MNsure℠
Where you choose health coverage

Application for Health Coverage and Help Paying Costs

THINGS TO KNOW

Apply faster online

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

Use this application to see what coverage choices you qualify for

- Affordable private health insurance plans that offer comprehensive coverage to help you stay well
- A new tax credit that can immediately help pay your premiums for health coverage
- Free or low-cost insurance from Medical Assistance (MA) or MinnesotaCare, Minnesota's Health Care Programs
- **You may qualify for a free or low-cost program even if you earn as much as $97,200 a year (for a family of four).**

Who can use this application?

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

What you may need to apply

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

Why do we ask for this information?

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

What happens next?

Send your complete, signed application using the instructions in Step 9 on page 20. We will review your application and notify you in writing of the results.

Get help with this application

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

800-657-3739 or 651-431-2670

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,ကိးဘဉ်လီတဲစိနိုၤဂ်ၢ်လၢထးအံၤန္ဉ်တက့်.

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.

Clear Form

DHS-6696-ENG 11-16

STEP 1 People to include on this application

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

DO include:

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

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

DO NOT include:

- Your children 19 years old or older that you do not expect to claim as tax dependents
- Your spouse's children 19 years old or older that you do not expect to claim as tax dependents
- Your unmarried partner, if you do not have any children together and do not file taxes together
- Your unmarried partner's children, if they are not related to you and you do not expect to claim them as tax dependents
- Other people that live with you but are not your spouse or children and that you do not file taxes with
- Your parents, if you are 19 years old or older, your parents do not expect to claim you as a tax dependent, and you do not expect to claim them as tax dependents

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

The amount of assistance or type of program you qualify for depends on the number of people in your family and their incomes. This information helps us make sure everyone gets the best coverage he or she can.

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

Other family members. If you have other family members that were not included in Step 2 of this application that would like to have coverage under a family health plan, see Step 7 of this application (page 19).

STEP 2: PERSON 1 Start with yourself

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

1. FIRST NAME, MIDDLE NAME, LAST NAME, SUFFIX

2. DATE OF BIRTH
_____ (MM/DD/YYYY)
If under the age of 18, are you under the legal control of a parent?
◯ Yes ◯ No

3. SEX
◯ Male
◯ Female

4. MARITAL STATUS
◯ Legally separated ◯ Married
◯ Divorced ◯ Widowed
◯ Never married

5. Do you have a Social Security number (SSN)?
◯ Yes – what is your SSN? _____
◯ No – have you applied for an SSN? ◯ Yes ◯ No – why not? Choose a reason code from the list on Attachment B: ____

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

7a. HOME ADDRESS

7b. APARTMENT OR SUITE NUMBER

8. CITY

9. STATE

10. ZIP CODE

11. COUNTY

NEED HELP WITH YOUR APPLICATION? Visit **www.mnsure.org** or call us at **855-366-7873**. If you need help in a language other than English, tell us the language you need. We will get you help at no cost to you.

STEP 2: PERSON 1 (Continue with yourself)

12. MAILING ADDRESS (if different from home address)			13. APARTMENT OR SUITE NUMBER
14. CITY	15. STATE	16. ZIP CODE	17. COUNTY

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

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

20a. YOUR PREFERRED SPOKEN LANGUAGE	20b. YOUR PREFERRED WRITTEN LANGUAGE	21. Do you need an interpreter? ◯ Yes ◯ No

22. SELECT YOUR PREFERRED METHOD OF CONTACT ABOUT THIS APPLICATION

Email: ◯ Yes ◯ No
U.S. Postal Mail: ◯ Yes ◯ No

EMAIL ADDRESS

23. Do you want someone to act on your behalf as an authorized representative?
◯ Yes – complete Appendix C ◯ No
(You can give a trusted person permission to talk about this application with us, see your information and act for you on matters related to this application, including getting information about your application and signing your application on your behalf.)

24. Do you plan to file a federal income tax return **next year**?
(You can still apply for health insurance even if you do not file a federal income tax return.)
◯ Yes – answer questions a-c. ◯ No – go to question c.

a. Will you file jointly with a 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: _____

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

26. Are you applying for health care coverage for yourself?
(Even if you have insurance, there might be a program with better coverage or lower costs.)
◯ Yes – answer **all** the questions below. ◯ No – go to the job and income questions on page 4.

27a. Do you plan to make Minnesota your home? ◯ Yes ◯ No	27b. Are you visiting Minnesota to get medical care or for personal reasons? ◯ Yes ◯ No

28. Are you a U.S. citizen or U.S. national?
◯ Yes – go to question 31. ◯ No – go to question 29.

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STEP 2: PERSON 1 (Continue with yourself)

29. What is your current immigration status? *(Choose a status code from the list on Attachment B, or 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. Date of entry (MM/DD/YYYY): _____

g. Do you have a sponsor? ◯ Yes ◯ No

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

i. Do you want help paying for a medical emergency?
◯ No ◯ Yes – what are the begin and end dates for the medical emergency?
_____ (MM/DD/YYYY) to _____ (MM/DD/YYYY)

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

30. Did you ever have an immigration status different from your current status (example: refugee or asylee)?
◯ No ◯ Yes – what is your previous immigration status? *(Choose a status code from the list on 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)

31. Do you want help from MA to pay for medical bills from the past three months?
(The start date for MA can go back up to three months from your application date if you have medical bills from that time and meet the MA requirements.)
◯ Yes – answer questions a and b. ◯ No – go to question 32.

