MNsure℠
Where you choose health coverage

Application for Health Coverage and Help Paying Costs

THINGS TO KNOW

Apply faster online

- The online application is fast and easy! You may be able to get real-time decisions using the online application at www.mnsure.org
- You can also get help online if you have questions during the application process.

Use this application to see what coverage choices you qualify for

- Affordable private health insurance plans that offer comprehensive coverage to help you stay well
- A tax credit that can immediately help pay your premiums for health coverage
- Free or low-cost insurance from Medical Assistance (MA) or MinnesotaCare, Minnesota's Health Care Programs
- **You may qualify for a free or low-cost program even if you earn more than $111,000 a year (for a family of four).** Visit compare.mnsure.org to get an estimate of what you may qualify for.

Who can use this application?

- Use this application to apply for anyone in your family.
- Apply even if you or your child already has health coverage. You could be eligible for lower-cost or free coverage.
- Families that include immigrants can apply. You can apply for your child even if you are not eligible for coverage.
- If someone is helping you fill out this application, you may need to complete Appendix C.
- For American Indians or Alaska Natives, complete Appendix B when filling out this application.

What you may need to apply

- Social Security numbers (or document numbers for any legal immigrants that need insurance)
- Employer and income information for everyone in your family (for example, from paystubs, W-2 forms or wage and tax statements)
- Policy numbers for any current health insurance
- Information about any job-related health insurance available to your family.

Why do we ask for this information?

We ask about income and other information to let you know what coverage you qualify for and if you can get any help paying for it. **We will keep all the information you provide private and secure, as required by law. Read the attached Notice of Privacy Practices for more details.**

What happens next?

Send your complete, signed application using the instructions in Step 8 on page 20.
We will review your application and notify you in writing of the results.

Get help with this application

- **Online: www.mnsure.org**
- **Phone:** Call MNsure at **651-539-2099** (855-366-7873 outside the Twin Cities).
- **In person:** There may be a navigator or broker in your area that can help. Visit our website, or call **651-539-2099** (855-366-7873 outside the Twin Cities) for more information.
- If you need help in a language other than English, tell us the language you need. We will get you help at no cost to you.

651-431-2670 or 800-657-3739

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

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

သတိ။ ဤစာရွက်စာတမ်းအားအခမဲ့ဘာသာပြန်ပေးခြင်း အကူအညီလိုအပ်ပါက၊ အထက်ပါဖုန်းနံပါတ်ကိုခေါ်ဆိုပါ။

កំណត់សំគាល់ ។ បើអ្នកត្រូវការជំនួយក្នុងការបកប្រែឯកសារនេះដោយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទតាមលេខខាងលើ ។

請注意，如果您需要免費協助傳譯這份文件，請撥打上面的電話號碼。

Attention. Si vous avez besoin d'une aide gratuite pour interpréter le présent document, veuillez appeler au numéro ci-dessus.

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.

ဟ်သူဉ်ဟ်သးဘဉ်တက့်.ဖဲနမ့်လိဉ်ဘဉ်တ်မၤစၢၤကလီလၢတ်ကကျိးထံဝဲဒဉ်လံာ်တီလံာ်မိတခါအံၤနူဉ်,ကိးဘဉ်လီတဲစိနိုဂ်ံလၢထးအံၤနူဉ်တက့်.

알려드립니다. 이 문서에 대한 이해를 돕기 위해 무료로 제공되는 도움을 받으시려면 위의 전화번호로 연락하십시오.

ໂປຣດຊາບ. ຖ້າຫາກ ທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປເອກະສານນີ້ຟຣີ, ຈົ່ງໂທຣໄປທີ່ໝາຍເລກຂ້າງເທິງນີ້.

Hubachiisa. Dokumentiin kun tola akka siif hiikamu gargaarsa hoo feete, lakkoobsa gubbatti kenname bilbili.

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 (afcelinta) qoraalkan, lambarka kore wac.

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.

LB2 (10-20)

ADA Advisory

For accessible formats of this information or assistance with additional equal access to human services, write to DHS.info@state.mn.us, call 800-657-3739, or use your preferred relay service. ADA1 (2-18)

Clear Form

STEP 1 People to include on this application

DHS-6696-ENG 11-22

Tell us about all the family members that live with you. If you file taxes, we need to know about everyone on your tax return.

DO include:

- Yourself
- Your spouse
- Your children under 19 that live with you
- Your spouse's children under 19 that live with you
- Your unmarried partner, if you have children together
- Anyone you include on your tax return, even if that person does not live with you
- Anyone else under 19 that you take care of and that lives with you

Include the people listed here, even if they do not need health care coverage.

DO NOT include:

- Your children or your spouse's children 19 or older that you do not expect to claim as tax dependents
- Your unmarried partner, if you have no children together and do not file taxes together
- Your unmarried partner's children, if they are not related to you and you do not expect to claim them as tax dependents
- Other people that live with you but are not your spouse or children and that you do not file taxes with
- Your parents, if you are 19 or older, they do not expect to claim you as a tax dependent, and you do not expect to claim them as tax dependents

These people may file a separate application for health care coverage.

The health coverage and help you qualify for depends on the number of people in your family and their incomes. This information helps us make sure everyone gets the best coverage they can.

Complete Step 2 for each person in your family. Start with yourself; then add other adults and children. If you have more than four people in your family, make copies of pages 14-17. You do not need to provide immigration status or a Social Security number (SSN) for people that are not applying for health care coverage. Providing an SSN for all household members can speed up the application process. We use SSNs to check income and other information to see who is eligible for help with health coverage costs. If someone wants help getting an SSN, call 800-772-1213 or visit www.socialsecurity.gov. If you are a TTY user, call 800-325-0778, or use your preferred relay service.

Other family members. If you have other family members that were not included in Step 2 of this application that would like to have coverage under a family health plan, see Step 7 of this application (page 20).

Safe at Home Program. If your household is in Minnesota's Safe at Home Program, you do not need to give us your full home address. In the Home Address spaces, you only need to provide the county you live in and your home zip code. Write your Safe at Home Program address in the Mailing Address spaces.

☐ Check this box if this application includes someone who is pregnant*.
*Your application may be processed faster if you or someone in your household is pregnant.

STEP 2: PERSON 1 Start with yourself

Complete Step 2 for yourself and others you need to include on this application. See Step 1 for information about the people to include. Person 1 should be the contact person for the application.

1. FIRST NAME	MIDDLE NAME	LAST NAME	SUFFIX

2. DATE OF BIRTH	3. SEX	4. MARITAL STATUS
_____ (MM/DD/YYYY) If under the age of 18, are you under the legal control of a parent? ◯ Yes ◯ No	◯ Male ◯ Female	◯ Legally separated ◯ Married ◯ Divorced ◯ Widowed ◯ Never married

5. Do you have a Social Security number (SSN)?
◯ Yes – what is your SSN?* _____
◯ No – have you applied for an SSN? ◯ Yes ◯ No – why not? Choose a reason code from the list on page 20: _____
* See the Notice of Privacy Practices and Notice of Rights and Responsibilities (Attachment A) for information about SSNs.

6. ☐ Check here if you are homeless.
If you checked the box, in which county do you live? _____

NEED HELP WITH THIS APPLICATION? Visit **www.mnsure.org** or call us at **651-539-2099** (855-366-7873 outside the Twin Cities). If you need help in a language other than English, tell us the language you need. We will get you help at no cost to you.

STEP 2: PERSON 1 (Continue with yourself)

7a. HOME ADDRESS (Do not write a post office box number here. Include any post office box number in question 12.)			7b. APARTMENT OR SUITE NUMBER
8. CITY	9. STATE	10. ZIP CODE	11. COUNTY
12. MAILING ADDRESS (if different from home address)			13. APARTMENT OR SUITE NUMBER
14. CITY	15. STATE	16. ZIP CODE	17. COUNTY

18. PHONE NUMBER where we can call you: ◯ Cell ◯ Home ◯ Work

19. OTHER PHONE NUMBER where we can call you: ◯ Cell ◯ Home ◯ Work

20a. YOUR PREFERRED SPOKEN LANGUAGE

20b. YOUR PREFERRED WRITTEN LANGUAGE

21. Do you need an interpreter? ◯ Yes ◯ No

22. SELECT YOUR PREFERRED METHOD OF CONTACT ABOUT THIS APPLICATION

Email: ◯ Yes ◯ No

U.S. Postal Mail: ◯ Yes ◯ No

EMAIL ADDRESS

23. Do you want someone to act on your behalf as an authorized representative? ◯ Yes - **complete Appendix C** ◯ No

(You can give a trusted person permission to talk about this application with us, see your information and act for you on matters related to this application, including getting information about your application and signing your application on your behalf.)

24. Do you plan to file a federal income tax return **next year**? *(You can still apply even if you do not file a federal income tax return.)*

◯ Yes - answer questions a, b and c. ◯ No - go to question c.

a. Will you file jointly with a spouse?

◯ Yes – name of spouse: _____

◯ No – Will you file as Married Filing Separately because of domestic abuse or spousal abandonment (spouse left household) or file as Head of Household? ◯ Yes ◯ No

b. Will you claim any dependents on your tax return? ◯ Yes - list names: _____ ◯ No

c. Will you be claimed as a dependent on someone else's tax return? ◯ Yes - name of tax filer: _____ ◯ No

If you claim any dependents on your tax return, you must list them on the application, even if they are not applying.

25. Are you pregnant? ◯ No ◯ Yes - how many babies are expected? _____ Due date: _____ (MM/DD/YYYY)

a. Were you pregnant in the past three months? ◯ No ◯ Yes - what date did the pregnancy end? _____ (MM/DD/YYYY)

26. Are you applying for health care coverage for yourself? *(Even if you have insurance, there might be a program with better coverage or lower costs.)*

◯ Yes – answer all the following questions. ◯ No – go to the job and income questions on page 4.

27. Answer yes or no to the following four questions.

a. Did you move to Minnesota in the last three months? ◯ Yes - what date? _____ ◯ No

b. Do you plan to make Minnesota your home? ◯ Yes ◯ No

c. Did you enter Minnesota with a job commitment or to seek employment? ◯ Yes ◯ No

d. Are you visiting Minnesota to get medical care or for personal reasons? ◯ Yes ◯ No

28. Ethnicity and Race: You do not have to answer these questions to get health care. We use this information to identify groups of people who have health concerns and try to find ways to improve their care.

a. Are you of Hispanic, Latino or Spanish origin? ◯ No, not Hispanic, Latino or Spanish origin ◯ Yes – check all that apply

☐ Yes, Cuban ☐ Yes, Mexican, Mexican American or Chicano/a ☐ Yes, Puerto Rican

☐ Yes, other: _____ ☐ I choose not to answer

b. Race (check all that apply):

☐ American Indian or Alaska Native ☐ Asian Indian ☐ Black or African American ☐ Chinese ☐ Filipino

☐ Guamanian or Chamorro ☐ Japanese ☐ Korean ☐ Native Hawaiian ☐ Other Asian ☐ Other Pacific Islander

☐ Samoan ☐ Vietnamese ☐ White ☐ Other: _____ ☐ I choose not to answer

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STEP 2: PERSON 1 (Continue with yourself)

29. Are you a U.S. citizen or U.S. national?

(A U.S. national is a person born in American Samoa or Swains Island, a person born outside the U.S. with one or both parents who are U.S. nationals, or a person born in the Northern Mariana Islands who chose to be a U.S. national.)

