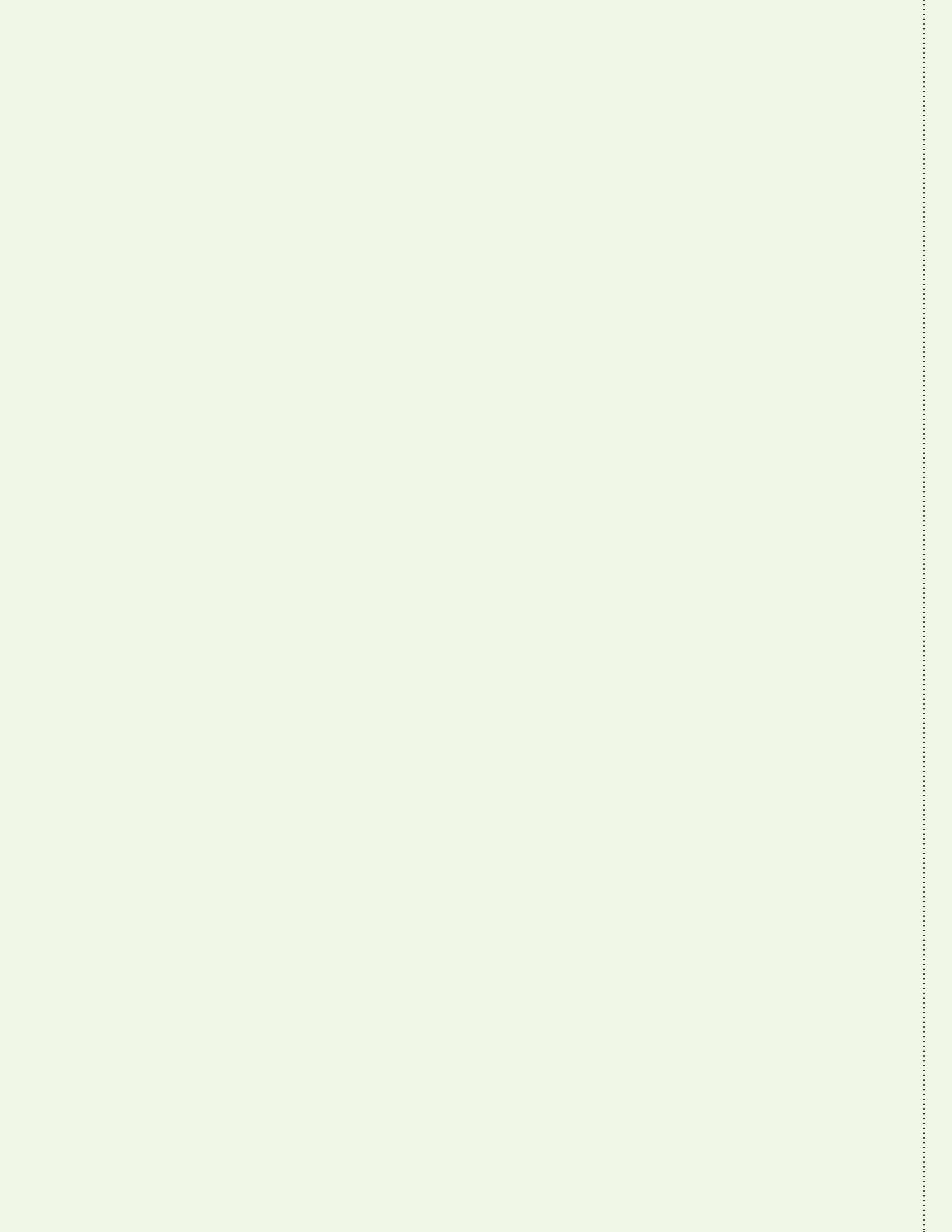
You must report changes to your worker within 10 days of the change happening. If you do not report changes, you may have to go through a fraud investigation. You may have to pay money back to the State for what we paid if you were not eligible.

If you are not sure if you should report a change, call your worker and explain what is happening. Your worker will tell you if you need to report it or not.

Examples of changes you need to report may include:

- **Starting:**
  - A new job; changing jobs, or stopping a job.
  - To get Social Security or other retirement income.
  - To get child support, unemployment or worker's comp income.
  - To get health insurance or Medicare.
- **When you:**
  - Sell your home.
  - Move to a new address.
  - Get an inheritance or a settlement.
  - Transfer or give away assets or income.
- **When someone in your household:**
  - Becomes pregnant or has a baby.
  - Moves in or out of your home.
  - Dies, gets married or gets a divorce.
  - Becomes disabled.
  - Starts or stops school.

Keep this page.



Minnesota Health Care Programs Application – Part B

Fill out and return Part B.

Instructions

- Fill out and return Part B. Answer all questions and print clearly.
- Write with blue or black ink.
- You may need more space to answer a question. Write the question number and answer on a separate piece of paper. Include it with this application. Add extra postage if mailing this application.

