



**DEPARTMENT OF
HUMAN SERVICES**

MINNESOTA HEALTH CARE PROGRAMS (MHCP)

Renewal for People Receiving Long-Term Care Services

■ What do I need to do with this form?

1. Read the Notice of Privacy Practices and Notice of Rights and Responsibilities on Attachment A. Tear these pages off and keep them.
2. Answer all questions that apply to you. If you need more space, write the question number and the answer on a separate piece of paper. Include it with the form.
3. Sign and date the form. You do not need to wait until the last day of the month to sign the form.
4. Attach proofs. **Send copies of proofs. Do not send original documents.**
5. Mail or take the form and proofs to your county or tribal agency as soon as you have completed the form.

■ Send in your renewal form right away even if you do not have all proofs. If we need more information, we will contact you.

■ What will happen if I do not return this form?

Coverage will stop if you do not return this form by the due date.

■ Questions?

If you have questions or need help filling out this form, call your worker right away.

MINNESOTA HEALTH CARE PROGRAMS (MHCP)

Renewal for People Receiving Long-Term Care Services

Office Use Only		
DATE RECEIVED	CASE NUMBER	WORKER NUMBER

- **Answer all questions the best you can.**
- **Return the form and proofs right away.**
- **Call your worker if you have questions.**

1. Name and address

FIRST NAME	MI	LAST NAME	DATE OF BIRTH	PHONE NUMBER	
STREET ADDRESS WHERE YOU ARE CURRENTLY LIVING		CITY	STATE	ZIP CODE	COUNTY
MAILING STREET ADDRESS (if different)		CITY	STATE	ZIP CODE	COUNTY
Are you currently in a long-term care facility? <input type="radio"/> Yes – fill in the information <input type="radio"/> No					
LONG-TERM CARE FACILITY NAME			DATE MOVED INTO THIS FACILITY (MM/DD/YYYY)		
STREET ADDRESS BEFORE MOVING TO THIS FACILITY		CITY	STATE	ZIP CODE	COUNTY
If you have a home, do you plan to return there? <input type="radio"/> Yes <input type="radio"/> No					

OPTIONAL INFORMATION →	<p>What is your living situation? <i>(choose one)</i></p> <p><input type="radio"/> I live in a hospital, nursing home, treatment facility or detox center.</p> <p><input type="radio"/> I have my own housing (rent, pay a mortgage or share housing costs with a roommate).</p> <p><input type="radio"/> I live with family or friends because of economic hardship.</p> <p><input type="radio"/> I live in an emergency shelter.</p> <p><input type="radio"/> I live in a service provider's housing (foster home, group home or assisted living).</p> <p><input type="radio"/> Unknown</p> <p><input type="radio"/> I live in a jail, prison or juvenile detention facility.</p> <p><input type="radio"/> I live in a hotel or motel.</p> <p><input type="radio"/> I decline to answer.</p> <p><input type="radio"/> I live in a place not meant for housing (anywhere outside, a vehicle, an abandoned building, a bus or train station, or an airport). In which county do you live? _____</p>
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Questions 2-13 are for only those household members who are 21 years old or older.

2. How much cash do you have on hand, in a safety deposit box, at home and at the facility where you live?	\$
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3. Do you have savings or checking accounts, money market accounts or certificates of deposit?

Yes – fill in the information No

Owner name(s)	Type of account	Bank name and address	Account number

You must provide proof of these assets. Proof may be recent account statements or a written statement from your bank, credit union or other financial institution showing the current balance or value of accounts.

4. Do you have stocks, bonds or retirement accounts?

Yes – fill in the information No

Owner name(s)	Type of investment	Company or bank name and address	Account number

You must provide proof of these assets. Proof may be copies of bonds, stock ownership, retirement accounts, or documents showing current loan balance owed against the asset.

5. Do you own or co-own houses, condominiums, summer or winter homes, cabins, mobile homes, time-shares, rental properties, any other real estate, or life estate interests or remainder interests in real property?

