Minnesota Department of **Human Services**

Minnesota Family Planning Program Application

(Part of Minnesota Health Care Programs)

What is this application for?

Use this application to apply for the Minnesota Family Planning Program (MFPP). MFPP covers only family planning services and supplies for men and women who are not enrolled in Medical Assistance (MA).

- Fill out page 1 and sign the application on page 5 to apply only for short-term coverage with MFPP.
- Fill out the entire application to apply for ongoing coverage with MFPP.

Can I get coverage right away?

- Some clinics use this application to see whether you can get short-term coverage. Short-term coverage begins right away and lasts for up to two months.
- For a list of clinics that can give short-term coverage, call MFPP at the numbers below.

What do I need to do with this form?

- Read the Notice of Privacy Practices and Notice of Rights and Responsibilities at the end of this application. Tear off these pages and keep them.
- Use one application for each person applying.
- Answer all questions on pages 1-4. If you are filling out this application by hand, use blue or black ink. Print clearly.
- Sign and date the application on page 5.
- Mail or fax the completed application to this address:

  Minnesota Department of Human Services
  PO Box 64960
  St. Paul, MN 55164-0960
  Fax: 651-431-7532

How do I apply for health coverage beyond family planning?

You can apply for health coverage and help paying costs in the following ways:

- Apply online at www.mnsure.org
- Fill out the Application for Health Coverage and Help Paying Costs (DHS-6696) (PDF). Find this application at www.mnsure.org. Or have one mailed to you by calling 651-431-2670 or 800-657-3739.

Questions

If you have questions or need help, call MFPP at 651-431-3480 (Twin Cities metro area) or 888-702-9968 (outside Twin Cities metro area).

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၊ ဖဲနမ့်လိဉ်ဘဉ်တ်မၤစၢၤကလီလၢတ်ကကျိးထံဝဲဒဉ်လံာ် တီလံာ်မိတခါအံၤန္ဉ်၊ကိးဘဉ်လိတဲစိနိုဉ်ဂ်ၢ်လၢထးအံၤန္ဉ်တက့်၊

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

ໂປຣດຊາບ. ຖ້າຫາກ ທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປເອກະສານນີ້ຟຣີ, ຈົ່ງໂທຣໄປທີ່ໝາຍເລກຂ້າງເທິງນີ້.

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

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

Digniin. Haddii aad u baahantahay caawimaad lacag-la’aan ah ee tarjumaadda qoraalkan, lambarka kore 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 (8-16)

ADA1 (9-15)

For accessible formats of this publication 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.

Minnesota Department of **Human Services**

DHS-4740-ENG 1-17

Minnesota Health Care Programs

Minnesota Family Planning Program Application

Provider Use Only (If PE is approved, complete the information below and fax pages 1 and 5 to 651-431-7532.)

PROVIDER NAME	PROVIDER ADDRESS		
Polk Norman Mahnomen Community Health Board			
NPI NUMBER		PROVIDER PHONE	DATE PE APPROVED
1427392455			

1. Tell us about yourself below.

FIRST NAME	MIDDLE INITIAL	LAST NAME

DATE OF BIRTH (MM/DD/YYYY)	SOCIAL SECURITY NUMBER*	DAYTIME PHONE NUMBER	GENDER	ARE YOU PREGNANT?
			◯ M ◯ F	◯ Yes ◯ No

HOME STREET ADDRESS	APT. NUMBER

CITY	STATE	ZIP CODE	COUNTY

MAILING ADDRESS (where you would like notices sent, if different from the address above)	APT. NUMBER

CITY	STATE	ZIP CODE

☐ Check this box if you are homeless.

Do you plan to make Minnesota your home?
◉ Yes ◯ No – EXPLAIN: _____

SPOKEN LANGUAGE
☐ English ☐ Spanish ☐ Other: _____

WRITTEN LANGUAGE
☐ English ☐ Spanish ☐ Other: _____

If you do not speak English well, do you need someone who speaks your language to help you? ◯ Yes ◯ No

Are you Latino or Hispanic? (optional)
◯ Yes ◯ No

What is your race? (optional)
☐ White ☐ Asian ☐ American Indian or Alaskan Native
☐ Black or African American ☐ Pacific Islander or Native Hawaiian

* You do not need to give us your Social Security number if you are applying only for short-term coverage.

