



Minnesota Department of **Human Services**

Minnesota Health Care Programs Application

■ What is this application for?

Use this application to apply for health care coverage.

Do **not** use this application if you are:

- Applying for cash or food support. Use the Combined Application Form (DHS-5223).
- A person with a disability or age 65 or older who may need to move to a nursing home or would like services to help you stay in your home. Use the Minnesota Health Care Programs Application for Payment of Long-Term Care Services (DHS-3531) and ask your county agency about a Long-Term Care Consultation.

You can find these applications on the web at www.dhs.state.mn.us/healthcare or have one mailed to you by calling your county agency. The phone numbers are listed on pages B and C at the back of this form.

■ What do I need to do with this form?

1. Read the Notice of Privacy Practices and Rights and Responsibilities on pages D through F at the back of this form. Tear them off and keep them.
2. Answer all questions on the application. If you need more space, write the number of the question and the answer on a separate piece of paper. Include it with the application.
3. Sign and date the application.
4. Attach proofs. Proofs are listed on page A at the back of this form.
5. Mail or take the application to your county agency or MinnesotaCare state office in St. Paul. The addresses are listed on pages B and C at the back of this form.

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

■ Questions?

If you have questions or need help, call your county agency. The phone numbers are listed on pages B and C at the back of this form. You can also call the Senior LinkAge Line® if you are 60 or older at (800) 333-2433 or the Disability Linkage Line® if you are a person with a disability at (866) 333-2466.

The information below can help you decide which health care program is best for you.

Medical Assistance

- You do not pay a monthly premium for coverage.
- Coverage can begin three months before the month we get your application.
- Most options cover doctor visits, prescriptions, X-rays, hospital stays and most medical expenses.
- Income limits (the amount of money you can have and still be eligible) may be lower than for MinnesotaCare.
- You may have copays for certain services.
- You can have other health insurance, even if it is through an employer.
- If you have other health insurance, Medical Assistance may pay your premium.
- You may be required to choose a health plan and get all your health care services from providers in that plan.

MinnesotaCare

- You must pay a monthly premium.
- Coverage begins the month after you pay your first premium.
- Most medical expenses are covered, such as doctor visits, prescriptions, X-rays and hospital stays.
- Income limits (the amount of money you can have and still be eligible) may be higher than for Medical Assistance.
- You may have copays and limits on certain services.
- You must be without other insurance coverage for four months before you can qualify. This rule does not apply to some children.
- You cannot have access to health insurance through an employer or union who pays 50% or more of the premium. This rule does not apply to some children.
- You will be required to choose a health plan and get all your health care services from providers in that plan.

For more information:

- Call your county human services office or the MinnesotaCare state office. The phone numbers are listed in this application on pages B and C.
- Go to www.dhs.state.mn.us/healthcare for further information.

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 បើអ្នកចង់បានជំនួយបកប្រែព័ត៌មាននេះដោយមិនគិតថ្លៃ 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.

ໂປູດຊາບ. ຖ້າຫາກທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປຂໍ້ຄວາມດັ່ງກ່າວນີ້ພຣີ, ຈົ່ງຖາມນຳພນັກງານຊ່ວຍວຽກຂອງທ່ານຫຼືໂທໂທຕາມເລກໂທ 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 này miễn phí, xin gọi nhân-viên xã-hội của quý vị hoặc gọi số 1-888-554-8759.

L192-0008 (10-09)

This information is available in alternative formats to individuals with disabilities by calling (651) 431-2670 or (800) 657-3739. TTY users can call through Minnesota Relay at (800) 627-3529. For Speech-to-Speech, call (877) 627-3848. For additional assistance with legal rights and protections for equal access to human services programs, contact your agency's ADA coordinator.

ADA3 (5-09)



Minnesota Health Care Programs Application

Office Use Only		
DATE RECEIVED	CASE NUMBER	WORKER NUMBER

- Answer all questions the best you can.
- Return the form right away.
- We will contact you for any additional information we need.

1a. Choose the Minnesota Health Care Program you want to apply for:

Review the information on the page to your left. This will help you decide which program is best for you. If you tell us you want to apply for all health care programs, we will see if you qualify for Medical Assistance first. If you qualify, you will be enrolled in Medical Assistance. If you do not qualify, we will see if you qualify for MinnesotaCare.