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

32. Were you in foster care in Minnesota at the age of 18 or older? ◯ Yes ◯ No

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

a. Are you blind? ◯ Yes ◯ No

b. Do you have a physical, mental, or emotional health condition that limits your activities (like bathing, dressing, daily chores, etc.)? ◯ Yes ◯ No

c. Do you need help staying in your home or help paying for care in a long-term-care facility, such as a nursing home? ◯ Yes ◯ No

d. Have you been determined disabled by the Social Security Administration (SSA) or the State Medical Review Team (SMRT)? ◯ Yes ◯ No

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

34. Are you currently in jail or prison? ◯ Yes ◯ No

35. Your answers to the two tobacco questions below do not affect your eligibility for health care coverage.

a. Within the past six months, have you used tobacco regularly (four or more times per week on average)? Do not count religious or ceremonial uses. ◯ Yes ◯ No

b. When was the last time you used tobacco regularly? _____ (MM/DD/YYYY)

STEP 2: PERSON 1 (Continue with yourself)

36. If Hispanic or Latino ethnicity (OPTIONAL—check all that apply.)

☐ Mexican ☐ Mexican American ☐ Chicano or Chicana ☐ Puerto Rican ☐ Cuban ☐ Other _____

37. Race (OPTIONAL—check all that apply.)

☐ White	☐ Black or African American	☐ American Indian or Alaska Native	☐ Asian Indian
☐ Chinese	☐ Filipino	☐ Japanese	☐ Korean
☐ Vietnamese	☐ Other Asian	☐ Native Hawaiian	☐ Guamanian or Chamorro
☐ Samoan	☐ Other Pacific Islander	☐ Other _____	

Recent Job Changes

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

☐ Change jobs ☐ Stop working ☐ Start working fewer hours or have a salary cut ☐ None of these

Current Job and Income Information (Check all that apply.)

☐ **Employed**
If you are currently employed, tell us about your income. Start with question 39.

☐ **Self-employed**
Go to question 43.

☐ **Seasonally employed**
Go to question 44.

☐ **Not employed**
Go to question 45.

Current Job 1

39. EMPLOYER NAME AND ADDRESS

40. WAGES AND TIPS BEFORE TAXES: Choose one and fill in the dollar amount.

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

Current Job 2

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

41. EMPLOYER NAME AND ADDRESS

42. WAGES AND TIPS BEFORE TAXES: Choose one and fill in the dollar amount.

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

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

a. Type of work

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

Income amount $_____ or Loss amount $_____

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STEP 2: PERSON 1 (Continue with yourself)

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

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

EMPLOYER NAME AND ADDRESS

45. **OTHER INCOME THIS MONTH:** Check all that apply, and give the amount and how often you get it.
Note: You do not need to tell us about child support, veteran's payment, or Supplemental Security Income (SSI).

- ☐ None
- ☐ Unemployment $_____ How often? _____
- ☐ Pensions $_____ How often? _____
- ☐ Social Security $_____ monthly How much of this amount is not taxable? $_____
- ☐ Other retirement $_____ How often? _____
- ☐ Alimony received $_____ How often? _____
- ☐ Net rental or royalty $_____ How often? _____
- ☐ Interest $_____ How often? _____
  How much of this interest amount is not taxable? $_____
- ☐ Other taxable income that is expected within the next 12 months
  Type: _____ $_____ How often? _____
- ☐ Other taxable income this month (Taxable income is income you would list on the Income section of IRS Form 1040.)
  Type: _____ $_____ How often? _____

46. **INCOME ADJUSTMENTS:** Check all that apply, and give the amount and how often you pay it.

If you pay for certain things that can be subtracted from gross income on a federal income tax return, telling us about them could make the cost of health coverage a little lower. See the Adjusted Gross Income section of IRS Form 1040 or IRS Form 1040-A. **Note:** You should not include a cost that you already considered in your answer to self-employment income or loss (question 43b).

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

47. **PROJECTED ANNUAL INCOME FOR 2017:** Do you expect your annual income for 2017 to be different from the income you listed above?

- ◯ Yes – total income expected for 2017: $_____
- ◯ No

STEP 2: PERSON 2

Complete Steps 2-4 for any others you need to include on this application. See page 1 Step 1 for information about the people to include.

