HIV Care Services

Part B

Minnesota Department of **Human Services**

Program HH

What is this application for?

Use this application to apply for Program HH services.

What do I need to do with this form?

1. Read the Notice of Privacy Practices and Rights and Responsibilities on pages B through D at the back of this form. Tear them off and keep them.
2. Answer all questions on the application. If you need more space, write the number of the question and the answer on a separate piece of paper. Include it with the application.
3. Sign and date the application.
4. Attach proofs. Instructions for proofs are listed on page A at the back of this form.
5. Mail the completed application in the enclosed self-addressed stamped envelope. If no envelope, return to P.O. Box 64972, St. Paul, MN 55164-0972

We will contact you if we need additional information.

Questions?

You can call Program HH Customer Care at 651-431-2398. If you have questions or need help, call your HIV case manager or an HIV benefits counselor.

651-431-2414 or 800-657-3761

Attention. If you need free help interpreting this document, call the above number.

لحظة: إذا أردت مساعدة مجانية لترجمة هذه الوثيقة، اتصل على الرقم أعلاه.

កំណត់សំគាល់ ។ បើអ្នកត្រូវការជំនួយក្នុងការបកប្រែឯកសារនេះដោយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទតាមលេខខាងលើ ។

Pažnja. Ako vam treba besplatna pomoć za tumačenje ovog dokumenta, nazovite gore naveden broj.

Thov ua twb zoo nyeem. Yog hais tias koj xav tau kev pab txhais lus rau tsab ntaub ntawv no pub dawb, ces hu rau tus najnpawb xov tooj saum toj no.

ໂປຣດຊາບ. ຖ້າຫາກ ທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປເອກະສານນີ້ຟຣີ, ຈົ່ງໂທຣໄປທີ່ໝາຍເລກຂ້າງເທິງນີ້.

Hubachiisa. Dokumentiin kun bilisa akka siif hiikamu gargaarsa hoo feete, lakkoobsa gubbatti kenname bibi

Внимание: если вам нужна бесплатная помощь в устном переводе данного документа, позвоните по указанному выше телефону.

Digniin. Haddii aad u baahantahay caawimaad lacag-la'aan ah ee tarjumaadda qoraalkan, lambarka kore wa

Atención. Si desea recibir asistencia gratuita para interpretar este documento, llame al número indicado arriba.

Chú ý. Nếu quý vị cần được giúp đỡ dịch tài liệu này miễn phí, xin gọi số bên trên.

ADA1 (12-12)

This information is available in accessible formats for individuals with disabilities by calling 651-431-2414, toll-free 800-657-3761, or by using your preferred relay service. For other information on disability rights and protections, contact the agency's ADA coordinator.

CR (11-13)

Discrimination is against the law. You have the right to file a complaint if you believe you were discriminated against because of race, color, national origin, religion, creed, sex, sexual orientation, public assistance status, age or disability. To file a complaint, contact:

Minnesota Department of Human Services, Equal Opportunity and Access Division, P.O. Box 64997, St. Paul, MN 55164-0997; Telephone 651-431-3040 or use your preferred relay service.

Minnesota Department of Human Rights, Freeman Building, 625 North Robert St., St. Paul, MN 55155. Telephone 651-539-1100 and toll-free 800-657-3704. TTY 651-296-1283.

The **U.S. Department of Health and Human Services' Office for Civil Rights** prohibits discrimination in its programs because of race, color, national origin, disability, age, religion or sex. Contact the federal agency directly at U.S. Department of Health and Human Services Office for Civil Rights, Region V, 233 N. Michigan Ave., Suite 240, Chicago, IL 60601. Telephone 312-886-2359 and toll-free 800-368-1019. TTY 800-537-7697.