If you tell us you want to apply for MinnesotaCare only, we will not look to see if you qualify for Medical Assistance. If you are enrolled in MinnesotaCare, you can ask us at any time to see if you qualify for Medical Assistance. If you do not choose, we will see if you qualify for Medical Assistance first.

Check the Minnesota Health Care Program you want to apply for below.

- All health care programs.** Send this application to the county where you live. Addresses are on pages B and C.
- MinnesotaCare only.** Send this application to the MinnesotaCare state office. The address is on page C.

1b. Name and address

FIRST NAME	MI	LAST NAME	DATE OF BIRTH	SEX <input type="checkbox"/> M <input type="checkbox"/> F	MARITAL STATUS
STREET ADDRESS		CITY	STATE	ZIP CODE	COUNTY
MAILING ADDRESS (if different)		CITY	STATE	ZIP CODE	COUNTY
<input type="checkbox"/> Check this box if you are homeless		HOME PHONE	OTHER PHONE		
SOCIAL SECURITY NUMBER*	Are you applying for yourself? <input type="checkbox"/> No <input type="checkbox"/> Yes		Do you want us to send you a voter registration card? <input type="checkbox"/> Yes <input type="checkbox"/> No		
What language do you speak most of the time?			Do you need an interpreter? <input type="checkbox"/> Yes <input type="checkbox"/> No		
OPTIONAL INFORMATION →	RACE (check all that apply) <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> American Indian/Native Alaskan <input type="checkbox"/> Pacific Islander or Native Hawaiian <input type="checkbox"/> White				HISPANIC OR LATINO? <input type="checkbox"/> Yes <input type="checkbox"/> No
	American Indians: Some applicants are limited to the amount of assets they can own. Some health care programs require a monthly premium payment. If you are an American Indian, certain assets do not count and you may not have to pay a premium.				
	<input type="checkbox"/> Check this box if you are an American Indian living on a reservation.				
	Some American Indians living on a reservation have the option to not receive their health care services through a health plan.				

* See Notice of Privacy Practices for information about Social Security numbers.

See Required Proofs on Page A

If you need more space, write the question number and the answer on a separate piece of paper.

2. Others living with you (List your spouse, parents/guardians of children under 21, stepparents, children and stepchildren living in your home.)

Name (First, MI, Last)	Social Security number*	Relationship to you	Sex	Marital status	Date of birth	Is this person applying?	OPTIONAL INFORMATION	
							Race (Use codes below**)	Hispanic or Latino?
			<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No

****Codes:** (choose all that apply) A - Asian B - Black/African American N - American Indian/Native Alaskan P - Pacific Islander or Native Hawaiian W - White

3. Is anyone living away from home for a short time? No Yes – fill in below

FIRST NAME	MI	LAST NAME	SOCIAL SECURITY NUMBER*	DATE OF BIRTH	RELATIONSHIP TO YOU
Are you applying for this person? <input type="checkbox"/> No <input type="checkbox"/> Yes		DATE LEFT	DATE EXPECTED TO RETURN	REASON FOR NOT LIVING AT HOME	

4. Is everyone applying a U.S. citizen or U.S. national? Yes No – fill in below

Name	Immigration status	Date entered the U.S.	Does this person have a sponsor?
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No

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

An authorized representative is a person authorized to act on your behalf as an applicant or enrollee in any of the health care programs. In most cases, authorized representatives have the same responsibilities and rights as applicants or enrollees. An authorized representative will receive forms, notices, and premium notices on your behalf. An authorized representative must be at least 18 years old and know your circumstances in order to provide necessary information. This person must sign the application.

No Yes – fill in below

FIRST NAME	MI	LAST NAME	PHONE NUMBER
STREET ADDRESS		CITY	STATE ZIP CODE

* See Notice of Privacy Practices for information about Social Security numbers.

See Required Proofs on Page A

If you need more space, write the question number and the answer on a separate piece of paper.

