DEPARTMENT OF HUMAN SERVICES

Application for Title IV–E Foster Care

What is this application for?

Use this application to apply for Title IV-E funding that can assist with the cost of foster care placement and services for any child/youth who has been placed in a foster care setting.

What is a removal home?

The removal home for Title IV-E purposes is always considered the home of the person(s) who is the subject of a judicial finding of contrary to the welfare, or who signed a Voluntary Placement Agreement with the Title IV-E agency.

For the purposes of determining Title IV-E eligibility, a child must be “living with” and “removed from” the same specified relative.

What is the eligibility month?

For voluntary placement, the eligibility month is the month that the Voluntary Placement Agreement (VPA) was signed by all parties.

For a court-ordered placement, the eligibility month is the month that the petition which led to the current physical removal is filed OR the date of the court hearing at which physical removal is ordered, when no new removal petition is filed or one is filed after the court hearing.

Please follow these instructions as you complete the application

- Read all instructions carefully and answer all questions completely.
- Complete the entire Title IV-E Foster Care Application. The applicant is the relative caretaker in the removal home. A youth age 18-21 meets the removal home requirement and should complete the application.
- If you need more room, attach additional sheets of paper.
- **Provide additional verifications and information such as:**
  - Proof of income and assets. List all sources of income received during the Eligibility Month for all household members.
  - Verification of child/youth's age.
  - Verification of the child's relationship to the caretaker of the removal home.
- Carefully read the Notice of Privacy Practices section of this form.
- Sign and date the application.
- Mail, fax or bring the completed application to the county or tribal agency.
- Send in your application right away even if you do not have all proofs. We will contact you if we need more information.
- **If you have questions or need help, call your county or tribal agency.**

The application must include every person living in the **removal home** of _____ during the **eligibility month** of _____.

Attention. If you need free help interpreting this document, ask your worker or call the number below for your language.

ያስተውሉ፡ ይህንን ዶኩመንት ለመተርጎም እርዳታ የሚፈልጉ ከሆነ፡ የጉዳዮን ሰራተኛ ይጠይቁ ወይም በሰልክ ቁጥር 1-844-217-3547 ይደውሉ።

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

သတိ။ ဤစာရွက်စာတမ်းအားအခမဲ့ဘာသာပြန်ပေးခြင်း အကူအညီလိုအပ်ပါက၊ သင့်လူမှုရေးအလုပ်သမား အားမေးမြန်း ခြင်းသို့ မဟုတ် 1-844-217-3563 ကိုခေါ်ဆိုပါ။

កំណត់សំគាល់ ។ ប្រើអ្នកត្រូវការជំនួយក្នុងការបកប្រែឯកសារនេះដោយឥតគិតថ្លៃ សូមសួរអ្នកកាន់សំណុំរឿង របស់អ្នក ឬហៅទូរស័ព្ទមកលខេ 1-888-468-3787 ។

請注意，如果您需要免費協助傳譯這份文件，請告訴您的工作人員或撥打 1-844-217-3564。

Attention. Si vous avez besoin d’une aide gratuite pour interpréter le présent document, demandez à votre agent chargé du traitement de cas ou appelez le 1-844-217-3548.

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.

ဟ်သူဉ်ဟ်သးဘဉ်တက့ါ. ဖဲနမ့ါ်လိဉ်ဘဉ်တါ်မၤစၢၤကလီလၢတါ်ကကျိးထံဝဲဇဉ်လံာ် တီလံာ်မီတခါအံၤန့ဉ်,သံကွါ်ဘဉ်ပှၤဂ့ါ်ဝီအပှၤမၤစၢၤတါ်လၢနဂီါ်မ့တမ့ါ်ကိးဘဉ် 1-844-217-3549 တက့ါ.

알려드립니다. 이 문서에 대한 이해를 돕기 위해 무료로 제공되는 도움을 받으시려면 담당자에게 문의하시거나 1-844-217-3565으로 연락하십시오.

