



# Combined Application Form

## For Food Support, Cash Assistance and Health Care Programs

**Note for Health Care only applicants.** Do not use this application if you are:

- Applying for health care coverage **only**. Ask the county agency for the Minnesota Health Care Programs Application (DHS-3417).
- A person with a disability or age 65 or older who may need to move to a nursing home or would like services to stay in your home. Ask the county agency for the Minnesota Health Care Programs Application for Payment of Long-Term Care and Home and Community-Based Waiver Services (DHS-3531) and a Long-Term Care Consultation.

### How to fill out this form

Fill out this form in black or dark blue ink.

- **Complete and turn in this application form as soon as possible.** We can set your application date if we have your name, address and signature (page 1), but we must have the complete form to decide if you can get help.
- **For your application to be complete,** the application process includes completing all questions on the application and having certain information verified. The Food Support and cash programs also require an interview with a county worker. For the Food Support program this can be a phone interview. If you are required 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 food support benefits and/or cash.
- **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 Food Support, cash 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.**
- The general information, instructions and questions are in yellow.
- **List the names of all people who live with you on pages 3 and 4.** Include everyone, even if you are not asking for assistance for them. If your household has more than five people or if more space is needed to write the information for other questions, use 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 Food Support, cash 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 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.

**Tell someone if you need help filling out this form.**

**Be sure to sign and date the form on page 10.**

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 បើអ្នកចង់បានជំនួយបកប្រែព័ត៌មាននេះដោយមិនគិតថ្លៃ 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.

ໂປຼດຊາບ. ຖ້າຫາກທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປຂໍ້ຄວາມດັ່ງກ່າວນີ້ຟຣີ, ຈົ່ງຖາມນຳພນັກງານຊ່ວຍວຽກຂອງທ່ານຫຼືໂທໂທລະທາມເລກໂທລ໌ 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 này miễn phí, xin gọi nhân-viên xã-hội của quý vị hoặc gọi số 1-888-554-8759.

LB2-0009 (10-09)

**Agency use:**

- Provide client with the following documents.
- R and R (tear off page on CAF)
  - Family Violence Referral (DHS-3323)
  - Domestic Violence Information brochure (DHS-3477)
  - Important Information sheet (tear off page on CAF)
  - Change Report Form (DHS-2402)
  - ADA brochure (DHS-4133)
  - Notice of Privacy Practices (DHS-3979)

ADA5 (5-09)

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 programs, contact your agency's ADA coordinator.



# Combined Application Form

## For Food Support, Cash Assistance and Health Care Programs

Your application date or the day your cash and food support benefits can start is the date the county agency gets 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 (page 1). 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 ___

<b>PERSON 1</b> APPLICANT'S LEGAL NAME (last/first/middle)		OTHER NAMES YOU USE (maiden name, nickname, etc.)		BIRTH DATE	GENDER <input type="checkbox"/> M <input type="checkbox"/> F	
ADDRESS WHERE YOU LIVE (If you do not have an address, write "homeless.")					APT. 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? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, which one? _____			PHONE NUMBER WHERE YOU CAN BE REACHED (include area code) Home _____ Other _____			
DO YOU NEED AN INTERPRETER? <input type="checkbox"/> Yes <input type="checkbox"/> No		WHAT IS YOUR PREFERRED SPOKEN LANGUAGE?		WHAT IS YOUR PREFERRED WRITTEN LANGUAGE?		
MARITAL STATUS*		SOCIAL SECURITY NUMBER		MOST RECENTLY MOVED TO MINNESOTA (mm/dd/yy) Date _____ From: _____		
ETHNICITY (optional) Hispanic? <input type="checkbox"/> Yes <input type="checkbox"/> No		RACE (optional)*	U.S. CITIZEN OR U.S. NATIONAL? <input type="checkbox"/> Yes <input type="checkbox"/> No		LIST CITY, STATE AND COUNTRY OF BIRTH	
WHAT PROGRAMS IS THIS PERSON APPLYING FOR? <input type="checkbox"/> Food Support <input type="checkbox"/> Cash <input type="checkbox"/> Emergency help <input type="checkbox"/> Health care <input type="checkbox"/> None					LAST SCHOOL GRADE COMPLETED	

\*See MARITAL and RACE codes on the top of page 3.