6. Additional household information

Does everyone plan to make Minnesota their home? <input type="checkbox"/> Yes <input type="checkbox"/> No	IF NO, WHO?	EXPLAIN
Is anyone 16 or older a student? <input type="checkbox"/> No <input type="checkbox"/> Yes	IF YES, WHO?	
Is anyone pregnant? <input type="checkbox"/> Not Applicable (N/A) <input type="checkbox"/> No <input type="checkbox"/> Yes	IF YES, WHO?	DUE DATE
Is anyone blind, or does anyone have a physical or mental health condition that limits the ability to work or perform daily activities? <input type="checkbox"/> No <input type="checkbox"/> Yes	IF YES, WHO?	
Is anyone getting services from the Center for Victims of Torture? <input type="checkbox"/> No <input type="checkbox"/> Yes	IF YES, WHO?	
Has anyone under the age of 21 ever been married, in the armed forces or have a court order saying they are no longer under the legal control of his or her parents? <input type="checkbox"/> N/A <input type="checkbox"/> No <input type="checkbox"/> Yes	IF YES, WHO?	
Has anyone ever been in the United States military? <input type="checkbox"/> No <input type="checkbox"/> Yes	IF YES, WHO?	
Has anyone returned from a tour of active military duty in the last 24 months? <input type="checkbox"/> No <input type="checkbox"/> Yes	IF YES, WHO?	DATE LAST ACTIVE TOUR OF DUTY ENDED
Do you want help paying for medical bills from the past three months? <input type="checkbox"/> No <input type="checkbox"/> Yes	IF YES, LIST MONTHS	
Does anyone currently have medical benefits from another state? <input type="checkbox"/> No <input type="checkbox"/> Yes	IF YES, WHO?	

7. Does each child under age 18 have both parents living with them?

Not Applicable (N/A) Yes No – fill in below

	First child's name	Second child's name	Third child's name
Name of parent(s) who does not live with the child			
Is the parent's name on the birth certificate?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is there a signed Recognition of Parentage or court order for paternity?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is there a court order to provide health insurance?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does the parent provide health insurance?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you want help getting medical or cash child support?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

See Required Proofs on Page A

If you need more space, write the question number and the answer on a separate piece of paper.

8. Is anyone self-employed or does anyone expect to be self-employed? No Yes – fill in below

Name	Business name	Start date	End date	Yearly income
				\$
				\$

Are the total assets of all businesses worth more than \$200,000? No Yes

Do any of the listed businesses have bank accounts that contain personal funds or are used to pay personal expenses?

No Yes – fill in below

Business name	Type of account	Name of bank	Current balance
			\$
			\$

9. Did anyone work in the last 30 days or does anyone expect to work next month?

Include temporary work. Include all seasonal work during the last year.

- If seasonally employed, enter original start date for the listed employer.
- Enter gross income per pay period (before taxes and deductions)

No Yes – fill in below

Name	Employer name	Start date	Gross income per pay period (include tips)	How often paid?	Is this job seasonal?	Has this job ended?
			\$		<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes IF YES, DATE ENDED
			\$		<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes IF YES, DATE ENDED
			\$		<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes IF YES, DATE ENDED
			\$		<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes IF YES, DATE ENDED

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

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

No Yes – fill in below

Name	Type of income	Start date	Gross amount	How often received	Has this income ended?
			\$		<input type="checkbox"/> No <input type="checkbox"/> Yes IF YES, DATE ENDED
			\$		<input type="checkbox"/> No <input type="checkbox"/> Yes IF YES, DATE ENDED
			\$		<input type="checkbox"/> No <input type="checkbox"/> Yes IF YES, DATE ENDED
			\$		<input type="checkbox"/> No <input type="checkbox"/> Yes IF YES, DATE ENDED

See Required Proofs on Page A

If you need more space, write the question number and the answer on a separate piece of paper.

11. If no income has been reported, explain in the box below how you pay for your living expenses such as food, housing, clothing and other things you need.

12. Is anyone paying for day care for a child or adult while they work? No Yes – fill in below

NAME OF PERSON PAYING	NAME OF DAY CARE PROVIDER	NAMES OF CHILDREN OR ADULTS IN DAY CARE	AMOUNT PAID PER MONTH \$
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13. Is anyone in the home court-ordered to pay child or medical support? No Yes – fill in below

NAME OF PERSON PAYING	AMOUNT PER MONTH \$	CURRENTLY PAYING? <input type="checkbox"/> No <input type="checkbox"/> Yes
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14. Does anyone have cash, a savings or checking account, or certificates of deposit?

Do not include business accounts.

