Minnesota Department of **Human Services**

Minnesota Health Care Programs

Application for Certain Populations

What is this application for?

Use this application to apply for health care coverage, if everyone in the household:

- Is 65 years of age or older.
- Is only requesting help with Medicare costs.
- Is a child in foster care.
- Is over 21 years of age with no dependents and has Medicare coverage.
- Receives SSI income.
- Is applying for Medical Assistance for Employed Person with Disabilities (MA-EPD).
- If you are a person who lives in or may need to move to a nursing home use the Minnesota Health Care Programs Application for Payment of Long-Term Care Services (DHS-3531) or the online application, ApplyMN, at applymn.dhs.mn.gov.
- If you are a person with a disability or age 65 or older who 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). Also ask your county agency about a Long-Term Care Consultation.
- People who are not described above should apply for health care coverage through MNsure, Minnesota's health insurance marketplace. Use the online application at www.mnsure.org, or the Application for Health Coverage and Help Paying Costs (DHS-6696).

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. The addresses are listed on pages B and C at the back of this form.
6. 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

- Coverage can begin three months before the month we get your application.
- Most health care services are covered including doctor visits, lab and x-ray services, prescriptions, and hospital stays.
- Income limits (the amount of money you can have and still be eligible) may be lower than for a Medicare Savings Program.
- You may have copays for certain services.
- You can have other health insurance, even if it is through an employer. Help with payment of other health insurance may be possible.
- A claim may be placed against your estate for benefits paid.
- You may be required to choose a health plan and get all your health care services from providers in that plan.

Medicare Savings Programs

- Helps pay for Medicare costs such as Part A or Part B premiums.
- Payment of your Part B premiums can begin three months before the month we get your application.
- You may qualify for payment of your Medicare deductibles and copays.
- Income and asset limits are higher than Medical Assistance.
- No claim is placed against your estate for benefits paid.

Medical Assistance for Employed Persons with a Disability (MA-EPD)

- Must have earnings and pay FICA taxes.
- You must pay a monthly premium. The premium may be less than another type of health care coverage.
- Contact the Disability Linkage Line 866-333-2466 for help deciding the best program to meet your health care needs.

For more information:

- Call your county human services 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 need free help interpreting this document, ask your worker or call the number below for your language.

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

កំណត់សំគាល់ ។ បើអ្នកត្រូវការជំនួយក្នុងការបកប្រែឯកសារនេះដោយ ឥតគិតថ្លៃ សូមសួរអ្នកការងារសង្គមរបស់អ្នក ឬហៅទូរស័ព្ទមកលេខ 1-888-468-3787 ។

Pažnja. Ako vam treba besplatna pomoć za tumačenje ovog dokumenta, pitajte vašeg radnika ili nazovite 1-888-234-3785.

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

ໂປຣດຊາບ. ຖ້າຫາກ ທ່ານຕ້ອງການ ການຊ່ວຍເຫຼືອໃນການແປເອກະສານນີ້ຟຣີ, ຈົ່ງຖາມ ພະນັກງານກຳກັບການຊ່ວຍເຫຼືອຂອງທ່ານ ຫຼື ໂທຣໄປທີ່ 1-888-487-8251.

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

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

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

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

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

LB1-0003 (3-13)

ADA1 (12-12)

This information is available in accessible formats for individuals with disabilities by calling 651-431-2670, toll-free 800-657-3739, or by using your preferred relay service. For other information on disability rights and protections, contact the agency's ADA coordinator.

Clear Form

Minnesota Department of **Human Services**

DHS-3876-ENG 3-15

Minnesota Health Care Programs Application for Certain Populations

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. If you have dependents under the age of 19, apply online at www.mnsure.org. Do not use this application form.

If you only want to apply for a Medicare Savings Program, check the box below.

☐ I only want to apply for Medicare Savings Programs. I do not want to apply for other health care programs.

