Minnesota Department of Human Services

Combined Application Form

For Cash Assistance, Food Support and Health Care Programs

Note for Health Care only applicants: If you are applying for health care coverage **only**, ask the county agency for the Minnesota Health Care Programs Application (DHS-3417). Do not use this application form.

How to fill out this form

Fill out this form in black or dark blue ink.

- The general information, instructions and questions are in yellow.
- List the names of all people who live with you on page 3. Include everyone, even if you are not asking for assistance for them. If your household has more than five people, complete questions on page 8 for those additional people. If more space is needed write the information on additional sheets of paper.
- For recertifications report **all** changes in the past 12 months. You may need to provide proof of the reported information.
- The county human services agency will use this form to decide if you can get cash, Food Support, and health care. For **each** person check **each** program that person is applying for (if unsure, talk to your county worker). Program rules require some people to get benefits together.
- If you need additional room or want to make comments, use the open space on page 8.
- If you are applying for cash or food support benefits and have child care needs, ask your worker how to apply for the Child Care Assistance Program.
- **All adults** age 18 and older who are applying for health care programs must sign the form.
- You may need to provide proof of the information on this form. Refer to the Instructions for Completing the Combined Application Form (CAF) information sheet (DHS-2989). You cannot get help from cash, Food Support or health care programs until we get proof of this information. **Bring the proofs with you to the interview or send them to your worker as soon as you can.**
- If we require you to have an interview and you miss your interview appointment, you must reschedule. If you do not reschedule, we may stop or not approve your cash and/or food support benefits.

Tell someone if you need help filling out this form.

Be sure to sign and date the form on page 7.

Attention. If you want free help translating this information, ask your worker or call the number below for your language.

ملاحظة: إذا أردت مساعدة مجانية في ترجمة هذه المعلومات، فاسأل مساعدك في مكتب الخدمة الاجتماعية أو اتصل على الرقم 1-800-358-0377.

កំណត់សំគាល់ បើអ្នកចង់បានជំនួយបកប្រែពត៌មាននេះដោយមិនគិតថ្លៃ សូមសួរអ្នកកាន់សំណុំរឿងរបស់អ្នក ឬ ទូរស័ព្ទទៅលេខ 1-888-468-3787 ។

Pažnja. Ako vam je potrebna besplatna pomoć za prevod ove informacije, pitajte vašeg radnika ili nazovite 1-888-234-3785.

Ceeb toom. Yog koj xav tau kev pab txhais cov xov no rau koj dawb, nug koj tus neeg lis dej num (worker) lossis hu 1-888-486-8377.

ໂປດຊາບ. ຖ້າຫາກທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປຂໍ້ຄວາມດັ່ງກ່າວນີ້ຟຣີ, ຈົ່ງຖາມນຳພນັກງານຊ່ວຍວຽກຂອງທ່ານຫຼືໂທຣ໌ ຫາຕາມເລກໂທຣ໌ 1-888-487-8251.

Hubaddhu. Yoo akka odeeffannoon kun sii hiikamu gargaarsa tolaa feeta ta'e, hojjataa kee gaafaddhu ykn lakkoofsa kana bilbili 1-888-234-3798.

Внимание: если вам нужна бесплатная помощь в переводе этой информации, обратитесь к своему социальному работнику или позвоните по следующему телефону: 1-888-562-5877.

Ogow. Haddii aad dooneyso in lagaa kaalmeeyo tarjamadda macluumaadkani oo lacag la'aan ah, weydii hawl-wadeenkaaga ama wac lambarkan 1-888-547-8829.

Atención. Si desea recibir asistencia gratuita para traducir esta información, consulte a su trabajador o llame al 1-888-428-3438.

Chú Ý. Nếu quý vị cần dịch thông-tin nầy miễn phí, xin gọi nhân-viên xã-hội của quý vị hoặc gọi số 1-888-554-8759.

LB2-0009 (1-08)

This information is available in alternative formats to individuals with disabilities by calling your county worker. TTY users can call through Minnesota Relay at (800) 627-3529. For Speech-to-Speech, call (877) 627-3848. For additional assistance with legal rights and protections for equal access to human services benefits, contact your agency's ADA coordinator.