1. FIRST NAME, MIDDLE NAME, LAST NAME, SUFFIX

2. MARITAL STATUS
◯ Legally separated ◯ Married
◯ Divorced ◯ Widowed
◯ Never married

3. RELATIONSHIP TO YOU

4. DATE OF BIRTH
_____ (MM/DD/YYYY)
If under the age of 18, is this person under the legal control of a parent?
◯ Yes ◯ No

5. SEX
◯ Male
◯ Female

6. Does PERSON 2 have a Social Security number (SSN)?
◯ Yes – what is PERSON 2's SSN? _____
◯ No – has PERSON 2 applied for an SSN?
◯ Yes ◯ No – why not? Choose a reason code from the list on Attachment B: _____

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

8. Does PERSON 2 plan to file a federal income tax return **next year**?
(PERSON 2 can still apply for health insurance even if he or she does not file a federal income tax return.)
◯ Yes – answer questions a-c ◯ No – go to question c.

a. Will PERSON 2 file jointly with a spouse? ◯ Yes ◯ No
If yes, name of spouse: _____

b. Will PERSON 2 claim any dependents on his or her tax return? ◯ Yes ◯ No
If yes, list name(s) of dependent(s): _____

c. Will PERSON 2 be claimed as a dependent on someone else's tax return? ◯ Yes ◯ No
If yes, list the name of the tax filer: _____
How is PERSON 2 related to the tax filer? _____

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

10. Does PERSON 2 want to apply for health care coverage?
(Even if PERSON 2 has insurance, there might be a program with better coverage or lower costs.)
◯ Yes – answer **all** the questions below. ◯ No – go to the job and income questions on page 8.

11a. Is PERSON 2 visiting Minnesota to get medical care or for personal reasons? ◯ Yes ◯ No

11b. Does PERSON 2 plan to make Minnesota his or her home? ◯ Yes ◯ No

12. Is PERSON 2 a U.S. citizen or U.S. national?
◯ Yes – go to question 15. ◯ No – go to question 13.

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STEP 2: PERSON 2 (Continue with PERSON 2)

13. What is PERSON 2's current immigration status? *(Choose a status code from the list on Attachment B, or write in PERSON 2's status if it is not on the list.)* Code or status: _____

    a. Immigration document type: _____

    b. Alien ID number: _____

    c. Card number: _____

    d. Did PERSON 2 enter the United States before August 22, 1996? ◯ Yes ◯ No

    e. Has PERSON 2 lived in the United States for five years or more in a qualified status? *(See Attachment B to determine whether PERSON 2 has a qualified status.)* ◯ Yes ◯ No

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

    g. Does PERSON 2 have a sponsor? ◯ Yes ◯ No

    h. Is PERSON 2, or his or her spouse or parent, a veteran or active-duty member of the military? ◯ Yes ◯ No

    i. Does PERSON 2 want help paying for a medical emergency?
    ◯ No ◯ Yes – what are the begin and end dates for the medical emergency?
    _____ (MM/DD/YYYY) to _____ (MM/DD/YYYY)

    j. Is PERSON 2 getting services from the Center for Victims of Torture? ◯ Yes ◯ No

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

15. Does PERSON 2 want help from MA to pay for medical bills from the past three months?
    (The start date for MA can go back up to three months from your application date if PERSON 2 has medical bills from that time and meets the MA requirements.)
    ◯ Yes – answer questions a and b. ◯ No – go to question 16.

    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

16. Was PERSON 2 in foster care in Minnesota at the age of 18 or older? ◯ Yes ◯ No

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

    a. Is PERSON 2 blind? ◯ Yes ◯ No

    b. Does PERSON 2 have a physical, mental, or emotional health condition that limits PERSON 2's activities (like bathing, dressing, daily chores, etc.)? ◯ Yes ◯ No

    c. Does PERSON 2 need help staying in his or her home or help paying for care in a long-term-care facility, such as a nursing home? ◯ Yes ◯ No

    d. Has PERSON 2 been determined disabled by the Social Security Administration (SSA) or the State Medical Review Team (SMRT)? ◯ Yes ◯ No

    e. Is PERSON 2 in a residential treatment program for mental illness or drug or alcohol dependency? ◯ Yes ◯ No

18. Is PERSON 2 currently in jail or prison? ◯ Yes ◯ No

19. The answers to the two tobacco questions below do not affect PERSON 2's eligibility for health care coverage.

    a. Within the past six months, has PERSON 2 used tobacco regularly (four or more times per week on average)? Do not count religious or ceremonial uses. ◯ Yes ◯ No

    b. When was the last time PERSON 2 used tobacco regularly? _____ (MM/DD/YYYY)

STEP 2: PERSON 2 (Continue with PERSON 2)

20. If Hispanic or Latino ethnicity (OPTIONAL—check all that apply.)

☐ Mexican ☐ Mexican American ☐ Chicano or Chicana ☐ Puerto Rican ☐ Cuban ☐ Other _____

21. Race (OPTIONAL—check all that apply.)

☐ White	☐ Black or African American	☐ American Indian or Alaska Native	☐ Asian Indian
☐ Chinese	☐ Filipino	☐ Japanese	☐ Korean
☐ Vietnamese	☐ Other Asian	☐ Native Hawaiian	☐ Guamanian or Chamorro
☐ Samoan	☐ Other Pacific Islander	☐ Other _____	

Recent Job Changes

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

☐ Change jobs ☐ Stop working ☐ Start working fewer hours or have a salary cut ☐ None of these

Current Job and Income Information (Check all that apply.)