◯ Yes – go to question 32. ◯ No – go to question 30.

30. What is your current immigration status? *(Choose a status code from the list on page 20, or write in your status if it is not on the list.)*

Code or status: _____

a. Immigration document type: _____ b. Alien I.D. number: _____

c. Card number: _____ d. Document expiration date (MM/DD/YYYY): _____

e. Date of entry (MM/DD/YYYY): _____

f. Did you enter the United States before August 22, 1996? ◯ Yes ◯ No

g. Have you lived in the United States for five years or more in a qualified status? *(See page 20 to determine whether you have a qualified status.)* ◯ Yes ◯ No

h. Do you have a sponsor? ◯ Yes – sponsor's name: _____ ◯ No

i. Are you, or is your spouse or parent, a veteran or active-duty member of the military? ◯ Yes ◯ No

j. Are you getting services from the Center for Victims of Torture? ◯ Yes ◯ No

k. Do you want help paying for a medical emergency?

◯ No ◯ Yes – what is the begin and end date for the medical emergency?

_____ (MM/DD/YYYY) to _____ (MM/DD/YYYY)

31. Did you ever have an immigration status different from your current status (example: refugee or asylee)?

◯ No ◯ Yes – what is your previous immigration status? *(Choose a status code from the list on page 20, or write in your previous status if it is not on the list.)*

Code or status: _____ Original date of entry: _____ (MM/DD/YYYY)

32. Do you want help from Medical Assistance (MA) to pay for medical bills from the past three months?

(MA can start up to three months before your application date if you have medical bills from that time and meet the MA requirements.)

◯ Yes – answer questions a and b. ◯ No – go to question 33.

a. Which months before the month of application do you want help for? (Check all that apply)

☐ One month ago ☐ Two months ago ☐ Three months ago

b. Is everything you told us on the application the same for the selected month(s)? (For example, income, pregnancy and family size)

◯ Yes ◯ No

33. If you are under age 26, were you in foster care in any state? ◯ Yes – answer questions a - c ◯ No

a. In what state were you in foster care? _____

b. Did your foster care stop when you were age 18 or older? ◯ Yes ◯ No

c. Were you on Medical Assistance or another Medicaid program at the time foster care ended? ◯ Yes ◯ No

34. Answer yes or no to the following five questions.

a. Are you blind? ◯ Yes ◯ No

b. Do you have a physical, mental, or emotional health condition that limits your activities (like bathing, dressing, daily chores, etc.)?

◯ Yes ◯ No

c. Do you need help staying in your home or help paying for care in a long-term-care facility, such as a nursing home?

◯ Yes ◯ No

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

◯ Yes ◯ No

e. Are you in a residential treatment program for mental illness or drug or alcohol dependency? ◯ Yes ◯ No

35. Are you in jail or prison? ◯ No ◯ Yes – If in jail, are you awaiting disposition of charges? ◯ Yes ◯ No

STEP 2: PERSON 1 (Continue with yourself)

Recent Job Changes

36. IN THE PAST SIX MONTHS, DID YOU DO ANY OF THESE THINGS? (Check all that apply)

☐ Change jobs ☐ Stop working ☐ Start working fewer hours or have a salary cut

Optional: If you changed jobs or stopped working in the last 6 months, providing the name and Employer Identification Number (EIN) of your former employer may help speed up the application process.

EMPLOYER NAME(S)	EIN

Current Job and Income Information (Check all that apply)

☐ **Employed**
If you are currently employed, tell us about your income. Start with question 37.

☐ **Self-employed**
Answer question 41.

☐ **Seasonally employed**
Answer question 42.

☐ **Not employed**
Answer question 43.

Current Job 1

37. EMPLOYER NAME AND ADDRESS: Write the employer name that appears on your paycheck.	EMPLOYER IDENTIFICATION NUMBER (EIN)

38. TAXABLE WAGES AND TIPS: List the amount after pretax payroll deductions and before taxes. Pretax payroll deductions may be for a retiree plan, health insurance plan, childcare plan or a parking and transportation program. Choose one and fill in the dollar amount. If work hours and wages vary, write the total wages expected for the next 12 months in the "Yearly" box.

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

Current Job 2

(If you have more jobs and need more space, attach another sheet of paper and include that information.)

39. EMPLOYER NAME AND ADDRESS: Write the employer name that appears on your paycheck.	EMPLOYER IDENTIFICATION NUMBER (EIN)

40. TAXABLE WAGES AND TIPS: List the amount after pretax payroll deductions and before taxes. Pretax payroll deductions may be for a retiree plan, health insurance plan, childcare plan or a parking and transportation program. Choose one and fill in the dollar amount. If work hours and wages vary, write the total wages expected for the next 12 months in the "Yearly" box.

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

41. **SELF-EMPLOYED:** INCOME OR LOSS FROM FARMING, FISHING OR OTHER BUSINESS. ANSWER THE FOLLOWING QUESTIONS:

a. Type of work _____

b. How much income or loss do you expect from self-employment for the next 12 months?
Income amount $_____ or Loss amount $_____

42. **SEASONAL INCOME: Complete only if you are seasonally employed.**

YOUR TOTAL SEASONAL INCOME FOR THE NEXT 12 MONTHS	YOUR TOTAL UNEMPLOYMENT FOR THE NEXT 12 MONTHS

EMPLOYER NAME AND ADDRESS: Write the employer name that appears on your paycheck.	EMPLOYER IDENTIFICATION NUMBER (EIN)

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STEP 2: PERSON 1 (Continue with yourself)

43. **OTHER INCOME:** Check all that apply. List the amount before taxes and deductions. If you do not receive any other type of income, mark "none."

Note: Do not list child support, nontaxable veteran's payments, money from an Achieving a Better Life Experience (ABLE) account, or Supplemental Security Income (SSI).

- ☐ None
- ☐ Unemployment $ _____ weekly
- ☐ Pensions or retirement, including taxable veteran's pensions $ _____ monthly
- ☐ Social Security benefits* $ _____ monthly
- ☐ Alimony received** $ _____ monthly
- ☐ Net rental or royalty $ _____ yearly
- ☐ Interest $ _____ yearly

  How much of this interest amount is not taxable? $ _____
- ☐ Lottery or gambling winnings greater than $80,000 since January of 2018

  Total amount of winnings: $ _____ Month and year winnings were received: _____
- ☐ Other taxable income that is expected within the next 12 months (Taxable income is income you would list on the Income section of IRS Form 1040).

  Type: _____ $ _____ How often? _____
- ☐ Other taxable income this month

  Type: _____ $ _____ How often? _____

*Social Security benefits include retirement, disability and Railroad Retirement benefits. Supplemental Security Income (SSI) is not Social Security benefits. List the gross amount before any deductions. Include both taxable and nontaxable Social Security benefits.

**Do not list alimony received if your divorce or separation agreement is dated after 2018.

44. **ADJUSTMENTS TO INCOME:** Check all that apply. List the amount you expect to pay over the next 12 months.

If you pay for certain things that can be subtracted from gross income on a federal income tax return, telling us about them could lower the cost of your health coverage. **Note**: Do not list an expense already included in your self-employment income or loss (question 41b).

See the instructions for Schedule 1 of the IRS 1040 form for more information about these adjustments.

Yearly amount

- ☐ Educator expenses (up to $250) $ _____
- ☐ Certain business expenses of reservists, performing artists, and fee-basis government officials $ _____
- ☐ Health savings account deduction $ _____
- ☐ Moving expenses for active duty military members $ _____
- ☐ Deductible part of self-employment tax $ _____
- ☐ Self-employed SEP, SIMPLE and qualified plans $ _____
- ☐ Self-employed health insurance deduction $ _____
- ☐ Penalty on early withdrawal of savings $ _____
- ☐ Alimony paid* $ _____
- ☐ IRA deduction $ _____
- ☐ Student loan interest $ _____

*Do not list alimony payments if the payments are based on a divorce or separation agreement dated after 2018.

45. **PROJECTED ANNUAL INCOME FOR 2023:** Do you expect your total annual income for 2023 to be the same as the income you listed on this application?

- ◯ Yes – My total income expected for 2023 will be the same as the income I listed on this application.
- ◯ No – My total income expected for 2023 will be: $ _____

  Add up all of the income you received from January 1 until now, and all of the income you expect to receive through December 31.

See page 20 for more information about how to calculate your projected annual income.

STEP 2: PERSON 2

Complete Steps 2-4 for any others you need to include on this application. See page 1 Step 1 for information about the people to include. If you have no more people to include, go to page 18 Step 3.

1. FIRST NAME	MIDDLE NAME	LAST NAME	SUFFIX	2. MARITAL STATUS
				◯ Legally separated ◯ Married ◯ Divorced ◯ Widowed ◯ Never married

3. RELATIONSHIP TO YOU	4. DATE OF BIRTH	5. SEX
	_____ (MM/DD/YYYY) If under the age of 18, is this person under the legal control of a parent? ◯ Yes ◯ No	◯ Male ◯ Female

6. Does PERSON 2 have a Social Security number (SSN)?

◯ Yes – what is PERSON 2's SSN?* _____

◯ No – has PERSON 2 applied for an SSN? ◯ Yes ◯ No – why not? Choose a reason code from the list on page 20: _____

*See the Notice of Privacy Practices and Notice of Rights and Responsibilities (Attachment A) for information about SSNs.

7. Does PERSON 2 live at the same address with you? ◯ Yes ◯ No – list address: _____

8. Does PERSON 2 plan to file a federal income tax return **next year**? (Person 2 can still apply even if he or she does not file a federal income tax return.)

◯ Yes – answer questions a, b and c. ◯ No – go to question c.

a. Will PERSON 2 file jointly with a spouse?

◯ Yes – name of spouse: _____

◯ No – Will PERSON 2 file as Married Filing Separately because of domestic abuse or spousal abandonment (spouse left household) or file as Head of Household? ◯ Yes ◯ No

b. Will PERSON 2 claim any dependents on his or her tax return? ◯ Yes - list names: _____ ◯ No

c. Will PERSON 2 be claimed as a dependent on someone else's tax return? ◯ Yes – name of tax filer: _____ ◯ No

How is PERSON 2 related to the tax filer: _____

9. Is PERSON 2 pregnant? ◯ No ◯ Yes - how many babies are expected? _____ Due date: _____ (MM/DD/YYYY)

a. Was PERSON 2 pregnant in the past three months? ◯ No ◯ Yes - what date did the pregnancy end? _____ (MM/DD/YYYY)

10. Does PERSON 2 want to apply for health care coverage?

(Even if PERSON 2 has insurance, there might be a program with better coverage or lower costs.)