ໂປຣດຊາບ. ຖ້າຫາກ ທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປເອກະສານນີ້ຟຣີ, ຈົ່ງຖາມພະນັກງານກຳກັບການຊ່ວຍເຫຼືອ ຂອງທ່ານ 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 (8-16)

ADA Advisory

For accessible formats of this information, ask your county worker. For assistance with additional equal access to human services, contact your county's ADA coordinator. ADA4 (2-18)

Clear Form

DEPARTMENT OF HUMAN SERVICES

DHS-3478-ENG 4-19

CHILD SAFETY AND PERMANENCY

Title IV–E Foster Care Application

Office Use Only			
MAXIS APPL month/year	MAXIS CASE NUMBER	WORKER NAME	WORKER PHONE NUMBER

Information about the relative caretaker/removal home

PERSON 1

FIRST NAME	MI	LAST NAME

SOCIAL SECURITY NUMBER	DATE OF BIRTH	GENDER	MARITAL STATUS
		◯ Male ◯ Female	◯ Married ◯ Separated ◯ Divorced ◯ Single

REMOVAL HOME ADDRESS	APARTMENT NUMBER	CITY	STATE	ZIP CODE

MAILING ADDRESS (if different from address above)	APARTMENT NUMBER	CITY	STATE	ZIP CODE

HOME PHONE NUMBER	OTHER PHONE NUMBER	DO YOU NEED AN INTERPRETER?	WHAT IS YOUR PREFERRED SPOKEN LANGUAGE?
		◯ Yes ◯ No	

RACE (optional)	ETHNICITY	DO YOU PLAN TO MAKE MINNESOTA YOUR HOME?
☐ Asian ☐ American Indian/Alaska Native ☐ Black or African American ☐ White ☐ Pacific Islander/Native Hawaiian	Hispanic? ◯ Yes ◯ No	◯ Yes ◯ No

Do you have a guardian or conservator? ◯ No ◯ Yes – complete the following:

GUARDIAN/CONSERVATOR FIRST NAME	GUARDIAN/CONSERVATOR LAST NAME	PHONE NUMBER

Do you have a physical, mental or emotional health condition that limits the ability to work or care for your children?
◯ Yes ◯ No

If yes, have you been determined disabled by the Social Security Administration (SSA), Workers Compensation, the State Medical Review Team (SMRT) or a licensed medical professional?
◯ Yes ◯ No

List all of the people in your home

List in this order: Your spouse, other adult(s), children, all other people, anyone temporarily away from home, including child/ren being considered for Title IV–E Foster Care. Do not include yourself.

PERSON 2

FIRST NAME	MI	LAST NAME

SOCIAL SECURITY NUMBER	DATE OF BIRTH	GENDER	MARITAL STATUS
		◯ Male ◯ Female	◯ Married ◯ Separated ◯ Divorced ◯ Single

DOES PERSON NEED AN INTERPRETER?	WHAT IS PERSON'S PREFERRED SPOKEN LANGUAGE?
◯ Yes ◯ No	

RACE (optional)	ETHNICITY	DOES PERSON PLAN TO MAKE MINNESOTA HIS OR HER HOME?
☐ Asian ☐ American Indian/Alaska Native ☐ Black or African American ☐ White ☐ Pacific Islander/Native Hawaiian	Hispanic? ◯ Yes ◯ No	◯ Yes ◯ No

RELATIONSHIP TO THE FOSTER CARE CHILD

PERSON 3

FIRST NAME	MI	LAST NAME

SOCIAL SECURITY NUMBER	DATE OF BIRTH	GENDER	MARITAL STATUS
		◯ Male ◯ Female	◯ Married ◯ Separated ◯ Divorced ◯ Single

DOES PERSON NEED AN INTERPRETER?	WHAT IS PERSON'S PREFERRED SPOKEN LANGUAGE?
◯ Yes ◯ No	

RACE (optional)	ETHNICITY	DOES PERSON PLAN TO MAKE MINNESOTA HIS OR HER HOME?
☐ Asian ☐ American Indian/Alaska Native ☐ Black or African American ☐ White ☐ Pacific Islander/Native Hawaiian	Hispanic? ◯ Yes ◯ No	◯ Yes ◯ No