Clear Form Data
FILLABLE FORM

(Tear off here)

Combined Application Form (CAF)

Cash Assistance, Food Support and Health Care

Your application date or the day your cash and food support benefits can start is the date the county agency gets this page of the application form. Some health care programs may provide coverage for up to three months before the application date. We can set your application date if we have your name, address and signature (pages 1 and 2). We must have the complete form to decide if you can get help. **Print in black or dark blue ink.**

CASE NUMBER

HOW MANY PEOPLE LIVE IN YOUR HOUSEHOLD?
Adults ___ Children ___

1. APPLICANT'S LEGAL NAME (last/first/middle)	OTHER NAMES YOU USE (maiden name, nickname, etc.)	BIRTH DATE	GENDER ☐ M ☐ F

ADDRESS WHERE YOU LIVE (If you do not have an address, write "homeless.")	SOCIAL SECURITY NUMBER

CITY	COUNTY	STATE	ZIP CODE

MAILING ADDRESS (If different from address where you live)

CITY	COUNTY	STATE	ZIP CODE

DO YOU LIVE ON A RESERVATION?	PHONE NUMBER WHERE YOU CAN BE REACHED (include area code)
☐ Yes ☐ No If yes, which one?_____	Home Other

DO YOU NEED AN INTERPRETER?	WHAT IS YOUR PREFERRED SPOKEN LANGUAGE?	WHAT IS YOUR PREFERRED WRITTEN LANGUAGE?
☐ Yes ☐ No		

Do you need help right away? Some people can get food support benefits within 24 hours. **Questions 1-7** below will help us decide if you can get food support benefits right away.

☐ Yes ☐ No **1.** Has anyone in the household ever received cash assistance, medical assistance, commodities or food support benefits before? **If yes:**
When? Where? What?

☐ Yes ☐ No **2a.** Did all of your household **income recently stop? If yes,** When?

2b. How much income (cash or checks) did or will your household get **this month?**

☐ Yes ☐ No **3.** Did anyone in your household **quit a job in the last 60 days**? **If yes,**
Employer name?
Dates of employment? From to

☐ Yes ☐ No **4.** Does your family expect a **change in income**? **If yes,** When?

5. How much does your household (including children) have in **cash, checking or savings**?
$

6. How much does your household pay for: **Rent/mortgage?** $
Utilities? $

☐ Yes ☐ No **7.** Is anyone in your household a **migrant or seasonal farm worker**?

☐ Yes ☐ No **8.** Is anyone in your household **pregnant**?

☐ Yes ☐ No **9.** Do you need help now because of a **medical or other emergency?**

Read the "Your responsibilities" and "Your rights" pages on the back of this form before signing.
I have looked over my answers and believe they are all true and correct to the best of my knowledge.

SIGNATURE OF APPLICANT OR AUTHORIZED REPRESENTATIVE	DATE	AGENCY SIGNATURE	DATE RECEIVED

You may authorize another person to act on your behalf to help you:

- **Fill out forms and apply for help from the county agency** (for example, go to an interview for you)
- **Get notices and information related to your case**
- **Get your food support benefits and buy food for you through your Electronic Benefits Transfer (EBT) account.**

The authorized person may be a friend, relative, conservator acting on your behalf, a person authorized by the courts, or a person with your power of attorney. This person can act for you until you notify your worker that you want this to end. Ask your worker for more information about authorized representatives.

I want the person named to:

☐ Fill out forms
☐ Get notices
☐ Get and use my food support benefits

NAME	RELATIONSHIP	PHONE NUMBER
ADDRESS		
CITY	STATE	ZIP CODE

☐ Fill out forms
☐ Get notices
☐ Get and use my food support benefits

NAME	RELATIONSHIP	PHONE NUMBER
ADDRESS		
CITY	STATE	ZIP CODE

Legal guardian. Do you have a legal guardian or conservator, or is there a power of attorney? ☐ Yes ☐ No

If yes, what is this person's full name (attach copies of legal documents)?

NAME	DO YOU PAY A FEE?	HOW OFTEN?
	☐ Yes ☐ No If yes, amount? _____	

Principal Wage Earner (PWE). Food Support households with children must designate the person they want as the PWE. Any adult in your Food Support household can be the PWE. Talk to your worker before designating the Food Support PWE.

DESIGNATED PWE	SIGATURE OF APPLICANT

Check if you need help with or information about the following areas.