Yes – fill in the information No

Owner name(s)	Type of property	Property address	Do you or your spouse live here all year?
			<input type="radio"/> Yes <input type="radio"/> No
			<input type="radio"/> Yes <input type="radio"/> No

You must provide proof of these assets if you have not already provided it or if your equity value in the asset has changed. Proof may be real property tax statements, warranty deeds, quit claim deeds, life estate or other real property agreements or documents showing the amounts owed against the property.

6. Do you own or co-own promissory notes, contracts for deed or other property agreements?

Yes – fill in the information No

Owner name(s)	Type of asset

You must provide proof of these assets if you have not already provided it or if you have amended the terms of a contract. Proof may be copies of the contract for deed, mortgage, loan contract or promissory note.

7. Do you have any vehicles in your name?

Include cars, trucks, vans, motorcycles, motor homes, campers, boats, snowmobiles, all-terrain vehicles, etc.

Yes – fill in the information No

Owner name(s)	Type of vehicle	Year, make, model

You must provide proof of these assets if you have more than one vehicle and either of the following applies:

- **You have not already provided proof**
- **Your equity value in the vehicle has changed**

Proof may be copies of your vehicle title or documents showing the amounts owed against the vehicle.

8. Do you have an interest in a trust or annuity?

Yes – fill in the information No

Owner name(s)	Type

We may ask for proofs later.

9. Do you have life insurance that does not fund a burial agreement?

Yes – fill in the information No

Owner name(s)	Policy number	Insurance company name and address

You must provide proof of the current cash surrender value of all policies. You must provide copies of the life insurance policy if you have not already provided them.

10. Do you have assets currently used for self-employment or in a business in which you or your spouse has an interest?

Yes – fill in the information No

Owner name(s)	Type of asset

You must provide proof of these assets if you have not already provided it. Proof may be current tax documents, business ledgers or account statements.

11. Do you own or co-own any other assets you have not listed?

Yes – fill in the information No

Owner name(s)	Type of asset

You must provide proof of these assets.

12. Do you live in a continuing care retirement community?

Yes No

You must provide proof of the entrance fee if you have not already provided it or if the contract has changed the terms of the entrance fee.

13. Have you bought, changed or canceled a prepaid burial account or burial trust in the last year?

This includes revocable and irrevocable accounts, insurance-funded burials, annuity-funded burials, Cremation Society agreements, burial spaces, burial space items and other funds designated for burial.

Yes – fill in the information No

OWNER OF ASSET	TYPE OF BURIAL ASSET	WHAT WAS THE CHANGE?	DATE OF CHANGE (MM/DD/YYYY)

You must provide proof of these assets if you have not already provided it. Proof may be copies of the life insurance policy, burial contracts or other documents showing the current value of the assets.

14. Did you do any of the following in the last year?

- Create a trust
- Sell, trade or give away items or income
- Not accept items or income you could have taken, such as an inheritance or pension
- Buy or make changes to an annuity
- Buy a life estate in another person's home, a promissory note, loan or mortgage

Yes – fill in the information No

NAME(S)	ITEM(S) OR INCOME	DATE HAPPENED
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15. Are you working, or do you expect to work in the next month?

Include temporary and seasonal work.

Yes – fill in the information No

EMPLOYER NAME		START DATE (MM/DD/YYYY)
Is this job seasonal? <input type="radio"/> Yes <input type="radio"/> No	Has this job ended? <input type="radio"/> Yes <input type="radio"/> No	IF YES, END DATE (MM/DD/YYYY)

Wages and tips before taxes (Choose one and fill in the dollar amount and your hours per week.)

- Hourly \$ _____ per hour Hours per week: _____
- Weekly \$ _____ Hours per week: _____
- Every two weeks \$ _____ Hours per week: _____
- Twice a month \$ _____ Hours per week: _____
- Monthly \$ _____ Hours per week: _____
- Yearly \$ _____ Hours per week: _____

You must provide proof of this income. Proof may be paystubs or a written statement of earnings from your employer if you do not have paystubs.