No Yes – fill in below

Owner(s) name	Type	Name of bank	Current balance
			\$
			\$
			\$
			\$

15. Does anyone own or co-own stocks, bonds, retirement accounts, life insurance, burial contracts, annuities, trusts, contracts for deed or other assets? No Yes – fill in below

Owner(s) name	Type of asset	Name of company, bank or funeral home	Estimated value
			\$
			\$
			\$
			\$

16. Does anyone have a vehicle?

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

No Yes – fill in below

Owner(s) name	Type of vehicle	Year/Make/Model	Estimated value	Amount owed
			\$	\$
			\$	\$
			\$	\$
			\$	\$

See Required Proofs on Page A

If you need more space, write the question number and the answer on a separate piece of paper.

17. Does anyone own or co-own a home, life estate, cabin, land, time share, rental property or any real estate? No Yes – fill in below

Owner(s) name	Address	Type of property	Estimated value
			\$
			\$

18. Is anyone getting medical care for an accident or injury that happened in the last six years?

No Yes – fill in below

NAME(S)	DATE HAPPENED	TYPE OF ACCIDENT OR INJURY	IS THERE A LAWSUIT? <input type="checkbox"/> No <input type="checkbox"/> Yes

19. Health insurance information

Does anyone have Medicare coverage? <input type="checkbox"/> No <input type="checkbox"/> Yes	IF YES, WHO?		
Can anyone get health insurance through a current employer or union? <input type="checkbox"/> No <input type="checkbox"/> Yes	IF YES, WHO?		
Did anyone turn down or drop health insurance from a current employer or union? <input type="checkbox"/> No <input type="checkbox"/> Yes	IF YES, WHO?	DATE HAPPENED	
Did anyone's current employer or union stop offering health insurance in the last 18 months? <input type="checkbox"/> No <input type="checkbox"/> Yes	IF YES, WHO?	DATE STOPPED	
Did anyone have health insurance that ended during the last four months? <input type="checkbox"/> No <input type="checkbox"/> Yes	IF YES, WHO?	DATE ENDED	

20. Did anyone have health insurance this month or does anyone expect to have health insurance next month? No Yes – fill in below

COVERAGE TYPES – CHECK ALL THAT APPLY

- Medical Hospital only HMO Prescription drug Dental Vision Long-term care
 Other – list type: _____

POLICYHOLDER'S NAME	INSURANCE COMPANY NAME	START DATE	END DATE

POLICY NUMBER	LIST EVERYONE WHO IS COVERED BY THIS POLICY

Is this health insurance through an employer or union? No Yes – fill in cost of insurance below

Cost of Insurance for Employee Only		Cost of Insurance for Spouse/Dependents	
EMPLOYEE PAYS PER MONTH \$	EMPLOYER/UNION PAYS PER MONTH \$	EMPLOYEE PAYS PER MONTH \$	EMPLOYER/UNION PAYS PER MONTH \$

See Required Proofs on Page A

If you need more space, write the question number and the answer on a separate piece of paper.

Signature Page

(Effective Date: March 1, 2012)

Read the following information and sign.

Authorization to Share Information for Fraud Investigation

I agree that third parties may share information about me with persons investigating fraud. This may include, but is not limited to:

- Employers and schools,
- Landlords and utility companies,
- Financial and insurance agencies, and
- Other government offices.

If I am enrolled in MinnesotaCare, the Minnesota Department of Revenue may share copies of my income tax returns with investigators.

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

Authorization for Release (Sharing) of My Medical Information

I give my consent to the following agencies or individuals to share between them medical information about me only for the limited purposes indicated:

- Health providers including school districts, health plans, insurance agencies, Minnesota Health Care Programs, county advocates, my county or state case workers, and their contractors and subcontractors:
 - To determine who should pay for my health care, and
 - To provide, manage, and coordinate health care services.
- All other agencies or persons as listed on the Notice of Privacy Practices.

This consent applies to medical information about my minor children I applied for on this application. I understand the school district needs a separate consent to share information about my children with private insurance plans. I can stop this consent at any time by asking in writing for it to end. The written notice to stop this consent will not affect information the agency has already given to others. This consent is good while I am enrolled in Minnesota Health Care Programs, up to one year, or longer if the law permits. However, it does not end after one year for records given to consulting providers, records given for payment of my bills, fraud investigations, or quality of care review and studies. An agency or person who gets my information through this consent could give the information to others.

If I do not sign or I end this consent, I cannot enroll or stay enrolled in Minnesota Health Care Programs.

Medical Assignment of Benefits

I give my rights to all medical payments for me and anyone else I apply for to the State of Minnesota. This includes medical payments from all other persons or companies. For MA for Long-Term Care, this includes my right to support from my spouse under Minnesota Statutes, section 256B.14, subdivision 3. This begins as soon as health care coverage starts.