☐ **Employed**
If PERSON 2 is currently employed, tell us about his or her income. Start with question 23.

☐ **Self-employed**
Go to question 27.

☐ **Seasonally employed**
Go to question 28.

☐ **Not employed**
Go to question 29.

Current Job 1

23. EMPLOYER NAME AND ADDRESS

24. WAGES AND TIPS BEFORE TAXES: Choose one and fill in the dollar amount.

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

Current Job 2

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

25. EMPLOYER NAME AND ADDRESS

26. WAGES AND TIPS BEFORE TAXES: Choose one and fill in the dollar amount.

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

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

a. Type of work

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

Income amount $_____ or Loss amount $_____

NEED HELP WITH YOUR APPLICATION? Visit **www.mnsure.org** or call us at **855-366-7873**. If you need help in a language other than English, tell us the language you need. We will get you help at no cost to you.

STEP 2: PERSON 2 (Continue with PERSON 2)

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

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

EMPLOYER NAME AND ADDRESS

29. **OTHER INCOME THIS MONTH:** Check all that apply, and give the amount and how often PERSON 2 gets it.
Note: PERSON 2 does not need to tell us about child support, veteran's payment, or Supplemental Security Income (SSI).

- ☐ None
- ☐ Unemployment $_____ How often? _____
- ☐ Pensions $_____ How often? _____
- ☐ Social Security $_____ monthly How much of this amount is not taxable? $_____
- ☐ Other retirement $_____ How often? _____
- ☐ Alimony received $_____ How often? _____
- ☐ Net rental or royalty $_____ How often? _____
- ☐ Interest $_____ How often? _____
  How much of this interest amount is not taxable? $_____
- ☐ Other taxable income that is expected within the next 12 months
  Type: _____ $_____ How often? _____
- ☐ Other taxable income this month (Taxable income is income you would list on the Income section of IRS Form 1040.)
  Type: _____ $_____ How often? _____

30. **INCOME ADJUSTMENTS:** Check all that apply, and give the amount and how often PERSON 2 pays it.

If PERSON 2 pays for certain things that can be subtracted from gross income on a federal income tax return, telling us about them could make the cost of health coverage a little lower. See the Adjusted Gross Income section of IRS Form 1040 or IRS Form 1040-A. Note: PERSON 2 should not include a cost that he or she already considered in his or her answer to self-employment income or loss (question 27b).

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

31. **PROJECTED ANNUAL INCOME FOR 2017:** Does PERSON 2 expect his or her annual income for 2017 to be different from the income listed above?

- ◯ Yes – total income expected for 2017: $_____
- ◯ No

STEP 2: PERSON 3

Complete Steps 2-4 for any others you need to include on this application. See page 1 Step 1 for information about the people to include.

1. FIRST NAME, MIDDLE NAME, LAST NAME, SUFFIX

2. MARITAL STATUS
◯ Legally separated ◯ Married
◯ Divorced ◯ Widowed
◯ Never married

3. RELATIONSHIP TO YOU

4. DATE OF BIRTH
_____ (MM/DD/YYYY)
If under the age of 18, is this person under the legal control of a parent?
◯ Yes ◯ No

5. SEX
◯ Male
◯ Female

6. Does PERSON 3 have a Social Security number (SSN)?
◯ Yes – what is PERSON 3's SSN? _____
◯ No – has PERSON 3 applied for an SSN?
◯ Yes ◯ No – why not? Choose a reason code from the list on Attachment B: _____

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

8. Does PERSON 3 plan to file a federal income tax return **next year**?
(PERSON 3 can still apply for health insurance even if he or she does not file a federal income tax return.)
◯ Yes – answer questions a-c ◯ No – go to question c.

a. Will PERSON 3 file jointly with a spouse? ◯ Yes ◯ No
If yes, name of spouse: _____

b. Will PERSON 3 claim any dependents on his or her tax return? ◯ Yes ◯ No
If yes, list name(s) of dependent(s): _____

c. Will PERSON 3 be claimed as a dependent on someone else's tax return? ◯ Yes ◯ No
If yes, list the name of the tax filer: _____
How is PERSON 3 related to the tax filer? _____

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

10. Does PERSON 3 want to apply for health care coverage?
(Even if PERSON 3 has insurance, there might be a program with better coverage or lower costs.)
◯ Yes – answer **all** the questions below. ◯ No – go to the job and income questions on page 12.