RELATIONSHIP TO THE FOSTER CARE CHILD

PERSON 4

FIRST NAME	MI	LAST NAME

SOCIAL SECURITY NUMBER	DATE OF BIRTH	GENDER	MARITAL STATUS
		◯ Male ◯ Female	◯ Married ◯ Separated ◯ Divorced ◯ Single

DOES PERSON NEED AN INTERPRETER?	WHAT IS PERSON'S PREFERRED SPOKEN LANGUAGE?
◯ Yes ◯ No	

RACE (optional)	ETHNICITY	DOES PERSON PLAN TO MAKE MINNESOTA HIS OR HER HOME?
☐ Asian ☐ American Indian/Alaska Native ☐ Black or African American ☐ White ☐ Pacific Islander/Native Hawaiian	Hispanic? ◯ Yes ◯ No	◯ Yes ◯ No

RELATIONSHIP TO THE FOSTER CARE CHILD

PERSON 5

FIRST NAME	MI	LAST NAME

SOCIAL SECURITY NUMBER	DATE OF BIRTH	GENDER	MARITAL STATUS
		◯ Male ◯ Female	◯ Married ◯ Separated ◯ Divorced ◯ Single

DOES PERSON NEED AN INTERPRETER?	WHAT IS PERSON'S PREFERRED SPOKEN LANGUAGE?
◯ Yes ◯ No	

RACE (optional)	ETHNICITY	DOES PERSON PLAN TO MAKE MINNESOTA HIS OR HER HOME?
☐ Asian ☐ American Indian/Alaska Native ☐ Black or African American ☐ White ☐ Pacific Islander/Native Hawaiian	Hispanic? ◯ Yes ◯ No	◯ Yes ◯ No

RELATIONSHIP TO THE FOSTER CARE CHILD

1. Is anyone in the home a student?

◯ Yes ◯ No

If yes, who? _____

2. Does anyone have a physical, mental or emotional health condition?

◯ Yes ◯ No

If yes, have they been determined disabled by the Social Security Administration (SSA), Workers Compensation, the State Medical Review Team (SMRT) or a licensed medical professional?

◯ Yes ◯ No If yes, who? _____

3. Is anyone living away from home for a short time? (Examples, away for school or work, foster care)

◯ Yes - complete the following: ◯ No

FIRST NAME	MI	LAST NAME	DATE LEFT	DATE EXPECTED TO RETURN

REASON FOR NOT LIVING AT HOME

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

◯ Yes ◯ No - fill in below

NAME

IMMIGRATION STATUS

a. IMMIGRATION DOCUMENT TYPE	b. ALIEN ID NUMBER	c. CARD NUMBER

5. Is anyone self-employed or does anyone expect to receive income from self-employment in the eligibility month?

◯ Yes ◯ No

Name	Type of work	Monthly income	Monthly expenses	Start date (MM/DD/YYYY)
		$	$	
		$	$	

You must provide proof of this income. Proof may include the most recent tax returns and all related schedules, or business records.

6. Is anyone working, or does anyone expect to receive income from work in the eligibility month?

◯ Yes - fill in below: ◯ No

EMPLOYEE NAME

EMPLOYER NAME

Is this job seasonal?
◯ Yes ◯ No

Has this job ended?
◯ Yes ◯ No

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 include paystubs or a written statement of earnings from your employer if you do not have paystubs.

7. In the last 60 days did anyone in the household stop working, quit a job, refuse a job offer, ask to work fewer hours or go on strike?

◯ Yes ◯ No If yes, who? _____

8. Did anyone get money during the eligibility month from sources other than work?

(Include: Social Security, Supplemental Security Income (SSI), child or spousal support, unemployment, worker's compensation, veteran's benefits, dividends, interest, retirement or pension payments, public assistance payments (Minnesota Family Investment Program, Adoption Assistance, Northstar Adoption Assistance or Northstar Kinship Assistance, Relative Custody Assistance), rental income, trusts, payments from a contract for deed, annuities, tribal per capita payments, any other payments.)