I agree to help the state to get paid back for medical expenses that should have been paid by others. I may not have to help the state if I have a good reason for not doing so and the state approves the reason.

If I have Medicare Part B, Medicare can pay my health providers for the care I get while I am on a Minnesota Health Care Program.

By signing below:

- I agree that I have reviewed and understand my options for choosing the health care program I want to apply for.
- I agree that I have read and understand the Notice of Privacy Practices, the list of my responsibilities in that Notice, and the sections under Following the Rules and Changes.
- I agree and understand that my information will be released to the parties listed in the Notice of Privacy Practices in order to verify eligibility for Minnesota Health Care Programs.
- I agree and understand that my information will be shared for fraud investigations as stated in the Authorization to Share Information for Fraud Investigations section.
- I agree to assign my medical benefits as stated in the Medical Assignment of Benefits.
- I agree to the release of my Minnesota Health Care Programs health records to the parties listed in the Authorization for Release (Sharing) of My Medical Information section.
- I declare that, under penalty of perjury, all parts of this application and any updates to information on this application I give during the year are true and correct statements, to the best of my knowledge. 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.

You must sign this application even if you are authorizing someone to act on your behalf.

If an applicant is unable to sign, provide copies of legal documents of conservatorship or power of attorney.

YOUR SIGNATURE	DATE
SIGNATURE OF AUTHORIZED REPRESENTATIVE	DATE

Did you remember to:

- Sign and date this form?
- Attach the proofs you have? See page A for required proofs.
- Mail or take this form to your county or MinnesotaCare state office in St. Paul? Do this right away even if you do not have all your proofs ready. See pages B and C at the back of this form for the address.

Required Proofs

Send one of the listed proofs for everyone applying who is:

- **An immigrant**

Alien identification card (green card, I-551, I-94), visa, passport, or documentation from Immigration Services

Send these listed proofs for everyone who is:

- **An American Indian**

A document issued by an American Indian/Alaska Native tribe such as an enrollment or membership card, document from Indian Health Services (IHS) showing the person may get IHS services as an American Indian, or a document from the Bureau of Indian Affairs (BIA) that says the person is an American Indian.

- **Pregnant**

Statement from a doctor, midwife, nurse, nurse practitioner or doctor's assistant that includes the date you became pregnant, number you are expecting to deliver if more than one, and the date you expect to give birth.

- **Working**

Pay stubs from the last 30 days and from each month prior to the last 30 days for which you want coverage or a written statement of earnings from your employer if you do not have pay stubs.

- **Self-employed**

Most recent income tax returns and all related schedules or business records if taxes are not filed.

- **Getting other income** (Includes any income or payments from sources other than work.)

A statement from the person or company that sends the income, copy of checks, award letter, student financial aid award letter, tax forms, court order, or other documents from the last 30 days.

Send these listed proofs for everyone who is 21 or older:

- **Bank accounts**

Recent bank statements or written statement from bank showing current balance or value of accounts.

- **Other assets** (Includes stocks, bonds, retirement accounts, annuities, trusts, property agreements, etc.)

Copies of bonds, annuities, trusts, stock ownership statements or other documents showing value of assets. Include documents showing current loan balance owed against the asset.

Send copies of proofs. Do not send original documents.

Agency Addresses

(Effective Date: March 2012)

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 55303-5047
(763) 422-7200
Fax: (763) 712-2318