Office Use Only		
DATE RECEIVED	CASE NUMBER	WORKER NUMBER

1. Language information

What is the main language your household speaks? ☐ English ☐ Spanish ☐ Other ______________

What is the main language your household writes? ☐ English ☐ Spanish ☐ Other ______________

Do you need someone who speaks your language to help you? ☐ **Yes** ☐ **No**

2. Who is filling out this application?

First name ____________________________ MI ______ Last ______________________________

How is this person related to the household? ☐ Mother ☐ Father ☐ Child ☐ Friend ☐ Other

3. Fill out information for all household members.

- You must tell us if each person applying is a U.S. citizen, a national, or a non-citizen.
- Nationals include people from American Samoa and Swains Island.
- **Most citizens and nationals must give us proof of U.S. citizenship or national status.** See the list of proofs on green pages F and G.
- **People who are not U.S. citizens must give us copies of immigration documents.** All immigration information you give us is private. See the information on green page F.
- Let us know if you need help getting proofs.

WORKER NOTES

3a. Head of household (This is usually the household member who is filling out this form or their spouse)

First name ______________________ MI _____ Last ______________________

Date of birth _____/_____/__________ Gender ☐ Male ☐ Female

Marital Status ______________ **Are you applying?** ☐ **Yes – continue** ☐ **No – go to question 3b**

Social Security Number _______-______-________

Are you a U.S. citizen or national? ☐ **Yes** ☐ **No**

If yes, write the city and state where you were born ______________________ and your full name at birth ______________________.

If you are not a U.S. Citizen what is your immigration status? ______________________

Date of entry into U.S. _____/_____/__________ Do you have a sponsor? ☐ **Yes** ☐ **No**

You do not have to answer the next two questions if you do not want to. We use it for reports only.

Are you Latino or Hispanic? ☐ **Yes** ☐ **No**

What is your race? ☐ White ☐ Asian ☐ American Indian or Alaskan Native ☐ Black/African American ☐ Pacific Islander or Native Hawaiian

3b. Do you live alone? ☐ **Yes** – go to question 4 ☐ **No** – go to question 3c

3c. Second household member (This is either a spouse, another adult or children living in the household).

First name ______________________ MI _____ Last ______________________

Date of birth _____/_____/__________ Gender ☐ Male ☐ Female

Relationship to head of household ______________________ Marital Status ______________________

Is this person applying? ☐ **Yes – continue** ☐ **No – go to next person**

Social Security Number _______-______-________

Is this person a U.S. citizen or national? ☐ **Yes** ☐ **No**

If yes, write the city and state where this person was born ______________________ and full name at birth ______________________.

If this person is not a U.S. Citizen what is their immigration status? ______________________

Date of entry into U.S. _____/_____/__________ Does this person have a sponsor? ☐ **Yes** ☐ **No**

You do not have to answer the next two questions if you do not want to. We use it for reports only.

Is this person Latino or Hispanic? ☐ **Yes** ☐ **No**

What is this person's race? ☐ White ☐ Asian ☐ American Indian or Alaskan Native ☐ Black/African American ☐ Pacific Islander or Native Hawaiian

3d. Third household member

First name ______________________________ MI ______ Last ________________________________

Date of birth _____/_____/__________ Gender ☐ Male ☐ Female

Relationship to head of household ________________________ Marital Status ____________________

Is this person applying? ☐ **Yes – continue** ☐ **No – go to next person**

Social Security Number _______-______-________

Is this person a U.S. citizen or national? ☐ **Yes** ☐ **No**

If yes, write the city and state where this person was born ___________________________________ and full name at birth ___________________________________.

If this person is not a U.S. Citizen what is their immigration status? ______________________________

Date of entry into U.S. _____/_____/__________ Does this person have a sponsor? ☐ **Yes** ☐ **No**

You do not have to answer the next two questions if you do not want to. We use it for reports only.

Is this person Latino or Hispanic? ☐ **Yes** ☐ **No**

What is this person's race? ☐ White ☐ Asian ☐ American Indian or Alaskan Native ☐ Black/African American ☐ Pacific Islander or Native Hawaiian

3e. Fourth household member

First name ______________________________ MI ______ Last ________________________________

Date of birth _____/_____/__________ Gender ☐ Male ☐ Female

Relationship to head of household ________________________ Marital Status ____________________

Is this person applying? ☐ **Yes – continue** ☐ **No – go to next person**

Social Security Number _______-______-________

Is this person a U.S. citizen or national? ☐ **Yes** ☐ **No**

If yes, write the city and state where this person was born ___________________________________ and full name at birth ___________________________________.

If this person is not a U.S. Citizen what is their immigration status? ______________________________

Date of entry into U.S. _____/_____/__________ Does this person have a sponsor? ☐ **Yes** ☐ **No**

You do not have to answer the next two questions if you do not want to. We use it for reports only.