◯ Yes – answer **all** the following questions. ◯ No – go to the job and income questions on page 8.

11. Answer yes or no to the following four questions

a. Did PERSON 2 move to Minnesota in the last three months? ◯ Yes - what date? _____ ◯ No

b. Does PERSON 2 plan to make Minnesota his or her home? ◯ Yes ◯ No

c. Did PERSON 2 enter Minnesota with a job commitment or to seek employment? ◯ Yes ◯ No

d. Is PERSON 2 visiting Minnesota to get medical care or for personal reasons? ◯ Yes ◯ No

12. Ethnicity and Race for PERSON 2: You do not have to answer these questions to get health care. We use this information to identify groups of people who have health concerns and try to find ways to improve their care.

a. Is PERSON 2 of Hispanic, Latino or Spanish origin? ◯ No, not Hispanic, Latino or Spanish origin ◯ Yes – check all that apply

☐ Yes, Cuban ☐ Yes, Mexican, Mexican American or Chicano/a ☐ Yes, Puerto Rican

☐ Yes, other: _____ ☐ I choose not to answer

b. Race (check all that apply):

☐ American Indian or Alaska Native ☐ Asian Indian ☐ Black or African American ☐ Chinese ☐ Filipino

☐ Guamanian or Chamorro ☐ Japanese ☐ Korean ☐ Native Hawaiian ☐ Other Asian ☐ Other Pacific Islander

☐ Samoan ☐ Vietnamese ☐ White ☐ Other: _____ ☐ I choose not to answer

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STEP 2: PERSON 2 (Continue with PERSON 2)

13. Is PERSON 2 a U.S. citizen or U.S. national?
(A U.S. national is a person born in American Samoa or Swains Island, a person born outside the U.S. with one or both parents who are U.S. nationals, or a person born in the Northern Mariana Islands who chose to be a U.S. national.)
◯ Yes – go to question 16. ◯ No – go to question 14.

14. What is PERSON 2's current immigration status? *(Choose a status code from the list on page 20, or write status if it is not on the list.)*
Code or status: _____
a. Immigration document type: _____ b. Alien I.D. number: _____
c. Card number: _____ d. Document expiration date (MM/DD/YYYY): _____
e. Date of entry (MM/DD/YYYY): _____
f. Did PERSON 2 enter the United States before August 22, 1996? ◯ Yes ◯ No
g. Has PERSON 2 lived in the United States for five years or more in a qualified status? *(See page 20 to determine whether PERSON 2 has a qualified status.)* ◯ Yes ◯ No
h. Does PERSON 2 have a sponsor? ◯ Yes – sponsor's name: _____ ◯ No
i. Is PERSON 2, or is his or her spouse or parent, a veteran or active-duty member of the military? ◯ Yes ◯ No
j. Is PERSON 2 getting services from the Center for Victims of Torture? ◯ Yes ◯ No
k. Does PERSON 2 want help paying for a medical emergency?
◯ No ◯ Yes – what is the begin and end date for the medical emergency?
_____ (MM/DD/YYYY) to _____ (MM/DD/YYYY)

15. Did PERSON 2 ever have an immigration status different from his or her current status (example: refugee or asylee)?
◯ No ◯ Yes – what is PERSON 2's previous immigration status? *(Choose a status code from the list on page 20, or write in PERSON 2's previous status if it is not on the list.)*
Code or status: _____ Original date of entry: _____ (MM/DD/YYYY)

16. Does PERSON 2 want help from Medical Assistance (MA) to pay for medical bills from the past three months?
(MA can start up to three months before your application date if PERSON 2 has medical bills from that time and meets the MA requirements.)
◯ Yes – answer questions a and b. ◯ No – go to question 17.
a. Which months before the month of application do you want help for? (Check all that apply)
☐ One month ago ☐ Two months ago ☐ Three months ago
b. Is everything you told us on the application the same for the selected month(s)? (For example, income, pregnancy and family size)
◯ Yes ◯ No

17. If under age 26, was PERSON 2 in foster care in any state? ◯ Yes – answer questions a - c ◯ No
a. In what state was PERSON 2 in foster care? _____
b. Did foster care stop when PERSON 2 was age 18 or older? ◯ Yes ◯ No
c. Was PERSON 2 on Medical Assistance or another Medicaid program at the time foster care ended? ◯ Yes ◯ No

18. Answer yes or no to the following five questions.
a. Is PERSON 2 blind? ◯ Yes ◯ No
b. Does PERSON 2 have a physical, mental, or emotional health condition that limits PERSON 2's activities (like bathing, dressing, daily chores, etc.)? ◯ Yes ◯ No
c. Does PERSON 2 need help staying in his or her home or help paying for care in a long-term-care facility, such as a nursing home?
◯ Yes ◯ No
d. Has PERSON 2 been determined disabled by the Social Security Administration (SSA) or the State Medical Review Team (SMRT)?
◯ Yes ◯ No
e. Is PERSON 2 in a residential treatment program for mental illness or drug or alcohol dependency? ◯ Yes ◯ No

19. Is PERSON 2 in jail or prison? ◯ No ◯ Yes – If in jail, is PERSON 2 awaiting disposition of charges? ◯ Yes ◯ No

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STEP 2: PERSON 2 (Continue with PERSON 2)

Recent Job Changes

20. IN THE PAST SIX MONTHS, DID PERSON 2 DO ANY OF THESE THINGS? (Check all that apply)

☐ Change jobs ☐ Stop working ☐ Start working fewer hours or have a salary cut

Optional: If PERSON 2 changed jobs or stopped working in the last 6 months, providing the name and Employer Identification Number (EIN) of PERSON 2's former employer may help speed up the application process.

EMPLOYER NAME(S)	EIN

Current Job and Income Information (Check all that apply)

☐ **Employed**
If PERSON 2 is employed, tell us about his or her income. Start with question 21.

☐ **Self-employed**
Answer question 25.

☐ **Seasonally employed**
Answer question 26.

☐ **Not employed**
Answer question 27.

Current Job 1

21. EMPLOYER NAME AND ADDRESS: Write the employer name that appears on your paycheck.	EMPLOYER IDENTIFICATION NUMBER (EIN)

22. TAXABLE WAGES AND TIPS: List the amount after pretax payroll deductions and before taxes. Pretax payroll deductions may be for a retiree plan, health insurance plan, childcare plan or a parking and transportation program. Choose one and fill in the dollar amount. If work hours and wages vary, write the total wages expected for the next 12 months in the "Yearly" box.

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

Current Job 2

(If PERSON 2 has more jobs and need more space, attach another sheet of paper and include that information.)

23. EMPLOYER NAME AND ADDRESS: Write the employer name that appears on your paycheck.	EMPLOYER IDENTIFICATION NUMBER (EIN)

24. TAXABLE WAGES AND TIPS: List the amount after pretax payroll deductions and before taxes. Pretax payroll deductions may be for a retiree plan, health insurance plan, childcare plan or a parking and transportation program. Choose one and fill in the dollar amount. If work hours and wages vary, write the total wages expected for the next 12 months in the "Yearly" box.

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

25. **SELF-EMPLOYED:** INCOME OR LOSS FROM FARMING, FISHING OR OTHER BUSINESS. ANSWER THE FOLLOWING QUESTIONS:

a. Type of work _____

b. How much income or loss does PERSON 2 expect from self-employment for the next 12 months? Income amount $_____ or Loss amount $_____

26. **SEASONAL INCOME: Complete only if PERSON 2 is seasonally employed.**

PERSON 2's TOTAL SEASONAL INCOME FOR THE NEXT 12 MONTHS	PERSON 2's TOTAL UNEMPLOYMENT FOR THE NEXT 12 MONTHS

EMPLOYER NAME AND ADDRESS: Write the employer name that appears on your paycheck.	EMPLOYER IDENTIFICATION NUMBER (EIN)

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STEP 2: PERSON 2 (Continue with PERSON 2)

27. **OTHER INCOME:** Check all that apply. List the amount before taxes and deductions. If PERSON 2 does not receive any other type of income, mark "none."
Note: PERSON 2 does not need to list child support, nontaxable veteran's payments, money from an Achieving a Better Life Experience (ABLE) account, or Supplemental Security Income (SSI).

- ☐ None
- ☐ Unemployment $ _____ weekly
- ☐ Pensions or retirement, including taxable veteran's pensions $ _____ monthly
- ☐ Social Security benefits* $ _____ monthly
- ☐ Alimony received** $ _____ monthly
- ☐ Net rental or royalty $ _____ yearly
- ☐ Interest $ _____ yearly
  How much of this interest amount is not taxable? $ _____
- ☐ Lottery or gambling winnings greater than $80,000 since January of 2018
  Total amount of winnings: $ _____ Month and year winnings were received: _____
- ☐ Other taxable income that is expected within the next 12 months (Taxable income is income you would list on the Income section of IRS Form 1040).
  Type: _____ $ _____ How often? _____
- ☐ Other taxable income this month
  Type: _____ $ _____ How often? _____

*Social Security benefits include retirement, disability and Railroad Retirement benefits. Supplemental Security Income (SSI) is not Social Security benefits. List the gross amount before any deductions. Include both taxable and nontaxable Social Security benefits.

**Do not list alimony received if your divorce or separation agreement is dated after 2018.

28. **ADJUSTMENTS TO INCOME:** Check all that apply. List the amount PERSON 2 expects to pay over the next 12 months.

If PERSON 2 pays for certain things that can be subtracted from gross income on a federal income tax return, telling us about them could lower the cost of PERSON 2's health coverage. **Note:** Do not list an expense already included in PERSON 2's self-employment income or loss (question 25b).

See the instructions for Schedule 1 of the IRS 1040 form for more information about these adjustments.

	Yearly amount
☐ Educator expenses (up to $250)	$ _____
☐ Certain business expenses of reservists, performing artists, and fee-basis government officials	$ _____
☐ Health savings account deduction	$ _____
☐ Moving expenses for active duty military members	$ _____
☐ Deductible part of self-employment tax	$ _____
☐ Self-employed SEP, SIMPLE and qualified plans	$ _____
☐ Self-employed health insurance deduction	$ _____
☐ Penalty on early withdrawal of savings	$ _____
☐ Alimony paid*	$ _____
☐ IRA deduction	$ _____
☐ Student loan interest	$ _____

*Do not list alimony payments if the payments are based on a divorce or separation agreement dated after 2018.

29. **PROJECTED ANNUAL INCOME FOR 2023:** Does PERSON 2 expect his or her total annual income for 2023 to be the same as the income listed on this application?

- ◯ Yes – PERSON 2's total income expected for 2023 will be the same as the income listed on this application.
- ◯ No – PERSON 2's total income expected for 2023 will be: $ _____

  Add up all of the income PERSON 2 received from January 1 until now, and all of the income PERSON 2 expects to receive through December 31.

See page 20 for more information about how to calculate PERSON 2's projected annual income.