Becker County

712 Minnesota Avenue
Detroit Lakes, MN 56501
(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

531 Dewey Street
Foley, MN 56329-0740
(320) 968-5087 / (800) 530-6254
Fax: (320) 968-5330

Big Stone County

340 2nd Street NW
Ortonville, MN 56278-1413
(320) 839-2555
Fax: (320) 839-3966

Blue Earth County

410 S 5th Street
Mankato, MN 56002-3526
(507) 304-4335
Fax: (507) 304-4336

Brown County

1117 Center Street
New Ulm, MN 56073-0788
(507) 354-8246 / (800) 450-8246
Fax: (507) 359-6542

Carlton County

14 N. 11th Street
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

400 Michigan Avenue W
Walker, MN 56484-0519
(218) 547-1340
Fax: (218) 547-1448

Chippewa County

719 N Seventh Street, Suite 200
Montevideo, MN 56265-1397
(320) 269-6401 / (877) 450-6401
Fax: (320) 269-6405

Chisago County

313 North Main Street, Rm 239
Center City, MN 55012-9665
(651) 213-5640 / (888) 234-1246
Fax: (651) 213-5685

Clay County

715 North 11th Street, Suite 102
Moorhead, MN 56560-2095
(218) 299-5200 / (800) 757-3880
Fax: (218) 299-7106

Clearwater County

216 Park Avenue NW
Bagley, MN 56621-0682
(218) 694-6164 / (800) 245-6064
Fax: (218) 694-3535

Cook County

411 West Second Street
Grand Marais, MN 55604-2307
(218) 387-3620
Fax: (218) 387-3020

Cottonwood County

11 Fourth Street
Windom, MN 56101-0009
(507) 831-1891
Fax: (507) 831-0126

Crow Wing County

204 Laurel Street, 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) 554-5709

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 Street, Suite 1186
Alexandria, MN 56308
(320) 762-2302
Fax: (320) 762-3833

Faribault County

412 N Nicollet
Blue Earth, MN 56013-0217
(507) 526-3265
Fax: (507) 526-2039

Fillmore County

902 Houston Street NW, #1
Preston, MN 55965-1080
(507) 765-2175
Fax: (507) 765-3895

Freeborn County

203 W Clark Street
Albert Lea, MN 56007-1246
(507) 377-5400
Fax: (507) 377-5498

Goodhue County

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

Grant County

28 Central S
Elbow Lake, MN 56531-1006
(218) 685-8200 / (800) 291-2827
Fax: (218) 685-4978

Hennepin County

330 South 12th Street
Minneapolis, MN 55404-9760
(612) 596-1300
Fax: (612) 466-9923

Houston County

304 S. Marshall Street, Rm 104
Caledonia, MN 55921-0310
(507) 725-5811
Fax: (507) 725-3990

Hubbard County

301 Court Avenue
Park Rapids, MN 56470-1483
(218) 732-1451 / (877) 450-1451
Fax: (218) 732-3231

Isanti County

1700 E Rum River Dr S, Suite A
Cambridge, MN 55008-9386
(763) 689-1711
Fax: (763) 689-9877

Itasca County

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

Jackson County

310 Sherman Street
Jackson, MN 56143-0067
(507) 847-4000
Fax: (507) 847-5616

Kanabec County

905 Forest Avenue East, #150
Mora, MN 55051-1316
(320) 679-6350
Fax: (320) 679-6351

Kandiyohi County

2200 23rd Street NE, Suite 1020
Willmar, MN 56201-9423
(320) 231-7800 / (877) 464-7800
Fax: (320) 231-6285

Kittson County

410 South Fifth Street, Suite 100
Hallock, MN 56728
(218) 843-2689 / (800) 672-8026
Fax: (218) 843-2607

Koochiching County

1000 Fifth Street
In'l Falls, MN 56649-2485
(218) 283-7000 / (800) 950-4630
Fax: (218) 283-7013

Lac Qui Parle County

930 First Avenue N
Madison, MN 56256-0007
(320) 598-7594
Fax: (320) 598-7597

Lake County

616 Third Avenue
Two Harbors, MN 55616-1560
(218) 834-8400
Fax: (218) 834-8412

Lake of the Woods County

206 8th Avenue SE, Suite 200
Baudette, MN 56623-0200
(218) 634-2642
Fax: (218) 634-4520

Le Sueur County

88 South Park Avenue
Le Center, MN 56057-1646
(507) 357-8288
Fax: (507) 357-6122

Lincoln County

SWHHS
319 Rebecca Street N
Ivanhoe, MN 56142-0044
(507) 694-1452 / (800) 657-3781
Fax: (507) 694-1859

Lyon County

SWHHS
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

311 N Main Street
Mahnomen, MN 56557-0460
(218) 935-2568
Fax: (218) 935-5459

Marshall County

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

Martin County

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 / (877) 915-5300
Fax: (320) 693-5344

Mille Lacs County

525 Second Street SE
Milaca, MN 56353
(320) 983-8208 / (888) 270-8208
Fax: (320) 983-8306

MinnesotaCare State Office

PO Box 64838
St. Paul, MN 55164-0838
(651) 297-3862 / (800) 657-3672
Fax: (651) 282-5100

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

SWHHS
3001 Maple Road, Suite 100
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