Is this person Latino or Hispanic? ☐ **Yes** ☐ **No**

What is this person's race? ☐ White ☐ Asian ☐ American Indian or Alaskan Native ☐ Black/African American ☐ Pacific Islander or Native Hawaiian

3f. Fifth household member

First name ______________________ MI _____ Last ________________________

Date of birth ____/____/________ Gender ☐ Male ☐ Female

Relationship to head of household __________________ Marital Status ______________

Is this person applying? ☐ **Yes – continue** ☐ **No – go to next person**

Social Security Number ______-______-______

Is this person a U.S. citizen or national? ☐ **Yes** ☐ **No**

If yes, write the city and state where this person was born __________________________ and full name at birth __________________________.

If this person is not a U.S. Citizen what is their immigration status? ____________________

Date of entry into U.S. ____/____/________ Does this person have a sponsor? ☐ **Yes** ☐ **No**

You do not have to answer the next two questions if you do not want to. We use it for reports only.

Is this person Latino or Hispanic? ☐ **Yes** ☐ **No**

What is this person's race? ☐ White ☐ Asian ☐ American Indian or Alaskan Native
☐ Black/African American ☐ Pacific Islander or Native Hawaiian

If there are more household members: Write "Question 3" on a separate piece of paper. Write the above information for each person. Include it with this application.

You must give us copies of documents that show citizenship, national status or immigration status for each household member who is applying. You may not get coverage if we do not get proof.

4. Questions about medical needs.

4a. Are any household members pregnant?

☐ **Yes** – fill out the information below ☐ **No** – go to question 4b

Who is pregnant? ________________________ What is her due date? ____/____/________

You must give us proof of the pregnancy from a doctor, midwife or clinic. The proof needs to tell us the date she became pregnant and when the baby is due. You may not get coverage if we do not get proof.

4b. Do any household members have a medical emergency?

A medical emergency means someone needs to get medical help right away. The person's health or life will be at risk without medical help.

☐ **Yes** – write their full names ____________________________ ☐ **No** – go to question 4c

4c. Are you or any household members blind or have serious medical problems?

☐ **Yes** – write their names below ☐ **No** – go to question 5

Name ______________________ Has this person worked in the past year? ☐ Yes ☐ No

Name ______________________ Has this person worked in the past year? ☐ Yes ☐ No

5. What is your address?

☐ Check this box if you are homeless.

Street address ______________________ Apt # _____ City ______________________

State _______ Zip code ____________ What county do you live in? ______________________

Mailing address where you want your notices sent (if different from the one above):

Street address ____

City ______________________ State _______ Zip code ____________

Do you want us to send you a voter registration card? ☐ **Yes** ☐ **No**

☐ Check this box if you are a migrant worker.

6. Have you and your household lived in Minnesota more than six months?

☐ **Yes** – go to question 7 ☐ **No** – write the date you began living in Minnesota _____/_____/________

Do you plan to make Minnesota your home? ☐ **Yes** ☐ **No** – explain ______________________

____

7. Write the name and phone number of an adult household member that we can call during the day.

We will only call if we have questions about this application.

Name ______________________ Phone number (   )____________

Home phone number (   )____________ Other phone number (   )____________

WORKER NOTES

8. Do you want someone else to help you and act on your behalf?

☐ **Yes** – fill out this person's information below ☐ **No** – go to question 8a

This person:
- Must be age 18 or older
- Can be a friend, relative, or someone else who knows all of your information
- Can help you fill out forms and give us information we need
- Must report changes to us within 10 days

You can allow this person to get your notices about your:
- Health care application and renewals
- Health care eligibility and benefits
- Fair hearings

First name ______________________ MI _____ Last ______________________

What is this person's relationship to you? (Example – son, daughter or friend) ______________

Street address ____

City ______________________ Apt # _______ State ______ Zip code ____________

Daytime phone number ( )______________

Do you want us to mail your notices and other information to this person also? ☐ **Yes** ☐ **No**

8a. Do you have a legal guardian or conservator, or is there a power of attorney?

☐ **Yes** – we will need a copy of the legal document ☐ **No**

What is that person's full name? ______________________________________

Do you pay this person a fee? ☐ **Yes** – how much? $__________ How often? __________ ☐ **No**

9. Are any household members under age 18 emancipated?

Emancipation means: a child under the age of 18 is married; was married; is serving in the armed forces; or a judge signed an order stating this child is no longer under the legal control of his or her parents.

☐ **Yes** – write their full names ______________________________________ ☐ **No**

10. Are any household members living away from home for a short time?

☐ **Yes** – fill out the information below ☐ **No** – go to question 11

First name ______________________ MI _____ Last ______________________

Date of birth _____/_____/__________ Relationship to head of household ______________

Date person left _____/_____/__________ Date person will return _____/_____/__________

Why is this person living away? ______________________________________

11. Are you or is any household member a student?

☐ **Yes** – write each student's name and their grade below. ☐ **No** – go to question 12

Full name of student	Elementary school grade	High School		College	
		Full time	Part time	Undergrad	Graduate

If more students live in the household: Write "Question 11" on a separate piece of paper. Write the above information for each student. Include it with this application.