11a. Is PERSON 3 visiting Minnesota to get medical care or for personal reasons? ◯ Yes ◯ No

11b. Does PERSON 3 plan to make Minnesota his or her home? ◯ Yes ◯ No

12. Is PERSON 3 a U.S. citizen or U.S. national?
◯ Yes – go to question 15. ◯ No – go to question 13.

STEP 2: PERSON 3 (Continue with PERSON 3)

13. What is PERSON 3's current immigration status? *(Choose a status code from the list on Attachment B, or write in PERSON 3's status if it is not on the list.)* Code or status: _____

    a. Immigration document type: _____

    b. Alien ID number: _____

    c. Card number: _____

    d. Did PERSON 3 enter the United States before August 22, 1996? ◯ Yes ◯ No

    e. Has PERSON 3 lived in the United States for five years or more in a qualified status? *(See Attachment B to determine whether PERSON 3 has a qualified status.)* ◯ Yes ◯ No

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

    g. Does PERSON 3 have a sponsor? ◯ Yes ◯ No

    h. Is PERSON 3, or his or her spouse or parent, a veteran or active-duty member of the military? ◯ Yes ◯ No

    i. Does PERSON 3 want help paying for a medical emergency?
    ◯ No ◯ Yes – what are the begin and end dates for the medical emergency?
    _____ (MM/DD/YYYY) to _____ (MM/DD/YYYY)

    j. Is PERSON 3 getting services from the Center for Victims of Torture? ◯ Yes ◯ No

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

15. Does PERSON 3 want help from MA to pay for medical bills from the past three months?
    (The start date for MA can go back up to three months from your application date if PERSON 3 has medical bills from that time and meets the MA requirements.)
    ◯ Yes – answer questions a and b. ◯ No – go to question 16.

    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

16. Was PERSON 3 in foster care in Minnesota at the age of 18 or older? ◯ Yes ◯ No

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

    a. Is PERSON 3 blind? ◯ Yes ◯ No

    b. Does PERSON 3 have a physical, mental, or emotional health condition that limits PERSON 3's activities (like bathing, dressing, daily chores, etc.)? ◯ Yes ◯ No

    c. Does PERSON 3 need help staying in his or her home or help paying for care in a long-term-care facility, such as a nursing home? ◯ Yes ◯ No

    d. Has PERSON 3 been determined disabled by the Social Security Administration (SSA) or the State Medical Review Team (SMRT)? ◯ Yes ◯ No

    e. Is PERSON 3 in a residential treatment program for mental illness or drug or alcohol dependency? ◯ Yes ◯ No

18. Is PERSON 3 currently in jail or prison? ◯ Yes ◯ No

19. The answers to the two tobacco questions below do not affect PERSON 3's eligibility for health care coverage.

    a. Within the past six months, has PERSON 3 used tobacco regularly (four or more times per week on average)? Do not count religious or ceremonial uses. ◯ Yes ◯ No

    b. When was the last time PERSON 3 used tobacco regularly? _____ (MM/DD/YYYY)

STEP 2: PERSON 3 (Continue with PERSON 3)

20. If Hispanic or Latino ethnicity (OPTIONAL—check all that apply.)

☐ Mexican ☐ Mexican American ☐ Chicano or Chicana ☐ Puerto Rican ☐ Cuban ☐ Other _____

21. Race (OPTIONAL—check all that apply.)

☐ White	☐ Black or African American	☐ American Indian or Alaska Native	☐ Asian Indian
☐ Chinese	☐ Filipino	☐ Japanese	☐ Korean
☐ Vietnamese	☐ Other Asian	☐ Native Hawaiian	☐ Guamanian or Chamorro
☐ Samoan	☐ Other Pacific Islander	☐ Other _____	

Recent Job Changes

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

☐ Change jobs ☐ Stop working ☐ Start working fewer hours or have a salary cut ☐ None of these

Current Job and Income Information (Check all that apply.)

☐ **Employed**
If PERSON 3 is currently employed, tell us about his or her income. Start with question 23.

☐ **Self-employed**
Go to question 27.

☐ **Seasonally employed**
Go to question 28.

☐ **Not employed**
Go to question 29.

Current Job 1

23. EMPLOYER NAME AND ADDRESS

24. WAGES AND TIPS BEFORE TAXES: Choose one and fill in the dollar amount.

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

Current Job 2

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

25. EMPLOYER NAME AND ADDRESS

26. WAGES AND TIPS BEFORE TAXES: Choose one and fill in the dollar amount.

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

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

a. Type of work

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

Income amount $_____ or Loss amount $_____

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STEP 2: PERSON 3 (Continue with PERSON 3)

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

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

EMPLOYER NAME AND ADDRESS

29. **OTHER INCOME THIS MONTH:** Check all that apply, and give the amount and how often PERSON 3 gets it.
Note: PERSON 3 does not need to tell us about child support, veteran's payment, or Supplemental Security Income (SSI).