**Do you need help right away?** Some people can get food support benefits within 24 hours. **Questions 1-4** below will help us decide if you can get food support benefits right away.

- How much income (cash or checks) did or will your household get **this month**? \_\_\_\_\_
- How much does your household (including children) have in **cash, checking or savings**? \$ \_\_\_\_\_
- How much does your household pay for: **Rent/mortgage**? \$ \_\_\_\_\_ **Utilities**? \$ \_\_\_\_\_
- Is anyone in your household a **migrant or seasonal farm worker**?  Yes  No

<b>Agency use:</b>
Eligible for expedited Food Support? <input type="checkbox"/> Yes <input type="checkbox"/> No
Same-day interview offered? <input type="checkbox"/> Yes <input type="checkbox"/> No; Declined? <input type="checkbox"/> Yes <input type="checkbox"/> No
Next-day interview offered? <input type="checkbox"/> Yes <input type="checkbox"/> No; Declined? <input type="checkbox"/> Yes <input type="checkbox"/> No

Yes  No **5.** Has anyone in the household ever received cash assistance, medical assistance, commodities or food support benefits before? **If yes:**  
When? \_\_\_\_\_ Where? \_\_\_\_\_ What? \_\_\_\_\_

Yes  No **6.** Is anyone in your household **pregnant**? Who? \_\_\_\_\_

Yes  No **7.** Do you need help now because of a **medical or other emergency**?

**Read the "Your responsibilities" and "Your rights" pages at the end 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
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**You may authorize another person(s) 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.**

You can ask more than one person(s) to help you with the items listed above. 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(s) 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

If you are having an organization or agency help you complete this form, tell us who:

ORGANIZATION/AGENCY NAME

**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? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, amount? _____	HOW OFTEN?
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**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	SIGNATURE OF APPLICANT
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**Check if you need help with or information about the following areas.**

*Note: You do not have to complete this section*

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

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Personal or family problems | <input type="checkbox"/> Special needs children | <input type="checkbox"/> Applying/interviewing for programs |
| <input type="checkbox"/> Family/domestic violence    | <input type="checkbox"/> A language barrier     | <input type="checkbox"/> Housing assistance                 |
| <input type="checkbox"/> Chemical dependency         | <input type="checkbox"/> Child care             | <input type="checkbox"/> Veteran services                   |
| <input type="checkbox"/> Mental health issues        | <input type="checkbox"/> Transportation         | <input type="checkbox"/> Help with budgeting or bad credit  |
| <input type="checkbox"/> Family planning information | <input type="checkbox"/> Food shelves           | <input type="checkbox"/> <b>Free</b> help filing your taxes |
| <input type="checkbox"/> Learning disability         | <input type="checkbox"/> Child support          |   |
| <input type="checkbox"/> 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?



<b>PERSON 5</b> LEGAL NAME (last/first/middle)		OTHER NAMES		GENDER <input type="checkbox"/> M <input type="checkbox"/> F	RELATIONSHIP TO YOU
BIRTH DATE (mm/dd/yy)	MARITAL STATUS	SOCIAL SECURITY NUMBER	MOST RECENTLY MOVED TO MINNESOTA (mm/dd/yy) Date _____ From: _____		
ETHNICITY (optional) Hispanic? <input type="checkbox"/> Yes <input type="checkbox"/> No		RACE (optional)	U.S. CITIZEN OR U.S. NATIONAL? <input type="checkbox"/> Yes <input type="checkbox"/> No		LIST CITY, STATE AND COUNTRY OF BIRTH
WHAT PROGRAMS IS THIS PERSON APPLYING FOR? <input type="checkbox"/> Food Support <input type="checkbox"/> Cash <input type="checkbox"/> Emergency help <input type="checkbox"/> Health care <input type="checkbox"/> None					LAST SCHOOL GRADE COMPLETED