STEP 2: PERSON 3

Complete Steps 2-4 for any others you need to include on this application. See page 1 Step 1 for information about the people to include. If you have no more people to include, go to page 18 Step 3.

1. FIRST NAME	MIDDLE NAME	LAST NAME	SUFFIX	2. MARITAL STATUS
				◯ Legally separated ◯ Married ◯ Divorced ◯ Widowed ◯ Never married

3. RELATIONSHIP TO YOU	4. DATE OF BIRTH	5. SEX
	_____ (MM/DD/YYYY) If under the age of 18, is this person under the legal control of a parent? ◯ Yes ◯ No	◯ Male ◯ Female

6. Does PERSON 3 have a Social Security number (SSN)?

◯ Yes – what is PERSON 3's SSN?* _____

◯ No – has PERSON 3 applied for an SSN? ◯ Yes ◯ No – why not? Choose a reason code from the list on page 20: _____

*See the Notice of Privacy Practices and Notice of Rights and Responsibilities (Attachment A) for information about SSNs.

7. Does PERSON 3 live at the same address with you? ◯ Yes ◯ No – list address: _____

8. Does PERSON 3 plan to file a federal income tax return **next year**? (PERSON 3 can still apply even if he or she does not file a federal income tax return.)

◯ Yes – answer questions a, b and c. ◯ No – go to question c.

a. Will PERSON 3 file jointly with a spouse?

◯ Yes – name of spouse: _____

◯ No – Will PERSON 3 file as Married Filing Separately because of domestic abuse or spousal abandonment (spouse left household) or file as Head of Household? ◯ Yes ◯ No

b. Will PERSON 3 claim any dependents on his or her tax return? ◯ Yes - list names _____ ◯ No

c. Will PERSON 3 be claimed as a dependent on someone else's tax return? ◯ Yes - name of tax filer _____ ◯ No

How is PERSON 3 related to the tax filer: _____

9. Is PERSON 3 pregnant? ◯ No ◯ Yes - how many babies are expected? _____ Due date: _____ (MM/DD/YYYY)

a. Was PERSON 3 pregnant in the past three months? ◯ No ◯ Yes - what date did the pregnancy end? _____ (MM/DD/YYYY)

10. Does PERSON 3 want to apply for health care coverage?

(Even if PERSON 3 has insurance, there might be a program with better coverage or lower costs.)

◯ Yes – answer **all** the following questions. ◯ No – go to the job and income questions on page 12.

11. Answer yes or no to the following four questions

a. Did PERSON 3 move to Minnesota in the last three months? ◯ Yes - what date? _____ ◯ No

b. Does PERSON 3 plan to make Minnesota his or her home? ◯ Yes ◯ No

c. Did PERSON 3 enter Minnesota with a job commitment or to seek employment? ◯ Yes ◯ No

d. Is PERSON 3 visiting Minnesota to get medical care or for personal reasons? ◯ Yes ◯ No

12. Ethnicity and Race for PERSON 3: You do not have to answer these questions to get health care. We use this information to identify groups of people who have health concerns and try to find ways to improve their care.

a. Is PERSON 3 of Hispanic, Latino or Spanish origin? ◯ No, not Hispanic, Latino or Spanish origin ◯ Yes – check all that apply

☐ Yes, Cuban ☐ Yes, Mexican, Mexican American or Chicano/a ☐ Yes, Puerto Rican

☐ Yes, other: _____ ☐ I choose not to answer

b. Race (check all that apply):

☐ American Indian or Alaska Native ☐ Asian Indian ☐ Black or African American ☐ Chinese ☐ Filipino

☐ Guamanian or Chamorro ☐ Japanese ☐ Korean ☐ Native Hawaiian ☐ Other Asian ☐ Other Pacific Islander

☐ Samoan ☐ Vietnamese ☐ White ☐ Other: _____ ☐ I choose not to answer

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STEP 2: PERSON 3 (Continue with PERSON 3)

13. Is PERSON 3 a U.S. citizen or U.S. national?
(A U.S. national is a person born in American Samoa or Swains Island, a person born outside the U.S. with one or both parents who are U.S. nationals, or a person born in the Northern Mariana Islands who chose to be a U.S. national.)
◯ Yes – go to question 16. ◯ No – go to question 14.

14. What is PERSON 3's current immigration status? *(Choose a status code from the list on page 20, or write status if it is not on the list.)*
Code or status: _____
a. Immigration document type: _____ b. Alien I.D. number: _____
c. Card number: _____ d. Document expiration date (MM/DD/YYYY): _____
e. Date of entry (MM/DD/YYYY): _____
f. Did PERSON 3 enter the United States before August 22, 1996? ◯ Yes ◯ No
g. Has PERSON 3 lived in the United States for five years or more in a qualified status? *(See page 20 to determine whether PERSON 3 has a qualified status.)* ◯ Yes ◯ No
h. Does PERSON 3 have a sponsor? ◯ Yes – sponsor's name: _____ ◯ No
i. Is PERSON 3, or is his or her spouse or parent, a veteran or active-duty member of the military? ◯ Yes ◯ No
j. Is PERSON 3 getting services from the Center for Victims of Torture? ◯ Yes ◯ No
k. Does PERSON 3 want help paying for a medical emergency?
◯ No ◯ Yes – what is the begin and end date for the medical emergency?
_____ (MM/DD/YYYY) to _____ (MM/DD/YYYY)

15. Did PERSON 3 ever have an immigration status different from his or her current status (example: refugee or asylee)?
◯ No ◯ Yes – what is PERSON 3's previous immigration status? *(Choose a status code from the list on page 20, or write in PERSON 3's previous status if it is not on the list.)*
Code or status: _____ Original date of entry: _____ (MM/DD/YYYY)

16. Does PERSON 3 want help from Medical Assistance (MA) to pay for medical bills from the past three months?
(MA can start up to three months before your application date if PERSON 3 has medical bills from that time and meets the MA requirements.)
◯ Yes – answer questions a and b. ◯ No – go to question 17.
a. Which months before the month of application do you want help for? (Check all that apply)
☐ One month ago ☐ Two months ago ☐ Three months ago
b. Is everything you told us on the application the same for the selected month(s)? (For example, income, pregnancy and family size)
◯ Yes ◯ No

17. If under age 26, was PERSON 3 in foster care in any state? ◯ Yes – answer questions a - c ◯ No
a. In what state was PERSON 3 in foster care? _____
b. Did foster care stop when PERSON 3 was age 18 or older? ◯ Yes ◯ No
c. Was PERSON 3 on Medical Assistance or another Medicaid program at the time foster care ended? ◯ Yes ◯ No

18. Answer yes or no to the following five questions.
a. Is PERSON 3 blind? ◯ Yes ◯ No
b. Does PERSON 3 have a physical, mental, or emotional health condition that limits PERSON 3's activities (like bathing, dressing, daily chores, etc.)? ◯ Yes ◯ No
c. Does PERSON 3 need help staying in his or her home or help paying for care in a long-term-care facility, such as a nursing home?
◯ Yes ◯ No
d. Has PERSON 3 been determined disabled by the Social Security Administration (SSA) or the State Medical Review Team (SMRT)?
◯ Yes ◯ No
e. Is PERSON 3 in a residential treatment program for mental illness or drug or alcohol dependency? ◯ Yes ◯ No

19. Is PERSON 3 in jail or prison? ◯ No ◯ Yes – If in jail, is PERSON 3 awaiting disposition of charges? ◯ Yes ◯ No

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STEP 2: PERSON 3 (Continue with PERSON 3)

Recent Job Changes

20. IN THE PAST SIX MONTHS, DID PERSON 3 DO ANY OF THESE THINGS? (Check all that apply)

☐ Change jobs ☐ Stop working ☐ Start working fewer hours or have a salary cut

Optional: If PERSON 3 changed jobs or stopped working in the last 6 months, providing the name and Employer Identification Number (EIN) of PERSON 3's former employer may help speed up the application process.

EMPLOYER NAME(S)	EIN

Current Job and Income Information (Check all that apply)

☐ **Employed**
If PERSON 3 is employed, tell us about his or her income. Start with question 21.

☐ **Self-employed**
Answer question 25.

☐ **Seasonally employed**
Answer question 26.

☐ **Not employed**
Answer question 27.

Current Job 1

21. EMPLOYER NAME AND ADDRESS: Write the employer name that appears on your paycheck.	EMPLOYER IDENTIFICATION NUMBER (EIN)

22. TAXABLE WAGES AND TIPS: List the amount after pretax payroll deductions and before taxes. Pretax payroll deductions may be for a retiree plan, health insurance plan, childcare plan or a parking and transportation program. Choose one and fill in the dollar amount. If work hours and wages vary, write the total wages expected for the next 12 months in the "Yearly" box.

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

Current Job 2

(If PERSON 3 has more jobs and need more space, attach another sheet of paper and include that information.)

23. EMPLOYER NAME AND ADDRESS: Write the employer name that appears on your paycheck.	EMPLOYER IDENTIFICATION NUMBER (EIN)

24. TAXABLE WAGES AND TIPS: List the amount after pretax payroll deductions and before taxes. Pretax payroll deductions may be for a retiree plan, health insurance plan, childcare plan or a parking and transportation program. Choose one and fill in the dollar amount. If work hours and wages vary, write the total wages expected for the next 12 months in the "Yearly" box.

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

25. **SELF-EMPLOYED:** INCOME OR LOSS FROM FARMING, FISHING OR OTHER BUSINESS. ANSWER THE FOLLOWING QUESTIONS:

a. Type of work _____

b. How much income or loss does PERSON 3 expect from self-employment for the next 12 months? Income amount $_____ or Loss amount $_____

26. **SEASONAL INCOME: Complete only if PERSON 3 is seasonally employed.**

PERSON 3's TOTAL SEASONAL INCOME FOR THE NEXT 12 MONTHS	PERSON 3's TOTAL UNEMPLOYMENT FOR THE NEXT 12 MONTHS

EMPLOYER NAME AND ADDRESS: Write the employer name that appears on your paycheck.	EMPLOYER IDENTIFICATION NUMBER (EIN)

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STEP 2: PERSON 3 (Continue with PERSON 3)

27. **OTHER INCOME:** Check all that apply. List the amount before taxes and deductions. If PERSON 3 does not receive any other type of income, mark "none."
Note: PERSON 3 does not need to list child support, nontaxable veteran's payments, money from an Achieving a Better Life Experience (ABLE) account, or Supplemental Security Income (SSI).

