

Supplement to MNsure Application for Health Coverage and Help Paying Costs (DHS-6696)

Why am I getting this form?

You recently received a notice from the Minnesota Department of Human Services (DHS) about a MNsure application or current Medical Assistance (MA) coverage for you or for someone else if you are acting on that person's behalf.

Throughout this form, "you" means the person requesting coverage.

You may be eligible for an MA program or a Medicare Savings Program (MSP) that we have not considered yet. We can determine eligibility for these programs even if you are not eligible for MA or MinnesotaCare or a qualified health plan. We are asking you some more questions to see what other help is available to meet your health care needs.

What is this form for?

This form is to help us gather more information to determine what health care coverage might be available to you.

This form is for people who are one or more of the following:

- 65 years of age or older
- Requesting help with Medicare costs
- Receiving Supplemental Security income (SSI)
- Applying for Medical Assistance for Employed Person with Disabilities (MA-EPD)
- Living in, or may need to move to, a nursing home
- A person with a disability or age 65 or older who would like services to stay at home. You may also need a long-term care consultation
- A child with disabilities whose family income is too high to qualify for Medical Assistance

What do I need to do with this form?

1. Complete the sections on this form that apply to you. Follow the instructions on this form carefully so that we can accurately determine eligibility for health care coverage.
2. Read the Notice of Privacy Practices and Rights and Responsibilities on Attachment A at the back of this form. Tear off these pages and keep them.
3. Answer all questions on the form that apply to you. If you need more space, write the number of the question and the answer on a separate piece of paper. Include it with the form.
4. Sign and date the form.
5. Attach proofs. Send copies of proofs. Do not send original documents.
6. Mail or take the form to your county or tribal agency. The addresses are listed on Attachment B at the back of this form.
7. Send in the form 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 or tribal agency. The phone numbers are listed on Attachment B at the back of this form. You can also call the Senior LinkAge Line® if you are 60 years old or older at 800-333-2433 or the Disability Hub MN™ if you are a person with a disability at 866-333-2466.

This form helps us determine whether you are eligible for any of the following health care programs.

Medical Assistance under the TEFRA option for children with disabilities

- Medical Assistance under the TEFRA option is named for the Tax Equity and Fiscal Responsibility Act that created the rules for the option.
- Parents' income is generally counted when determining a child's eligibility for Medical Assistance. When a child is eligible for Medical Assistance under the TEFRA option, only the child's income is counted. (There is no Medical Assistance asset limit for any child.)
- Your child must meet all of the following requirements to enroll in the TEFRA option:
 - Be ineligible for MA when parents' income is counted.
 - Be under age 19.
 - Live with at least one biological or adoptive parent.
 - Be certified disabled by the Social Security Administration (SSA) or the State Medical Review Team (SMRT).
 - Need a level of care to stay at home that is similar to the level of care provided in a hospital, nursing home or intermediate care facility for people with developmental disabilities (SMRT makes the level-of-care determination).
- Children may be eligible for MA under the TEFRA option even if they are covered by other health insurance.
- Parents may be required to contribute towards the cost of the child's care by paying a parental fee. Parental fees are calculated on a sliding scale based on the parents' income. This is a separate process from the eligibility determination.

Medical Assistance with a spenddown

- A spenddown is a cost-sharing approach that allows MA eligibility for people whose income is greater than the applicable limit.
- You can be eligible for MA by "spending down" your excess income to a certain level. The excess income is reduced by deducting certain health care expenses.
- Income limits (the amount of money you can have and still be eligible) may be lower than limits for a Medicare Savings Program.

Medicare Savings Programs

- Helps pay for Medicare costs such as Part A or Part B premiums.
- Payment of your Part B premiums can begin up to 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 the limits for Medical Assistance.
- No claim is placed against your estate for benefits paid.

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

- You must have a disability determination through the Social Security Administration or the State Medical Review Team.
- Must have earnings of \$65 or more per month and pay FICA taxes.
- You must pay a monthly premium unless you are an American Indian. MA-EPD premiums may be less than MinnesotaCare premiums or an MA spenddown.
- Contact the Disability Hub MN™ at 866-333-2466 for help deciding the best program to meet your health care needs.

For more information

- Call your county or tribal human services office. The phone numbers are listed in this application on Attachment B.
- Go to www.dhs.state.mn.us/healthcare.

Supplement to MNsure Application for Health Coverage and Help Paying Costs (DHS-6696)

SECTION A Complete Section A.

1. FIRST NAME, MIDDLE NAME, LAST NAME & SUFFIX		
2. PHONE NUMBER where we can call you	3. DATE OF BIRTH (mm/dd/yyyy)	4. SOCIAL SECURITY NUMBER (SSN)

SECTION B Complete Section B if you are over age 21.