Clear Form

Minnesota Department of **Human Services**

DHS-3539-ENG 7-15

HIV/AIDS Programs (Program HH) Application

DATE RECEIVED	PMI NUMBER

- **Answer all questions the best you can**
- **Do not leave fields blank, instead use "NA" when not applicable**
- **Return the form right away**
- **We will contact you if we need additional information.**

1. What is your name and address? (please print clearly)

FIRST NAME	MI	LAST NAME	DATE OF BIRTH	MARITAL STATUS

SOCIAL SECURITY NUMBER*	EMAIL ADDRESS

GENDER

☐ Male ☐ Female ☐ Transgender: Female to Male ☐ Transgender: Male to Female ☐ Transgender unknown ☐ Gender unknown

STREET ADDRESS	CITY	STATE	ZIP CODE	COUNTY

MAILING ADDRESS (if different)	CITY	STATE	ZIP CODE	COUNTY

PRIMARY PHONE NUMBER	TYPE	Can we contact you here?	Can we leave a message?
( )-	☐ Home ☐ Work ☐ Cell ☐ Other_____	◯ No ◯ Yes	◯ No ◯ Yes
SECONDARY PHONE NUMBER	TYPE	Can we contact you here?	Can we leave a message?
( )	☐ Home ☐ Work ☐ Cell ☐ Other_____	◯ No ◯ Yes	◯ No ◯ Yes

What language do you speak most of the time? _____ Do you need an interpreter? ◯ No ◯ Yes

RACE AND ETHNICITY (check all that apply)

☐ Black ☐ White ☐ American Indian or Alaska native

☐ Asian — ☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other

☐ Pacific — ☐ Native Hawaiian ☐ Guamanian Chamorro ☐ Samoan ☐ Other

Hispanic or Latino?

◯ No ◯ Yes, if so:

☐ Mexican ☐ Puerto Rican ☐ Cuban ☐ Other

What is your country of birth? ☐ United States ☐ Unknown ☐ Other, specify: _____

Date moved to Minnesota: (can be estimated) mm/dd/yyyy _____ ☐ Born in Minnesota

What is your current housing status? ☐ Stable/permanent ☐ Temporary ☐ Unstable

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

Remember to: ☐ Sign and date this application ☐ Attach your proofs (See page A for required proofs)

Return the completed form to: Minnesota Dept of Human Services, P.O. Box 64972, St. Paul, MN 55164-0972 or FAX to 651-431-7414

See Required Proofs on Page A

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

2. Who else lives with you?

List legal spouse, parents/guardians of children under 21, stepparents, children and stepchildren who live in your home.

Name (First, MI, Last)	Social Security number*	Relationship to you	Sex	Marital status	Date of birth	OPTIONAL INFORMATION: Race (use codes below**)	OPTIONAL INFORMATION: Hispanic or Latino?
			☐ M ☐ F				◯ No ◯ Yes
			☐ M ☐ F				◯ No ◯ Yes
			☐ M ☐ F				◯ No ◯ Yes
			☐ M ☐ F				◯ No ◯ Yes

**Race codes: (choose all that apply) A - Asian B - Black/African American N - American Indian/Native Alaskan P - Pacific Islander or Native Hawaiian W - White

3. What is your citizenship status?

Program HH asks for information regarding citizenship to best determine which health care program you qualify for. Information collected in the Program HH application will not be shared with any other program or agency for the purpose of determining citizenship. **Fill in below:**

☐ Citizen ☐ Visa ☐ Green card ☐ Undocumented ☐ Other, specify: _____

4. Do you have a case manager or social worker?

Do you have a case manager? ◯ No ◯ Yes — if yes, complete to right	CASE MANAGER'S NAME	PHONE NUMBER ( )
Do you have a benefit counselor? ◯ No ◯ Yes — if yes, complete to right	BENEFIT COUNSELOR'S NAME	PHONE NUMBER ( )
Do you have a social worker? ◯ No ◯ Yes — if yes, complete to right	SOCIAL WORKER'S NAME	PHONE NUMBER ( )

If you have one of the above, did he/she help you fill out this application? ◯ No ◯ Yes

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

◯ No ◯ Yes — if yes, fill in their information below

An authorized representative is someone authorized to act on your behalf as an applicant or enrollee in any of the health care programs. In most cases, authorized representatives have the same responsibilities and rights as applicants or enrollees. An authorized representative will receive forms, notices, and premium notices on your behalf. An authorized representative must be at least 18 years old and know your circumstances in order to provide necessary information. **This person must sign the application.**

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

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

See Required Proofs on Page A

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

6. Is there someone else (e.g., legal spouse, partner, family member) who you allow Program HH staff to talk to about your Program HH benefits and/or eligibility?