- ☐ None
- ☐ Unemployment $ _____ weekly
- ☐ Pensions or retirement, including taxable veteran's pensions $ _____ monthly
- ☐ Social Security benefits* $ _____ monthly
- ☐ Alimony received** $ _____ monthly
- ☐ Net rental or royalty $ _____ yearly
- ☐ Interest $ _____ yearly
  How much of this interest amount is not taxable? $ _____
- ☐ Lottery or gambling winnings greater than $80,000 since January of 2018
  Total amount of winnings: $ _____ Month and year winnings were received: _____
- ☐ Other taxable income that is expected within the next 12 months (Taxable income is income you would list on the Income section of IRS Form 1040).
  Type: _____ $ _____ How often? _____
- ☐ Other taxable income this month
  Type: _____ $ _____ How often? _____

*Social Security benefits include retirement, disability and Railroad Retirement benefits. Supplemental Security Income (SSI) is not Social Security benefits. List the gross amount before any deductions. Include both taxable and nontaxable Social Security benefits.

**Do not list alimony received if your divorce or separation agreement is dated after 2018.

28. **ADJUSTMENTS TO INCOME:** Check all that apply. List the amount PERSON 3 expects to pay over the next 12 months.
If PERSON 3 pays for certain things that can be subtracted from gross income on a federal income tax return, telling us about them could lower the cost of PERSON 3's health coverage. **Note:** Do not list an expense already included in PERSON 3's self-employment income or loss (question 25b).

See the instructions for Schedule 1 of the IRS 1040 form for more information about these adjustments.

	Yearly amount
☐ Educator expenses (up to $250)	$ _____
☐ Certain business expenses of reservists, performing artists, and fee-basis government officials	$ _____
☐ Health savings account deduction	$ _____
☐ Moving expenses for active duty military members	$ _____
☐ Deductible part of self-employment tax	$ _____
☐ Self-employed SEP, SIMPLE and qualified plans	$ _____
☐ Self-employed health insurance deduction	$ _____
☐ Penalty on early withdrawal of savings	$ _____
☐ Alimony paid*	$ _____
☐ IRA deduction	$ _____
☐ Student loan interest	$ _____

*Do not list alimony payments if the payments are based on a divorce or separation agreement dated after 2018.

29. **PROJECTED ANNUAL INCOME FOR 2023:** Does PERSON 3 expect his or her total annual income for 2023 to be the same as the income listed on this application?

- ◯ Yes – PERSON 3's total income expected for 2023 will be the same as the income listed on this application.
- ◯ No – PERSON 3's total income expected for 2023 will be: $ _____

  Add up all of the income PERSON 3 received from January 1 until now, and all of the income PERSON 3 expects to receive through December 31.

See page 20 for more information about how to calculate PERSON 3's projected annual income.

If you have more than four people in your family, make copies of pages 14-17 and complete the copied pages to include all family members in this application for coverage.

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STEP 2: PERSON 4

Complete Steps 2-4 for any others you need to include on this application. See page 1 Step 1 for information about the people to include. If you have no more people to include, go to page 18 Step 3.

1. FIRST NAME	MIDDLE NAME	LAST NAME	SUFFIX	2. MARITAL STATUS
				◯ Legally separated ◯ Married ◯ Divorced ◯ Widowed ◯ Never married

3. RELATIONSHIP TO YOU	4. DATE OF BIRTH	5. SEX
	_____ (MM/DD/YYYY) If under the age of 18, is this person under the legal control of a parent? ◯ Yes ◯ No	◯ Male ◯ Female

6. Does PERSON 4 have a Social Security number (SSN)?

◯ Yes – what is PERSON 4's SSN?* _____

◯ No – has PERSON 4 applied for an SSN? ◯ Yes ◯ No – why not? Choose a reason code from the list on page 20: _____

*See the Notice of Privacy Practices and Notice of Rights and Responsibilities (Attachment A) for information about SSNs.

7. Does PERSON 4 live at the same address with you? ◯ Yes ◯ No – list address: _____

8. Does PERSON 4 plan to file a federal income tax return **next year**? (PERSON 4 can still apply even if he or she does not file a federal income tax return.)

◯ Yes – answer questions a, b and c. ◯ No – go to question c.

a. Will PERSON 4 file jointly with a spouse?

◯ Yes – name of spouse: _____

◯ No – Will PERSON 4 file as Married Filing Separately because of domestic abuse or spousal abandonment (spouse left household) or file as Head of Household? ◯ Yes ◯ No

b. Will PERSON 4 claim any dependents on his or her tax return? ◯ Yes - list names _____ ◯ No

c. Will PERSON 4 be claimed as a dependent on someone else's tax return? ◯ Yes - name of tax filer _____ ◯ No

How is PERSON 4 related to the tax filer: _____

9. Is PERSON 4 pregnant? ◯ No ◯ Yes - how many babies are expected? _____ Due date: _____ (MM/DD/YYYY)

a. Was PERSON 4 pregnant in the past three months? ◯ No ◯ Yes - what date did the pregnancy end? _____ (MM/DD/YYYY)

10. Does PERSON 4 want to apply for health care coverage?

(Even if PERSON 4 has insurance, there might be a program with better coverage or lower costs.)

◯ Yes – answer **all** the following questions. ◯ No – go to the job and income questions on page 16.

11. Answer yes or no to the following four questions

a. Did PERSON 4 move to Minnesota in the last three months? ◯ Yes - what date? _____ ◯ No

b. Does PERSON 4 plan to make Minnesota his or her home? ◯ Yes ◯ No

c. Did PERSON 4 enter Minnesota with a job commitment or to seek employment? ◯ Yes ◯ No

d. Is PERSON 4 visiting Minnesota to get medical care or for personal reasons? ◯ Yes ◯ No

12. Ethnicity and Race for PERSON 4: You do not have to answer these questions to get health care. We use this information to identify groups of people who have health concerns and try to find ways to improve their care.

a. Is PERSON 4 of Hispanic, Latino or Spanish origin? ◯ No, not Hispanic, Latino or Spanish origin ◯ Yes – check all that apply

☐ Yes, Cuban ☐ Yes, Mexican, Mexican American or Chicano/a ☐ Yes, Puerto Rican

☐ Yes, other: _____ ☐ I choose not to answer

b. Race (check all that apply):

☐ American Indian or Alaska Native ☐ Asian Indian ☐ Black or African American ☐ Chinese ☐ Filipino

☐ Guamanian or Chamorro ☐ Japanese ☐ Korean ☐ Native Hawaiian ☐ Other Asian ☐ Other Pacific Islander

☐ Samoan ☐ Vietnamese ☐ White ☐ Other: _____ ☐ I choose not to answer

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STEP 2: PERSON 4 (Continue with PERSON 4)

13. Is PERSON 4 a U.S. citizen or U.S. national?
(A U.S. national is a person born in American Samoa or Swains Island, a person born outside the U.S. with one or both parents who are U.S. nationals, or a person born in the Northern Mariana Islands who chose to be a U.S. national.)
◯ Yes – go to question 16. ◯ No – go to question 14.

14. What is PERSON 4's current immigration status? *(Choose a status code from the list on page 20, or write status if it is not on the list.)*
Code or status: _____
a. Immigration document type: _____ b. Alien I.D. number: _____
c. Card number: _____ d. Document expiration date (MM/DD/YYYY): _____
e. Date of entry (MM/DD/YYYY): _____
f. Did PERSON 4 enter the United States before August 22, 1996? ◯ Yes ◯ No
g. Has PERSON 4 lived in the United States for five years or more in a qualified status? *(See page 20 to determine whether PERSON 4 has a qualified status.)* ◯ Yes ◯ No
h. Does PERSON 4 have a sponsor? ◯ Yes – sponsor's name: _____ ◯ No
i. Is PERSON 4, or is his or her spouse or parent, a veteran or active-duty member of the military? ◯ Yes ◯ No
j. Is PERSON 4 getting services from the Center for Victims of Torture? ◯ Yes ◯ No
k. Does PERSON 4 want help paying for a medical emergency?
◯ No ◯ Yes – what is the begin and end date for the medical emergency?
_____ (MM/DD/YYYY) to _____ (MM/DD/YYYY)

15. Did PERSON 4 ever have an immigration status different from his or her current status (example: refugee or asylee)?
◯ No ◯ Yes – what is PERSON 4's previous immigration status? *(Choose a status code from the list on page 20, or write in PERSON 4's previous status if it is not on the list.)*
Code or status: _____ Original date of entry: _____ (MM/DD/YYYY)

16. Does PERSON 4 want help from Medical Assistance (MA) to pay for medical bills from the past three months?
(MA can start up to three months before your application date if PERSON 4 has medical bills from that time and meets the MA requirements.)
◯ Yes – answer questions a and b. ◯ No – go to question 17.
a. Which months before the month of application do you want help for? (Check all that apply)
☐ One month ago ☐ Two months ago ☐ Three months ago
b. Is everything you told us on the application the same for the selected month(s)? (For example, income, pregnancy and family size)
◯ Yes ◯ No

17. If under age 26, was PERSON 4 in foster care in any state? ◯ Yes – answer questions a - c ◯ No
a. In what state was PERSON 4 in foster care? _____
b. Did foster care stop when PERSON 4 was age 18 or older? ◯ Yes ◯ No
c. Was PERSON 4 on Medical Assistance or another Medicaid program at the time foster care ended? ◯ Yes ◯ No

18. Answer yes or no to the following five questions.
a. Is PERSON 4 blind? ◯ Yes ◯ No
b. Does PERSON 4 have a physical, mental, or emotional health condition that limits PERSON 4's activities (like bathing, dressing, daily chores, etc.)? ◯ Yes ◯ No
c. Does PERSON 4 need help staying in his or her home or help paying for care in a long-term-care facility, such as a nursing home?
◯ Yes ◯ No
d. Has PERSON 4 been determined disabled by the Social Security Administration (SSA) or the State Medical Review Team (SMRT)?
◯ Yes ◯ No
e. Is PERSON 4 in a residential treatment program for mental illness or drug or alcohol dependency? ◯ Yes ◯ No

19. Is PERSON 4 in jail or prison? ◯ No ◯ Yes – If in jail, is PERSON 4 awaiting disposition of charges? ◯ Yes ◯ No

STEP 2: PERSON 4 (Continue with PERSON 4)

Recent Job Changes

20. IN THE PAST SIX MONTHS, DID PERSON 4 DO ANY OF THESE THINGS? (Check all that apply)

☐ Change jobs ☐ Stop working ☐ Start working fewer hours or have a salary cut

Optional: If PERSON 4 changed jobs or stopped working in the last 6 months, providing the name and Employer Identification Number (EIN) of PERSON 4's former employer may help speed up the application process.

EMPLOYER NAME(S)	EIN

Current Job and Income Information (Check all that apply)

☐ **Employed**
If PERSON 4 is employed, tell us about his or her income. Start with question 21.

☐ **Self-employed**
Answer question 25.

☐ **Seasonally employed**
Answer question 26.

☐ **Not employed**
Answer question 27.

Current Job 1

21. EMPLOYER NAME AND ADDRESS: Write the employer name that appears on your paycheck.	EMPLOYER IDENTIFICATION NUMBER (EIN)

22. TAXABLE WAGES AND TIPS: List the amount after pretax payroll deductions and before taxes. Pretax payroll deductions may be for a retiree plan, health insurance plan, childcare plan or a parking and transportation program. Choose one and fill in the dollar amount. If work hours and wages vary, write the total wages expected for the next 12 months in the "Yearly" box.