12. Are both parents of all children living in the home?

☐ **Yes** – go to question 13

☐ **No** – fill out information below for each child whose parent lives somewhere else

	First child	Second child	Third child
Child's name			
Name(s) of other parent(s) – List both parents if neither one lives with the child			
Is the parent's name on the **birth certificate**?	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**
Is there a signed **Recognition of Parentage**?	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**
Is there a court order for **paternity**?	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**
Is there a court order for **medical support**?	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**
If paternity is not established do you want help getting Medical Support?	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**

If the parents of more children live somewhere else: Write "Question 12" on a separate piece of paper. Write the above information for each child. Include it with this application.

WORKER NOTES

13. Are you or any household members getting services from the Center for Victims of Torture?

☐ **Yes** – write their full names ______________________ ☐ **No** – go to question 14

14. Are you or are any household members getting or expecting wages or a salary from a job?

This includes wages or a salary from an employer, seasonal employment, temporary jobs and cash jobs. If you are age 21 or older and living with your parents, you only need to give us your income.

☐ **Yes** – fill out the information below for each job and for each person who is working

☐ **No** – go to question 15

14a. Name of person working ______________________ Start date _____/_____/_________

Name of employer ______________________ Employer's phone number (   )____________

Contact person ______________________ ☐ Check this box if employment is seasonal or temporary.

How often paid? ☐ Every week ☐ Every two weeks ☐ Once a month ☐ ______________

Date of most recent paycheck _____/_____/_________

Amount of income before taxes and other deductions are taken out $______________

Does this employer offer health insurance? ☐ **Yes** – ☐ Single coverage **or** ☐ Household coverage ☐ **No**

14b. Name of person working ______________________ Start date _____/_____/_________

Name of employer ______________________ Employer's phone number (   )____________

Contact person ______________________ ☐ Check this box if employment is seasonal or temporary.

How often paid? ☐ Every week ☐ Every two weeks ☐ Once a month ☐ ______________

Date of most recent paycheck _____/_____/_________

Amount of income before taxes and other deductions are taken out $______________

Does this employer offer health insurance? ☐ **Yes** – ☐ Single coverage **or** ☐ Household coverage ☐ **No**

If you have other jobs to report: write "Question 14" on a separate piece of paper. Write the above information for each person and job. Include it with this application.

You must give us proof of income. Proof can be pay stubs from the last 30 days or a statement from the employer. You may not get coverage if we do not get proof.

You must give us proof that shows if employers offers health insurance. For each employed person, fill out Form A at the back of this application. You may not get coverage if we do not get proof.

15. Are you or any household members self-employed?

☐ **Yes** – fill out the information below and give us proof ☐ **No** – go to question 16

Name of person	Name of business	Start date of business	Gross yearly income
			$
			$

Do the net business assets of all businesses total $200,000 or less? ☐ **Yes** ☐ **No**

You must give us proof of this income. Proof can be the most recent income tax returns and all related schedules, or business records if taxes are not filed. You may not get coverage if we do not get proof.

16. Are any household members getting or expecting to get other types of income?

Other income may include: child support, spousal support, unemployment, worker's comp, Social Security, Supplemental Security Income (SSI), pensions, Veteran's benefits, retirement, annuities, trusts, interest, dividends, contracts for deed, rent, property agreements, public assistance payments and other types of income.

☐ **Yes** – fill out the information below and give us proof. ☐ **No** – go to question 17

Name	Where is the income from?	Amount	How often is it received? (Every week, every two weeks, once a month)	Date of the last payment
		$		
		$		
		$		
		$		

You must give us proof of this income. Proof can be a statement from the place that sends the income, or a direct deposit statement from your bank. You may not get coverage if we do not get proof.

17. Do you or any household members pay for child or adult day care while they work?

☐ **Yes** – fill out the information below ☐ **No** – go to question 18

Name of person who is working	Name of person(s) in day care	Amount paid each month
		$
		$

18. Do you or any household members pay court-ordered child or medical support?

☐ **Yes** – fill out the information below and give us proof ☐ **No** – go to question 19

Name of person paying support	Amount paid each month
	$
	$

You must give us proof of the amount. Proof can be a copy of the court order. You may not get coverage if we do not get proof.

19. Do any disabled or blind household members have work expenses?

☐ **Yes** – fill out the information below ☐ **No** – go to question 20

Name of person who is working	Type of expense	Amount paid each month
		$
		$
		$

20. In what month and year do you want health care coverage to start?

Are you pregnant, a parent or caretaker of a child under age 18, blind, disabled, under age 21 or age 65 or older? If you are, the coverage start date may go back three months from the date you turn in your application. Otherwise, coverage cannot start until the date you turn in this application. In most cases, if you have a monthly payment, coverage starts the month after we get your payment.

Month ____________________ Year _____________

You must give us proof of income and you may need to give us proof of assets for each prior month that you want coverage. You may not get coverage if we do not get proof.