2. What is your household and income information?

Complete these questions if you are applying for short-term MFPP coverage.

a. How many family members live in your household? (Include yourself, parents, spouse, and children under age 19 who live with you.) _____

b. How much is the income for your household? (Choose one and fill in the amount.) If you are under 21, count only your own income.

◯ Yearly amount $_____ ◯ Monthly amount $_____ ◯ Weekly amount $_____

3. Do you have a Social Security number (SSN)?

◯ Yes
◯ No
If yes, what is your SSN? _____
If no, have you applied for an SSN? ◯ Yes ◯ No – choose a reason and write the letter here: ____
Reasons for not applying for an SSN:
A. Not eligible for an SSN
B. Can be issued for nonwork reason only
C. No SSN because of religious objections

4. Do you live with your spouse? ◯ No ◯ Yes – fill in below

Include a spouse who is living away from home for a short time.

SPOUSE'S FIRST NAME	MI	LAST NAME	If you live with your wife, is she pregnant? ◯ No ◯ Yes

5. Do you live with your children or stepchildren ◯ No ◯ Yes – fill in below

Include children who are living away from home for a short time.

a. Number of children under age 19: _____
b. Names of children under age 19: _____

6. What is your tax-filing status?

Provide your tax-filing status. You can still apply for MFPP even if you do not file a federal income tax return.

Do you plan to file a federal income tax return next year? ◯ Yes – answer questions a–c ◯ No – answer question c

a. Will you file jointly with your spouse? ◯ Yes ◯ No
If yes, name of spouse: _____

b. Will you claim any dependents on your tax return? ◯ Yes ◯ No
If yes, list name(s) of dependent(s): _____

c. Will you be claimed as a dependent on someone else's tax return? ◯ Yes ◯ No
If yes, list the name of the tax filer: _____
How are you related to the tax filer? _____

7. Do you, or does anyone you listed in question 4, 5, or 6, work? ◯ No ◯ Yes – fill in below

Subtract pretax deductions for childcare, health insurance, retirement plans, transportation assistance or other nontaxable benefits.

Name	Employer name	Is this a seasonal or temporary job?	How often paid? (weekly, every two weeks, monthly, other)	Gross income per pay period (include tips)	Date of most recent paycheck
		◯ No ◯ Yes		$	
		◯ No ◯ Yes		$	
		◯ No ◯ Yes		$	
		◯ No ◯ Yes		$	

You must give us proof of this income. Proof can be pay stubs from the last 30 days, a statement from your employer, or your most recent federal tax return if your income has not changed.

8. Are you, or is anyone you listed in question 4, 5, or 6, self-employed?

◯ No ◯ Yes – fill in below.

Name of person	Name of business	Yearly income or loss
		$
		$

You must give us proof of this income. Proof can be your most recent federal income tax return (including all related schedules and forms) or your business records if you do not file a tax return.

9. Do you, or does anyone you listed in question 4, 5, or 6, get money from sources other than work or self-employment? ◯ No ◯ Yes – fill in below

Do not include child support, workers' compensation, Supplemental Security Income (SSI) benefits, or veterans' benefits. Include any onetime lump-sum income (for example, prizes, awards, gambling winnings); unemployment benefits; pension or other retirement income; Social Security disability or retirement benefits; alimony received; net rental or royalty income; and interest and dividends.

Name	Type of income	Start date	Amount	How often received	Date payment last received
			$		
			$		
			$		
			$		

You must give us proof of this income. Proof can be a statement from the place that sends the income or a direct deposit statement from your bank from the last 30 days.

10. Do you, or does anyone you listed in question 4, 5, or 6, have income adjustments? ◯ No ◯ Yes – fill in below

If you pay for certain things that can be subtracted from gross income on a federal income tax return, telling us about them could help you qualify for MFPP. (See the list of allowed income adjustments on Attachment B.)