◯ No ◯ Yes — If yes, please list his/her information below:

FIRST NAME	MI	LAST NAME	THIS PERSON'S RELATIONSHIP TO YOU

STREET ADDRESS	CITY	STATE	ZIP CODE	COUNTY

7. Additional household information

Are you pregnant? ◯ No ◯ Yes ◯ Not applicable (N/A)	Are you under the age of 18 and no longer under the legal control of your parents? ◯ No ◯ Yes ◯ Not applicable (N/A)	Have you ever been in the United States military? ◯ No ◯ Yes

Do you want help paying for prescription medications from the past three months? ◯ No ◯ Yes	IF YES, LIST MONTHS
Do you currently have medical benefits from another state? ◯ No ◯ Yes	IF YES, WHAT STATE?
Have you received AIDS Drug Assistance Program (ADAP) benefits in another state? ◯ No ◯ Yes	IF YES, WHAT STATE?

8. Are you paying child support? (send proof)

◯ No ◯ Yes — If yes, **SEND PROOF USING INSTRUCTIONS ON PAGE A**. This can reduce your income to qualify.	MONTHLY AMOUNT $	NUMBER OF CHILDREN

9. Is anyone self-employed? (send proof)

◯ No ◯ Yes — If yes, please list his/her information below:

Name	Business name	Start date	Yearly income
			$
			$
			$
			$
			$

See Required Proofs on Page A

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

10. Did anyone work in the last six months or does anyone expect to work next month?

◯ No ◯ Yes — If yes, please list information below and send proofs:

Include temporary work. Include all seasonal work during the last year.

- If seasonally employed, enter original start date for the listed employer.
- Enter gross monthly income (before taxes and deductions):

Name of person who worked	Employer name	Start date	Monthly income (include tips)	How often paid?	If seasonal, how many months are worked?	Has this job ended?	
			$			◯ No ◯ Yes	IF YES, DATE ENDED
			$			◯ No ◯ Yes	IF YES, DATE ENDED
			$			◯ No ◯ Yes	IF YES, DATE ENDED
			$			◯ No ◯ Yes	IF YES, DATE ENDED

11. Did anyone receive income this month or does anyone expect to receive income next month from any of these sources below?

◯ No ◯ Yes — If yes, please list information below and send proofs:

Include:

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

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

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

See Required Proofs on Page A

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

13. Health insurance information

PUBLIC PLANS		
Does anyone have Medical Assistance (MA)?	◯ No ◯ Yes	IF YES, WHO?
Does anyone have Minnesota Care?	◯ No ◯ Yes	IF YES, WHO?
Does anyone have Medical Assistance for Employed Persons with Disabilities (MA-EPD)?	◯ No ◯ Yes	IF YES, WHO?
PRIVATE PLANS		
Does anyone have a qualified health plan through MNsure?	◯ No ◯ Yes	IF YES, WHO?
Does anyone have Medicare coverage?	◯ No ◯ Yes	IF YES, WHO?
IF YES TO MEDICARE ☐ Part A Start date _____ ☐ Part B Start date _____ ☐ Part D Start date _____		
Does anyone have or expect to get health insurance through employer? **IF YES, COMPLETE PAGE 11 and SIGN PAGE 12**	◯ No ◯ Yes	IF YES, WHO?
Did anyone turn down or drop insurance through an employer?	◯ No ◯ Yes	IF YES, WHO?