WORKER NOTES

21. Do you or any household members have medical bills that have not been paid?

☐ **Yes** – list the bills below ☐ **No**

21a. Do you or any household members have medical bills from the past three months?

☐ **Yes** – list the bills below ☐ **No** – go to question 22

Name of person	Date of service	Provider name	Amount	Has this bill been paid?
			$	☐ Yes ☐ No
			$	☐ Yes ☐ No
			$	☐ Yes ☐ No
			$	☐ Yes ☐ No
			$	☐ Yes ☐ No
			$	☐ Yes ☐ No
			$	☐ Yes ☐ No
			$	☐ Yes ☐ No
			$	☐ Yes ☐ No
			$	☐ Yes ☐ No
			$	☐ Yes ☐ No

If you have more medical bills, list them on a separate piece of paper and include the list with this application.

You must give us copies of these medical bills and proof of any health insurance payments. You may not get coverage if we do not get proof.

WORKER NOTES

22. Do you and your household members have any assets?

Assets are things you own. Assets include items such as: cash, bank accounts, certificates of deposit, stocks, bonds, retirement accounts, interest in annuities, trusts, property agreements, contracts for deed, timeshares, rental property, life estates, livestock, tools, and farm machinery. You will list vehicles in question 23.

☐ **Yes** – fill out the information below and give us proof. ☐ **No** – go to question 23

Owner's name	Type of asset	Name of bank/company	Value of asset	Amount of loan (If none, write "0")
			$	$
			$	$
			$	$
			$	$
			$	$
			$	$

You must give us proof of your assets. Proof can be statements from the bank or company. The proof must be dated within the last 30 days. You may not get coverage if we do not get proof.

23. Do you or any household members have vehicles?

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

☐ **Yes** – fill out the information below and give us proof ☐ **No** – go to question 24

Owner's name	Vehicle year/make/model	Value of asset	Amount of loan (If none, write "0")
		$	$
		$	$
		$	$
		$	$

You must give us proof of all vehicles and proof of loan balances. Proof can be the registration card or title **and** a statement from the bank or loan company showing the loan balance. You may not get coverage if we do not get proof.

24. Do you or any household members own or plan to buy real estate?

Real estate includes homes, cabins, lake homes, land and other property that you rent to someone else.

☐ **Yes** – fill out the information below ☐ **No** – go to question 25

Name of owner(s)	Address of real estate	Value	Loan amount (If none, write "0")	Do you live here?
		$	$	☐ Yes ☐ No
		$	$	☐ Yes ☐ No

You must give us proof of all real estate that you own that is not where you live. Proof can be real estate tax statements and loan balance statements. You may not get coverage if we do not get proof.

25. Do you or any household members have life insurance policies?

☐ **Yes** – fill out the information below and give us proof. ☐ **No** – go to question 26

Owner's name	Name of insurance company	Face value	Cash surrender value
		$	$
		$	$

You must give us proof of the face value and the cash surrender value of all life insurance policies. Proof can be a copy of the policy or a statement from the insurance company that is dated within the last 30 days. You may not get coverage if we do not get proof.

26. Do you or any household members have a burial contract or money for a burial?

☐ **Yes** – fill out the information below and give us proof. ☐ **No** – go to question 27

Owner's name	Name of funeral home or company that holds the burial agreement	Value	Date of the agreement
		$	
		$	

You must give us proof of burial agreements. Proof can be a copy of the agreement or a statement from the company or funeral home with the statement of goods and services. You may not get coverage if we do not get proof.

27. In the last 60 months, did you or any household member:

- Sell any assets for less than what they were worth
- Trade assets or income
- Transfer assets or income
- Give away assets or income
- Not accept an inheritance
- Purchase an annuity, life estate in another person's home, promissory note, loan or mortgage?

☐ **Yes** – fill out the information below ☐ **No** – go to the Health Insurance Section

Owner(s) of the asset or income	Type of asset or income	Value of asset or income	Who was it given to or sold to?	When? mm/dd/yyyy	How much were you paid for the asset?
		$			$
		$			$
		$			$
		$			$
		$			$
		$			$

If you have more transfers: List them on a separate piece of paper and include the list with this application.

You must give us proof to show what was sold or given away. You may not get coverage if we do not get proof.

Health Insurance Section

Health insurance is coverage through:

- Your spouse
- Your parents
- An employer
- Medicare
- Union or other group
- A private insurance company
- A college
- An HMO (Health Maintenance Organization)

Do not cancel any health insurance coverage until we look at the policy. When we look at the policy, we will see if we can help pay for the cost.

You must give us proof of all health insurance polices. Proof can be a copy of the policy and/or both sides of the member identification card. You may not get coverage if we do not get proof.

28. Did you or any household members have health insurance that ended during the last four months?

☐ **Yes** – fill out the information below ☐ **No** – go to question 29

List the first and last names of household members whose coverage ended

____________________ ____________________

____________________ ____________________

____________________ ____________________

Month, day and year that the insurance ended _____/_____/__________

Why did the insurance end? ____

____

29. Do you or any household members have health insurance now?

This includes health insurance through an employer, a union or group, a spouse, a parent, a private insurance company, long-term care insurance and prescription drug coverage.