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

Current Job 2

(If PERSON 4 has more jobs and need more space, attach another sheet of paper and include that information.)

23. EMPLOYER NAME AND ADDRESS: Write the employer name that appears on your paycheck.	EMPLOYER IDENTIFICATION NUMBER (EIN)

24. TAXABLE WAGES AND TIPS: List the amount after pretax payroll deductions and before taxes. Pretax payroll deductions may be for a retiree plan, health insurance plan, childcare plan or a parking and transportation program. Choose one and fill in the dollar amount. If work hours and wages vary, write the total wages expected for the next 12 months in the "Yearly" box.

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

25. **SELF-EMPLOYED:** INCOME OR LOSS FROM FARMING, FISHING OR OTHER BUSINESS. ANSWER THE FOLLOWING QUESTIONS:

a. Type of work _____

b. How much income or loss does PERSON 4 expect from self-employment for the next 12 months? Income amount $_____ or Loss amount $_____

26. **SEASONAL INCOME: Complete only if PERSON 4 is seasonally employed.**

PERSON 4's TOTAL SEASONAL INCOME FOR THE NEXT 12 MONTHS	PERSON 4's TOTAL UNEMPLOYMENT FOR THE NEXT 12 MONTHS

EMPLOYER NAME AND ADDRESS: Write the employer name that appears on your paycheck.	EMPLOYER IDENTIFICATION NUMBER (EIN)

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STEP 2: PERSON 4 (Continue with PERSON 4)

27. **OTHER INCOME:** Check all that apply. List the amount before taxes and deductions. If PERSON 4 does not receive any other type of income, mark "none."
Note: PERSON 4 does not need to list child support, nontaxable veteran's payments, money from an Achieving a Better Life Experience (ABLE) account, or Supplemental Security Income (SSI).

- ☐ None
- ☐ Unemployment $ _____ weekly
- ☐ Pensions or retirement, including taxable veteran's pensions $ _____ monthly
- ☐ Social Security benefits* $ _____ monthly
- ☐ Alimony received** $ _____ monthly
- ☐ Net rental or royalty $ _____ yearly
- ☐ Interest $ _____ yearly
  How much of this interest amount is not taxable? $ _____
- ☐ Lottery or gambling winnings greater than $80,000 since January of 2018
  Total amount of winnings: $ _____ Month and year winnings were received: _____
- ☐ Other taxable income that is expected within the next 12 months (Taxable income is income you would list on the Income section of IRS Form 1040).
  Type: _____ $ _____ How often? _____
- ☐ Other taxable income this month
  Type: _____ $ _____ How often? _____

*Social Security benefits include retirement, disability and Railroad Retirement benefits. Supplemental Security Income (SSI) is not Social Security benefits. List the gross amount before any deductions. Include both taxable and nontaxable Social Security benefits.

**Do not list alimony received if your divorce or separation agreement is dated after 2018.

28. **ADJUSTMENTS TO INCOME:** Check all that apply. List the amount PERSON 4 expects to pay over the next 12 months.
If PERSON 4 pays for certain things that can be subtracted from gross income on a federal income tax return, telling us about them could lower the cost of PERSON 4's health coverage. **Note:** Do not list an expense already included in PERSON 4's self-employment income or loss (question 25b).

See the instructions for Schedule 1 of the IRS 1040 form for more information about these adjustments.

	Yearly amount
☐ Educator expenses (up to $250)	$ _____
☐ Certain business expenses of reservists, performing artists, and fee-basis government officials	$ _____
☐ Health savings account deduction	$ _____
☐ Moving expenses for active duty military members	$ _____
☐ Deductible part of self-employment tax	$ _____
☐ Self-employed SEP, SIMPLE and qualified plans	$ _____
☐ Self-employed health insurance deduction	$ _____
☐ Penalty on early withdrawal of savings	$ _____
☐ Alimony paid*	$ _____
☐ IRA deduction	$ _____
☐ Student loan interest	$ _____

*Do not list alimony payments if the payments are based on a divorce or separation agreement dated after 2018.

29. **PROJECTED ANNUAL INCOME FOR 2023:** Does PERSON 4 expect his or her total annual income for 2023 to be the same as the income listed on this application?

- ◯ Yes – PERSON 4's total income expected for 2023 will be the same as the income listed on this application.
- ◯ No – PERSON 4's total income expected for 2023 will be: $ _____

  Add up all of the income PERSON 4 received from January 1 until now, and all of the income PERSON 4 expects to receive through December 31.

See page 20 for more information about how to calculate PERSON 4's projected annual income.

Continue to Step 3

NEED HELP WITH THIS APPLICATION? Visit **www.mnsure.org** or call us at **651-539-2099** (855-366-7873 outside the Twin Cities). If you need help in a language other than English, tell us the language you need. We will get you help at no cost to you.

STEP 3 Your Household's Health Coverage

Answer questions 1-3 in this step for anyone that needs health coverage.

1. Is anyone now **enrolled** in health coverage?

◯ Yes – check the type of coverage and provide the information about the coverage. If there is more than one insurance company, please provide the same information on an attached sheet of paper.

◯ No – Continue to question 2.

☐ Medical Assistance (MA) ☐ MinnesotaCare ☐ Medicare ☐ COBRA
☐ Employer insurance ☐ Private or other insurance ☐ VA health care programs ☐ Prescription drug coverage
☐ TRICARE (Do not check if you have direct care or line of duty) ☐ Peace Corps ☐ Long-term-care (LTC) insurance
☐ Dental ☐ Vision

POLICYHOLDER'S NAME	POLICYHOLDER'S DATE OF BIRTH	INSURANCE COMPANY NAME	
START DATE	END DATE	GROUP NUMBER	NAME OF INSURANCE POLICY
LIST EVERYONE THAT IS COVERED BY THIS POLICY			
NAME	POLICY NUMBER	NAME	POLICY NUMBER
NAME	POLICY NUMBER	NAME	POLICY NUMBER

2. Is anyone listed on this application **offered**, but not enrolled in, health coverage from a job? Check "yes" even if the coverage is from someone else's job, such as a parent or spouse.

◯ Yes – **Complete Appendix A**. Is this coverage a state employee benefit plan? ◯ Yes ◯ No

◯ No – Continue to question 3.

3. Is anyone getting medical care for an accident or injury? ◯ No ◯ Yes – who? _____

STEP 4 Household Details

1. Are you or is anyone in your family American Indian or Alaska Native? ◯ No ◯ Yes – **Complete Appendix B**.
2. Is anyone temporarily outside of Minnesota for more than 30 days? ◯ No ◯ Yes – who? _____

   Date left: _____ (MM/DD/YYYY) Date expected to return: _____ (MM/DD/YYYY)

   Reason for being temporarily outside Minnesota: _____
3. Has anyone ever been in the United States military? ◯ No ◯ Yes – who? _____
4. Has anyone returned from a tour of active military duty in the last 24 months?

   ◯ No ◯ Yes – who? _____ Date last active tour of duty ended: _____ (MM/DD/YYYY)
5. Does any child on the application have a parent living outside of the home? ◯ Yes ◯ No

STEP 5 Household Changes

1. Has anyone on the application applied for unemployment benefits? ◯ Yes ◯ No
2. Has your family size changed since last year, or do you think your family size will change this year (such as because of a new baby)?

   ◯ Yes ◯ No
3. Has the income of any tax filer included in the application decreased from last year? ◯ Yes ◯ No
4. Has your tax filing status changed, or do you think it will change in the next year? ◯ Yes ◯ No

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STEP 6 Please complete this page and read the attached Notice of Privacy Practices and Notice of Rights and Responsibilities before signing.

Verifying Eligibility and Renewing Coverage

Each year, MNsure and DHS match data to verify and renew eligibility for help paying for health coverage. We need consent to use information from tax returns to verify and renew your financial assistance for coverage. If you do not give consent to use this information, your financial assistance cannot be verified during the year and renewed. You can change your consent at any time. **If you do not check a box, you are agreeing to the use of your information for 5 years.**

I agree to the use of tax return information to verify and renew my eligibility for help paying for health coverage for:

☐ 5 years ☐ 4 years ☐ 3 years ☐ 2 years ☐ 1 year

☐ Do not use information from tax returns to renew my eligibility for help paying for health coverage.

Contacting You

Can we send you updates and reminders about your case in the future? By checking "yes" here, you consent to receive electronic notifications. DHS and MNsure are not responsible for any charges for electronic notifications. It is the applicant's responsibility to check with the individual carrier, as standard messaging and data rates may apply.

Is it OK to reach out to you via text message? ◯ No ◯ Yes – which number should receive texts? _____

Is it OK to contact you via email? ◯ No ◯ Yes – email address: _____

Do you want us to create an online account for you? ◯ No ◯ Yes – answer the following questions

Indicate your preferred username*: _____

*If this username already exists for someone else, your username will be slightly changed and you will be notified.

Provide the email address to be associated with the account: _____

By Signing Here

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 understand that if I am providing information on behalf of other people in my household, I must have consent to provide and view information about all the people that I have listed on the application and agree to safeguard their information.

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 (MA) and MinnesotaCare:

- **If anyone on this application is eligible for MA or MinnesotaCare**, I consent to the release of medical records as described in the Consent for Sharing of Medical Information section of the Notice of Rights and Responsibilities.
- **If anyone on this application is eligible for MA,** I give the MA agency our rights to pursue and get any money from other health insurance, legal settlements, or other third parties.
- **If anyone on this application is eligible for MA,** 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.
- **If anyone on this application is eligible for MA or MinnesotaCare,** 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 and the Notice of Rights and Responsibilities.
- **If I am a parent that is eligible for MA,** I know I will 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 MA agency the rights to medical support paid for my children.

Remember to return with this application any appendixes you completed.

Sign this application and continue to Step 7.

SIGNATURE	DATE (MM/DD/YYYY)

NEED HELP WITH THIS APPLICATION? Visit **www.mnsure.org** or call us at **651-539-2099** (855-366-7873 outside the Twin Cities). If you need help in a language other than English, tell us the language you need. We will get you help at no cost to you.

STEP 7 Other Family Members

If you have other family members that were not included in Step 2 of this application that you would like to have covered under a family health plan, call the MNsure Contact Center at 855-366-7873.

Qualified family members that may be eligible to be included under a family health plan include:

- Children that do not live with you
- Children that are not included on your federal income tax return
- Adult children 19-26 years old
- Grandchildren that have resided with you continuously from birth and that are financially dependent on you or your covered spouse
- Children under the legal guardianship of you and/or your spouse

STEP 8 Submit your completed and signed application

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

- Fax your application for faster processing.
- Mail your application using the enclosed envelope.
- Submit your application in person.

Mail, fax, or bring your application to your county or tribal agency or MinnesotaCare Operations. The addresses and fax numbers are listed on Attachment B at the back of the application.

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

SOCIAL SECURITY NUMBER CODES

Choose a reason for not applying for a Social Security number (SSN) and place your letter choice in the proper question.