◯ Yes - fill in below: ◯ No

NAME

Type of income	Amount	How often received?	Has this income ended?	If yes, end date
	$		◯ Yes ◯ No	
	$		◯ Yes ◯ No	
	$		◯ Yes ◯ No	
	$		◯ Yes ◯ No	

NAME

Type of income	Amount	How often received?	Has this income ended?	If yes, end date
	$		◯ Yes ◯ No	
	$		◯ Yes ◯ No	
	$		◯ Yes ◯ No	
	$		◯ Yes ◯ No	

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

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

9. Does anyone in the removal home have cash on hand, in a safety deposit box, or at home?

◯ Yes - fill in below: ◯ No

WHO	AMOUNT

10. Does anyone in the removal home have savings or checking accounts, money market accounts or certificates of deposit in the eligibility month?

◯ Yes - fill in below: ◯ No

Owner Name	Type of Account	Bank Name	Bank Address	Account number

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

11. Does anyone in the removal home have stocks, bonds, or retirement accounts in the eligibility month?

◯ Yes - fill in below: ◯ No

Owner Name(s)	Type of Investment	Company or Bank Name	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.

12. Does anyone in the removal home 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 in the eligibility month?

◯ Yes - fill in below ◯ No

Owner Name(s)	Type of Property	Property Address	Do you or your spouse live here all year?
			◯ Yes ◯ No
			◯ Yes ◯ No
			◯ Yes ◯ No
			◯ Yes ◯ No

You must provide proof of these assets. 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.

13. Does anyone in the removal home own or co-own promissory notes, contracts for deed, other property agreements, or interest in a trust or annuity in the eligibility month?

◯ Yes - fill in below: ◯ No

Owner Name(s)	Type of Asset

You must provide proof of these assets. Proof may be copies of the contract for deed, mortgage, loan contract, or promissory note, the annuity contract, other documents showing the value of the annuity or copies of the entire trust document.

14. Does anyone in the removal home have any vehicles in their name in the eligibility month?

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

◯ Yes - fill in below: ◯ No

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

You must provide proof of these assets. Proof may be copies of your vehicle title.

15. Does anyone in the removal home have life insurance in the eligibility month?

◯ Yes - fill in below: ◯ No

Owner Name(s)	Policy Number	Insurance Company Name	Insurance Company Address

You must provide proof of the current cash surrender value of all policies.

16. Does anyone in the removal home have a prepaid burial account or burial trust in the eligibility month?

Include 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 below: ◯ No

Owner Name(s)	Type of burial asset	Company or bank name	Company or bank address

You must provide proof of these assets. Proof may be copies of the life insurance policy, burial contracts or other documents showing the current value of the assets.

17. Does anyone in the removal home have assets currently used for self-employment or in a business in which they have an interest in the eligibility month?

◯ Yes - fill in below: ◯ No

Owner Name(s)	Type of asset

You must provide proof of these assets. Proof may be current tax documents, business ledgers, or account statements.

18. Complete this section when both parents (biological/adoptive) of any mutual child in the removal home are present in this eligibility month. Do not complete this section if either parent has been certified disabled by the Social Security Administration, Workers Compensation, or other medical certification.

1. Is at least one parent working? ◯ Yes ◯ No 2. Is at least one parent working part time? ◯ Yes ◯ No

Parent #1

NAME	AMOUNT EARNED IN THE LAST 24 MONTHS PRIOR TO THE ELIGIBILITY MONTH

Total hours worked:

Two months prior to eligibility month	Last month prior to eligibility month	Eligibility Month	Month following eligibility month

Have you lost or refused employment in the 30 days prior to the eligibility month?

◯ No ◯ Yes – Date you lost or refused job: _____ Reason: _____

Did you receive or could you have received Unemployment Insurance (UI) in the 12 months prior to the eligibility month?