318 9th Street
PO Box 189
Worthington, MN 56187-0189
(507) 372-2157
Fax: (507) 372-5094

Norman County

15 Second Avenue East, Room 108
Ada, MN 56510-1389
(218) 784-5400
Fax: (218) 784-7142

Olmsted County

2117 Campus Drive SE, Suite 100
Rochester, MN 55904-4825
(507) 328-6600
Fax: (507) 328-6339

Otter Tail County

535 Fir Avenue W
Fergus Falls, MN 56537-2703
(218) 998-8230
Fax: (218) 998-8270

Pennington County

318 N Knight Avenue
Thief River Falls, MN 56701-0340
(218) 681-2880
Fax: (218) 683-7013

Pine County

130 Oriole Street East, Suite 1
Sandstone, MN 55072-5134
(320) 216-4100 / (800) 450-7263
Fax: (320) 216-4101

Pipestone County

1091 North Hiawatha Avenue
Pipestone, MN 56164-0157
(507) 825-6720 / (888) 632-4325
Fax: (507) 825-6727

Polk County

612 N Broadway, Room 302
Crookston, MN 56716-1483
(218) 281-3127 / (877) 281-3127
Fax: (218) 281-7347

Or

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

Or

104 N. Kaiser Avenue
Fosston, MN 56542
(218) 435-1585
Fax: (218) 435-1552

Pope County

211 East MN Avenue, 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

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

Redwood County

302 E Third Street
Redwood Falls, MN 56283
(507) 637-4050 / (888) 234-1292
Fax: (507) 637-4055

Renville County

105 S 5th Street, Suite 203H
Olivia, MN 56277-1301
(320) 523-2202
Fax: (320) 523-3565

Rice County

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

Rock County

SWHHS
2 Roundwind Road
Luverne, MN 56156-0715
(507) 283-5070
Fax: (507) 283-5074

Roseau County

208 6th Street SW
Roseau, MN 56751-1451
(218) 463-2411 / (866) 255-2932
Fax: (218) 463-3872

St. Louis County

320 West 2nd Street, Room 301
Duluth, MN 55802-1495
(218) 726-2101 / (800) 450-9777
Fax: (218) 733-2975

Or

307 1st Street S – PO Box 1148
Virginia, MN 55792-1148
(218) 749-7137
Fax: (218) 749-7123

Or

118 South 4th Avenue E, Rm 12
Ely, MN 55731-1465
(218) 365-8220
Fax: (218) 365-8217

Or

1814 14th Avenue East
Hibbing, MN 55746-1314
(218) 262-6000
Fax: (218) 262-6049

Scott County For Adults

Government Center, Room 300
200 Fourth Avenue 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 Business Center Drive
Elk River, MN 55330-4600
(763) 241-2600 / (800) 433-5239
Fax: (763) 241-2698

Sibley County

111 8th Street
Gaylord, MN 55334-0237
(507) 237-4000
Fax: (507) 237-4031

Stearns County

705 Courthouse Square
St. Cloud, MN 56302-1107
(320) 656-6000 / (800) 450-3663
Fax: (320) 656-6447

Steele County

630 Florence Avenue
Owatonna, MN 55060-0890
(507) 444-7500
Fax: (507) 451-5947

Stevens County

400 Colorado Avenue, Suite 104
Morris, MN 56267
(320) 208-6600 / (800) 950-4429
Fax: (320) 589-3972

Swift County

410 21st Street South
Benson, MN 56215-0208
(320) 843-3160
Fax: (320) 843-4582

Todd County

212 Second Avenue South
Long Prairie, MN 56347-1640
(320) 732-4500 / (888) 838-4066
Fax: (320) 732-4540

Traverse County

202 8th Street North
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

299 Johnson Avenue SW, Suite 160
Waseca, MN 56093-2498
(507) 835-0560
Fax: (507) 835-0566

Washington County

14949 62nd Street North
PO Box 30
Stillwater, MN 55082-0030
(651) 430-6459
Fax: (651) 430-6605

Watonwan County

715 Second Avenue S
St. James, MN 56081-0031
(507) 375-3294 / (888) 299-5941
Fax: (507) 375-7359

Wilkin County

300 S Fifth Street
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

1004 Commercial Drive
Buffalo, MN 55313-1736
(763) 682-7414 / (800) 362-3667
Fax: (763) 682-8920

Yellow Medicine County

930 4th Street, #4
Granite Falls, MN 56241-1367
(320) 564-2211
Fax: (320) 564-4165

Notice of Privacy Practices

Minnesota Department of Human Services

(Effective Date: February 1, 2012)

This notice tells how medical and other 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?