- ☐ None
- ☐ Unemployment $_____ How often? _____
- ☐ Pensions $_____ How often? _____
- ☐ Social Security $_____ monthly How much of this amount is not taxable? $_____
- ☐ Other retirement $_____ How often? _____
- ☐ Alimony received $_____ How often? _____
- ☐ Net rental or royalty $_____ How often? _____
- ☐ Interest $_____ How often? _____
  How much of this interest amount is not taxable? $_____
- ☐ Other taxable income that is expected within the next 12 months
  Type: _____ $_____ How often? _____
- ☐ Other taxable income this month (Taxable income is income you would list on the Income section of IRS Form 1040.)
  Type: _____ $_____ How often? _____

30. **INCOME ADJUSTMENTS:** Check all that apply, and give the amount and how often PERSON 3 pays it.

If PERSON 3 pays for certain things that can be subtracted from gross income on a federal income tax return, telling us about them could make the cost of health coverage a little lower. See the Adjusted Gross Income section of IRS Form 1040 or IRS Form 1040-A. Note: PERSON 3 should not include a cost that he or she already considered in his or her answer to self-employment income or loss (question 27b).

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

31. **PROJECTED ANNUAL INCOME FOR 2017:** Does PERSON 3 expect his or her annual income for 2017 to be different from the income listed above?

- ◯ Yes – total income expected for 2017: $_____
- ◯ No

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

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STEP 2: PERSON 4

Complete Steps 2-4 for any others you need to include on this application. See page 1 Step 1 for information about the people to include.

1. FIRST NAME, MIDDLE NAME, LAST NAME, SUFFIX

2. MARITAL STATUS
◯ Legally separated ◯ Married
◯ Divorced ◯ Widowed
◯ Never married

3. RELATIONSHIP TO YOU

4. DATE OF BIRTH
_____ (MM/DD/YYYY)
If under the age of 18, is this person under the legal control of a parent?
◯ Yes ◯ No

5. SEX
◯ Male
◯ Female

6. Does PERSON 4 have a Social Security number (SSN)?
◯ Yes – what is PERSON 4's SSN? _____
◯ No – has PERSON 4 applied for an SSN?
◯ Yes ◯ No – why not? Choose a reason code from the list on Attachment B: _____

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

8. Does PERSON 4 plan to file a federal income tax return **next year**?
(PERSON 4 can still apply for health insurance even if he or she does not file a federal income tax return.)
◯ Yes – answer questions a-c ◯ No – go to question c.

a. Will PERSON 4 file jointly with a spouse? ◯ Yes ◯ No
If yes, name of spouse: _____

b. Will PERSON 4 claim any dependents on his or her tax return? ◯ Yes ◯ No
If yes, list name(s) of dependent(s): _____

c. Will PERSON 4 be claimed as a dependent on someone else's tax return? ◯ Yes ◯ No
If yes, list the name of the tax filer: _____
How is PERSON 4 related to the tax filer? _____

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

10. Does PERSON 4 want to apply for health care coverage?
(Even if PERSON 4 has insurance, there might be a program with better coverage or lower costs.)
◯ Yes – answer **all** the questions below. ◯ No – go to the job and income questions on page 16.

11a. Is PERSON 4 visiting Minnesota to get medical care or for personal reasons? ◯ Yes ◯ No

11b. Does PERSON 4 plan to make Minnesota his or her home? ◯ Yes ◯ No

12. Is PERSON 4 a U.S. citizen or U.S. national?
◯ Yes – go to question 15. ◯ No – go to question 13.

STEP 2: PERSON 4 (Continue with PERSON 4)

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

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

15. Does PERSON 4 want help from MA to pay for medical bills from the past three months?
    (The start date for MA can go back up to three months from your application date if PERSON 4 has medical bills from that time and meets the MA requirements.)
    ◯ Yes – answer questions a and b. ◯ No – go to question 16.
    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

16. Was PERSON 4 in foster care in Minnesota at the age of 18 or older? ◯ Yes ◯ No

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

18. Is PERSON 4 currently in jail or prison? ◯ Yes ◯ No

19. The answers to the two tobacco questions below do not affect PERSON 4's eligibility for health care coverage.
    a. Within the past six months, has PERSON 4 used tobacco regularly (four or more times per week on average)? Do not count religious or ceremonial uses. ◯ Yes ◯ No
    b. When was the last time PERSON 4 used tobacco regularly? _____ (MM/DD/YYYY)

STEP 2: PERSON 4 (Continue with PERSON 4)

20. If Hispanic or Latino ethnicity (OPTIONAL—check all that apply.)

☐ Mexican ☐ Mexican American ☐ Chicano or Chicana ☐ Puerto Rican ☐ Cuban ☐ Other _____

21. Race (OPTIONAL—check all that apply.)

☐ White	☐ Black or African American	☐ American Indian or Alaska Native	☐ Asian Indian
☐ Chinese	☐ Filipino	☐ Japanese	☐ Korean
☐ Vietnamese	☐ Other Asian	☐ Native Hawaiian	☐ Guamanian or Chamorro
☐ Samoan	☐ Other Pacific Islander	☐ Other _____	

Recent Job Changes

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

☐ Change jobs ☐ Stop working ☐ Start working fewer hours or have a salary cut ☐ None of these

Current Job and Income Information (Check all that apply.)