Reasons for not applying for an SSN:

A. Not eligible for an SSN
B. Can be issued for nonwork reason only
C. Religious objections
D. Other reason

IMMIGRATION STATUS CODES

Choose an immigration status from this list and place your letter choice in the proper question. The immigration statuses with an asterisk (*) are qualified statuses.

A. American Indian born in Canada (Immigration and Nationality Act [INA], section 289)*
B. Amerasian noncitizen*
C. Asylee*
D. Conditional entrant*
E. Cuban or Haitian entrant*
F. Withholding of removal or deportation being withheld under section 243(h) or 241(b)(3) of the INA*
G. Refugee*
H. Special Iraqi or Afghani immigrant*
I. Victim of severe trafficking (LPR or T Visa)*
J. Battered noncitizen*
K. Lawful permanent resident (LPR)*
L. Paroled for at least one year*
M. Temporary nonimmigrant
N. Deferred action for childhood arrivals
O. Citizen of Marshall Islands, Micronesia or Palau*

PROJECTED ANNUAL INCOME HELP

Projected annual income is the total income that a person expects to have for the entire year, from January through December. A person's projected annual income includes all the types of income the person would list on a federal 1040 tax return, plus nontaxable Social Security benefits, tax exempt interest and foreign income. Include all of the income you received from January 1 through this month and from next month through December 31 of this year. If you have stopped working at a job, you can find the year-to-date (YTD) income on your last paycheck, or review your bank accounts and statements. Include any taxable lump sums you received during the year. Certain expenses are subtracted from the total income for the year. (See Adjustments to Income, page 5, question 44 for the types of expenses to subtract.)

NEED HELP WITH THIS APPLICATION? Visit **www.mnsure.org** or call us at **651-539-2099** (855-366-7873 outside the Twin Cities). If you need help in a language other than English, tell us the language you need. We will get you help at no cost to you.

APPENDIX A Health Coverage from Jobs

Complete this appendix only if someone in the household is eligible for health coverage from a job, but is not enrolled. You must provide this information to complete this application. Attach a copy of this page for each job that offers coverage. **The employee can take this form to the employer that offers coverage to help answer these questions.**

EMPLOYEE Information

1. FIRST NAME	MIDDLE NAME	LAST NAME	SUFFIX	2. EMPLOYEE DATE OF BIRTH (MM/DD/YYYY)

EMPLOYER Information

3. EMPLOYER NAME		4. EMPLOYER IDENTIFICATION NUMBER (EIN)
5. EMPLOYER ADDRESS		6. EMPLOYER PHONE NUMBER
7. CITY	8. STATE	9. ZIP CODE

10. Whom can we contact about employee health coverage at this job? (This information is not required but providing it will make it easier for us to contact the employer.)	11. PHONE NUMBER (if different from above)

12. Was the employee offered coverage through a job for the current plan year, or will the employee be eligible for coverage in the next three months? **Note:** Answer yes if the employee could have enrolled but did not, even if the employee did not want coverage or thought it was too expensive.

◯ Yes – continue answering the remaining questions

12a. If the employee is in a waiting or probationary period, when could coverage begin? (Declining enrollment is not considered a waiting or probationary period.) (MM/DD/YYYY)
12b. List the names of anyone else that is eligible for coverage from this job.

◯ No – stop here and go to STEP 3 in the application

Tell us about the health plan offered by this employer for the employee only.

13. Does the employer offer a health plan that pays at least 60 percent of allowed costs and covers most inpatient hospital and physician services (minimum value standard)?*

◯ Yes ◯ No

a. What is the name of the lowest-cost plan offered **only to the employee** by the employer? _____

b. How much would the employee pay for this plan if the employee received the maximum discount for not using tobacco or any tobacco cessation program offered? $ _____

c. How often? ☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

14. What change will the employer make for the new plan year (if known)?

☐ Employer will not offer health coverage for employee.

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect discounts for not using tobacco and tobacco cessation programs. See question 13.)

a. How much would the employee pay for this plan? $ _____

b. How often? ☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

Date of change (MM/DD/YYYY): _____

* See Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986. The employer can tell you the answer to this question.

Continue to Next Page

APPENDIX A Health Coverage from Jobs

Tell us about the health plan offered by this employer for family coverage.

15. Does the employer offer a family health plan that pays at least 60 percent of allowed costs and covers most inpatient hospital and physician services (minimum value standard)?*

◯ Yes ◯ No

a. What is the name of the lowest-cost plan offered **for family coverage** by the employer? _____

b. How much would the employee pay for this plan if the employee received the maximum discount for not using tobacco or any tobacco cessation program offered? $ _____

c. How often? ☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

16. What change will the employer make for the new plan year (if known)?

☐ Employer will not offer health coverage for spouse or dependents.

☐ Employer will start offering health coverage to employees' spouse or dependents or change the premium for the lowest-cost plan available for family coverage that meets the minimum value standard.* (Premium should reflect discounts for not using tobacco and tobacco cessation programs.)

a. How much would the employee pay for this plan? $ _____

b. How often? ☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

Date of change (MM/DD/YYYY): _____

* See Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986. The employer can tell you the answer to this question.

APPENDIX B American Indian or Alaska Native Family Member (AI or AN)

Complete this appendix if you or a family member is American Indian or Alaska Native (AI or AN). Submit this with your Application for Health Coverage and Help Paying Costs.

Tell us about your American Indian or Alaska Native family member(s).

American Indians and Alaska Natives have certain health coverage benefits and protections. You can get services from the Indian Health Service, tribal health programs or urban Indian health programs. You may not have to pay cost sharing and may get special monthly enrollment periods. Answer the following questions to make sure your family gets the most help possible.

Note: If you have more people to include, make copies of this page and attach them.

	AI or AN PERSON 1	AI or AN PERSON 2
1. Name (First Name, Middle Name, Last Name, Suffix)	FIRST / MIDDLE / LAST / SUFFIX	FIRST / MIDDLE / LAST / SUFFIX
2. Member of a federally recognized tribe?	◯ Yes TRIBE NAME TRIBAL ID NUMBER ◯ No	◯ Yes TRIBE NAME TRIBAL ID NUMBER ◯ No
3. Is this person receiving or has this person ever received a service from the Indian Health Service, a tribal health program, an urban Indian health program or through a referral to a provider under contract with one of these programs? Note: American Indians and Alaska Natives who have received services from these types of providers do not have any cost sharing for Medical Assistance.	◯ Yes ◯ No	◯ Yes ◯ No
4. Certain money received may not be counted for Medical Assistance (MA) or MinnesotaCare. List any income (amount and how often) reported on your application that includes money from these sources: • Per capita payments from a tribe that come from natural resources, usage rights, leases or royalties • Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations) • Money from selling things that have cultural significance	$ _____ How often? _____	$ _____ How often? _____
5. Does this person live on a reservation?	◯ Yes ◯ No	◯ Yes ◯ No

NEED HELP WITH THIS APPLICATION? Visit **www.mnsure.org** or call us at **651-539-2099** (855-366-7873 outside the Twin Cities). If you need help in a language other than English, tell us the language you need. We will get you help at no cost to you.

APPENDIX C Assistance with Completing this Application

You can choose an authorized representative

You can give a trusted person permission to talk about this application with us, see your information and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an "authorized representative." If you ever need to change your authorized representative, call the MNsure Contact Center at 855-366-7873.

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

Authorized Representative

1. FIRST NAME	MIDDLE NAME	LAST NAME	SUFFIX	RELATIONSHIP TO YOU, IF ANY

2. ADDRESS	3. APARTMENT OR SUITE NUMBER

4. CITY	5. STATE	6. ZIP CODE

7. PHONE NUMBER	8. ORGANIZATION NAME	9. ID NUMBER (If applicable)

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

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

Authorized Representative Signature

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

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

AUTHORIZED REPRESENTATIVE SIGNATURE	DATE (MM/DD/YYYY)

For certified application counselors, navigators, in-person assisters, agents, and brokers only.

Complete this section if you are a certified application counselor, navigator, in-person assister, agent or broker filling out this application for somebody else.

1. APPLICATION START DATE (MM/DD/YYYY)	2. APPLICANT FIRST NAME	MIDDLE NAME	LAST NAME	SUFFIX

3. ASSISTER FIRST NAME	MIDDLE NAME	LAST NAME	SUFFIX	4. ASSISTER PHONE NUMBER

5. ORGANIZATION NAME	6. ASSISTER ID NUMBER

DEPARTMENT OF HUMAN SERVICES

MINNESOTA DEPARTMENT OF HUMAN SERVICES AND MNSURE

Notice of Privacy Practices and Notice of Rights and Responsibilities

(Effective Date: November 2023)

This notice informs you of the privacy practices of the Minnesota Department of Human Services and MNsure, and your rights and responsibilities when applying for and enrolling in health insurance coverage through these agencies. When you apply for help paying for coverage, you may be found eligible for a public program like Medical Assistance and MinnesotaCare or a qualified health plan on the individual market for which you may receive tax credits and cost-sharing reductions. At the time that you apply, you may not know which program you qualify for, and in some cases, a single household may be covered by different programs. Therefore, please review the privacy practices and rights and responsibilities for each program for which you or your household members may qualify.

MNsure manages eligibility and enrollment in individual market qualified health plans (with or without advanced premium tax credits), with coordination through the health insurance carrier that you select.

The Minnesota Department of Human Services and Minnesota county and tribal agencies manage eligibility and enrollment in Medical Assistance and MinnesotaCare.

Notice of Privacy Practices

Privacy Practices for All Programs

This part of the notice describes how private or confidential information about you and your family may be used and disclosed.

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 need protective services (for Medical Assistance and MinnesotaCare only)
- To decide about out-of-home care and in-home care for you (for Medical Assistance and MinnesotaCare only)
- 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 for your Social Security number?

We need a Social Security number (SSN) for every person applying for health care coverage, if they have one. (See 42 CFR § 435.910; 45 CFR § 155.310.)

You do not have to give us the SSN for people in your home that are not applying for coverage, but providing an SSN may help speed up the application process.

We use SSNs to verify identity and prevent duplication of state and federal benefits. Additionally, SSNs are used to conduct computer data matches with federal and local agencies to verify income, resources and other information that may affect your eligibility or benefits. We will keep all the information you provide private and secure, as required by law. We will use personal information only to check if you're eligible for health coverage.

If someone who is applying does not have an SSN, they may be required to apply for one to get Medical Assistance. There are exceptions to this for people who:

- are not eligible for a Social Security number,
- can only get a Social Security number for a valid non-work reason, or
- refuse to get a Social Security number due to a well-established religious objection.

If you want help getting an SSN, visit socialsecurity.gov, or call 800-772-1213. TTY users should call 800-325-0778.

Why do we ask for your income information?

We ask for income information and check state and federal sources to confirm your income and family size. We will use this information only for the purposes authorized by law, such as verifying eligibility or determining eligibility for the advanced premium tax credit and cost-sharing reductions, and the amount of the credit or reduction. 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 can be investigated and charged with fraud.