<b>Agency use:</b>	
Intends to reside in MN?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has sponsor?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Immigration status	_____
Verification:	<input type="checkbox"/> requested <input type="checkbox"/> attached

**If more than 5 people, use DHS-5223S or attach additional paper with this information for each person.**

**Tell us about your household. (Answer questions below.)**

<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>1. Does <b>everyone</b> in your household buy, fix <b>or</b> eat food with you?</b>
<b>Agency use:</b>	
<input type="checkbox"/> Confirmed response	
Verification: <input type="checkbox"/> requested <input type="checkbox"/> attached	

<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>2. Is <b>anyone</b> in the household, who is age 60 or over or disabled, unable to buy or fix food due to a disability?</b>
<b>Agency use:</b>	
<input type="checkbox"/> Confirmed response	
Verification: <input type="checkbox"/> requested <input type="checkbox"/> attached	

<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>3. Is <b>anyone</b> in the household attending school?</b>
<b>Agency use:</b>	
<input type="checkbox"/> Confirmed response	
Verification: <input type="checkbox"/> requested <input type="checkbox"/> attached	

<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>4. Is <b>anyone</b> in your household temporarily not living in your home? (for example: vacation, foster care, treatment, hospital, job search)</b>
<b>Agency use:</b>	
<input type="checkbox"/> Confirmed response	
Verification: <input type="checkbox"/> requested <input type="checkbox"/> attached	

<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>5. Is <b>anyone</b> blind, or does anyone have a physical or mental health condition that limits the ability to work or perform daily activities?</b>
<b>Agency use:</b>	
<input type="checkbox"/> Confirmed response	
Verification: <input type="checkbox"/> requested <input type="checkbox"/> attached	

<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>6. Is <b>anyone</b> unable to work for reasons other than illness or disability?</b>
<b>Agency use:</b>	
<input type="checkbox"/> Confirmed response	
Verification: <input type="checkbox"/> requested <input type="checkbox"/> attached	

Yes  No 7. In the last 60 days did **anyone** in the household:

- Stop working or quit a job?
- Refuse a job offer?
- Ask to work fewer hours?
- Go on strike?

**Agency use:**

*Confirmed response*  
 Verification:  *requested*  *attached*

**What kinds of income do you have?** (Answer questions below.)

Yes  No 8. Has **anyone** in the household had a job or been self-employed in the past 12 months?

**Agency use:**

*Confirmed response*  
 Verification:  *requested*  *attached*

Yes  No 9. Does **anyone** in the household have a job or expect to get income from a job this month or next month?

**Bring or send proof.**

**Note:** Include income from Work Study and paid internships.  
 Include free benefits or reduced expenses received for work (shelter, food, clothing, etc.).

**Agency use:**

*Confirmed response*  
 Verification:  *requested*  *attached*

Yes  No 10. 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
- Conservation Reserve Program (CRP)
- Personal services
- Farming
- Paper route
- In-home day care
- Roomers/boarders
- Property rental
- Taxi driver
- Other

**Agency use:**

*Confirmed response*  
 Verification:  *requested*  *attached*


*Do net business assets of all businesses total \$200,000 or less?*  Yes  No

Yes  No 11. Do you expect any changes in income, expenses or work hours?

**Agency use:**

*Confirmed response*  
 Verification:  *requested*  *attached*

Check yes or no for each item. **12. Has **anyone** in the household applied for or does anyone get any of the following types of income?**

**Bring or send proof.**   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


**Agency use:**  
 *Confirmed response*  
 Verification:  *requested*  *attached*

Yes  No **13. Does **anyone** in the household have or expect to get any loans, scholarships or grants for attending school?**

**Agency use:**  
 *Confirmed response*  
 Verification:  *requested*  *attached*


**What kinds of expenses do you have? (Answer questions below.)**

Check yes or no for each item. **14. Does **your household** have the following housing expenses?**

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

**Agency use:**  
 *Confirmed response*  
 Verification:  *requested*  *attached*

Check yes or no for each item. **15. Does **your household** have the following utility expenses **any time** during the year?**

**Bring or send proof.**   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

**Agency use:**  
 *Confirmed response*  
 Verification:  *requested*  *attached*

Yes  No **16. 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.