14. Please complete for all private insurance types listed above (if necessary)

1. COVERAGE TYPES – CHECK ALL THAT APPLY

☐ Medical ☐ Prescription drug ☐ Dental ☐ Vision ☐ Other – list type: _____

POLICYHOLDER'S NAME	INSURANCE COMPANY NAME	START DATE	END DATE

POLICY NUMBER	LIST EVERYONE COVERED BY THIS POLICY

2. COVERAGE TYPES – CHECK ALL THAT APPLY

☐ Medical ☐ Prescription drug ☐ Dental ☐ Vision ☐ Other – list type:

POLICYHOLDER'S NAME	INSURANCE COMPANY NAME	START DATE	END DATE

POLICY NUMBER	LIST EVERYONE COVERED BY THIS POLICY

3. COVERAGE TYPES – CHECK ALL THAT APPLY

☐ Medical ☐ Prescription drug ☐ Dental ☐ Vision ☐ Other – list type:

POLICYHOLDER'S NAME	INSURANCE COMPANY NAME	START DATE	END DATE

POLICY NUMBER	LIST EVERYONE COVERED BY THIS POLICY

See Required Proofs on Page A

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

15. Risk factors

The following information is used for programming information only.

The information below is necessary for us to process this application and:

- Is not shared with other service providers, insurance companies or employers
- Is used to improve programming and outreach efforts for Program HH
- Helps us ensure our services reach all populations of Minnesotans living with HIV.

Please check all possible risk categories which may have exposed you to the HIV virus:

☐ Male to male sex (1) ☐ Male to female sex (2) ☐ Injection drug use (3) ☐ Blood recipient (4) ☐ Hemophilia (5)

☐ Perinatal (mother to infant/fetus) (6) ☐ Other (7) ☐ Unknown (10) ☐ I prefer not to disclose (8)

☐ I have been diagnosed with Hepatitis C

In an effort to collect better information on HIV and methamphetamine utilization, the following question strictly is voluntary and will not be used in Program HH eligibility or for any other Minnesota Health Care Program. This information will only be used as an ongoing, aggregate count of the number of "Yes" answers.

In the past 12 months, I have used methamphetamine at least once. ◯ No ◯ Yes

THANK YOU

See Required Proofs on Page A

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

Health Care Provider Section

1. **Applicant please complete Box 1.**
2. **Have your doctor or clinician complete Box 2.**

Box 1

I authorize my physician to release the information on this form to the Department of Human Services HIV/AIDS Program. I give my physician/clinician permission to communicate with the Department of Human Services HIV/AIDS Program regarding my health status, residence, and Program HH status.

APPLICANT'S SIGNATURE	DATE: (MM/DD/YYYY)

PATIENT'S LAST NAME	FIRST NAME	MIDDLE NAME

DATE OF BIRTH: (MM/DD/YYYY)	8-DIGIT RECIPIENT ID/PMI NUMBER

PHYSICIAN'S NAME	PHYSICIAN'S PHONE
	( )

CLINIC NAME

To be completed by the physician or clinician and sent in by you
MUST BE SIGNED BY A PROVIDER

Box 2

Has patient been diagnosed with HIV? ◯ No ◯ Yes (If date is unknown, please enter date of first appointment at your clinic)	IF YES, DATE (MM/DD/YYYY)
Has patient been diagnosed with AIDS? ◯ No ◯ Yes	IF YES, DATE (MM/DD/YYYY)

Health status update		Employment ability update
MOST RECENT CD4 COUNT	DATE (MM/DD/YYYY)	Is this patient unable to work due to HIV-related disability? ◯ No ◯ Yes
MOST RECENT VIRAL LOAD COUNT	DATE (MM/DD/YYYY)	Patient currently working, but needs reduced hours for HIV-related health issues. ◯ No ◯ Yes
MOST RECENT HEALTH CARE VISIT	DATE (MM/DD/YYYY)	I recommend this patient be reviewed for disability eligibility. ◯ No ◯ Yes

CLINICIAN'S SIGNATURE	DATE

Please mail or fax to Program HH at:
Minnesota Dept of Human Services, P.O. Box 64972, St. Paul, MN 55164-0972
or FAX to 651-431-7414

See Required Proofs on Page A

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

Signature Page

(Effective Date: June 1, 2013)

Read the following information and sign.

