DHS-3417-ENG 12-07

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 to apply for:

- Long-term care, such as nursing home or waiver services.
- Cash or food support.

You can find these applications on the Web at www.dhs.state.mn.us or 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 Important Information 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.

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.

ກໍດກ່ຽວກັບ ເບີອົງການ ຖ້າທ່ານຕ້ອງການ ການຊ່ວຍ ແປ ຂໍ້ມູນ ນີ້ ໂດ ບ ບ ໃ ດ ໜຶ່ ງ ທ່ານ ສາ ມາ ດ ໂ ທ ຫາ ເ ລ ກ ທ່ ານ ນ ີ້ ເ ພື່ ອ ຂ ໍ ຄ ວ າ ມ ຊ ່ ວ ຍ ເ ຫ ລ ື ອ ໂ ດ ຍ ບ ໍ ່ ເ ສ ຍ ຄ ່ າ ໂ ທ ລ ະ ສ ັ ບ ຫ າ ທ ່ ານ ໄ ດ ້ ທ ີ່ ເ ລ ກ 1-888-468-3787 ฯ

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.

ໂປດຊາບ. ຖ້າຫາກທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປຂໍ້ຄວາມດັ່ງກ່າວນີ້ຟຣີ, ຈົ່ງຖາມນຳພນັກງານຊ່ວຍວຽກຂອງທ່ານຫຼືໂທຣ ຫາ ຕາ ມ ເ ລ ກ ໂ ທ ຣ 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.

LB2-0001 (1-08)

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.

Clear Form Data
FILLABLE FORM

DHS-3417-ENG 12-07

Minnesota Department of Human Services

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.***

1. Name and address

FIRST NAME	MI	LAST NAME	DATE OF BIRTH	SEX ☐ M ☐ F	MARITAL STATUS

STREET ADDRESS	CITY	STATE	ZIP CODE	COUNTY
MAILING ADDRESS (if different)	CITY	STATE	ZIP CODE	COUNTY

☐ Check this box if you are homeless	HOME PHONE	OTHER PHONE	Do you want us to send you a voter registration card? ☐ Yes ☐ No

What language do you speak most of the time?	Do you need an interpreter? ☐ Yes ☐ No	Are you applying for yourself? ☐ Yes ☐ No

OPTIONAL INFORMATION →	RACE ☐ Asian ☐ Black/African American ☐ American Indian/Native Alaskan ☐ Pacific Islander or Native Hawaiian ☐ White	HISPANIC OR LATINO? ☐ Yes ☐ No

2. Others living with you (List your spouse, parents/guardians, stepparents, children and step-children living in your home.)

Name (First, MI, Last)	Relationship to you	Sex	Marital status	Date of birth	Is this person applying?	OPTIONAL INFORMATION Race (Use codes below*)	OPTIONAL INFORMATION Hispanic or Latino?
		☐ M ☐ F			☐ Yes ☐ No		☐ Yes ☐ No
		☐ M ☐ F			☐ Yes ☐ No		☐ Yes ☐ No
		☐ M ☐ F			☐ Yes ☐ No		☐ Yes ☐ No
		☐ M ☐ F			☐ Yes ☐ No		☐ Yes ☐ No
		☐ M ☐ F			☐ Yes ☐ No		☐ Yes ☐ No

***Codes:** A - Asian B - Black/African American N - American Indian/Native Alaskan P - Pacific Islander or Native Hawaiian W - White

See Required Proofs on Page A

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

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

FIRST NAME	MI	LAST NAME	DATE OF BIRTH	RELATIONSHIP TO YOU

Are you applying for this person? ☐ No ☐ Yes	DATE LEFT	DATE EXPECTED TO RETURN	REASON FOR NOT LIVING AT HOME

4. Applicant information (Complete for each person who is applying.)

Name of person applying	Social Security Number	If a U.S. citizen, city and state born

5. 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?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

6. Does everyone plan to make Minnesota their home? ☐ Yes ☐ No – fill in below

NAME(S)	EXPLAIN

7. Has anyone lived in Minnesota for less than six months? ☐ No ☐ Yes – fill in below

NAME(S)	DATE MOVED TO MINNESOTA

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. 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.