**Agency use:**  
 *Confirmed response.*  
 Verification:  *requested*  *attached*

Yes  No 17. 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?

**Agency use:**

*Confirmed response*  
Verification:  *requested*  *attached*

**Bring proof of medical expenses.**

18. 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.

**Agency use:**


*Confirmed response*  
Verification:  *requested*  *attached*

Yes  No 19. **For General Assistance only:** 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.

**Agency use:**

*Confirmed response*  
Verification:  *requested*  *attached*

**What do you own? (Answer questions below.)**

Check yes or no for each item. **Bring or send proof.**  20. Does **anyone** in the household own, or is **anyone** buying, any of the following?

<input type="checkbox"/> Yes <input type="checkbox"/> No	Cash	<input type="checkbox"/> Yes <input type="checkbox"/> No	Life or burial insurance
<input type="checkbox"/> Yes <input type="checkbox"/> No	Bank accounts (savings, checking, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stocks bonds, annuities, etc.
<input type="checkbox"/> Yes <input type="checkbox"/> No	Vehicles (cars, trucks, motorcycles, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Real estate property (house, land, etc.)
<input type="checkbox"/> Yes <input type="checkbox"/> No	Other assets (tools, boats, livestock, etc.)		

**Agency use:**

*Confirmed response*  
EFT offered?  *Yes*  *No*  
Verification:  *requested*  *attached*

Yes  No 21. 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.

**Agency use:**

*Confirmed response*  
Verification:  *requested*  *attached*

**Tell us about your health insurance.** (Answer questions below.)

Yes  No **22a.** Does **anyone** have Medicare Part A, B or D coverage?

**Agency use:**

*Confirmed response*  
Verification:  *requested*  *attached*

Yes  No **22b.** Can **anyone** get health insurance through a current employer?

**Agency use:**

*Confirmed response*  
Verification:  *requested*  *attached*

Yes  No **22c.** Did **anyone** turn down or drop health insurance from a current employer?

**Agency use:**

*Confirmed response*  
Verification:  *requested*  *attached*

Yes  No **22d.** Did **anyone's** current employer stop offering health insurance in the last 18 months?

**Agency use:**

*Confirmed response*  
Verification:  *requested*  *attached*

Yes  No **22e.** Did **anyone** have health insurance that ended in the last four months?

**Agency use:**

*Confirmed response*  
Verification:  *requested*  *attached*

Yes  No **23.** Has **anyone** in the household been injured or had an accident in the past 72 months?

**Agency use:**

*Confirmed response*  
Verification:  *requested*  *attached*

**Other information:** (Answer questions below.)

Yes  No **24. For recertifications:** Did anyone move in or out of your home in the past 12 months.

**Agency use:**

*Confirmed response*  
Verification:  *requested*  *attached*

Yes  No **25.** Are **both** parents of **each** child under age 19 living in the home?

**Agency use:**

*Confirmed response*  
*Referral made to Child Support and Collection*  
 Yes  No

Yes  No **26. For Minnesota Supplemental Aid recipients only:** Is **anyone** in the household on a diet prescribed by a doctor?

**Agency use:**

*Confirmed response*  
Verification:  *requested*  *attached*

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, General Assistance Medical Care or MinnesotaCare for adults without children 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. **The trade or sale of benefits valued at over \$500 results in permanent ineligibility.**
- **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 24 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. 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. 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. 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:**
- I understand cash assistance is provided to help eligible families meet their basic needs.
  - 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 attached CAF Important Information sheet 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 9.
  - 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 sections above, the Social Security numbers section of the “Important Information” sheet and the Notice of Privacy Practices (DHS-3979) 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	INTERVIEW DATE