Your county worker can tell you if the county can help you with these areas or tell you where you can get help:

☐ Personal or family problems
☐ Family/domestic violence
☐ Chemical dependency
☐ Mental health issues
☐ Family planning information
☐ Learning disability
☐ Special needs children
☐ A language barrier
☐ Child care
☐ Transportation
☐ Food shelves
☐ Child support
☐ Applying/interviewing for programs
☐ Housing assistance
☐ Veteran services
☐ Help with budgeting or bad credit
☐ **Free** help filing your taxes
☐ Other

☐ Yes ☐ No Are you currently getting help from a **social worker or social services agency.**

☐ Yes ☐ No Are you or anyone in your household getting services from the **Center for Victims of Torture**?

☐ Yes ☐ No Do you want to register to vote or update your registration?

Note: *You do not have to answer this question*

List all of the people living in your home even if you are not applying for them and/or the person is not asking for assistance. Program rules require some people to get benefits together. You have to give a Social Security number **only** for people who are applying for help. If anyone in the household uses another name (maiden name, nickname, etc.) list the other name(s) in the "OTHER NAMES" boxes below.

List in this order: Yourself, your spouse, other adult(s), children, all other people, anyone temporarily away from home. If anyone is pregnant, list fetus as "unborn child" and the due date. *For more than five household members, go to page 8.*

Use these codes to complete MARITAL STATUS and RACE fields for each person.

Marital Status: (choose one) **N** = Never married **M** = Married living with spouse **S** = Separated (married, living apart) **L** = Legally separated **D** = Divorced **W** = Widowed

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

PERSON 1 YOUR LEGAL NAME (last/first/middle) | OTHER NAMES | SEX ☐ M ☐ F | RELATIONSHIP TO YOU **SELF**

BIRTH DATE (mm/dd/yy) | MARITAL STATUS | SOCIAL SECURITY NUMBER | DATE MOST RECENTLY MOVED TO MINNESOTA (mm/dd/yy)

ETHNICITY (optional) Hispanic? ☐ Yes ☐ No | RACE (optional) | U.S. CITIZEN OR U.S. NATIONAL? ☐ Yes ☐ No | LIST CITY, STATE AND COUNTRY OF BIRTH

WHAT PROGRAMS IS THIS PERSON APPLYING FOR? ☐ Cash ☐ Food Support ☐ Emergency help ☐ Health care ☐ None | LAST SCHOOL GRADE COMPLETED

PERSON 2 LEGAL NAME (last/first/middle) | OTHER NAMES | SEX ☐ M ☐ F | RELATIONSHIP TO YOU

BIRTH DATE (mm/dd/yy) | MARITAL STATUS | SOCIAL SECURITY NUMBER | DATE MOST RECENTLY MOVED TO MINNESOTA (mm/dd/yy)

ETHNICITY (optional) Hispanic? ☐ Yes ☐ No | RACE (optional) | U.S. CITIZEN OR U.S. NATIONAL? ☐ Yes ☐ No | LIST CITY, STATE AND COUNTRY OF BIRTH

WHAT PROGRAMS IS THIS PERSON APPLYING FOR? ☐ Cash ☐ Food Support ☐ Emergency help ☐ Health care ☐ None | LAST SCHOOL GRADE COMPLETED

PERSON 3 LEGAL NAME (last/first/middle) | OTHER NAMES | SEX ☐ M ☐ F | RELATIONSHIP TO YOU

BIRTH DATE (mm/dd/yy) | MARITAL STATUS | SOCIAL SECURITY NUMBER | DATE MOST RECENTLY MOVED TO MINNESOTA (mm/dd/yy)

ETHNICITY (optional) Hispanic? ☐ Yes ☐ No | RACE (optional) | U.S. CITIZEN OR U.S. NATIONAL? ☐ Yes ☐ No | LIST CITY, STATE AND COUNTRY OF BIRTH

WHAT PROGRAMS IS THIS PERSON APPLYING FOR? ☐ Cash ☐ Food Support ☐ Emergency help ☐ Health care ☐ None | LAST SCHOOL GRADE COMPLETED

PERSON 4 LEGAL NAME (last/first/middle) | OTHER NAMES | SEX ☐ M ☐ F | RELATIONSHIP TO YOU

BIRTH DATE (mm/dd/yy) | MARITAL STATUS | SOCIAL SECURITY NUMBER | DATE MOST RECENTLY MOVED TO MINNESOTA (mm/dd/yy)

ETHNICITY (optional) Hispanic? ☐ Yes ☐ No | RACE (optional) | U.S. CITIZEN OR U.S. NATIONAL? ☐ Yes ☐ No | LIST CITY, STATE AND COUNTRY OF BIRTH

WHAT PROGRAMS IS THIS PERSON APPLYING FOR? ☐ Cash ☐ Food Support ☐ Emergency help ☐ Health care ☐ None | LAST SCHOOL GRADE COMPLETED