☐ No ☐ Yes – fill in below

FIRST NAME	MI	LAST NAME	PHONE NUMBER

STREET ADDRESS	CITY	STATE	ZIP CODE

9. Additional household information

Is anyone 16 or older a student? ☐ Not Applicable (N/A) ☐ No ☐ Yes	IF YES, WHO?	
Is anyone pregnant? ☐ N/A ☐ No ☐ Yes	IF YES, WHO?	DUE DATE
Is anyone blind, have a disability, or seriously ill? ☐ No ☐ Yes	IF YES, WHO?	
Has anyone under the age of 21 ever been married, in the armed forces or have a court say they are no longer under the legal control of his or her parents? ☐ N/A ☐ No ☐ Yes	IF YES, WHO?	
Is anyone getting services from the Center for Victims of Torture? ☐ No ☐ Yes	IF YES, WHO?	
Do you want help paying for medical bills from the past three months? ☐ No ☐ Yes	IF YES, LIST MONTHS	

10. 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?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is there a signed Recognition of Parentage or court order for paternity?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is there a court order to provide health insurance?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Does the parent provide health insurance?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Do you want help getting medical or cash child support?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ 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.

11. Did anyone work this month or does anyone expect to work next month?

Include temporary and seasonal work.

☐ No ☐ Yes – fill in below

Name	Employer name	Start date	Monthly income (include tips)	Is this job seasonal?	Has this job ended?	
			$	☐ No ☐ Yes	☐ No ☐ Yes	IF YES, DATE ENDED
			$	☐ No ☐ Yes	☐ No ☐ Yes	IF YES, DATE ENDED
			$	☐ No ☐ Yes	☐ No ☐ Yes	IF YES, DATE ENDED
			$	☐ No ☐ Yes	☐ No ☐ Yes	IF YES, DATE ENDED

12. Is anyone self-employed this month or does anyone expect to be self-employed next month?

☐ 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

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

Include Social Security, Supplemental Security Income (SSI), child or spousal support, unemployment, workers' compensation, veterans' benefits, retirement or pension payments, public assistance payments, rental income, annuities, trusts, interest, dividends, payments from a contract for deed and any other source of income.

☐ No ☐ Yes – fill in below

Name	Type of income	Start date	Amount	How often received	Has this income ended?	
			$		☐ No ☐ Yes	IF YES, DATE ENDED
			$		☐ No ☐ Yes	IF YES, DATE ENDED
			$		☐ No ☐ Yes	IF YES, DATE ENDED
			$		☐ No ☐ Yes	IF YES, DATE ENDED

14. Is anyone paying for day care for a child or adult while they work?

☐ No ☐ Yes – fill in below

NAME OF PERSON PAYING	NAMES OF CHILDREN OR ADULTS IN DAY CARE	AMOUNT PAID 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.

15. 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?
	$	☐ No ☐ Yes

16. Does anyone have cash, a savings or checking account, or certificates of deposit?

☐ No ☐ Yes – fill in below

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

17. 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
			$
			$
			$
			$

18. Does anyone have a vehicle?

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

☐ No ☐ Yes – fill in below

Owner(s) name	Type of vehicle	Year/Make/Model

19. 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
			$
			$

See Required Proofs on Page A

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

20. Did anyone do any of the following in the last 60 months?

- Sell, trade or give away items or income for less than they were worth
- Not accept items or income they could have taken, such as an inheritance
- Buy an annuity, life estate in another person's home, a promissory note, loan or mortgage

☐ No ☐ Yes – fill in below

NAME(S)	ITEM(S) OR INCOME	DATE HAPPENED

21. 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? ☐ No ☐ Yes

22. Health insurance information

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

23. 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

LIST EVERYONE WHO IS COVERED BY THIS POLICY

Is this health insurance through an employer or union? ☐ No ☐ Yes – fill in 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 2008)