<p>1. Do you or your spouse have cash on hand, in a safety deposit box, at home or at the facility where you live?</p> <p>Do not include business accounts.</p> <p><input type="radio"/> No <input type="radio"/> Yes – fill in the total amount of cash </p>			
TOTAL AMOUNT OF CASH			
<p>2. Do you or your spouse have savings or checking accounts, money market accounts or certificates of deposit?</p> <p><input type="radio"/> No <input type="radio"/> Yes – fill in the information  and attach proof </p>			
Owner's name	Type	Name of bank	Current balance
<p>3. Do you or your spouse own or co-own stocks, bonds, retirement accounts, life insurance, burial contracts, prepaid burial account or burial trust, annuities, trusts, contracts for deed or other assets?</p> <p>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.</p> <p><input type="radio"/> No <input type="radio"/> Yes – fill in the information  and attach proof </p>			
Owner's name	Type	Name of company, bank or funeral home	Current balance

4. Do you or your spouse have a vehicle?

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

No Yes – fill in the information 

Owner's name	Type of vehicle	Year/Make/Model	Estimated value	Amount owed

5. Do you or your spouse own or co-own a home, 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?

No Yes – fill in the information  and attach proof 

Owner's name	Address	Type of property	Estimated value

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

No Yes – fill in the information  and attach proof 

Owner's name	Address	Type of property	Estimated value

7. Do you or your spouse have assets currently used for self-employment or in a business?

No Yes – fill in the information  and attach proof 

Owner's name	Type of asset

8. Do you or your spouse own or co-own any other assets not listed?

No Yes – fill in the information  and attach proof 

Owner's name	Type of asset

SECTION C

Skip Section C if you are age 65 or older, have a disability or are blind.

1. Is anyone 16 or older a student?

No Yes

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

No Yes – fill in the information ↓

NAME OF PERSON PAYING	NAME OF DAY CARE PROVIDER
NAMES OF CHILDREN OR ADULTS IN DAY CARE	AMOUNT PAID PER MONTH

3. Is anyone in the home court-ordered to pay child or medical support?

No Yes – fill in the information ↓ and attach proof 📎

NAME OF PERSON PAYING	AMOUNT PER MONTH	CURRENTLY PAYING? <input type="radio"/> No <input type="radio"/> Yes
-----------------------	------------------	---

4. Is anyone self-employed or does anyone expect to be self-employed?

No Yes – fill in the information ↓ and attach proof 📎

Name	Business name	Start date	End date	Yearly income

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

SECTION D

Complete Section D if you are age 65 or older, have a disability or are blind.

1. Have you been determined disabled by the Social Security Administration (SSA) or the State Medical Review Team (SMRT)?

No Yes I don't know

2. If you are blind or have a disability, do you have work expenses?

No Yes – fill in the information ↓

TYPE OF EXPENSE	MONTHLY AMOUNT
-----------------	----------------

SECTION E

Skip section E unless you are in a nursing home or need services to stay in your home, regardless of age or disability status.

1. Do you currently live in a long-term care (LTC) facility?

No Yes

If yes, NAME OF FACILITY

2. Do you plan to return to your home?

No Yes

3. Are you employed under an individual plan for rehabilitation?

No Yes

4. Do you have a legal guardian or conservator?

No Yes – fill in the information ↓ and attach proof 📎

FEE PAID

NAME

PHONE NUMBER

STREET ADDRESS

CITY

STATE

ZIP CODE

5. Have you had a long-term care consultation (LTCC) visit?

An LTCC is a visit from a person who talked with you about your needs and how you could meet your needs either with a community support plan or in an LTC facility.

No Yes – fill in the information ↓ I don't know

DATE OF VISIT

CASE MANAGER OR ASSESSOR'S NAME

6. Do you have a spouse?

No Yes – fill in the information ↓

SPOUSE'S FIRST NAME

MI

LAST NAME

Does your spouse live in an LTC facility or get services from a home and community-based waiver program?

Waiver programs are the Elderly Waiver (EW), Community Alternatives for Disabled Individuals (CADI), Community Alternative Care (CAC), Brain Injury (BI) and Developmental Disabilities (DD).

No Yes – fill in the information ↓

Have you completed an asset assessment? No Yes I don't know

If yes, LIST THE STATE OR COUNTY WHERE THIS WAS DONE

You may be able to give part of your income to your spouse. Do you want us to see if you can? No Yes

If yes, LIST TYPE(S) OF INCOME YOUR SPOUSE GETS

Does your spouse pay housing costs? No Yes – send proof of your spouse's income and housing costs 📎

7. You may be able to give part of your income to:

- A child under 21 years old
- A child age 21 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

Do you want us to see if you can?