PERSON 5 LEGAL NAME (last/first/middle) | OTHER NAMES | SEX ☐ M ☐ F | RELATIONSHIP TO YOU

BIRTH DATE (mm/dd/yy) | MARITAL STATUS | SOCIAL SECURITY NUMBER | DATE MOST RECENTLY MOVED TO MINNESOTA (mm/dd/yy)

ETHNICITY (optional) Hispanic? ☐ Yes ☐ No | RACE (optional) | U.S. CITIZEN OR U.S. NATIONAL? ☐ Yes ☐ No | LIST CITY, STATE AND COUNTRY OF BIRTH

WHAT PROGRAMS IS THIS PERSON APPLYING FOR? ☐ Cash ☐ Food Support ☐ Emergency help ☐ Health care ☐ None | LAST SCHOOL GRADE COMPLETED

☐ Yes ☐ No **1.** Does **everyone** in your household buy, fix or eat food with you?

☐ Yes ☐ No **2.** Is **anyone** in the household, who is age 60 or over or disabled, unable to buy or fix food due to a disability?

☐ Yes ☐ No **3.** Is **anyone** in the household attending school?

☐ Yes ☐ No **4.** Is **anyone** in your household temporarily not living in your home? (for example: vacation, foster care, treatment, hospital, job search)

☐ Yes ☐ No **5.** Did **anyone** move in or out of your home in the past 12 months?

☐ Yes ☐ No **6.** Is **either** parent of any child under age 19 dead or not living in the home?

☐ Yes ☐ No **7.** Is **anyone** mentally or physically ill, disabled or blind, or not able to care for themselves?

☐ Yes ☐ No **8.** Is **anyone** unable to work for reasons other than illness or disability?

☐ Yes ☐ No **9.** In the last 90 days did **anyone** in the household:
- Stop working or quit a job?
- Ask to work fewer hours?
- Refuse a job offer?
- Go on strike?

☐ Yes ☐ No **10.** Has **anyone** in the household been injured or had an accident in the past 72 months?

☐ Yes ☐ No **11.** Is **anyone** in the household on a diet prescribed by a doctor?

What do you own?

Check yes or no for each item.

→

Bring or send proof.

12. Does **anyone** in the household own, or is **anyone** buying, any of the following?

☐ Yes ☐ No Cash

☐ Yes ☐ No Life or burial insurance

☐ Yes ☐ No Stocks, bonds, annuities, etc.

☐ Yes ☐ No Other assets (tools, boats, livestock, etc.)

☐ Yes ☐ No Bank accounts (savings, checking, etc.)

☐ Yes ☐ No Vehicles (cars, trucks, motorcycles, etc.)

☐ Yes ☐ No Real estate property (house, land, etc.)

☐ Yes ☐ No **13.** Has **anyone** in the household given away, sold or traded anything of value **in the past 60 months?**
(for example: real estate property, bank accounts, annuities, vehicles, etc.)
Note: Include any transfers made by a spouse not living with you.

What kinds of income do you have?

☐ Yes ☐ No **14.** Has **anyone** in the household had a job or been self-employed in the past 12 months?

☐ Yes ☐ No **15.** Does **anyone** in the household have a job or expect to get income from a job this month or next month?
Note: Include income from Work Study and paid internships.
Include free benefits or reduced expenses received for work (shelter, food, clothing, etc.).

☐ Yes ☐ No **16.** Is **anyone** in the household self-employed or does anyone expect to get income from self-employment this month or next month? Examples:
- Product sales
- Paper route
- Property rental
- Crop Reserve Program (CRP)
- In-home day care
- Taxi driver
- Personal services
- Roomers/boarders
- Other
- Farming

Bring or send proof.

☐ Yes ☐ No **17.** Do you expect any changes in income, expenses or work hours?

Check yes or no for each item.

18. Has **anyone** in the household applied for or does anyone get any of the following types of income?

☐ Yes ☐ No Social Security (RSDI)
☐ Yes ☐ No Supplemental Security Income (SSI)
☐ Yes ☐ No Veteran benefits (VA)
☐ Yes ☐ No Unemployment Insurance
☐ Yes ☐ No Workers' Compensation
☐ Yes ☐ No Retirement benefits
☐ Yes ☐ No Tribal payments
☐ Yes ☐ No Child support or spousal support
☐ Yes ☐ No Other unearned income

Bring or send proof.