1a. Name and address

FIRST NAME	MI	LAST NAME	DATE OF BIRTH	SEX
				◯ M ◯ F

SOCIAL SECURITY NUMBER*	MARITAL STATUS	HOME PHONE	OTHER PHONE

STREET ADDRESS	CITY	STATE	ZIP CODE	COUNTY

MAILING ADDRESS (if different)	CITY	STATE	ZIP CODE	COUNTY

☐ Check this box if you are homeless	Are you applying for yourself? ◯ Yes ◯ No	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

OPTIONAL INFORMATION

RACE (check all that apply)	HISPANIC OR LATINO?
☐ Asian ☐ Black/African American ☐ American Indian/Native Alaskan ☐ Pacific Islander or Native Hawaiian ☐ White	◯ Yes ◯ No

American Indians: Some applicants are limited to the amount of assets they can own. If you are an American Indian, certain assets do not count.

Note: If you are an American Indian who has provided verification of American Indian status, you are exempt from paying a premium for MA-EPD.

☐ 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.

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**)	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: (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? ◯ Yes ◯ No	DATE LEFT	DATE EXPECTED TO RETURN	REASON FOR NOT LIVING AT HOME

4. Is everyone applying a U.S. Citizen or U.S. National?

◯ No – fill in below
◯ Yes

NAME	IMMIGRATION STATUS	DATE ENTERED THE U.S.	DOES THIS PERSON HAVE A SPONSOR?
			◯ Yes ◯ No
			◯ Yes ◯ No
			◯ Yes ◯ No
			◯ Yes ◯ No

Is anyone getting services from the Center for Victims of Torture? ◯ Yes ◯ No	IF YES, WHO?
Does anyone need help paying for a medical emergency? ◯ Yes ◯ No	IF YES, WHO?

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

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

◯ No
◯ Yes – fill in below

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.

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

6. Additional household information

Does everyone plan to make Minnesota their home? ◯ Yes ◯ No	IF NO, WHO?	EXPLAIN	
Is anyone 16 or older a student? ◯ Yes ◯ No	IF YES, WHO?		
Is anyone pregnant? ◯ Yes ◯ No ◯ Not Applicable (N/A)	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? ◯ Yes ◯ No	IF YES, WHO?		
Has anyone ever been in the United States military? ◯ Yes ◯ No	IF YES, WHO?		
Do you want help paying for medical bills from the past three months? ◯ Yes ◯ No	IF YES, LIST MONTHS		
Does anyone currently have medical benefits from another state? ◯ Yes ◯ No	IF YES, WHO?		

7. 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
				$
				$

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

◯ No
◯ Yes – fill in below

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)

NAME	EMPLOYER NAME	START DATE	GROSS INCOME PER PAY PERIOD (include tips)	HOW OFTEN PAID?	IS THIS JOB SEASONAL?	HAS THIS JOB ENDED?	
			$		◯ Yes ◯ No	◯ Yes ◯ No	IF YES, DATE ENDED
			$		◯ Yes ◯ No	◯ Yes ◯ No	IF YES, DATE ENDED
			$		◯ Yes ◯ No	◯ Yes ◯ No	IF YES, DATE ENDED
			$		◯ Yes ◯ No	◯ Yes ◯ No	IF YES, DATE ENDED

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

◯ No
◯ Yes – fill in below

Include:

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

NAME	TYPE OF INCOME	START DATE	GROSS AMOUNT	HOW OFTEN RECEIVED?	HAS THIS INCOME ENDED?	
			$		◯ Yes ◯ No	IF YES, DATE ENDED
			$		◯ Yes ◯ No	IF YES, DATE ENDED
			$		◯ Yes ◯ No	IF YES, DATE ENDED
			$		◯ Yes ◯ No	IF YES, DATE ENDED

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

◯ No
◯ Yes – fill in below

Do not include business accounts.

OWNER(S) NAME	TYPE	NAME OF BANK	CURRENT BALANCE
			$
			$
			$
			$

11. 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 TRUST	NAME OF COMPANY, BANK OR FUNERAL HOME	ESTIMATED VALUE
			$
			$
			$
			$

12. Does anyone own a vehicle?

◯ No
◯ Yes – fill in below

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

OWNER(S) NAME	TYPE OF VEHICLE	YEAR/MAKE/MODEL	ESTIMATED VALUE	AMOUNT OWED
			$	$
			$	$
			$	$
			$	$
			$	$

13. 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
			$
			$

14. 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? ◯ Yes ◯ No

15. Did you have Medicare or health insurance this month or does anyone expect to have Medicare or health insurance next month?