All of the people listed must read the following information and sign:

- Adults age 18 or older who are applying
- Parents, caretakers and guardians applying for children under the age of 21
- Children under age 18 who are applying on their own behalf and not living with a parent, caretaker or guardian
- The person you have chosen to act on your behalf as an authorized representative

Authorization to Share Information for Fraud Investigation

I give permission to authorized investigators and third parties to share information about me during the course of investigations regarding fraud, fraud prevention and misrepresentation. Third parties who can share information about me with investigators include but are not limited to financial institutions, credit reporting agencies, landlords, public housing agencies, schools, utility companies, insurance agencies, employers, other government agencies and others as they apply. I further authorize taxing authorities to release copies of my income tax returns. I also understand that my permission to share information about me remains in effect 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 payments from all other persons or entities. This assignment covers medical payments for me and anyone else for whom I apply.

It takes effect as soon as 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.

If I have Medicare Part B, I give Medicare consent to pay my health providers for the care I get while I have Minnesota Health Care Programs coverage.

Authorization for Release (Sharing) of My Medical Information

I give my consent that the following agencies or individuals may share among themselves medical information about me only for the limited purposes indicated:

- Health providers, health plans, insurance agencies, Minnesota Health Care Programs, my county case workers, and their contractors and subcontractors:
  - To determine who should pay for my health care, and
  - To provide and coordinate health care services
- Ombudspersons and county advocates for managed care to help me obtain medical care and payment of services.
- Researchers, auditors, investigators, and others who do quality of care reviews and studies or commence prosecutions or legal actions related to managing the health care programs.

This release also applies to the medical information of my minor children named in this application to the extent that I can consent to their medical treatment. Generally, I must give my written consent for the above agencies to give out the medical information. If I do not consent, it will not be released unless the law otherwise allows it. I may stop this consent with a written notice at any time, but this written notice will not affect information the agency has already released. This authorization is good while I am enrolled in Minnesota Health Care Programs, not to exceed one year, or longer if the law permits. I can refuse to sign or cancel this authorization. However, this Authorization does not expire after one year and cannot be revoked for release of records to consulting providers; or to release records to specified health payers for payment of claims, fraud investigation, or quality of care review 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. An agency or person who receives my information through this release could possibly re-disclose the information.

Over →

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.
- I agree to assign my medical benefits as stated.
- I declare that, under penalty of perjury, all parts of this application are true and correct statements, to the best of my knowledge, including the identity of all persons under age 16 listed on this application. 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 of the following people must sign below:

- Adults age 18 or older who are applying
- Parents, caretakers and guardians applying for children under the age of 21
- Children under age 18 who are applying on their own behalf and not living with a parent, caretaker or guardian
- The person who you have chosen to act on your behalf as an authorized representative

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 SPOUSE OR PARENT/GUARDIAN	DATE
SIGNATURE OF HOUSEHOLD MEMBER AGE 18 OR OLDER WHO IS APPLYING	DATE
SIGNATURE OF HOUSEHOLD MEMBER AGE 18 OR OLDER WHO IS APPLYING	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 these listed proofs for everyone who is applying:

- **U.S. citizenship and identity**
  U.S. passport, **or** Certificate of Naturalization, **or** Certificate of U.S. Citizenship
  OR
  One citizenship document and one identity document listed below:

  Citizenship documents:
  - U.S. birth certificate
  - Report of Birth Abroad of a U.S. citizen
  - U.S. citizen ID card
  - Hospital record of birth in one of the 50 states or U.S. territories.

  Identity documents:
  - State driver's license with picture
  - Minnesota ID card with picture
  - School ID card with picture
  - A parent, guardian, or relative caretaker's signature on the application proves identity for children under age 16.

You do not have to send proof of citizenship or identity for any person who is eligible for Medicare, receiving Supplemental Security Income (SSI), Social Security Disability, foster care or adoption assistance or a non-disabled adult under 65 without children.