☐ Yes ☐ No **19.** Does **anyone** in the household have or expect to get any loans, scholarships or grants for attending school?

What kinds of expenses do you have?

Check yes or no for each item.

20. Does **your household** have the following housing expenses?

☐ Yes ☐ No Rent (include mobile home lot rental)
☐ Yes ☐ No Mortgage/contract for deed payment
☐ Yes ☐ No Association fees
☐ Yes ☐ No Homeowner's insurance (if not included in mortgage)
☐ Yes ☐ No Real estate taxes (if not included in mortgage)
☐ Yes ☐ No Room and/or meals

Bring or send proof.

Check yes or no for each item.

21. Does **your household** have the following utility expenses **any time** during the year?

☐ Yes ☐ No Heating/air conditioning
☐ Yes ☐ No Electricity
☐ Yes ☐ No Cooking fuel
☐ Yes ☐ No Garbage removal
☐ Yes ☐ No Water and sewer
☐ Yes ☐ No Phone/cell phone

☐ Yes ☐ No **22.** Do **you or anyone living with you** have costs for care of a **child** or an **ill or disabled adult** because you or they were working, looking for work or going to school?
Note: The Child Care Fund may pay child care costs. Ask your financial worker for more information.

☐ Yes ☐ No **23.** Does **anyone in** the household **pay** court-ordered child support, spousal support, child care support, medical support or contribute to a tax dependent who does not live in your home?

☐ Yes ☐ No **24.** Does **anyone** in the household have expenses related to work, training or job search, such as transportation, meals or uniforms? Ask your financial worker if these expenses apply to the programs you are requesting.

☐ Yes ☐ No **25a.** Does **anyone** in your household currently have health insurance, long-term care insurance, or prescription drug coverage?

☐ Yes ☐ No **25b.** Does **anyone** in your household have Medicare Part A, B or D?

Bring proof of medical expenses.

26. For the following programs you will need to provide proof of your medical expenses:
Food Support applicants or recipients: To get a medical deduction, you must provide proof of all medical bills incurred by anyone in your household **who is disabled or 60 years or older. Do not** bring medical bills that are being paid for by any health care program, insurance or someone not living with you.

Health care program applicants or recipients: Some health care programs may pay for health care you received up to three months before you apply for help. Bring proof of any medical bills you or any household member incurred in the last three months.

☐ **Check here if you need someone to read or explain the information and rules on the following two pages.**

Penalty warnings and qualification questions

If you get cash, food support or health care benefits, you must follow the rules listed below. The state may bar household members who break any of these rules from the cash, Food Support or Minnesota Health Care programs. The bar lasts one year for the first fraud, two years for the second fraud and is permanent for the third fraud. The months you are barred from MFIP for breaking the rules may count toward your 60-month lifetime limit.

- **Do not give false information** or hide information to get or continue to get cash, food support or medical benefits. If you get cash or food support benefits and give false information or hide information about your ***identity*** and/or ***residence*** to get multiple benefits for the same period of time, you may be barred for 10 years.
- **Do not trade or sell** food support benefits or electronic benefits transfer (EBT) access cards.
- **Do not use food support benefits to buy ineligible items,** such as alcohol and tobacco.
- **Do not help others get medical services** that you know they should not get.
- **Do not use someone else's EBT access cards or health care membership cards** to get cash, food support or medical benefits for your household.

The maximum penalty is a fine of $250,000 or a jail term of 20 years, or both.

Special Food Support penalty warning: If a federal, state or local court finds you or any household member guilty of giving or receiving food support benefits in exchange for:

- **Controlled substances,** that household member will be barred from getting Food Support for 12 months for the first offense and permanently for the second offense.
- **Firearms, ammunition or explosives,** that household member will be barred from getting Food Support permanently.

If you admit committing a drug felony after July 1, 1997, the county agency may ask you to take random drug tests. The first time you fail a drug test, the county agency will reduce your household's MFIP or Food Support by 30 percent. If you fail the test a second time, you will be permanently disqualified.

☐ Yes ☐ No 1. Has a court or any other civil or administrative process in Minnesota or any other state found anyone in the household guilty or has anyone been disqualified from receiving public assistance for breaking any of the rules above?

☐ Yes ☐ No 2. Has anyone in the household been convicted of making fraudulent statements about their place of residence to get cash or medical benefits from more than one state?

☐ Yes ☐ No 3. Is anyone in your household hiding or running from the law to avoid prosecution, being taken into custody, or to avoid going to jail for a felony?