☐ **Employed**
If PERSON 4 is currently employed, tell us about his or her income. Start with question 23.

☐ **Self-employed**
Go to question 27.

☐ **Seasonally employed**
Go to question 28.

☐ **Not employed**
Go to question 29.

Current Job 1

23. EMPLOYER NAME AND ADDRESS

24. WAGES AND TIPS BEFORE TAXES: Choose one and fill in the dollar amount.

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

Current Job 2

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

25. EMPLOYER NAME AND ADDRESS

26. WAGES AND TIPS BEFORE TAXES: Choose one and fill in the dollar amount.

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

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

a. Type of work

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

Income amount $_____ or Loss amount $_____

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STEP 2: PERSON 4 (Continue with PERSON 4)

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

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

EMPLOYER NAME AND ADDRESS

29. **OTHER INCOME THIS MONTH:** Check all that apply, and give the amount and how often PERSON 4 gets it.
Note: PERSON 4 does not need to tell us about child support, veteran's payment, or Supplemental Security Income (SSI).

- ☐ None
- ☐ Unemployment $_____ How often? _____
- ☐ Pensions $_____ How often? _____
- ☐ Social Security $_____ monthly How much of this amount is not taxable? $_____
- ☐ Other retirement $_____ How often? _____
- ☐ Alimony received $_____ How often? _____
- ☐ Net rental or royalty $_____ How often? _____
- ☐ Interest $_____ How often? _____
  How much of this interest amount is not taxable? $_____
- ☐ Other taxable income that is expected within the next 12 months
  Type: _____ $_____ How often? _____
- ☐ Other taxable income this month (Taxable income is income you would list on the Income section of IRS Form 1040.)
  Type: _____ $_____ How often? _____

30. **INCOME ADJUSTMENTS:** Check all that apply, and give the amount and how often PERSON 4 pays it.

If PERSON 4 pays for certain things that can be subtracted from gross income on a federal income tax return, telling us about them could make the cost of health coverage a little lower. See the Adjusted Gross Income section of IRS Form 1040 or IRS Form 1040-A. Note: PERSON 4 should not include a cost that he or she already considered in his or her answer to self-employment income or loss (question 27b).

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

31. **PROJECTED ANNUAL INCOME FOR 2017:** Does PERSON 4 expect his or her annual income for 2017 to be different from the income listed above?

- ◯ Yes – total income expected for 2017: $_____
- ◯ No

Continue to Step 3 ➔

STEP 3 Your Family's Health Coverage

Answer these questions for anyone that needs health coverage.

1. Is anyone now enrolled in health coverage from the following?

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

◯ No

☐ Long-term-care (LTC) insurance ☐ Medical Assistance (MA) ☐ MinnesotaCare ☐ Medicare

☐ TRICARE (Do not check if you have direct care or line of duty) ☐ VA health care programs ☐ Peace Corps

☐ COBRA ☐ Employer insurance ☐ Private or other insurance ☐ Dental ☐ Vision

POLICYHOLDER'S NAME	POLICYHOLDER'S DATE OF BIRTH	INSURANCE COMPANY NAME	
START DATE	END DATE	POLICY NUMBER	GROUP NUMBER
LIST EVERYONE THAT IS COVERED BY THIS POLICY			
Is this health insurance through an employer or union? ◯ Yes ◯ No			

2. Is anyone getting medical care for an accident or injury?

◯ No ◯ Yes – who? _____

3. Is anyone listed on this application offered health coverage from a job? Check yes even if the coverage is from someone else's job, such as a parent or spouse.

◯ No ◯ Yes – you need to complete and include Appendix A. Is this coverage a state employee benefit plan? ◯ Yes ◯ No

STEP 4 American Indian or Alaska Native (AI or AN) family member(s)

1. Are you or is anyone in your family American Indian or Alaska Native?

◯ No – go to Step 5. ◯ Yes – you need to complete and include Appendix B.

STEP 5 Military Service

1. Has anyone ever been in the United States military? ◯ No ◯ Yes – who? _____
2. Has anyone returned from a tour of active military duty in the last 24 months?

◯ No ◯ Yes – who? _____

Date last active tour of duty ended: _____ (MM/DD/YYYY)

STEP 6 Family Changes

1. Has anyone on the application applied for unemployment benefits? ◯ Yes ◯ No
2. Has your family size changed since last year, or do you think your family size will change this year (such as because of a new baby)? ◯ Yes ◯ No
3. Has the income of any tax filer included in the application decreased from last year? ◯ Yes ◯ No
4. Has your tax filing status changed, or do you think it will change in the next year? ◯ Yes ◯ No

NEED HELP WITH YOUR APPLICATION? Visit **www.mnsure.org** or call us at **855-366-7873**. If you need help in a language other than English, tell us the language you need. We will get you help at no cost to you.