Authorization to Share Information for Fraud Investigation and Audits

I agree that third parties may share information about me with persons investigating fraud and completing federal or state audits. This may include, but is not limited to:

- Employers
- Financial and insurance agencies, and
- Other government offices.

I understand this consent is good for six months after my benefits stop.

Authorization for Release (Sharing) of My Medical Information

I give my consent to the following agencies or individuals to share between them medical information about me only for the limited purposes indicated:

- Health providers including health plans, insurance agencies, Minnesota Health Care Programs, county advocates, my county or state case workers, their contractors and subcontractors, Ryan White-funded benefits counseling and case management programs:
  - To determine who should pay for my health care, and
  - To provide, manage, and coordinate health care services.
- All other agencies or persons as listed on the Notice of Privacy Practices.

This consent applies to medical information about my minor children I applied for on this application. I can stop this consent at any time by asking in writing for it to end. The written notice to stop this consent will not affect information the agency has already given to others. This consent is good while I am enrolled in Minnesota Health Care Programs, up to one year, or longer if the law permits. However, it does not end after one year for records given to consulting providers, records given for payment of my bills, fraud investigations, or quality of care review and studies. An agency or person who gets my information through this consent could give the information to others.

If I do not sign or I end this consent, I cannot enroll or stay enrolled in Minnesota Health Care Programs.

Medical Assignment of Benefits

I give my rights to all medical payments for me and anyone else I apply for to the State of Minnesota. This includes medical payments from all other persons or companies. For MA for Long-Term Care, this includes my right to support from my spouse under Minnesota Statutes, section 256B.14, subdivision 3. This begins as soon as health care coverage starts.

I agree to help the state to get paid back for medical expenses that should have been paid by others. I may not have to help the state if I have a good reason for not doing so and the state approves the reason.

If I have Medicare Part B, Medicare can pay my health providers for the care I get while I am on a Minnesota Health Care Program.

Over ➔

By signing below:

- I agree that I have reviewed and understand my options for choosing the health care program I want to apply for.
- I agree that I have read and understand the Notice of Privacy Practices and the list of my responsibilities in that Notice.
- I agree that I have read and understand the Rights and Responsibilities section
- I agree and understand that my information will be released to the parties listed in the Notice of Privacy Practices in order to verify eligibility for Minnesota Health Care Programs.
- I agree and understand that my information will be shared for fraud investigations and audits as stated in the Authorization to Share Information for Fraud Investigations and Audits section.
- I agree to assign my medical benefits as stated in the Medical Assignment of Benefits.
- I agree to the release of my Minnesota Health Care Programs health records to the parties listed in the Authorization for Release (Sharing) of My Medical Information section.
- I declare that, under penalty of perjury, all parts of this application and any updates to information on this application I give during the year are true and correct statements, to the best of my knowledge. I understand what happens to people convicted of perjury (not telling the truth). They may be sentenced to prison for up to five years, a fine up to $10,000, or both.

MNsure Insurance Premium Assistance Acknowledgement

- I understand that I must promptly report any changes in my household income to MNsure.
- I understand that I must promptly report any change in premium to Program HH.
- I understand that if I receive a tax refund associated with Advance Premium Tax Credits (APTC), I am responsible for repaying that portion of my refund to Program HH.
- I understand that if I receive a demand for APTC repayment from the IRS I will be personally responsible for the repayment. Program HH may be able to assist with repayment if I report the payment request in a timely manner.
- I understand that I must promptly provide copies of any documents/correspondence regarding my insurance and insurance premium to Program HH.
- I understand that I must accept the Advanced Premium Tax Credit to reduce the amount that Program HH pays for my premium.
- I understand that I must file a yearly tax return during the April deadline, beginning with 2014 taxes that are filed in 2015.
- I understand that I am required to submit a copy of my filed tax return to Program HH as a condition of my continued eligibility for premium assistance.
- I understand that I must re-enroll annually in my health insurance plan through MNsure and that the Program HH supported plans through MNsure may change on an annual basis.