☐ **Yes** – fill out the information below ☐ **No** – go to question 31

Check a box for each type of coverage:

☐ Individual ☐ Group ☐ Long-term care ☐ Prescription Drug Coverage

☐ Other – explain the type of coverage ____________________________________

____

What is the policyholder's first and last name? ____________________________________

What is the name of insurance company? ____________________________________

What is the address of the insurance company? ____________________________________

____

What is the policy number? ____________________ What is the group number? ____________________

Date the insurance coverage started _____/_____/__________

The first and last name of household members covered by this policy

____________________ ____________________

____________________ ____________________

How much is the deductible per person? $________________

How much is the deductible for the family? $________________

How much is the co-pay for each doctor visit? $________________

How much is the co-pay for each prescription? $________________

How much is the premium each month? $________________

30. Is this health insurance through an employer or union?

You may have to ask your employer for this information.

☐ **Yes** – fill out the information below ☐ **No** – go to question 31

Employer's name ______________________ Street Address ______________________

City ______________________ State ______ Zip code ______________

How much does the employee pay for the premium each month? $____________

How much does the employer/union pay for the employee's premium each month? $____________

How much does the employer/union pay for family coverage each month? $____________

How much does the employee pay for family coverage each month? $____________

If you have more insurance policies, write "Insurance" and information about the policy on a separate piece of paper. Include it with this application.

31. Did you or any household member turn down health insurance from a current employer?

This means an employer offered health insurance and someone did not take the coverage.

☐ **Yes** – explain ______________________________________ ☐ **No**

32. Did you or any household member drop health insurance from a current employer?

This means someone had health insurance through their employer and ended the coverage.

☐ **Yes** – explain ______________________________________ ☐ **No**

33. Did a current employer who offered health insurance in the past 18 months stop offering it?

This means that someone works for an employer who gave them health insurance and then stopped offering it. ☐ **Yes** ☐ **No**

34. If college students are applying, can they get health insurance through their parents or through their school?

☐ **Yes** – name(s) of college student(s)______________________________ ☐ **No**

WORKER NOTES

35. Is any household member who is applying getting medical care for an accident or injury that happened in the last six years?

☐ **Yes** – fill out the information below ☐ **No** – go to question 36

Name of Person	Date of accident or injury	Does someone have coverage to help pay the medical costs?	Is there a lawsuit?
		☐ **Yes** – Who?_______________ ☐ **No**	☐ **Yes** ☐ **No**
		☐ **Yes** – Who?_______________ ☐ **No**	☐ **Yes** ☐ **No**

36. Do any household members have Medicare coverage?

☐ **Yes** – fill out the information below ☐ **No** – go to question 37

Name of Person	Medicare ID number	Part A Start Date	Part B Start Date	Part D Start Date List name of plan and monthly premium amount

37. Is any household member living in a long-term care facility (LTCF) or planning to get waiver program services?

- LTCF includes a skilled nursing facility, intermediate care facility and nursing facility care in an inpatient hospital.
- Waiver programs include Elderly Waiver (EW), Community Alternatives for Disabled Individuals (CADI), Community Alternative Care (CAC), Traumatic Brain Injury (TBI), and Mental Retardation and Related Conditions (MR/RC).

☐ **Yes** – fill out the information below ☐ **No** – go to the Signature Page

Check the one that applies:

☐ This person lives in a long-term care facility. ☐ This person expects to get waiver program services.

Person's first name ________________________ MI ____ Last name ______________________________

WORKER NOTES

38. Has this person bought, exchanged, or added a rider to a long-term care insurance policy on or after July 1, 2006?

☐ **Yes** – fill out the information below ☐ **No** – go to question 39

Is this policy paying benefits now? ☐ **Yes** ☐ **No**

Did this policy ever pay benefits? ☐ **Yes** – when? ______________________________ ☐ **No**

Name of insurance company ______________________________

First name of policy holder ______________ MI ____ Last name ______________

Date the insurance policy was issued _____/_____/_________ Policy number ______________

Street address of insurance company ______________________________

City ______________________________ State ______ Zip code ______________

39. Do you or your spouse have any interest in an annuity?

☐ **Yes** – fill out the information below ☐ **No** – go to question 40

Name of owner(s)	Interest Type: Owner, Annuitant, Beneficiary

You must give us proof. Proof can be a copy of the annuity contract or other statement from the company that issued the annuity.

40. Does this person own a home?

☐ **Yes** – continue ☐ **No** – go to question 41

Does this person live in this home now?

☐ **Yes** ☐ **No** – write the date they stopped living there (month/year) ______________/__________

Does a spouse, a child under the age of 21, or a blind or disabled child of any age live in the home?