16. Are you self-employed, or do you expect to be self-employed next month?

Yes – fill in the information No

TYPE OF WORK	MONTHLY INCOME	MONTHLY EXPENSES	START DATE (MM/DD/YYYY)
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You must provide proof of this income. Proof may be most recent income tax returns and all related schedules or business records if taxes are not filed.

17. Did you get money this month or do you 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
 - Any other payments

Yes – fill in the information No

Type of income	Amount	How often received	Has this income ended?
	\$		<input type="radio"/> Yes <input type="radio"/> No <small>IF YES, END DATE (MM/DD/YYYY)</small>
	\$		<input type="radio"/> Yes <input type="radio"/> No <small>IF YES, END DATE (MM/DD/YYYY)</small>

You must provide proof of this income. Proof may be award letters, copies of checks, tax forms, court orders or other documents.

18. Expenses

If you are blind or have a disability, do you have work expenses? <input type="radio"/> Yes <input type="radio"/> No	IF YES, TYPE OF EXPENSE(S)	MONTHLY AMOUNT
If you have a legal guardian or conservator, do you pay a fee? <input type="radio"/> Yes <input type="radio"/> No	IF YES, FEE PAID	
Do you have court-ordered child or medical support payments taken from your income? <input type="radio"/> Yes <input type="radio"/> No	IF YES, AMOUNT PER MONTH	
Do you have court-ordered spousal maintenance payments taken from your income? <input type="radio"/> Yes <input type="radio"/> No	IF YES, AMOUNT PER MONTH	

You must provide proof of these expenses. Proof may be court orders or paystubs.

19. Do you have medical expenses?

Include health insurance premiums, pharmacy co-pays, doctor office co-pays and all unpaid medical bills.

Yes – fill in the information No

LIST EACH MEDICAL EXPENSE

You must provide proof of these expenses. Proof may be receipts of pharmacy co-pays, unpaid medical bills, or notices of health insurance premiums.

20. Do you have a spouse? Yes – fill in the information No

NAME OF SPOUSE

Does your spouse live in a long-term care facility or get help from a waiver program? Yes NoIf no, do you want to give part of your income to your spouse? Yes – complete items a and b No

a. SPOUSE'S MONTHLY INCOME

b. SPOUSE'S MONTHLY HOUSING COSTS

If you want to give part of your income to your spouse, you must provide proof of your spouse's income and housing costs. Proof of income may be paystubs, a written statement of earnings from the employer, award letters, copies of checks, tax statements, court orders or other documents. Proof of housing costs may be copies of mortgage statements, rent statements, lease agreements, property tax statements or utility bills.

21. Do you want to give part of your income to any of the following family members?

- A child under 21
- A child 21 years old or older whom you list as a dependent on your tax forms
- A parent or sibling whom you list as a dependent on your tax forms

 Yes – fill in the information No

Name	Relationship	Date of birth (MM/DD/YYYY)	Family member's current monthly income	Is family member living with your spouse?
			\$	<input type="radio"/> Yes <input type="radio"/> No
			\$	<input type="radio"/> Yes <input type="radio"/> No

If you want to give part of your income to your family, you must provide proof of your family member's income. Proof may be paystubs, a written statement of earnings from the employer, award letters, copies of checks, tax statements, court orders or other documents.

22. Tell us about changes in health insurance during the last year.

Employer-sponsored coverage

Is anyone offered health coverage from a job? Check yes even if the coverage is from someone else's job, such as a parent or spouse.

Yes – fill in the information No

NAME	EMPLOYER NAME
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Has anyone who has coverage through an employer had a change in that coverage in the past year, including any changes to the health plan or costs?