You must sign this application even if you are authorizing someone to act on your behalf.

If an applicant is unable to sign, provide copies of legal documents of conservatorship or power of attorney.

YOUR SIGNATURE	DATE
LEGAL SPOUSE SIGNATURE	DATE
SIGNATURE OF AUTHORIZED REPRESENTATIVE	DATE

Minnesota Department of **Human Services**

Minnesota Health Care Programs

Employer Insurance Information Form

Client name: _____

PMI: _____

Why did I get this letter?

We need information about health insurance that may be offered through _____ 's employer or union.
EMPLOYEE NAME (print clearly)

What do I need to do?

Fill in and sign the Consent to Give Information section below. Give this form to your employer or union. Ask them to fill out page 12.

EMPLOYER/UNION NAME		PHONE NUMBER ( )	
ADDRESS	CITY	STATE	ZIP CODE

Consent to Give Information

I, _____ , give permission to _____
EMPLOYEE NAME EMPLOYER OR UNION

to give the requested information to the above agency. This information is used to see if I qualify for health care coverage through a Minnesota health care program.

State and Federal privacy laws protect my records. I know:

- Why I am being asked to give this information.
- I do not have to sign this consent, but it may affect my benefits or services if I do not.
- That, generally, I must give my written consent for the employer or union to give this information. If I do not consent, this information will not be given unless the law allows it.
- I may stop this consent with a written notice at any time. The written notice will not affect information already given.
- The person or agency who gets my information may be able to pass it on to others.
- If my information is passed on to others, it may no longer be protected.

This consent ends one year from the date I sign it, unless the law allows for a longer period.

EMPLOYEE SIGNATURE	DATE

Over →

To be Completed by the Employer or Union Human Resources

EMPLOYEE'S COMPLETE LEGAL NAME	EMPLOYER/UNION

Health insurance information

Please indicate the health insurance status for the employee and/or the employee's dependent(s):

Is insurance offered to this employee, spouse and/or dependent(s)?	◯ No ◯ Yes — if yes, fill in below	
Health insurance for employee	☐ Offered, and accepted	☐ Offered, but not accepted
Health insurance for employee's spouse	☐ Offered, and accepted	☐ Offered, but not accepted
Health insurance for employee's dependent(s)	☐ Offered, and accepted	☐ Offered, but not accepted

NAMES OF THE COVERED DEPENDENTS AND THEIR RELATIONSHIP TO THE EMPLOYEE

DATE EMPLOYEE WAS FIRST ELIGIBLE FOR INSURANCE	DATE YOUR OPEN ENROLLMENT PERIOD OPENS	DATE YOUR OPEN ENROLLMENT PERIOD CLOSES	GROUP NUMBER FOR POLICY	NAME OF INSURANCE COMPANY

COSTS

	EMPLOYEE PAYS	EMPLOYER/UNION PAYS	TOTAL COST
Cost of insurance for the employee only:	$ PER	$ PER	$ PER
Cost of insurance for the spouse only:	$ PER	$ PER	$ PER

Signature

NAME OF PERSON COMPLETING THIS FORM (PLEASE PRINT)	TITLE	PHONE NUMBER
		( )

SIGNATURE	DATE

Please return the completed form to the employee or mail/fax to:
Minnesota Dept of Human Services, P.O. Box 64972, St. Paul, MN 55164-0972
or FAX to 651-431-7414.

Required Proofs

Send these listed proofs for everyone who is applying for benefits:

- Photocopies of all paystubs received within the last thirty (30) days from all jobs
- Photocopies of your most recent Federal Tax Return (If you have not filed taxes please include a hand written signed statement that you have not filed taxes)
- Photocopies of all medical, dental or prescription drug insurance cards
- Photocopies of Medicare Part D prescription coverage card (if you have Medicare Part D)
- Photocopies of your most recent Social Security statement including all pages (only submit if you are collecting Social Security)
- Photocopies of statements for any other type of income including unemployment, pensions, short-term disability or long-term disability
- **Self-employed**
  Most recent income tax returns and all related schedules or business records if taxes are not filed.