☐ **Yes** – go to question 41 ☐ **No** – fill out the information below

Name of owner(s)	Address of home	Value	Amount of loan (If none, write "0")	Is home for sale?
		$	$	☐ Yes ☐ No

You must give us proof. Proof can be the real estate tax statement and a statement showing the mortgage or loan balance. You may not get coverage if we do not get proof.

Questions 41 and 41a only apply when this person lives in a long-term care facility or will be getting services through the Elderly Waiver.

41. Does this person want to give income to a spouse, a child under age 21, or another dependent?

Dependents may include a child over age 21 who is blind or disabled or a tax dependent, or parents or siblings who are listed as dependents on tax forms.

☐ **Yes** – fill out the information below ☐ **No** – go to question 41a

	Spouse	Child or Dependent	Child or Dependent
Name of spouse or dependent			
Date of birth			
Relationship to person applying			
Type of income (Write "0" if none)			
Amount	$	$	$
How often is income received?			

If this person wants to give income to more dependents: Write "Question 41" on a separate piece of paper. Write the above information for each person. Include it with this application.

You must give us proof of income. Proof can be a copy of the checks or a statement from the source.

41a. Does the spouse have housing expenses?

☐ **Yes** – fill out the information below ☐ **No** – go to question 41b

Write how much the spouse pays for each expense:	
Monthly rent or mortgage	$
Real estate taxes	$
Homeowner's insurance	$
Monthly heating bill	$
Monthly cooling bill	$
Monthly electricity bill	$
Monthly telephone bill	$
Other costs (such as an association fee) What is the expense?____________________	$

You must give us proof of each expense. Proof can be copies of the bills or statements.

41b. Is the spouse getting help from the Elderly Waiver program or are they residing in a long-term care facility?

☐ **Yes** ☐ **No**

42. Was an Asset Assessment ever completed in a county or another state?

This means a staff person reviewed all assets owned by both spouses.

☐ **Yes** – when? ______/______/___________ In what county or state?________________________ ☐ **No**

43. Is this person or the spouse a veteran?

☐ **Yes** – what is the veteran's name? ____ ☐ **No**

44. Facility Information

Fill out this information if the person lives in a facility such as a nursing home, intermediate care facility, assisted living or nursing facility care in an inpatient hospital.

Date this person began living in this facility ______/______/___________

Name of the facility ____

Facility street address ____

City ____ State _______ Zip code _________________

In what county is the facility? _______________________________

Phone number of the facility (   )_________________

Was this person in a hospital before moving to the facility or getting home care services?

☐ **Yes** – from ______/______/___________ to ______/______/___________ ☐ **No**

What was the person's address before moving to the facility?

Street address ____

City _______________________ State ______ Zip code ______________ County _________________

Go to page 21.

WORKER NOTES

Signature Page

All adults must read all of the following information and sign on page 22.

Fraud Investigation Release

I give third parties permission to share information about me with authorized state and county staff conducting investigations regarding fraud, fraud prevention and misrepresentation. Third parties 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 further authorize taxing authorities to release copies of my income tax returns. I also understand that my permission for release is effective for six months after my benefits stop.

Medical Assignment of Benefits

I assign all medical payments to the State of Minnesota. This assignment includes medical care payments from all other persons or entities. This assignment covers medical care payments for myself. It also covers anyone else for whom I apply.

It takes effect right away when health care coverage starts. I agree to cooperate with the State in any action to recover payment of medical expenses. If I claim good cause and good cause is approved, I may not have to cooperate.

Medical Release

I give consent to my health providers and health plan, including their contractors, to share my Minnesota Health Care Programs (MHCP) health records with the State of Minnesota, its agents, contractors and their subcontractors, Ombudsman and county advocates for managed care. I know I need to share this information to:

- Decide if I can get federally funded health care
- Pay my health care providers
- Provide and coordinate health care
- Do quality of care reviews and studies and
- Help in record reviews, prosecutions or legal actions related to managing the health care programs.

If I have Medicare Part B, I give Medicare consent to pay my health providers for the care I get while on MHCP. This release also applies to the MHCP health records of my minor children in this application.

This medical release is good while I am enrolled in MHCP, not to exceed one year, or longer if the law permits. I can refuse to sign or cancel the medical release. If I cancel I must do this in writing. I understand that the law overrides my canceling this release for these reasons:

- To share health information with health care consultants
- To pay my health care bills
- If fraud is suspected or
- For quality of care reviews and studies.

If I refuse to sign or if I cancel the release, I will not be able to enroll or stay enrolled in Minnesota Health Care Programs. I understand that this release allows my MHCP health records to be shared with others if the law permits. Privacy laws may no longer protect the information shared with others.

By signing below:

- I agree that I have read the Notice of Privacy Practices and the list of my responsibilities in that Notice.
- I understand that my information will be shared if fraud is suspected.
- I agree to the release of my Minnesota Health Care Programs health records to the parties listed above.
- I agree to assign my medical benefits as stated above.
- I agree to allow the State of Minnesota, its agents, contractors, and subcontractors to contact my employer(s) for the purpose of verifying access to employer subsidized health insurance.
- I declare that, under penalty of perjury, all parts of this application, to the best of my knowledge, are true and correct statements. I understand what happens to people convicted of perjury (not telling the truth). They may be sentenced to prison for up to five years, a fine up to $10,000, or both.