◯ No ◯ Yes

Work history for the past 5 years prior to eligibility month:

Employer Name	Address	Start Date	End Date	Total $

Parent #2

NAME	AMOUNT EARNED IN THE LAST 24 MONTHS PRIOR TO THE ELIGIBILITY MONTH

Total hours worked:

Two months prior to eligibility month	Last month prior to eligibility month	Eligibility Month	Month following eligibility month

Have you lost or refused employment in the 30 days prior to the eligibility month?

◯ No ◯ Yes – Date you lost or refused job: _____ Reason: _____

Did you receive or could you have received Unemployment Insurance (UI) in the 12 months prior to the eligibility month?

◯ No ◯ Yes

Work history for the past 5 years prior to eligibility month:

Employer Name	Address	Start Date	End Date	Total $

For agency use:

YEAR	JAN-FEB-MARCH	APRIL-MAY-JUNE	JULY-AUG-SEPT	OCT-NOV-DEC

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

◯ N/A ◯ Yes ◯ No - fill in below:

Child's name	Name of parent NOT living with child	Is parent listed on birth certificate?	Is there a signed Recognition of Parentage or court order for paternity?
		◯ Yes ◯ No	◯ Yes ◯ No
		◯ Yes ◯ No	◯ Yes ◯ No
		◯ Yes ◯ No	◯ Yes ◯ No
		◯ Yes ◯ No	◯ Yes ◯ No

20. Is anyone paying for daycare for a child while they work?

Include payments made by other programs

◯ No ◯ Yes - fill in below:

PERSON/AGENCY PAYING	NAME OF PROVIDER

NAMES OF CHILDREN IN CARE	TOTAL AMOUNT PAID

21. Is anyone in the home court ordered to pay child support?

◯ No ◯ Yes - fill in below:

PERSON/AGENCY PAYING	AMOUNT PAID IN ELIGIBILITY MONTH	CURRENTLY PAYING?
		◯ Yes ◯ No

You can choose an authorized representative

You can give a trusted person permission to talk about this application with us, see your information and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an "authorized representative." If you ever need to change your authorized representative, contact your county or tribal agency.

A legally appointed representative for someone on this application must submit proof with the application.

1. NAME OF AUTHORIZED REPRESENTATIVE (First name, Middle Name, Last Name)		RELATIONSHIP TO YOU, IF ANY	
2. ADDRESS		3. APARTMENT OR SUITE NUMBER	
4. CITY		5. STATE	6. ZIP CODE
7. PHONE NUMBER	8. ORGANIZATION NAME	9. ID NUMBER (if applicable)	

By signing, you allow this person to sign your application, get official information about this application and act for you on all future matters with this agency.

10. YOUR SIGNATURE	11. DATE (MM/DD/YYYY)

Authorized Representative Signature

By signing, I agree to be an authorized representative for this household. I understand my responsibilities including keeping information about the people applying on this application private.

☐ I would like to get information by email at: _____

AUTHORIZED REPRESENTATIVE SIGNATURE	DATE (MM/DD/YYYY)

I understand that when my child is placed in Title IV–E Foster Care, my rights to child support are assigned to the State of Minnesota.

SIGNATURE OF APPLICANT/AUTHORIZED REPRESENTATIVE	DATE

PERSON 6

FIRST NAME	MI	LAST NAME

SOCIAL SECURITY NUMBER	DATE OF BIRTH	GENDER	MARITAL STATUS
		◯ Male ◯ Female	◯ Married ◯ Separated ◯ Divorced ◯ Single

DOES PERSON NEED AN INTERPRETER?	WHAT IS PERSON'S PREFERRED SPOKEN LANGUAGE?
◯ Yes ◯ No	

RACE (optional)	ETHNICITY	DOES PERSON PLAN TO MAKE MINNESOTA HIS OR HER HOME?
☐ Asian ☐ American Indian/Alaska Native ☐ Black or African American ☐ White ☐ Pacific Islander/Native Hawaiian	Hispanic? ◯ Yes ◯ No	◯ Yes ◯ No