No Yes – fill in the information  and attach proof of each person's income 

Name	Relationship	Date of birth	Type(s) of income	Living with your spouse?
				<input type="radio"/> N/A <input type="radio"/> No <input type="radio"/> Yes
				<input type="radio"/> N/A <input type="radio"/> No <input type="radio"/> Yes

8. Do you have Long-Term Care Insurance?

No Yes – attach proof 

If yes, are you currently paying premiums? No Yes – attach proof

9. Have you received medical care or had medical expenses within the three months before the month you want MA payment of LTC services to begin?

No Yes – fill in the information  and attach proof 

Type of medical expense	Medical provider	Date of services	Did or will insurance or anyone else pay part or all of this expense?
			<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> I don't know
			<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> I don't know

If you have more medical expenses, write the same information on a separate piece of paper. Attach it to this form. Send copies of bills or receipts for each expense. Send proof of payments made by Medicare, other insurance or anyone else.

10. If you own a home, does your spouse, a child under the age of 21 or a child who is blind or disabled of any age live in the home?

No Yes – fill in the information  and send proof of how much money you owe on your home, if any 

OWNER(S) NAME	VALUE	AMOUNT OWED	FOR SALE? <input type="radio"/> No <input type="radio"/> Yes
STREET ADDRESS	CITY	STATE	ZIP CODE

11. Do you or your spouse have any interest in an annuity?

No Yes – fill in the information  and attach proof 

Owner(s) name	Interest type (owner, annuitant, beneficiary)

12. Did you or your spouse create a trust within the 60 months before the month you want MA payment of LTC services to begin?

No Yes – fill in the information  and attach proof 

NAME(S) OF WHO CREATED THE TRUST	DATE CREATED

13. Did you or your spouse buy an annuity, life estate in another person's home, a promissory note, loan or mortgage within the 60 months before the month you want MA payment of LTC services to begin?

No Yes – fill in the information  and attach proof 

WHAT WAS BOUGHT?

DATE BOUGHT

14. Did you or your spouse not accept items or income you could have taken, such as an inheritance or a pension, within the 60 months before the month you want MA payment of LTC services to begin?

No Yes – fill in the information 

ITEMS YOU DID NOT TAKE

VALUE

DATE HAPPENED

15. Did you or your spouse sell, trade or give away items or income within the 60 months before the month you want MA payment of LTC services to begin?

No Yes – fill in the information  and attach proof 

Owner(s) name	Items or income	Value	Who was it given, traded or sold to?	Date	Amount you were paid

If you have more items to report, write the same information on a separate piece of paper. Attach it to this form. Send proof to show what was sold, traded or given away.

15. Write anything else you think we should know.

Signature Page

(Effective Date: November 2019)

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.

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. The addresses and fax numbers are listed in Attachment C. 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.

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

Keep this page for your records.

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.

Keep this page for your records.

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.

Keep this page for your records.

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/lfservlet/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.

Keep this page for your records.

Keep this page for your records.

Agency Addresses

(Effective Date: October 2019)

Aitkin County

204 First Street NW
Aitkin, MN 56431-1291
218-927-7200 / 800-328-3744
Fax: 218-927-7210

Anoka County

Blaine Human Service Center
1201 89th Ave NE
Blaine, MN 55434
763-422-7200
Fax: 763-324-3620

Becker County

712 Minnesota Avenue
Detroit Lakes, MN 56501
218-847-5628
Fax: 218-847-6738

Beltrami County

616 America Ave NW
Bemidji, MN 56601
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
P.O. Box 338
Ortonville, MN 56278-0338
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, Suite 200
Cloquet, MN 55720-0660
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 502
Moorhead, MN 56560-2095
218-299-5200 / 800-757-3880
Fax: 218-299-7106

Clearwater County

216 Park Avenue NW
Bagley, MN 56621-9500
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

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

Crow Wing County

204 Laurel Street
Brainerd, MN 56401-0686
218-824-1250 / 888-772-8212
Fax: 218-824-1305

Dakota County

1 Mendota Road West, #100
West St. Paul, MN 55118-4765
651-554-5611
Fax: 651-554-5748

Dodge County

MnPrairie
22 Sixth Street East, Dept. 401
Mantorville, MN 55955
507-923-2900 / 888-850-9419
Fax: 507-635-6186

Douglas County

809 Elm Street, Suite 1186
Alexandria, MN 56308
320-762-2302
Fax: 320-762-3833

Faribault County

FMCHS
412 Nicollet Street North
Blue Earth, MN 56013
507-526-3265
Fax: 507-526-2039

Fillmore County

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

Freeborn County

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

Goodhue County

426 West Avenue
Red Wing, MN 55066
651-385-3200
Fax: 651-267-4879

Grant County

15 Central Avenue N, PO Box 1006
Elbow Lake, MN 56531-1006
218-685-8200 / 800-291-2827
Fax: 218-685-4978

Hennepin County

PO Box 107
Minneapolis, MN 55440-0107
612-596-1300
Fax: 612-288-2981
Call if you need office hours and
office location information.