Yes – fill in the information No

NAME	WHAT CHANGED?	DATE OF CHANGE (MM/DD/YYYY)
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Medicare coverage

Has anyone had a change in Medicare coverage in the past year, including gaining or losing Medicare coverage?

Yes – fill in the information No

WHO HAD THIS CHANGE?	WHAT CHANGED?	DATE OF CHANGE (MM/DD/YYYY)
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Other health coverage or long-term care insurance

Has anyone had a change in another type of health insurance, including gaining or losing coverage?

Yes – fill in the information No

WHO HAD THIS CHANGE?	WHAT CHANGED?	DATE OF CHANGE (MM/DD/YYYY)
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We may ask for proofs later.

23. Tell us about any changes that happened during the last year. *(Check all that apply.)*

<input type="checkbox"/> Pregnancy	IF BOX CHECKED, WHO HAD THIS CHANGE?		HOW MANY BABIES ARE EXPECTED?
	DUE DATE (MM/DD/YYYY)	IF THIS PERSON WAS RECENTLY PREGNANT, ENTER THE DATE THE PREGNANCY ENDED	
<input type="checkbox"/> Marital status	IF BOX CHECKED, WHO HAD THIS CHANGE?	WHAT CHANGED?	DATE OF CHANGE (MM/DD/YYYY)
<input type="checkbox"/> Student status	IF BOX CHECKED, WHO HAD THIS CHANGE?	WHAT CHANGED?	DATE OF CHANGE (MM/DD/YYYY)
<input type="checkbox"/> Immigration status	IF BOX CHECKED, WHO HAD THIS CHANGE?	WHAT CHANGED?	DATE OF CHANGE (MM/DD/YYYY)
<input type="checkbox"/> Disability status	IF BOX CHECKED, WHO HAD THIS CHANGE?	WHAT CHANGED?	DATE OF CHANGE (MM/DD/YYYY)
<input type="checkbox"/> Other changes	IF BOX CHECKED, WHAT CHANGED?		DATE OF CHANGE (MM/DD/YYYY)

We may ask for proofs later.

Signature Page

(Effective Date: February 2020)

Read the following information and sign.

Please complete this page and read the attached Notice of Privacy Practices and Notice of Rights and Responsibilities (Attachment A) before signing this page.

By signing this page:

I received and reviewed the Notice of Privacy Practices and the Notice of Rights and Responsibilities (Attachment A). I know that I must report changes to the information listed on this application.

I declare under the penalties of perjury that this application has been examined by me and to the best of my knowledge is a true and correct statement of every material point. I understand that a person convicted of perjury may be sentenced to imprisonment of not more than five years or payment of a fine of not more than \$10,000, or both. I understand that there may be other penalties for not telling the truth.

Additional agreements for Medical Assistance

I consent to the release of my Minnesota Health Care Programs health records to the parties listed in the Consent for Sharing of Medical Information section of the Notice of Rights and Responsibilities.

- I give the Medical Assistance agency our rights to pursue and get any money from other health insurance, legal settlements, or other third parties.
- I have read and understand that the state may claim repayment for the cost of medical care, or the cost of the premiums paid for care, from my estate or my spouse's estate.
- I understand that my information, and information about me shared from third parties, will be shared for fraud prevention investigations as stated in the Notice of Privacy Practices.
- If I am a parent that is eligible for Medical Assistance, I understand I may be asked to cooperate with the agency that collects medical support from an absent parent. If I think that cooperating to collect medical support will harm me or my children, I can tell the agency, and I may not have to cooperate. I give to the Medical Assistance agency the rights to medical support paid for my children.
- I understand that the assets owned by me in the last month I am eligible for MA-EPD, and, if allowed under law, the assets of my spouse, will be designated to my Employment Incentive Asset Account (EIAA). The assets designated to my EIAA will be disregarded if I continue my MA eligibility under the basis of a person age 65 or older if I have been enrolled in MA-EPD for 24 consecutive months and did not become ineligible for MA for a calendar month or more before my 65th birthday.