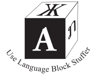
All adults age 18 and older who are applying must sign below.

- You must sign this application even if you are authorizing someone to act on your behalf.
- The person you are authorizing must also sign.
- If an applicant is unable to sign, provide copies of legal documents of conservatorship or power of attorney.

YOUR SIGNATURE	DATE
SIGNATURE OF SPOUSE	DATE
SIGNATURE OF HOUSEHOLD MEMBER AGE 18 AND OLDER WHO IS APPLYING	DATE
SIGNATURE OF HOUSEHOLD MEMBER AGE 18 AND OLDER WHO IS APPLYING	DATE
SIGNATURE OF HOUSEHOLD MEMBER AGE 18 AND OLDER WHO IS APPLYING	DATE
SIGNATURE OF PERSON ACTING ON YOUR BEHALF (if you answered "yes" to question 8)	DATE

WORKER NOTES

Minnesota Health Care Programs
Employer Health Insurance Form



Form A

Are you or is anyone in your household working?

If the answer is yes, we need proof to tell us if the employer or union offers health insurance. You must give us proof for each household member who is working. If anyone is working at more than one job, we need proof from each employer or union. **If we do not get proof, you may not get coverage or coverage may stop.**

There are three options for giving us proof.

- Get the proof yourself. To do this you need to sign the bottom of this page and give it to your employer or union to fill out. They must fill out the back side and sign it. After your employer has completed the form, return this form with your application or renewal. Make a copy of this if you need more than one form.
- Give us copies of the open enrollment papers or health insurance benefit papers from your employer or union. Return these papers with your application or renewal.
- Allow us to contact the employer or union to get the proof. To do this, the person who is working must fill out and sign the information below.

The employee needs to complete the information below and give it to their employer.

Employee first name ______________________ MI _____ Last name ______________________

Social Security Number _______-_______-________ Date of birth _____/_____/__________

Write the name and phone number of the person that we can contact.

Contact Name ________________________________ Phone number ( ) ________________

Authorization for Release of Information

Giving Permission: I give permission to the employer/union listed above to release the requested information to the above agency. This information is used to figure my eligibility for public assistance and/or services.

Consequences: State and Federal privacy laws protect my records. I know:

- Why I am being asked to share/release this information.
- I do not have to consent to this authorization, but it may affect my benefits or services if I do not give my consent.
- That, generally, I must give my written consent for this person/agency to give out this information, but if I do not consent, this information will not be released unless the law otherwise allows it.
- I may stop the authorization with a written notice at any time, but this written notice will not affect information the agency has already shared/requested.
- 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, unless the law allows for a longer period.

Employee Signature ____________________________________ Date ________________

This information is available in other forms to people with disabilities by contacting us at (651) 431-2670 (voice) or toll free at (800) 657-3739. TTY/TDD users can call the Minnesota Relay at 711 or (800) 627-3529. For the Speech-to-Speech Relay, call (877) 627-3848.

Employer or Union – Please fill out this form.

Employee first name ______________________________ MI _____ Last name ___________________________

Social Security Number _______-______-________ Date of birth _____/_____/__________

Please indicate if you offer health insurance for the employee and/or employee's dependents. (Check Yes or No.)

Health Insurance is offered for this employee. ☐ Yes (Complete A below) ☐ No

Health Insurance is offered for the employee's spouse. ☐ Yes (Complete B below) ☐ No

Health Insurance is offered for the employee's dependents. ☐ Yes (Complete B below) ☐ No

Name(s) of dependents and relationship ____

____

On what date was this employee first eligible for health insurance? _____/_____/__________

or On what date **will** this employee be eligible for health insurance? _____/_____/__________

Who is enrolled currently? ☐ Employee ☐ Spouse ☐ Dependents

A. List the cost of insurance for the employee only

1. Employee pays: $________ per _________
2. Employer/union pays: $________ per _________
3. **Total cost:** $________ per _________

B. List the cost of insurance for the spouse/dependents

1. Employee pays: $________ per _________
2. Employer/union pays: $________ per _________
3. **Total cost:** $________ per _________

C. Total cost of insurance for employee/spouse/dependents

Add the two Total Costs from Line 3: $_________ + $_________ = $_________ per _________

D. Do you offer a cafeteria-style health insurance plan?

☐ No

☐ Yes – The employer/union pays: $_________ per _________

E. Do you offer money in lieu of insurance or for the purchase of health insurance?

☐ No

☐ Yes – The employer/union pays: $_________ per _________

Please attach a copy of your employee benefits summary or other plan information, if available.		
NAME OF EMPLOYER	EMPLOYER ADDRESS	
NAME OF INDIVIDUAL COMPLETING THIS FORM (please print)	TITLE	PHONE
SIGNATURE		DATE