Type of adjustment	Amount	How often?

You must give us proof of these adjustments. Proof can be your most recent federal income tax return that show these adjustments or other statements or receipts for these expenses.

11. Is any part of the income you reported in questions 7, 8, and 9 educational funds or American Indian or Alaska Native income?

Educational funds are scholarships, awards or grants that are used for educational purposes.

American Indian or Alaska Native income is:

- per-capita or other payments from a tribe that come from natural resources, usage rights, leases, or royalties; and
- 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).

◯ No, none of the income I listed is from these sources ◯ Yes – fill in below

Amount of educational funds used for educational purposes: $ _____

Amount of American Indian or Alaska Native income from the sources above: $ _____

12. Are you a U.S. citizen or U.S. national? ◯ Yes ◯ No

If yes, go to question 14. If no, go to question 13.

13. What is your current immigration status?

Choose an immigration status from the list in Attachment B and place your letter choice in the blank below. Write in your status below if it is not on the list.

Code or status: _____

a. Immigration document type: _____

b. Alien ID number: _____

c. Card number: _____

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

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

f. Do you have a sponsor? ◯ Yes ◯ No

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

h. 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 Attachment B, or write in your previous status below if it is not on the list.)*

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

14. Do you have health insurance?

◯ No, I do not have health insurance.

◯ Yes, I have or may have health insurance. But I do not want you to contact my insurance company. I have good reason for not giving you insurance information. I would be at risk of physical or emotional harm if I gave it. The risk could come from asking the policyholder for insurance information, or from the insurance company's telling the policyholder about the services I get.

◯ ~~Yes, I have health insurance. You may contact my insurance company to see whether it will pay for my services. I understand the insurance company may tell the policyholder about the services I get. Complete the information below or send us a copy of the front and back of your insurance card.~~

TYPE OF COVERAGE	POLICYHOLDER'S NAME	POLICY NUMBER	GROUP NUMBER
◯ Individual ◯ Group ◯ Prescription drug ◯ Medicare ◯ Other	INSURANCE COMPANY NAME		DATE INSURANCE COVERAGE STARTED
	INSURANCE COMPANY ADDRESS		

15. Do you want help from MFPP to pay for family planning medical bills from the past three months?

(The start date for MFPP can go back up to three months from your application date if you have family planning medical bills from that time and meet the MFPP requirements.)

◯ Yes - answer questions a and b. ◯ No - go to next page.

a. How many months? ◯ One ◯ Two ◯ Three

b. Is everything you told us on the application the same for the past month(s)? ◯ Yes ◯ No

Signature Page

(Effective Date: January 1, 2017)

Read the following information and sign.

By signing below:

- I have read and understand the Notice of Privacy Practices and the Notice of Rights and Responsibilities, including the information under "Changes."
- I understand that my information will be released to the parties listed in the Notice of Privacy Practices and the Notice of Rights and Responsibilities to verify eligibility for MFPP.
- I agree to the release of my MFPP records to the parties listed in the "Consent for Sharing of Medical Information" section of the Notice of Rights and Responsibilities.
- I agree to assign my medical benefits as stated in the "Assignment of Medical Payments" section of the Notice of Rights and Responsibilities.
- I understand that I am applying for the MFPP, which covers only family planning services and supplies.

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.

YOUR SIGNATURE	DATE

Attachment A
Notice of Privacy Practices and Notice of Rights and Responsibilities

Minnesota Department of Human Services

(Effective Date: January 1, 2017)

Notice of Privacy Practices

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

Why do we ask for this information?

- To determine whether and how we can help you, we collect information:
  - To tell you apart from other people with the same or similar name
  - To decide what you are eligible for
  - To help you get medical and mental health services and decide whether you can pay for some services
  - To decide whether you or your family need protective services
  - To decide about out-of-home care and in-home care for you or your children
  - To make reports, do research, do audits, and evaluate our programs
  - To investigate reports of people who may lie about the help they need or to get assistance they may not be entitled to receive
  - To collect money from other agencies, like insurance companies, if they should pay for your care
  - To collect money from the state or federal government for help we give you

Why do we ask you for your Social Security number?