YOUR SIGNATURE	DATE
AUTHORIZED REPRESENTATIVE SIGNATURE, IF APPLICABLE	DATE

Submit your completed and signed application

Submit your completed and signed application and your proofs in one of these three ways:

- Fax your application for faster processing.
- Mail your application.
- Submit your application in person.

Mail, fax, or bring your application and proofs to your county or tribal agency. Send copies of proofs. Do not send original documents. Note: Ask your worker if you need help getting proofs. Some required proofs, such as certification of disability, citizenship and identity, will first be requested electronically from other government agencies.

If you want to register to vote in Minnesota, you can complete a voter registration form at sos.state.mn.us.

MINNESOTA DEPARTMENT OF HUMAN SERVICES

Notice of Privacy Practices and Notice of Rights and Responsibilities

(Effective Date: November 2018)

Notice of Privacy Practices

This part of the notice describes how private or confidential information about you may be used and disclosed. 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 and mental health services and decide whether you can pay for some services
- To decide whether you or your family need protective services
- To decide about out-of-home care and in-home care for you or your children
- To make reports, do research, do audits, and evaluate our programs
- To investigate reports of people that may lie about the help they need or to get assistance they may not be entitled to receive
- To collect money from other agencies, like insurance companies, if they should pay for your care
- To collect money from the state or federal government for help we give you

Why do we ask you for your Social Security number?

We need your Social Security number (SSN) to give you Medical Assistance (MA), some kinds of financial help, and child support enforcement services (42 USC 666; Minn. Stat. 256L.04, subd. 1a; 42 CFR 435.910).

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 our partner nonprofit and private agencies to verify income, resources, and other information that may affect your eligibility or benefits.

You do not have to give us the SSN for people in your home who are not applying for coverage. You also do not have to give us your SSN:

- 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, are 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

Why do we ask you for your financial information?

We use this information only for the purposes authorized by law, such as verifying eligibility or determining the amount of a premium. We will not share this information with any other person or entity.

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 could be investigated and then charged with a crime.

With whom may we share information?

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

- Employees or volunteers with other state, county, local, federal, and partner nonprofit and private agencies
- Researchers, auditors, investigators, and others that do quality-of-care reviews and studies or begin prosecutions or legal actions related to managing the human services programs
- Court officials, county attorneys, attorneys general, other law enforcement officials, child support officials, child protection and fraud investigators, and fraud prevention 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 that pay for your care
- Guardians, conservators or people with power of attorney who are authorized representatives
- 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, in limited situations
- Certified application counselors, in-person assisters, and navigators and anyone else the law says we must or can give the information to

What are our responsibilities?

- We must protect the privacy of your personal, health care 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 people 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 and give you a copy of it, but we may change our privacy policy. Those changes will apply to all information we have about you. The new notice will be available on request, and we will put changes to it on our website at <https://edocs.dhs.state.mn.us/lfserver/Public/DHS-4839E-ENG>.
- The law requires us to keep your private information private and secure.
- If something happens that causes your private information to no longer be private and secure, we will let you know right away.

This part of the notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

We can use and share your health care information to

- **Help manage the health care treatment you receive**
 - We can use your health information and share it with professionals who are treating you. *Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.*
 - We can also share your information with guardians, conservators or people with power of attorney who are authorized representatives
- **Run our organization**
 - We can use and share your information to run our organization and contact you when necessary. This includes sharing your information with employees or volunteers with other state, county, local, federal, and partner nonprofit and private agencies, including child support offices.
 - We can share your information with these people and groups:
 - Auditors, investigators, and others that do quality-of-care reviews and studies
 - Credit bureaus, creditors or collection agencies if you do not pay fees you owe to us for services, in limited situations
 - Certified application counselors, in-person assisters, and navigators and anyone else the law says we must or can give the information to
 - We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long-term-care plans. *Example: We use health information about you to develop better services for you.*

• Pay for your health services

- We can use and share your health information as we pay for your health services. *Example: We share information about you with your dental plan to coordinate payment for your dental work.*

• Help with public health and safety issues

- We can share health information about you for purposes like these:
 - Preventing disease
 - Helping with product recalls
 - Reporting adverse reactions to medications
 - Reporting suspected abuse, neglect, or domestic violence
 - Preventing or reducing a serious threat to anyone's health or safety

• Do research

- We can use or share your information for health research.