◯ No
◯ Yes – fill in below

COVERAGE TYPES – CHECK ALL THAT APPLY

☐ Medicare ☐ Medicare Part D ☐ Medicare Advantage Plan ☐ 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

MEDICARE COVERAGE: Policy holder has: (check all coverage)

☐ Part A ☐ Part B ☐ Part D – list name of plan: _____

Start date: Part A _____ Part B _____ Part D _____

15a. Does anyone else have Medicare or health insurance or expect to have Medicare or health insurance next month?

◯ No
◯ Yes – fill in below

COVERAGE TYPES – CHECK ALL THAT APPLY

☐ Medicare ☐ Medicare Part D ☐ Medicare Advantage Plan ☐ 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

MEDICARE COVERAGE: Policy holder has: (check all coverage)

☐ Part A ☐ Part B ☐ Part D – list name of plan: _____

Start date: Part A _____ Part B _____ Part D _____

Signature Page

(Effective Date: March 1, 2014)

Read the following information and sign.

Authorization to Share Information for Fraud Investigation and Audits

I agree that third parties may share information about me with persons investigating fraud and completing federal or state audits. 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.

Over →

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 and the list of my responsibilities in that Notice.
- I agree that I have read and understand the Rights and Responsibilities section including Following the rules, Changes and Liens and Estate Claims.
- 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 and audits as stated in the Authorization to Share Information for Fraud Investigations and Audits 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 office? 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.
- 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: February 2015)

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
PO Box 338
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
MnPrairie
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
469 12th Street
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
205 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
407 5th 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
Int'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

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

MinnesotaCare Operations
540 Cedar Street
PO Box 64252
St. Paul, MN 55164-0252
651-297-3862 / 800-657-3672
Fax: 651-431-7750

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

Mower County
201 1st Street NE
PO Box 537
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
Fax: 507-931-9562

Nobles County
318 9th Street
PO Box 189
Worthington, MN 56187-0189
507-295-5213
Fax: 507-372-5094

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

Olmsted County
2117 Campus Drive SE, Suite 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
SWHHS
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: 651-266-3708

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

Redwood County
SWHHS
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
320 Miners Dr. E
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
792 Canterbury Road S
Shakopee, MN 55379-1375
952-496-8686
Fax: 952-496-8685
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
763-765-4000 / 800-433-5239
Fax: 763-765-4096

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
MnPrairie
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
320-422-7777 / 855-735-8916
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
MnPrairie
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: March 2014)

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 will not sell any data collected, created, or maintained as part of this application.
- We must follow the terms of this notice, but we may change our privacy policy because privacy laws change. We will put changes to our privacy rules on our website at: http://edocs.dhs.state.mn.us/lfserver/Public/DHS-3979-ENG

What privacy rights do children have?

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

What if you believe your privacy rights have been violated?

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
  800-537-7697 (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

Discrimination is against the law. The U.S. Department of Health and Human Services' Office for Civil Rights prohibits discrimination in its programs because of race, color, national origin, age, disability and sex, including sex stereotypes and gender identity. If you believe you have been discriminated against, you have the right to file a complaint directly with the federal agency.

U.S. Department of Health and Human Services
Office for Civil Rights, Region V
233 North Michigan Avenue, Suite 240
Chicago, IL 60601
312-886-2359 (Voice)
800-368-1019 (Toll Free)
312-353-5693 (TTY)

In Minnesota, if you believe you have been discriminated against because of race, color, national origin, religion, creed, sex, sexual orientation, public assistance status, age, or disability, you have the right to file a complaint with:

- Minnesota Department of Human Services
  Equal Opportunity and Access
  PO Box 64997
  St. Paul, MN 55164-0997
  651-431-3040 (Voice)
  711 or 800-627-3529 (MN Relay)
- Minnesota Department of Human Rights
  Freeman Building
  625 Robert St. N.
  St. Paul, MN 55155
  651-539-1100 (Voice)
  800-657-3704 (Toll-Free)
  651-296-1283 (TTY)

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. Some adults without children who get their coverage through MinnesotaCare and break the rules, may have their 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.