☐ Yes ☐ No 4. Has anyone in your household been convicted of a drug felony since July 1, 1997?

☐ Yes ☐ No 5. Is anyone in your household currently violating a condition of parole, probation or supervised release?

If you checked yes to any of the above questions, list the household member(s) and question number below:

QUESTION NO.	HOUSEHOLD MEMBER	QUESTION NO.	HOUSEHOLD MEMBER

Medical assignment of benefits

I assign all medical payments to the State of Minnesota. This assignment includes medical care payments from all other persons or entities. This assignment covers medical care payments for me and anyone else for whom I apply. It takes effect right away when health care coverage starts. I agree to cooperate with the State in any action to recover payment of medical expenses. If I claim good cause and good cause is approved, I may not have to cooperate.

If I have Medicare Part B, I give Medicare consent to pay my health providers for the care I get while I have Minnesota Health Care Programs coverage.

Assignment of support

I understand that when I get MFIP, Child Care or MA for Long-Term Care (LTC), I must assign all rights to support to the State of Minnesota. This assignment includes my pre-MFIP support arrears. When I no longer receive MFIP, payments collected (except federal tax refunds) on these pre-MFIP arrears will be sent to me. For MA-LTC, this covers the total income and assets reduced by any share my spouse is allowed to keep (Minn. Stat. 256B.14, 256B.058.059). For Medical Assistance only, I understand I assign only my rights to current medical care payments.

Authorization for release (sharing) of my medical information

I give my consent that the following agencies or individuals may share among themselves medical information about me only for the limited purposes indicated:

- Health providers, health plans, insurance agencies, Minnesota Health Care Programs (MHCP), my county case workers, and their contractors and subcontractors:
  a. To determine who should pay for my health care, and
  b. To provide and coordinate health care services.
- Ombudspersons and county advocates for managed care to help me obtain medical care and payment of services
- Researchers, auditors, investigators, and others who do quality of care reviews and studies or commence prosecutions or legal actions related to managing the health care programs.

This release also applies to the medical information of my minor children named in this application to the extent that I can consent to their medical treatment. Generally, I must give my written consent for the above agencies to give out the medical information. If I do not consent, it will not be released unless the law otherwise allows it. I may stop this consent with a written notice at any time, but this written notice will not affect information the agency has already released. This authorization is good while I am enrolled in Minnesota Health Care Programs, not to exceed one year, or longer if the law permits. I can refuse to sign or cancel this authorization. However, this Authorization does not expire after one year and cannot be revoked for release of records to consulting providers; or to release records to specified health payers for payment of claims, fraud investigation, or quality of care review and studies.

If I refuse to sign or if I cancel the release, I will not be able to enroll or stay enrolled in Minnesota Health Care Programs. An agency or person who receives my information through this release could possibly redisclose the information.

Authorization to share information for fraud investigation

I give permission to authorized investigators and third parties to share information about me during the course of investigations regarding fraud, fraud prevention and misrepresentation. Third parties who can share information about me with investigators include but are not limited to financial institutions, credit reporting agencies, landlords, public housing agencies, schools, utility companies, insurance agencies, employers, other government agencies and others as they apply. I also understand that my permission to share information about me remains in effect for six months after my benefits stop.

Employment services registration

Cash and Food Support applicants: I understand that signing this application registers me for employment services. I also understand that doing so automatically registers for employment services everyone in my home the county approves to receive assistance with me. I understand that I or others in my home might have to take part in employment services to receive cash assistance or food support benefits.

Perjury and general declarations

I declare under the penalties of perjury that I have examined this application and to the best of my knowledge it is a true and correct statement of every material point, including the identity of all pesons under age 16 listed on the application. 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. (Minn. Stat. 256.984, subd. 1)

By signing below:

- I understand if I give incorrect information or misuse an electronic benefits transfer (EBT) card, I may be prosecuted for fraud. (Minn. Stat. 256.98 and 609.821)
- I acknowledge that since my last application or recertification, I have received my cash and/or food support benefits directly or used my EBT card to get my cash and/or food support benefits.
- I acknowledge that my worker gave me a copy of the Notice of Privacy Practices (DHS-3979), the CAF Important Information sheet (DHS-5223B) and the "Your responsibilities" and "Your rights" pages and explained them to me.
- I acknowledge that I have read and understand the "Penalty warnings and qualification questions" section on page 6.
- I agree to assign my support and medical benefits as stated above.
- I agree to the sharing of information as stated on the medical and fraud release information above and the Social Security numbers section of the "Important Information" sheet (DHS-5223B) given with this application.