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

Send these listed proofs for everyone who is:

- **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 or a written statement of earnings from your employer.
- **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.)
  Copy of check, award letter, tax forms, court order, or other documents.

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: April 2008)

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 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
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 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
P.O. Box 217
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
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
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 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 Street NE, Suite 1020
Willmar, MN 56201-9423
(320) 231-7800 / (877) 464-7800
Fax: (320) 231-6285

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

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

Lac qui Parle County
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
206 8th Ave SE, Suite 200
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

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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
P.O. 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
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
318 9th Street
P.O. 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
2116 Campus Drive SE
Rochester, MN 55904-3711
(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
P.O. Box 340
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) 245-3020 / (800) 450-7263
Fax: (320) 216-4101

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

Polk County
223 7th Street, Suite 109
Crookston, MN 56716-1483
(218) 281-3127 / (877) 281-3127
Fax: (218) 281-7347

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
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
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 South – 2nd Floor
Virginia, MN 55792-1148
(218) 749-7100
Fax: (218) 749-7123

Or

118 South 4th Ave 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 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 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) 430-6605

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) 682-7414 / (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: August 24, 2007)

This notice tells you how medical and other private information about you may be used and disclosed and how you can get this information. **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.
- 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.

Why do we ask for your Social Security Number?

We need your social security number 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]). We also need your Social Security Number to check information you give us through matching programs that are part of an Income Eligibility Verification System (IEVS) (5 U.S.C. § 552a(o)(1)(D)).

You do not have to give us the number:

- 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 only
- If you are from another country, in U.S. on a temporary basis and do not have permission from 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. We need this information to tell if you can get help from us. 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?

Sometimes we share information about you with other agencies. We will only share information as needed and as allowed or required by law. For example, 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 and non-profit agencies
- Court officials, county attorney, attorney general, other law enforcement officials, and child protection and fraud investigators
- Child support officials
- Educational institutions and organizations
- 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
- Human services offices, including child support enforcement offices
- Anyone else the law says we must or can give the information

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

- You may see and copy medical or other private information we may have about you. You may have to pay for the copies.
- You may give other people permission to see and have copies of information about you.
- 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 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 ask us to do this in writing. 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 that we have shared your health information with. 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 Department of Human Services for another copy of this notice.

Keep this page.

What are our responsibilities?

- We must let you know our legal duties and privacy practices, which we are doing by providing you with this notice.
- 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 unless we get special written permission from you. We may not share your information with individuals and agencies other than those listed on this form unless we get special written permission from you.
- We are required to follow the terms of this notice, but 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 put them on our Web site at: http://edocs.dhs.state.mn.us/lfserver/Legacy/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/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
  Attn: Privacy Official
  PO Box 64998
  St. Paul, MN 55164-0998

Important Information

Proof of Citizenship or National Status

Certain people applying for health care must give us proof that they are U.S. citizens or nationals.

You do not have to prove you are a U.S. citizen or national if you are eligible for Medicare, receive Supplemental Security Income (SSI) or receive Social Security payments because of a disability.

Non-disabled adults under age 65 without children and children receiving foster care or adoption assistance payments are not required to give us proof that they are U.S. citizens or nationals.

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 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
- A non-immigrant or undocumented person who is pregnant
- Not applying for 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 can file a complaint. 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 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 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 the:

- 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. 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. You can also be prosecuted for fraud if you break these rules. The maximum penalty is a fine of $250,000 or a jail term of 20 years, or both.

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. You may need to give information about the other parent to get medical support for your child. Your children will still get coverage if you do not help child support, but you will not get coverage unless you are pregnant. Your coverage will stop if you are already getting coverage.

If you fear the other parent may cause harm to you or your child, you can give proof to support your fears and 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.

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. We will review the policy and tell you if you can stop the coverage.

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

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 paid by Medical Assistance (MA) or General Assistance Medical Care (GAMC). The state may file a claim against your estate or a lien against your 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 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.

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

When you die, a lien may be set up against the portion of property you own to repay us for your medical care.

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 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.

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