We need your Social Security number (SSN) to give you medical assistance, some kinds of financial help, and child support enforcement services (42 CFR 435.910; Minn. Stat. 256L.04, subd. 1a; 45 CFR 205.52; 42 USC 666; 45 CFR 303.30).

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

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

- If you have religious objections
- If you are not a U.S. citizen and are applying for Emergency Medical Assistance only
- If you are from another country, are in the U.S. on a temporary basis, and do not have permission from the U.S. Citizenship and Immigration Services (USCIS) to live in the U.S. permanently
- If you are living in the U.S. without the knowledge or approval of the USCIS

With whom may we share information?

We will share information about you only as needed and as allowed or required by law. We may share your information with the following agencies or people 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, child support officials, child protection and fraud investigators, and fraud prevention investigators
- Human services offices, including child support enforcement offices
- Governmental agencies in other states administering public benefits programs
- Health care providers, including mental health agencies and drug and alcohol treatment facilities
- Health care insurers, health care agencies, managed care organizations and others that pay for your care
- Guardians, conservators or people with power of attorney who are authorized representatives
- Coroners and medical investigators if you die and they investigate your death
- Credit bureaus, creditors or collection agencies if you do not pay fees you owe to us for services, in limited situations
- Certified application counselors, in-person assisters, and navigators and anyone else the law says we must or can give the information to

Why do we ask you for your financial information?

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

Do you have to answer the questions we ask?

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

We can use and share your health care information to

- **Help manage the health care treatment you receive**
  - We can use your health information and share it with professionals who are treating you.
    Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.
  - We can also share your information with guardians, conservators or people with power of attorney who are authorized representatives.
- **Run our organization**
  - We can use and share your information to run our organization and contact you when necessary. This includes sharing your information with employees or volunteers with other state, county, local, federal, and partner nonprofit and private agencies, including child support offices.
  - We can share your information with these people and groups:
    - Auditors, investigators, and others that do quality-of-care reviews and studies
    - Credit bureaus, creditors or collection agencies if you do not pay fees you owe to us for services, in limited situations
    - Certified application counselors, in-person assisters, and navigators and anyone else the law says we must or can give the information to
  - We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long-term-care plans.
    Example: We use health information about you to develop better services for you.
- **Pay for your health services**
  - We can use and share your health information as we pay for your health services.
    Example: We share information about you with your dental plan to coordinate payment for your dental work
- **Help with public health and safety issues**
  - We can share health information about you for purposes like these:
    - Preventing disease
    - Helping with product recalls
    - Reporting adverse reactions to medications
    - Reporting suspected abuse, neglect, or domestic violence
    - Preventing or reducing a serious threat to anyone's health or safety
- **Do research**
  - We can use or share your information for health research.
- **Comply with the law**
  - We will share information about you if state or federal laws require it. This includes sharing information with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
- **Respond to organ and tissue donation requests and work with a medical examiner or funeral director**
  - We can share health information about you with organ procurement organizations.
  - We can share health information with a coroner, medical examiner, or funeral director when a person dies.
- **Address workers' compensation, law enforcement, and other government requests**
  - For workers' compensation claims
  - For law enforcement purposes or with a law enforcement official
  - With health oversight agencies for activities authorized by law
  - With governmental agencies in other states administering public benefits programs
  - For special government functions, such as military, national security, and presidential protective services
- **Respond to lawsuits and legal actions**
  We can share health information about you in response to a court order. We may share the information with court officials, county attorneys, attorneys general, other law enforcement officials, child support officials, child protection and fraud investigators, and fraud prevention investigators.

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

Get a copy of health and claims records

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

Ask us to correct health and claims records

- You may question whether the information we have about you is correct. Send your concerns in writing. Tell us why the information is wrong or not complete. Send your own explanation of the information you do not agree with. We will attach your explanation anytime information is shared.

Request confidential communications

- You have the right to ask us in writing to share health information with you in a certain way or in a certain place.
- We will consider all reasonable requests. We must say yes if you tell us you would be in danger if we did not. For example, you may ask us to send health information to your work address instead of your home address. If we find that your request is reasonable, we will grant it.