• Comply with the law

- We will share information about you if state or federal laws require it. This includes sharing information with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

• Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when a person dies.

• Address workers' compensation, law enforcement, and other government requests

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- With governmental agencies in other states administering public benefits programs
- For special government functions, such as military, national security, and presidential protective services

• Respond to lawsuits and legal actions

- We can share health information about you in response to a court order. We may share the information with court officials, county attorneys, attorneys general, other law enforcement officials, child support officials, child protection and fraud investigators, and fraud prevention investigators.

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

Get a copy of health and claims records

- You and people you have given permission to may see and copy private information we have about you, such as health and claims records. You may have to pay for the copies.
- You can choose someone to act for you with a medical power of attorney or as a legal guardian. That person can exercise your rights and make choices about your information.

Ask us to correct health and claims records

- You may question whether 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 anytime information is shared.

Request confidential communications

- You have the right to ask us in writing to share health information with you in a certain way or in a certain place.
- We will consider all reasonable requests. We must say yes if you tell us you would be in danger if we did not. 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.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request and we may say no if it would affect your care.

Get a list of those with whom we've shared information

- This list will not include disclosures for treatment, payment, and health care operations. It will also not include certain other disclosures, such as any you asked us to make.
- We'll provide one list a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

If you do not understand the information, ask your worker to explain it to you. You may ask the Minnesota Department of Human Services for another copy of this notice.

What are your choices?

For certain health information, you can tell us your choices about what we share.

You have both the right and choice to tell us to:

- Share health information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

Tell us what you want us to do, and we will follow your instructions. If you are not able to tell us your preference, for example, if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

What privacy rights do children have?

If you are under 18, when parental consent for medical treatment is not required, information will be provided to parents only when the medical provider believes that your health is at risk if the information is not shared. 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 to either the county agency, the organization or 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)
800-368-1019 (toll free)
800-537-7697 (TTY)
312-886-1807 (fax)

If you believe the Minnesota Department of Human Services violated your privacy rights, you may also contact:

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

Whom do you contact if you need more information about privacy practices?

If you need more information about privacy practices, call the Minnesota Health Care Programs (MHCP) Member Help Desk at 800-657-3739 or 651-431-2670.

Notice of Rights and Responsibilities

Changes

If you have MA, you must report a change within 10 days of the change happening. Call your county or tribal agency to report the change.

If you do not report changes, you may have to pay money back to the state or federal government for benefits that you received but were not eligible for. If you are not sure whether to report a change, call and explain what is happening. Examples of changes you need to report include the following:

Income changes when you

- Start a new job, change jobs or stop a job
- Start to get, or receive changes in the amount of, other income like Social Security, other retirement income and unemployment

Residence changes when you

- Move to a new address

Life changes in your household when someone

- Starts or stops other health insurance or Medicare
- Becomes pregnant or has a baby
- Moves in or out of your home
- Changes tax filing status
- Loses Minnesota residency
- Changes citizenship or lawful presence status
- Changes incarceration status
- Dies, gets married or gets a divorce
- Becomes disabled

Reviews

The state or federal agency's health care program auditors may look at your case. They will review the information you gave us and check to make sure we processed your case correctly. They will let you know if they need to ask you questions.