Send copies of proofs. Do not send original documents.

Keep this page.

Notice of Privacy Practices

Minnesota Department of Human Services

(Effective Date: March 2014)

This notice tells how medical and other private information about you may be used and disclosed and how you can get this information. Please review it carefully.

Why do we ask for this information?

- To tell you apart from other people with the same or similar name
- To decide what you are eligible for
- To help you get medical, mental health, or social services and decide if you can pay for some services
- To make reports, do research, do audits, and evaluate our programs
- To investigate reports of people who may lie about the help they need
- To collect money from other agencies, like insurance companies, if they should pay for your care
- To decide if you or your family need protective services
- To collect money from the state or federal government for help we give you.

Why do we ask you for your Social Security number?

We need your SSN to verify identity and prevent duplication of state and federal benefits. Additionally, your SSN is used to conduct computer data matches with collaborative, nonprofit and private agencies to verify income, resources, or other information that may affect your eligibility and/or benefits.

You do not have to give us the SSN:

- For persons in your home who are not applying for coverage
- If you have religious objections
- If you are from another country, in the U.S. on a temporary basis and do not have permission from the U.S. Citizenship and Immigration Services (USCIS) to live in the U.S. permanently
- If you are living in the U.S. without the knowledge or approval of the USCIS.

Do you have to answer the questions we ask?

You do not have to give us your personal information. Without the information, we may not be able to help you. If you give us wrong information on purpose, you can be investigated and charged with fraud.

With whom may we share information?

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

- Employees or volunteers with other state, county, local, federal, collaborative, nonprofit and private agencies
- Researchers, auditors, investigators, and others who do quality of care reviews and studies or commence prosecutions or legal actions related to managing the human services programs.
- Court officials, county attorney, attorney general, other law enforcement officials, and child protection and fraud investigators
- Governmental agencies in other states administering public benefits programs
- Health care providers, including mental health agencies and drug and alcohol treatment facilities
- Health care insurers, health care agencies, managed care organizations and others who pay for your care
- Guardians, conservators or persons with power of attorney
- Coroners and medical investigators if you die and they investigate your death
- Credit bureaus, creditors or collection agencies if you do not pay fees you owe to us for services
- Anyone else to whom the law says we must or can give the information.

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

- You and people you have given permission to may see and copy medical or other private information we have about you. You may have to pay for the copies.
- You may question if the information we have about you is correct. Send your concerns in writing. Tell us why the information is wrong or not complete. Send your own explanation of the information you do not agree with. We will attach your explanation any time information is shared with another agency.
- You have the right to ask us in writing to share health information with you in a certain way or in a certain place. For example, you may ask us to send health information to your work address instead of your home address. If we find that your request is reasonable, we will grant it.
- You have the right to ask us to limit or restrict the way that we use or disclose your information, but we are not required to agree to this request.
- You have the right to get a record of some of the people or organizations with whom we have shared your information. This record was started on April 14, 2003. You must ask for a copy of this record in writing to our Privacy Official.
- If you do not understand the information, ask your worker to explain it to you. You can ask the Minnesota Department of Human Services for another copy of this notice.

Keep this page.

What are our responsibilities?

- We must protect the privacy of your medical and other private information according to the terms of this notice.
- We may not use your information for reasons other than the reasons listed on this form or share your information with individuals and agencies other than those listed on this form unless you tell us in writing that we can.
- We will not sell any data collected, created, or maintained as part of this application.
- We must follow the terms of this notice, but we may change our privacy policy because privacy laws change. We will put changes to our privacy rules on our website at: http://edocs.dhs.state.mn.us/lfserver/Public/DHS-3979-ENG

What privacy rights do children have?

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

What if you believe your privacy rights have been violated?