Ask us to limit what we use or share

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

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

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

Get a copy of this privacy notice

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

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

Attachment A - Keep this page.

What are your choices?

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

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

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 are our responsibilities?

- We must protect the privacy of your personal, health care and other private information according to the terms of this notice.
- We may not use your information for reasons other than the reasons listed on this form or share your information with people and agencies other than those listed on this form unless you tell us in writing that we can.
- We will not sell any data collected, created or maintained as part of this application.
- We must follow the terms of this notice and give you a copy of it, but we may change our privacy policy. Those changes will apply to all information we have about you. The new notice will be available on request, and we will put changes to it on our website at https:// edocs.dhs.state.mn.us/lfserver/Public/DHS-4839A-ENG
- The law requires us to keep your private information private and secure.
- If something happens that causes your private information to no longer be private and secure, we will let you know right away.

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

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

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

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

Notice of Rights and Responsibilities

Changes

You must report a change to your worker within 10 days of the change happening. Call your county or tribal agency to report the change. If you do not report changes, you may have to pay money back to the state or federal government for benefits that you received but were not eligible for.

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

Income changes when you

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

Residence changes when you

Move to a new address

Life changes in your household when someone

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

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 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

Genetic Information

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

Record Retention

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

Civil Rights Notice

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

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

Auxiliary Aids and Services: DHS provides auxiliary aids and services, like qualified interpreters or information in accessible formats, free of charge and in a timely manner to ensure an equal opportunity to participate in our health care programs. **Contact the Minnesota Health Care Programs (MHCP) Member Help Desk at dhs.info@state.mn.us or 800-657-3739, or use your preferred relay service.**

Language Assistance Services: DHS provides translated documents and spoken language interpreting, free of charge and in a timely manner, when language assistance services are necessary to ensure limited English speakers have meaningful access to our information and services. **Contact the Minnesota Health Care Programs (MHCP) Member Help Desk at dhs.info@state.mn.us or 800-657-3739, or use your preferred relay service.**

Civil Rights Complaints

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

U.S. Department of Health and Human Services' Office for Civil Rights (OCR)
You have the right to file a complaint with the OCR, a federal agency, if you believe you have been discriminated against because of any of the following:

- race
- color
- national origin
- age
- disability
- sex (including sex stereotypes and gender identity)

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

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

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

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

Attachment A - Keep this page.

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

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

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

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

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

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

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

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

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

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 MFPP 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, MFPP, MA, 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 MFPP, 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 MFPP.

Assignment of Medical Payments

By accepting MFPP, you give your rights to all medical payments for yourself and anyone else you apply for to the State of Minnesota. These include medical payments from all other people or companies, including medical support payments from an absent parent. This assignment of medical payments begins as soon as health care coverage starts.

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.

If you have Medicare Part B, Medicare can pay your health providers for the care you get while you have MFPP coverage.

Attachment B

Instructions for Completing This Application

Income Adjustments

Income adjustments are costs you can subtract from gross income on a federal income tax return. See the Adjusted Gross Income section of IRS Form 1040 or IRS Form 1040-A for more information. If you pay for any of these things, tell us about them in question 10.

Alimony paid
Student loan interest
Educator expenses
Certain business expenses of reservists, performing artists, and fee-basis government officials
Health savings account deduction
Moving expenses
Deductible part of self-employment tax
Self-employment SEP, SIMPLE and qualified plans
Penalty on early withdrawal of savings
IRA deduction
Tuition and fees
Domestic production activities deduction

Immigration Status

Choose an immigration status from the list below and place your letter choice in question 13. 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. Deportation being withheld under section 243(h) or 231(b)(3) of the INA
G. Refugee*
H. Special Iraqi or Afghani immigrant
I. Victim of severe trafficking (LPR or T Visa)*
J. Withholding of removal*
K. Battered noncitizen*
L. Lawful permanent resident (LPR)*
M. Paroled for at least one year*
N. Temporary nonimmigrant
O. Deferred action for childhood arrivals