Consent for Sharing of Medical Information

In your application for Minnesota Health Care Program coverage, you have given your written and signed consent to the following agencies and people to share between them medical information about you only for the limited purposes indicated:

- Health providers, including health plans, insurance agencies, Minnesota Health Care Programs, county advocates, school districts, your county or state case workers, and their contractors and subcontractors, for these purposes:
 - To determine who should pay for your health care
 - To provide, manage and coordinate health care services
- All other agencies or people listed on this Notice of Privacy Practices and Notice of Rights and Responsibilities, for this purpose:
 - To administer Minnesota Health Care Programs, pay for services, and conduct research and investigations

This consent applies to medical information about your minor children you applied for on this application.

You 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 you are 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 or for payment of your bills, fraud investigations or quality-of-care review and studies.

An agency or person who gets your information through this consent could give the information to others.

If you end this consent, you cannot enroll or stay enrolled in Minnesota Health Care Programs.

Other Health Care

You and your household members enrolled in MA must tell us about any other health insurance that you have or that is available to you, including employer-sponsored coverage, private health insurance, long-term-care insurance, and any limited health coverage, such as dental or accident coverage. You must tell us whether your employer offers insurance and whether you accepted it.

You and your household members enrolled in MA may need to accept and keep a health insurance policy when the policy is found to be cost effective. If you have a good reason for not doing that, you may ask the state to approve the reason. If you do not give us information about your health insurance policy, you may not get coverage.

You must also tell us when you become eligible for Medicare. MA pays for the Medicare premiums of some low-income people. Once you are eligible for Medicare Part B and Part D, MA will no longer pay for services that could be covered by a Medicare program.

MA Medical 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 if both you and your child are eligible for MA. This includes helping the state prove who the father of your children is and helping the state to get the other parent to help pay the children's medical expenses. If you do not help child support staff, your children will still get coverage, but your coverage will end, unless you are pregnant.

If you are afraid the other parent may cause harm to you or your child, you can give your county or tribal agency proof to support your fears. The agency will review your proof and tell you whether you still must give information to child support staff.

Assignment of Medical Payments

By accepting MA, you give your rights to all medical payments for yourself and anyone else you apply for to the state of Minnesota. These include medical payments from all other people or companies, including medical support payments from an absent parent. This assignment of medical payments begins as soon as health care coverage starts. For MA for Long-Term Care, this includes your right to support from your spouse under Minnesota Statutes, section 256B.14, subdivision 3.

You also agree to help the state get paid back for medical expenses that should have been paid by others. You may not have to help the state if you have a good reason for not helping and the state approves the reason.

MA Estate Claims and Liens

In certain circumstances, federal and state law require the Minnesota Department of Human Services and local agencies to recover costs that the MA program paid for its members health care services. This recovery process is done through Minnesota's MA estate recovery and lien program.

If you are enrolled in MA when you are 55 years old or older, then, after you die, Minnesota must try to recover certain payments the MA program made for your health care, including:

- Nursing home services
- Home and community-based services
- Related hospital and prescription drug costs

If you permanently live in a medical institution, Minnesota must also try to recover the costs of all MA services you receive at any age while living in a medical institution. If you are permanently living in a medical institution and you do not have a spouse or disabled child living on your homesteaded real property, the state may file an MA lien against your real property to recover MA costs before your death. However, MA members who qualify for services under modified adjusted gross income (MAGI) eligibility criteria are not subject to recovery for services received before the age of 55.

After you die, the state also may file a notice of potential claim, which is a form of lien, against real property to recover MA costs. Liens to recover MA costs may be filed against the following:

- Your life estate or joint tenancy interest in real property
- Your real property that you own solely
- Your real property that you own with someone else

Minnesota cannot start recovery of these costs while your spouse is still living or if you have a child under 21 years old or a child who is permanently disabled. Once your spouse dies, Minnesota must try to recover your MA costs from your spouse's estate. However, recovery is further delayed if you still have a child who is under 21 or permanently disabled.

Your children do not have to use their assets to reimburse the state for any MA services you received.