- 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 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 family need protective services
- To collect money from the state or federal government for help we give you.

Why do we ask you for your Social Security number?

We need your Social Security number (SSN) to give you medical assistance, 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 SSN to verify identity and prevent duplication of state and federal benefits. Additionally, your SSN 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 SSN:

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

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.

We may disclose your health information to a record locator service. This can help health care providers find health plans and other health care providers that have health information about you. The health care provider can then get that information to help make better decisions about your treatment. If you prefer not to be included in the record locator service, you may “opt out” by contacting the Community Health Information Collaborative (CHIC) service desk at (877) 411-CHIC (toll free), (218) 625-5515 (voice), (218) 625-5518 (fax).

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

- You and people you have given permission to may see and copy medical or other 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 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. 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.
- You have the right to get a record of some of the people or organizations with whom we have shared your information. This record was started on April 14, 2003. You must ask for a copy of this record in writing to our Privacy Official.
- 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 medical and other private information according to the terms of this notice.
- We may not use your information for reasons other than the reasons listed on this form or share your information with 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/lfsrver/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?

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 to the county agency, the organization or to the federal civil rights office at:

- U.S. Department of Health and Human Services
Office for Civil Rights, Region V
233 N. Michigan Avenue, Suite 240
Chicago, IL 60601
(312) 886-2359 (Voice) or
toll free (800) 368-1019 or (866) 282-0659
(312) 353-5693 (TTY)
(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
Attn: Privacy Official
PO Box 64998
St. Paul, MN 55164-0998

Rights and Responsibilities

Immigration

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 unless you are applying for payment of long term care services.

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

- Applying for emergency medical care only.
- Helping someone else apply.
- Living in the United States without the knowledge or approval of the United States Citizenship and Immigration Services (USCIS) and are pregnant.
- Not applying for yourself.

You Have the Right to Fair Treatment

We cannot treat you different because of your race, color, national origin, sex, sexual orientation, age, creed, religion, political beliefs, disability or status with regard to public assistance. If you feel the state or local agency did not treat you fairly, you can file a complaint with any of the following places:

- 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 for 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 your benefits are wrong or your application has not been processed correctly, you may ask for a fair hearing. You can ask for a hearing by telling your worker or by writing to:

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

Following the rules

People who are enrolled in Minnesota Health Care Programs must follow the rules listed below:

- Do not give false information or hide information to get or continue to get 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.

If you break the rules you may not be able to keep your coverage. If you get coverage through MinnesotaCare for adults without children and break the rules, you may have your coverage stop for one year the first time; for two years the second time; and forever after the third time. You can also be prosecuted for fraud if you break the rules. Additional fines and penalties may apply.

Child Support

If you are applying for yourself and your children and you do not live with the other parent, the law says you may have to give information to child support staff. This includes helping the state prove who the father of your children is and getting the other parent to help pay the children's medical expenses. Your children will still get coverage if you do not help child support, but you may not get coverage unless you are pregnant.

If you are afraid the other parent may cause harm to you or your child, you can give proof to support your fears. We will review your proof and tell you if you still need to give information about the other parent.

Reviews

The state or federal office may look at your case. They will review the information you gave us and check to make sure we did your case correctly. They will let you know if they need to ask you questions. If you do not answer their questions, your coverage may stop.

Other Health Care

You and your household members may need to accept and keep a health insurance policy. This includes Medicare. If you do not give us information about your policy, you may not get coverage.

Liens and Estate Claims

The state or county may try to recover the cost of medical services paid by Medical Assistance (MA) or General Assistance Medical Care (GAMC). The state may file a claim against your estate, against the estate of your surviving spouse or file a lien against your ownership interest in real property if you received:

- GAMC at any age.
- MA when you were over age 55.
- MA at any age if you lived in a long term care facility for six months or more.

Liens can be filed against:

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

You should talk to your lawyer or advisor if you have questions.

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 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. Examples of changes you need to report include:

Income:

- Starting a new job, changing jobs or stopping a job.
- Starting to get or changes in the amount of other income you get such as Social Security, other retirement income, child support, unemployment or workers' compensation.

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:

- Starts to get health insurance or Medicare.
- 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.