You may complain if you believe your privacy rights have been violated. You cannot be denied service or treated badly because you have made a complaint. If you believe that your medical privacy was violated by your doctor or clinic, a health insurer, a health plan, or a pharmacy, you may send a written complaint either to the county agency, the organization or to the federal civil rights office at:

- U.S. Department of Health and Human Services
  Office for Civil Rights, Region V
  233 N. Michigan Avenue, Suite 240
  Chicago, IL 60601
  312-886-2359 (Voice) or
  toll free 800-368-1019
  800-537-7697 (TTY)
  312-886-1807 (Fax)

If you think that the Minnesota Department of Human Services has violated your privacy rights, you may send a written complaint to the U.S. Department of Health and Human Services at the address above or to:

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

Rights and Responsibilities

Immigration

Immigration information you give to us is private. We use it to see if you can get coverage.

You do not have to give us your immigration information if you are:

- Helping someone else apply.
- Not applying for yourself.

Discrimination is against the law.

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

The Minnesota Department of Human Services, Equal Opportunity and Access Division, prohibits discrimination in its programs because of race, color, national origin, creed, religion, sexual orientation, public assistance status, age, disability or sex (including sex stereotypes and gender identity under any health program or activity receiving federal financial assistance). Contact the Equal Opportunity and Access Division directly:

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

The Minnesota Department of Human Rights prohibits discrimination in public services programs because of race, color, creed, religion, national origin, disability, sex, sexual orientation, or public assistance status. Contact the Minnesota Department of Human Rights directly:

- Minnesota Department of Human Rights
  Freeman Building, 625 North Robert Street
  St. Paul, MN 55155
  651-539-1100 (Telephone) and 800-657-3704 (Toll Free)
  651-296-1283 (TTY)

The U.S. Department of Health and Human Services' Office for Civil Rights prohibits discrimination in its programs because of race, color, national origin, age, disability and in some cases religion and sex. Sex includes sex stereotypes and gender identity under any health program or activity, receiving federal financial assistance, such as the Medicaid and CHIP programs, hospitals, clinics, employers, insurance companies and state health insurance exchanges created under Title I of the Affordable Care Act. Contact the federal agency directly:

- U.S. Department of Health and Human Services
  Office for Civil Rights, Region V
  233 North Michigan Avenue, Suite 240
  Chicago, IL 60601
  312-886-2359 (Telephone) and 800-368-1019 (Toll Free)
  800-537-7697 (TTY)

You Have the Right to Ask for a Hearing

If you feel your benefits are wrong or your application has not been processed correctly, you may ask for a fair hearing. You can ask for a hearing by telling your worker or by writing to:

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

Following the rules

People who are enrolled in Minnesota Health Care Programs must follow the rules listed below:

- Do not give false information or hide information to get or continue to get coverage.
- Do not trade or sell your membership cards.
- Do not help others get medical services that you know they should not get.
- Do not use someone else's membership card for yourself or other household members.

If you break the rules you may not be able to keep your coverage. You can also be prosecuted for fraud if you break the rules. Additional fines and penalties may apply.

Reviews

The state or federal office may look at your case. They will review the information you gave us and check to make sure we did your case correctly. They will let you know if they need to ask you questions. If you do not answer their questions, your coverage may stop.

Other Health Care

You and your household members may need to accept and keep a health insurance policy. This includes Medicare. If you do not give us information about your policy, you may not get coverage.

Changes

You must report changes to your worker within 10 days of the change happening. If you do not report changes, you may have to pay money back to the State for what we paid if you were not eligible.

If you are not sure if you should report a change, call your worker and explain what is happening. Examples of changes you need to report include:

Income:

- Starting a new job, changing jobs or stopping a job.
- Starting to get or changes in the amount of other income you get such as Social Security, other retirement income, unemployment or workers' compensation.

When you:

- Move to a new address
- Start to get health insurance or Medicare
- Become pregnant
- Get married or get a divorce
- Become disabled.

Keep this page.