You have the right to speak with a legal-aid group or a private attorney if you have specific questions about how MA estate recovery and liens may affect your circumstance and estate planning. The Minnesota Department of Human Services cannot provide you with legal advice. For more information, go to <http://mn.gov/dhs/ma-estate-recovery/>.

You Have the Right to Ask for a Hearing

If you feel your health care eligibility or benefits are wrong or your application was not processed correctly, you may ask for an appeal hearing. By requesting an appeal hearing, you are requesting a fair review of your case. You can represent yourself or use an attorney, advocate, authorized representative, relative, friend or other person. You will find specific appeal instructions on all eligibility notices that you receive. Learn more about the appeals process and how to ask for a hearing at www.dhs.state.mn.us/appeals/faqs.

You can complete and submit an appeal request online at <https://edocs.dhs.state.mn.us/lfserver/Public/DHS-0033-ENG>.

You can also print the form that is available at the address above and submit the completed form by fax to 651-431-7523 or by mail to this address:

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

Immigration

Immigration information you give to us is private. We use it to see whether you can get coverage. We share it only when the law allows it or requires it, such as to verify identity. 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 a pregnant woman living in the United States without the knowledge or approval of the United States Citizenship and Immigration Services (USCIS). You also do not have to give us your immigration information if you are:

- Applying for emergency medical care only
- Helping someone else apply
- Not applying for yourself

Genetic Information

DHS does not collect, maintain or use genetic information for purposes of eligibility.

Record Retention

Information provided in an application for coverage through DHS is subject to the False Claims Act and may be kept for up to 10 years. DHS follows the general records retention schedules for state agencies and for the Department of Human Services and maintains data according to state and federal law. After the appropriate time period, DHS destroys the data in a way that prevents their contents from being determined, including by shredding paper files and permanently removing electronic data so as to prevent recovery.

Civil Rights Notice

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

- race
- color
- national origin
- creed
- religion
- sexual orientation
- public assistance status
- marital status
- age
- disability
- sex (including sex stereotypes and gender identity)
- political beliefs

Auxiliary Aids and Services: DHS provides auxiliary aids and services, like qualified interpreters or information in accessible formats, free of charge and in a timely manner to ensure an equal opportunity to participate in our health care programs. Call 651-431-2670 or 800-657-3739 or use your preferred relay service.

Language Assistance Services: DHS provides translated documents and spoken language interpreting, free of charge and in a timely manner, when language assistance services are necessary to ensure limited English speakers have meaningful access to our information and services. Call 651-431-2670 or 800-657-3739 or use your preferred relay service.

Civil Rights Complaints

You have the right to file a discrimination complaint if you believe you were treated in a discriminatory way by a human services agency. You may contact any of the following three agencies directly to file a discrimination complaint.

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

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

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

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

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

Minnesota Department of Human Rights (MDHR)

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

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

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

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

DHS

You have the right to file a complaint with DHS if you believe you have been discriminated against in our health care programs because of any of the following:

- race
- color
- national origin
- creed
- religion
- sexual orientation
- public assistance status
- marital status
- age
- disability
- sex (including sex stereotypes and gender identity)
- political beliefs

Complaints must be in writing and filed within 180 days of the date you discovered the alleged discrimination. The complaint must contain your name and address and describe the discrimination you are complaining about. After we get your complaint, we will review it and notify you in writing about whether we have authority to investigate. If we do, we will investigate the complaint.

DHS will notify you in writing of the investigation's outcome. You have the right to appeal the outcome if you disagree with the decision. To appeal, you must send a written request to have DHS review the investigation outcome. Be brief and state why you disagree with the decision. Include additional information you think is important.

If you file a complaint in this way, the people who work for the agency named in the complaint cannot retaliate against you. This means they cannot punish you in any way for filing a complaint. Filing a complaint in this way does not stop you from seeking out other legal or administrative actions.

Contact **DHS** directly to file a discrimination complaint:

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