SIGNATURE OF APPLICANT OR AUTHORIZED REPRESENTATIVE	DATE	SIGNATURE OF HOUSEHOLD MEMBER 18 OR OLDER APPLYING FOR HEALTH CARE	DATE
SIGNATURE OF SPOUSE OR OTHER ADULT	DATE	AGENCY SIGNATURE	DATE RECEIVED

Use this space if you need additional room.

Complete for additional household members:

PERSON 6 LEGAL NAME (last/first/middle) | OTHER NAMES | SEX ☐ M ☐ F | RELATIONSHIP TO YOU

BIRTH DATE (mm/dd/yy) | MARITAL STATUS | SOCIAL SECURITY NUMBER | DATE MOST RECENTLY MOVED TO MINNESOTA (mm/dd/yy)

ETHNICITY (optional) Hispanic? ☐ Yes ☐ No | RACE (optional) | U.S. CITIZEN OR U.S. NATIONAL? ☐ Yes ☐ No | LIST CITY, STATE AND COUNTRY OF BIRTH

WHAT PROGRAMS IS THIS PERSON APPLYING FOR? ☐ Cash ☐ Food Support ☐ Emergency help ☐ Health care ☐ None | LAST SCHOOL GRADE COMPLETED

PERSON 7 LEGAL NAME (last/first/middle) | OTHER NAMES | SEX ☐ M ☐ F | RELATIONSHIP TO YOU

BIRTH DATE (mm/dd/yy) | MARITAL STATUS | SOCIAL SECURITY NUMBER | DATE MOST RECENTLY MOVED TO MINNESOTA (mm/dd/yy)

ETHNICITY (optional) Hispanic? ☐ Yes ☐ No | RACE (optional) | U.S. CITIZEN OR U.S. NATIONAL? ☐ Yes ☐ No | LIST CITY, STATE AND COUNTRY OF BIRTH

WHAT PROGRAMS IS THIS PERSON APPLYING FOR? ☐ Cash ☐ Food Support ☐ Emergency help ☐ Health care ☐ None | LAST SCHOOL GRADE COMPLETED

PERSON 8 LEGAL NAME (last/first/middle) | OTHER NAMES | SEX ☐ M ☐ F | RELATIONSHIP TO YOU

BIRTH DATE (mm/dd/yy) | MARITAL STATUS | SOCIAL SECURITY NUMBER | DATE MOST RECENTLY MOVED TO MINNESOTA (mm/dd/yy)

ETHNICITY (optional) Hispanic? ☐ Yes ☐ No | RACE (optional) | U.S. CITIZEN OR U.S. NATIONAL? ☐ Yes ☐ No | LIST CITY, STATE AND COUNTRY OF BIRTH

WHAT PROGRAMS IS THIS PERSON APPLYING FOR? ☐ Cash ☐ Food Support ☐ Emergency help ☐ Health care ☐ None | LAST SCHOOL GRADE COMPLETED

(Tear off here)

Your responsibilities

Note: If you sign this application as an Authorized Representative of a person who is requesting or receiving assistance, you are agreeing to assume all of the following responsibilities on behalf of that person.

- **You must report changes which may affect your benefits to the county agency *within 10 days*** after the change has occurred.

  Applicants - Report these changes to your worker when the change happens.

  This includes the following for everyone in your household:

  - **Employment** - Start or stop a job or business; change in hours, earnings or expenses.
  - **Income** - Receipt or change in child support, Social Security, Veteran benefits, Unemployment Insurance, inheritance, insurance benefits and other payments.
  - **Property** - Purchase, sale or transfer of a house, car or other items of value.
  - **Household** - When a person dies, moves in or out of your home or temporarily leaves; pregnancy; birth of a child.
  - **Address**
  - **Housing costs/rent subsidy**
  - **Utility costs**
  - **Filing a lawsuit**
  - **Absent parent custody or visits**
  - **Drug felony conviction**
  - **Marriage or divorce**
  - **School attendance**
  - **Health insurance**