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
218-732-1451 / 877-450-1451
Fax: 218-732-3231

Isanti County

1700 E Rum River Dr S, Suite A
Cambridge, MN 55008-2547
763-689-1711
Fax: 763-689-9877

Itasca County

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

Jackson County

DVHHS
407 5th Street, PO Box 67
Jackson, MN 56143-0067
507-847-4000
Fax: 507-847-5616

Kanabec County

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

Kandiyohi County

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

Kittson County

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

Koochiching County

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

Lac Qui Parle County

930 First Avenue
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
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

SWMHHS
319 N Rebecca Street
Ivanhoe, MN 56142
507-694-1452 / 800-657-3781
Fax: 507-694-1859

Lyon County

SWMHHS
607 West Main Street, Suite 100
Marshall, MN 56258
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

FMCHS
115 West First Street
Fairmont, MN 56031
507-238-4757
Fax: 507-238-1574

Meeker County

114 North Holcombe Ave, #180
Litchfield, MN 55355-2273
320-693-5300 / 877-915-5300
Fax: 320-693-5344

Mille Lacs County

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

MinnesotaCare 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, Suite 18
Austin, MN 55912-3405
507-437-9700
Fax: 507-437-9721

Murray County

SWMHHS
3001 Maple Road, Suite 100
Slayton, MN 56172
507-836-6144 / 800-657-3811
Fax: 507-836-8841

Nicollet County

622 South Front Street
St. Peter, MN 56082-2106
507-934-8559
Fax: 507-934-8552

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 200
Rochester, MN 55904
507-328-6500
Fax: 507-328-7956

Otter Tail County

535 Fir Avenue W
Fergus Falls, MN 56537
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

315 Main Street S, Suite 200
Pine City, MN 55063
320-591-1570
Fax: 320-591-1601

Or

1610 Highway 23 N
Sandstone, MN 55072-5009
Fax: 320-591-1601

Pipestone County

SWMHHS
1091 North Hiawatha Avenue
Pipestone, MN 56164
507-825-6720 / 888-632-4325
Fax: 507-825-5649

Polk County

612 N Broadway, Room 302
Crookston, MN 56716
218-281-3127 / 877-281-3127
Fax: 218-281-3926

Or

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

Or

250 SW Cleveland Avenue
PO Box 100
McIntosh, MN 56556
21-435-1585 / 877-281-3127
Fax: 218-435-1552

Pope County

211 East MN Avenue, Suite 200
Glenwood, MN 56334-1629
320-634-7755
Fax: 320-634-0164

Ramsey County

160 East Kellogg Boulevard
St. Paul, MN 55101-1494
651-266-4444
Fax: 651-266-3942

Red Lake County

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

Redwood County

SWMHHS
266 E Bridge 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
320-523-2202
Fax: 320-523-3565

Rice County

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

Rock County

SWMHHS
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
Duluth, MN 55802-1495
218-726-2101 / 800-450-9777
Fax: 218-726-2163

Or

307 S 1st Street – PO Box 1148
Virginia, MN 55792-1148
218-471-7137
Fax: 218-471-7123

Or

320 Miners Drive E
Ely, MN 55731-1402
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

752 Canterbury Rd S
Shakopee, MN 55379
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

PO Box 237
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
507-431-5600
Fax: 507-635-6186

Stevens County

400 Colorado Avenue, Suite 104
Morris, MN 56267-1235
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

411 Hiawatha Drive E
Wabasha, MN 55981-1573
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
507-837-6600
Fax: 507-635-6186

Washington County

14949 62nd Street North
PO Box 30
Stillwater, MN 55082-0030
651-430-6455
Fax: 651-430-6605

Watonwan County

715 Second Avenue S
St. James, MN 56081-1741
507-375-3294 / 888-299-5941
Fax: 507-375-7359

Wilkin County

227 6th Street North
PO Box 369
Breckenridge, MN 56520-0369
218-643-7161
Fax: 218-643-7175

Winona County

202 West Third Street
Winona, MN 55987-3146
507-457-6200
Fax: 507-454-9381

Wright County

1004 Commercial Drive
Buffalo, MN 55313-1736
763-682-7414 / 800-362-3667
Fax: 763-682-7701

Yellow Medicine County

415 9th Avenue, Suite 202
Granite Falls, MN 56241
320-564-2211
Fax: 320-564-4165

White Earth Financial Services

PO Box 100
Nay-tah-waush, MN 56566
218-935-5554

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

Keep this page for your records.