RELATIONSHIP TO THE FOSTER CARE CHILD

PERSON 7

FIRST NAME	MI	LAST NAME

SOCIAL SECURITY NUMBER	DATE OF BIRTH	GENDER	MARITAL STATUS
		◯ Male ◯ Female	◯ Married ◯ Separated ◯ Divorced ◯ Single

DOES PERSON NEED AN INTERPRETER?	WHAT IS PERSON'S PREFERRED SPOKEN LANGUAGE?
◯ Yes ◯ No	

RACE (optional)	ETHNICITY	DOES PERSON PLAN TO MAKE MINNESOTA HIS OR HER HOME?
☐ Asian ☐ American Indian/Alaska Native ☐ Black or African American ☐ White ☐ Pacific Islander/Native Hawaiian	Hispanic? ◯ Yes ◯ No	◯ Yes ◯ No

RELATIONSHIP TO THE FOSTER CARE CHILD

PERSON 8

FIRST NAME	MI	LAST NAME

SOCIAL SECURITY NUMBER	DATE OF BIRTH	GENDER	MARITAL STATUS
		◯ Male ◯ Female	◯ Married ◯ Separated ◯ Divorced ◯ Single

DOES PERSON NEED AN INTERPRETER?	WHAT IS PERSON'S PREFERRED SPOKEN LANGUAGE?
◯ Yes ◯ No	

RACE (optional)	ETHNICITY	DOES PERSON PLAN TO MAKE MINNESOTA HIS OR HER HOME?
☐ Asian ☐ American Indian/Alaska Native ☐ Black or African American ☐ White ☐ Pacific Islander/Native Hawaiian	Hispanic? ◯ Yes ◯ No	◯ Yes ◯ No

RELATIONSHIP TO THE FOSTER CARE CHILD

PERSON 9

FIRST NAME	MI	LAST NAME

SOCIAL SECURITY NUMBER	DATE OF BIRTH	GENDER	MARITAL STATUS
		◯ Male ◯ Female	◯ Married ◯ Separated ◯ Divorced ◯ Single

DOES PERSON NEED AN INTERPRETER?	WHAT IS PERSON'S PREFERRED SPOKEN LANGUAGE?
◯ Yes ◯ No	

RACE (optional)	ETHNICITY	DOES PERSON PLAN TO MAKE MINNESOTA HIS OR HER HOME?
☐ Asian ☐ American Indian/Alaska Native ☐ Black or African American ☐ White ☐ Pacific Islander/Native Hawaiian	Hispanic? ◯ Yes ◯ No	◯ Yes ◯ No

RELATIONSHIP TO THE FOSTER CARE CHILD

PERSON 10

FIRST NAME	MI	LAST NAME

SOCIAL SECURITY NUMBER	DATE OF BIRTH	GENDER	MARITAL STATUS
		◯ Male ◯ Female	◯ Married ◯ Separated ◯ Divorced ◯ Single

DOES PERSON NEED AN INTERPRETER?	WHAT IS PERSON'S PREFERRED SPOKEN LANGUAGE?
◯ Yes ◯ No	

RACE (optional)	ETHNICITY	DOES PERSON PLAN TO MAKE MINNESOTA HIS OR HER HOME?
☐ Asian ☐ American Indian/Alaska Native ☐ Black or African American ☐ White ☐ Pacific Islander/Native Hawaiian	Hispanic? ◯ Yes ◯ No	◯ Yes ◯ No

RELATIONSHIP TO THE FOSTER CARE CHILD

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
- political beliefs

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.

Contact **DHS** directly only if you have 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

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)
1-800-657-3704 (toll free)
711 or 1-800-627-3529 (MN Relay)
651-296-9042 (fax)
Info.MDHR@state.mn.us (email)

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
- religion

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
1-800-368-1019 (voice)
1-800-537-7697 (TDD)
Complaint Portal:
https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

In accordance with Federal civil rights law and **U.S. Department of Agriculture (USDA)** civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at 1-800-877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call 1-866- 632-9992. Submit your completed form or letter to USDA by:

(1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, DC 20250-9410;
(2) fax: 202-690-7442; or
(3) email: program.intake@usda.gov

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