- **Each time you use your electronic benefits transfer (EBT) card or sign your check,** you state that you have informed the county agency about any changes in your situation which may affect your benefits.
- **Each time your electronic benefits transfer (EBT) card** is used we assume you have received your cash or food support benefits, unless you reported your card lost or stolen to the county agency.
- **The county, state or federal agency may check any of the information you give.** To get some information we must have your signed consent. If you don't allow the county to confirm your information, you might not get assistance.
- **If you give us information you know is untrue or we get information you did not report,** we will investigate you for fraud.
- **Cooperation requirements:**
  - If the county approves you for the Minnesota Family Investment Program (MFIP) or the Diversionary Work Program (DWP), you must cooperate with the child support enforcement unit and employment services, unless you are exempt. You must develop and sign an employment plan or your DWP application will be denied.
  - After the county approves your MFIP or DWP, if you get child support directly from the noncustodial parent, you must report it to your financial worker. You must cooperate with the child support agency in any legal action brought against a third party for payment of medical expenses, unless you claim and are granted good cause.
  - If you get health care only, you must help the child support agency pursue any person responsible for providing medical support for you and your children, unless you apply only for your children.
  - If the county approves you for health care, you must enroll in any available insurance or benefit plan offered by your employer or your spouse's employer, if the State determines it is cost-effective.
- **The State or Federal Quality Control agency** may randomly choose your case for review. They will review statements you made on forms. They will check to see if we figured your eligibility correctly. The state agency may seek information from other sources. The State or Federal Quality Control agency will tell you about any contact they intend to make. ***If you do not cooperate, your benefits may stop.***
- **Contact your financial worker** if you have any questions or are unsure about any reporting rules. If your worker is not available, leave a message so the worker can get back to you.

Your rights

- **Your right to privacy.** Your private information, including your health information, is protected by state and federal laws. Your worker has given you a Notice of Privacy Practices (DHS-3979) information sheet. This sheet explains:
  - Why we are asking you to give us your private information
  - How we may use and share private information about you
  - Why we ask for your Social Security number
  - Your rights about your private information. You can:
    - Ask about how we can use information and with whom we will share this information
    - Ask to get this information in another format
    - Ask to see your information
    - Ask to whom we have given your information
    - File a privacy complaint.
  - How we must legally protect your private information
  - Whom you can contact if you think your private information has been mishandled.

Please read it carefully. For more information about your data privacy rights or a copy of the Notice of Privacy Practices, ask your worker. You can also get a copy of this notice at http://edocs.dhs.state.mn.us/lfserver/ Legacy/ DHS-3979-ENG.

- **You have the right to reapply** at any time if your benefits stop.
- **You have the right to know why, if we have not processed your application promptly.**
  - 15 days for medical care for pregnant women
  - 30 days for cash and food assistance
  - 45 days for medical care
  - 60 days for cash and medical care related to disability.
- **You have the right to know the rules of the program you are applying for** and for us to tell you how we figured your benefits.
- **You have the right to choose where and with whom you live** and, within certain limits, to choose your own doctor, hospital, etc.
- **Appeal rights.** If you are unhappy with the action taken or feel the agency did not act on your request for assistance, you may appeal. For cash, child care and health care, you may appeal **within 30 days** from the date you receive the notice by writing to the county agency, or directly to the State Appeals Office at the Minnesota Department of Human Services, PO Box 64941, St. Paul, MN 55164-0941. (If you show good cause for not appealing your cash and health care **within 30 days**, the agency can accept your appeal **for up to 90 days** from the date you receive the notice.) For Food Support, you may appeal **within 90 days** by writing or calling the county or the State Appeals Office.

  If you wish your assistance to continue until the hearing, you must appeal before the date of the proposed action or within 10 days after the date the agency notice was mailed, whichever is later. Ask your county worker to explain how the timing of your appeal could affect your present or future assistance.
- **Access to free legal services.** Contact your worker for information on free legal services.
- **Your right to file a complaint.** If you feel the county or the Minnesota Department of Human Services treated you differently in the handling of your public assistance application or benefits because of race, color, national origin, political beliefs, religion, creed, sex, sexual orientation, public assistance status, age or disability, including physical access to government buildings, you may file a complaint with your county agency or any of the following agencies.

Minnesota Department of Human Services
Office for Equal Opportunity
PO Box 64997
St. Paul, MN 55164-0997
(651) 431-3040 (Voice)
(866) 786-3945 (TTY)

Minnesota Department of Human Rights
190 East 5th Street, Suite 700
St. Paul, MN 55101
(800) 657-3704 (Voice)
(651) 296-1283 (TTY)

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)
(312) 353-5693 (TTY)

U.S. Department of Agriculture
Director, Office of Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410
(800) 795-3272 (Voice)
(202) 720-6382 (TTY)