With whom may we share information?

We will share information about you only as needed and as allowed or required by law. For all programs, we may share your information with the following agencies or people that 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, fraud investigators, and fraud prevention investigators
- 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
- Certified application counselors, in-person assisters, and navigators and anyone else the law says we must or can give the information to

Additionally, for Medical Assistance and MinnesotaCare only, we may share your information with the following agencies or people that need the information to do their jobs:

- Human services offices, including child support enforcement offices
- Child protection investigators
- Governmental agencies in other states administering public benefits programs
- Health care providers, including mental health agencies and drug and alcohol treatment facilities
- 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

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 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 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-4839K-ENG and www.mnsure.org.
- The law requires us to keep your private information private and secure.
- As the law requires, if something happens that causes your private information to no longer be private and secure, we will let you know.

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

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

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

Ask us to correct health or other records about you

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 will 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 or MNsure for another copy of this notice.

Genetic Information

MNsure does not collect, maintain or use genetic information.

Record Retention

Information provided in an application for coverage through MNsure is subject to the False Claims Act and will be kept for up to 10 years. MNsure follows a records retention schedule and maintains data according to state and federal law. After the appropriate time period, MNsure shreds paper files and permanently removes electronic data to prevent recovery.

Privacy Practices for Medical Assistance and MinnesotaCare Only

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.

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 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

If you believe MNsure has violated your privacy rights, you may also contact:

MNsure Privacy Manager
355 Randolph Ave., Suite 100
St. Paul, MN 55102

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

If you need more information about privacy practices, call the Health Care Consumer Support at 800-657-3739 or 651-431-2670.

Notice of Rights and Responsibilities

Rights and Responsibilities for All Programs

Changes

If you have Medical Assistance (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 have MinnesotaCare, you must report a change within 30 days of the change happening. If everyone in your household receives MinnesotaCare, call MinnesotaCare Operations at 800-657-3672 or 651-297-3862 to report the change. If anyone in your household has MA, call your county or tribal agency to report the change.

If you are enrolled in a qualified health plan (QHP), have advanced premium tax credits (APTC) applied to your coverage, or receive cost-sharing reductions (CSR), you must report a change within 30 days of the change happening. Call MNsure at 855-366-7873 to report any changes.

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 new income or stop getting income, like Social Security or unemployment
- Have changes in the amount of income you get from your business, from farming or other types of self-employment

Residence changes when you

- Move to a new address
- Are temporarily out of Minnesota for more than 30 days

Life changes in your household when someone

- Becomes pregnant or has a baby
- Moves in or out of your home
- Dies, gets married or divorced
- Starts or stops other health insurance or Medicare
- Becomes disabled
- Goes into or gets out of jail

Tax Filing

If you purchased a QHP through MNsure and are receiving APTC or wish to claim the Premium Tax Credit (PTC), you must file taxes with the Internal Revenue Service (IRS). If you are married at the end of the year, you must file a joint income tax return with your spouse.

When you file your federal income tax return, the IRS will compare the income on your tax return with the income on your application. If the income on your tax return is lower than the income on your application, you may be eligible to get an additional tax credit amount. On the other hand, if the income on your tax return is higher than the income on your application, you may owe additional federal income tax. At the end of the tax year, MNsure will issue a 1095A form for you to use in reporting health insurance coverage to the IRS. You can find more information about tax filing on the MNsure website: www.mnsure.org/individual-family/cost/1095-A.jsp

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 the MNsure appeals website at www.mnsure.org/help/appeals or at the DHS website at www.dhs.state.mn.us/appeals/faqs.

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

You can also print the form 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

Rights and Responsibilities for Medical Assistance and MinnesotaCare Only

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, MA or MinnesotaCare, 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 MA or MinnesotaCare, 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 or MinnesotaCare 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 have become eligible for Medicare. MA pays for the Medicare premiums of some low-income people.

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.

You may ask for a waiver from helping if it is against the best interests of your child or children, or against your best interests because of fear of physical or emotional harm. The agency will review your proof and tell you whether you still must give information to child support staff.

Assignment of Medical Payments

By accepting MA, you give your rights to all medical payments for yourself, and anyone else you apply for and for whom you can legally assign rights, 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.

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, 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
- Managed Care premiums (capitations) for coverage of these services.

Home and community-based services include home health and skilled nursing services, personal care attendant costs, and medical supplies and equipment. They also include physical therapy, occupational therapy and speech therapy, when the therapy is provided by a home health or home rehabilitation agency.

If you permanently live in a medical institution, Minnesota must also try to recover the costs of all MA services you received 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.

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/.

Your Civil Rights

Discrimination is against the law. MNsure and the Minnesota Department of Human Services (DHS) do not discriminate on the basis of any of the following: race, color, national origin, creed, religion, public assistance status, marital status, age, disability, sex (including sexual orientation and gender identity).

Free Services

Auxiliary aids

If you have a disability and need aids and services to have an equal opportunity to participate in our health care programs, MNsure and DHS will provide them timely and free of charge. These aids and services include qualified interpreters and information in accessible formats.

Language assistance

If you have difficulty understanding English and need language help to access information and services, DHS will provide language assistance services timely and free of charge. These services include translated documents and interpreting spoken language.

To request these free services from MNsure, contact the MNsure Accessibility and Equal Opportunity (AEO) Office at AEO@MNsure.org or 651-539-2099 or 855-366-7873 (toll free).

To request these free services from DHS, call DHS Health Care Consumer Support at 651-297-3862 or 800-657-3672. 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 a 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, or sex (including sexual orientation and gender identity).

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

Centralized Case Management Operations
U.S. Department of Health and Human Services
200 Independence Avenue SW
Room 509F, HHH Building
Washington, DC 20201
800-368-1019 (voice), 800-537-7697 (TDD)
202-619-3818 (fax)
OCRComplaint@hhs.gov (email)
https://ocrportal.hhs.gov/

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, or disability.

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

Minnesota Department of Human Rights
540 Fairview Avenue North, Suite 201
St. Paul, MN 55104
651-539-1100 (voice) or 800-657-3704 (toll free)
711 or 800-627-3529 (MN Relay)
651-296-9042 (fax)
Info.MDHR@state.mn.us (email)
https://mn.gov/mdhr/intake/consultationinquiryform/

MNsure and DHS

You have a right to file a complaint with MNsure or 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, public assistance status, marital status, age, disability, sex (including sexual orientation and gender identity).

Complaints must be in writing and filed within 180 days (or one year for MNsure consumers) 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.

MNsure or 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 MNsure or 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 remedies.

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

MNsure Accessibility and Equal Opportunity (AEO) Office
PO Box 64253
St. Paul, MN 55164-0253
651-539-2099 or 855-366-7873 (voice) or use your preferred relay service
AEO@MNsure.org (email)

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

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

Attachment B

Agency Addresses

(Effective Date: August 2023)

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

Anoka County
Economic Assistance Department
1201 89th Ave NE, Suite 400
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, PO 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, PO Box 788
New Ulm, MN 56073-0788
507-354-8246 / 800-450-8246
Fax: 507-359-4146

Carlton County
14 N. 11th Street, Suite 100
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
651-213-5600
Fax: 651-213-5685

Clay County
715 North 11th Street, Suite 102
Moorhead, MN 56560-2095
218-299-5200 / 800-757-3880
Fax: 218-299-7106

Clearwater County
216 Park Avenue NW
Bagley, MN 56621-9500
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, PO Box 9
Windom, MN 56101-0009
507-831-1891
Fax: 507-831-0126

Crow Wing County
204 Laurel Street, PO Box 686
Brainerd, MN 56401-0686
218-824-1250 / 888-772-8212
Fax: 218-824-1141

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

Dept of Human Services
Health Care Consumer Support
540 Cedar Street, PO Box 64252
St. Paul, MN 55164-0252
651-297-3862 / 800-657-3672
Fax: 651-431-7750

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
Western Prairie Human Services
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

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 / 800-450-8832
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
SWHHS
319 North Rebecca St., PO Box 44
Ivanhoe, MN 56142
507-694-1452 / 800-657-3781
Fax: 507-694-1859

Lyon County
SWHHS
607 West Main Street, Suite 100
Marshall, MN 56258
507-537-6747 / 800-657-3760
Fax: 507-537-6088

McLeod County
520 Chandler Avenue North
Glencoe, MN 55336
320-864-3144 / 800-247-1756
Fax: 320-864-5265

Mahnomen County
PO Box 460
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

Morrison County
213 SE First Avenue
Little Falls, MN 56345-3196
320-632-7800 / 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
SWHHS
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
218-998-8150
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
635 Northridge Dr NW, Suite 220
Pine City, MN 55063
320-591-1570
Fax: 320-591-1601

Or

1602 Highway 23 N
Sandstone, MN 55072-5009
320-216-4100
Fax: 320-216-4101

Pipestone County
SWHHS
1091 North Hiawatha Avenue
Pipestone, MN 56164
507-825-6720 / 888-632-4325
Fax: 507-825-6727

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 / 877-281-3127
Fax: 218-773-3602

Or

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

Pope County
Western Prairie Human Services
211 East MN Avenue
Glenwood, MN 56334-1629
320-634-7755 / 800-291-2827
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

Red Lake Nation
Oshkiimaajitahdah
15525 Mendota Ave, PO Box 416
Redby, MN 56670
218-679-3350 / 888-404-0686
Fax: 218-679-4317

Redwood County
SWHHS
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
SWHHS
2 Roundwind Road, PO Box 715
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: 218-733-2975

Or

201 S 3rd Avenue W, 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: 218-471-7123

Scott County
Scott County Health and Human Services
200 4th Avenue West
Shakopee, MN 55379
952-445-7751
Fax: 952-496-8685

Sherburne County
13880 Business Center Drive
Elk River, MN 55330-4600
763-765-4000 / 800-433-5239
Fax: 763-765-4096

Sibley County
111 8th Street, PO Box 237
Gaylord, MN 55334-0237
507-237-4000
Fax: 507-237-4031

Stearns County
PO Box 1107
705 Courthouse Square
St. Cloud, MN 56302-1107
320-656-6000 / 800-450-3663
Fax: 320-656-6447

Steele County
MnPrairie
PO Box 890
630 Florence Ave
Owatonna, MN 55060
507-431-5600
Fax: 507-451-5947

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, PO Box 208
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, PO Box 46
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
1000 West Elm Ave
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, PO Box 31
St. James, MN 56081-0031
507-375-3294 / 888-299-5941
Fax: 507-375-7359

White Earth Financial Services
PO Box 100
Naytahwaush, MN 56566
218-935-2359 / 844-282-6580
Fax: 218-694-6507

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
507-457-6500 / 844-317-8960
Fax: 507-454-9381

Wright County
3650 Braddock Ave NE, Suite 2100
Buffalo, MN 55313-3675
763-682-7400 / 800-362-3667
Fax: 763-682-8920

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

Attachment B – Keep this page for your records.