STEP 7 Other Family Members

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

Qualified family members that may not have been included in Step 2 but that may be eligible to be included under a family health plan include these:

- Children that do not live with you
- Children that are not included on your federal income tax return
- Adult children 19-26 years old
- Grandchildren that have resided with you continuously from birth and that are financially dependent on you or your covered spouse
- Children for whom you or your spouse is legal guardian

STEP 8 Please complete this page and read the attached Notice of Privacy Practices and Notice of Rights and Responsibilities before signing below.

Verifying Eligibility and Renewing Coverage

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

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

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

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

By Signing Below:

I received and reviewed the Notice of Privacy Practices and the Notice of Rights and Responsibilities (Attachment A). I know that I must report changes to the information listed on this application.

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

I declare under the penalties of perjury that this application has been examined by me and to the best of my knowledge is a true and correct statement of every material point. I understand that a person convicted of perjury may be sentenced to imprisonment of not more than five years or payment of a fine of not more than $10,000, or both. I understand that there may be other penalties for not telling the truth.

Additional Agreements for Medical Assistance and MinnesotaCare:

- **If anyone on this application is eligible for Medical Assistance or MinnesotaCare,** I consent to the release of my Minnesota Health Care Programs health records to the parties listed in the Consent for Sharing of Medical Information section of the Notice of Rights and Responsibilities.
- **If anyone on this application is eligible for Medical Assistance,** I give the Medical Assistance agency our rights to pursue and get any money from other health insurance, legal settlements, or other third parties.
- **If anyone on this application is eligible for Medical Assistance,** I have read and understand that the state may claim repayment for the cost of medical care, or the cost of the premiums paid for care, from my estate or my spouse's estate.
- **If anyone on this application is eligible for Medical Assistance,** I agree and understand that my information, and information about me shared from third parties, will be shared for fraud prevention investigations as stated in the Notice of Privacy Practices.
- **If I am a parent that is eligible for Medical Assistance,** I know I will be asked to cooperate with the agency that collects medical support from an absent parent. If I think that cooperating to collect medical support will harm me or my children, I can tell the agency, and I may not have to cooperate. I give to the Medical Assistance agency the rights to medical support paid for my children.

Does any child on the application have a parent living outside of the home? ◯ Yes ◯ No

Remember to return with this application any appendices you completed.

Sign this application.

SIGNATURE	DATE (MM/DD/YYYY)

Continue to Step 9 ➔

NEED HELP WITH YOUR APPLICATION? Visit **www.mnsure.org** or call us at **855-366-7873**. If you need help in a language other than English, tell us the language you need. We will get you help at no cost to you.

STEP 9 Submit your completed and signed application.

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

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

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

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

NEED HELP WITH YOUR APPLICATION? Visit **www.mnsure.org** or call us at **855-366-7873**. If you need help in a language other than English, tell us the language you need. We will get you help at no cost to you.

Attachment A

Notice of Privacy Practices and Notice of Rights and Responsibilities

Effective Date: November 2016

Notice of Privacy Practices

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

Why do we ask for this information?

To 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 investigate the accuracy of the information in your application

After we have begun to provide services or support to you, we may collect additional information:

- To make reports, do research, do audits, and evaluate our programs
- To investigate reports of people that may lie about the help they need or to get assistance they may not be entitled to receive
- To collect money from other agencies, like insurance companies, if they should pay for your care
- To collect money from the state or federal government for help we give you

Why do we ask you for your Social Security number?

We need your Social Security number (SSN) to give you Medical Assistance (MA), some kinds of financial help, and child support enforcement services (42 CFR 435.910 [2006]; Minn. Stat. 256D.03, subd.3(h); Minn. Stat. 256L.04, subd. 1a; 45 CFR 205.52 [2001]; 42 USC 666; 45 CFR 303.30 [2001]).

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 that 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

Why do we ask for your income information?

We ask for income information and check state and federal sources to confirm your income and family size. We will use this information only for the purposes authorized by law, such as verifying eligibility or determining eligibility for the advanced premium tax credit and cost-sharing reductions, and the amount of the credit or reduction. We will not share this information with any other person or entity. You do not have to provide income information if you are not requesting a subsidy, a tax credit or cost-sharing reductions.

Do you have to answer the questions we ask?

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

With whom may we share information?

We will share information about you only as needed and as allowed or required by law. 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

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

- You and people you have given permission to may see and copy private information we have about you. You may have to pay for the copies.
- 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 with another agency.
- You have the right to ask us in writing to share health information with you in a certain way or in a certain place. For example, you may ask us to send health information to your work address instead of your home address. If we find that your request is reasonable, we will grant it.
- You have the right to ask us to limit or restrict the way that we use or disclose your information, but we are not required to agree to this request.
- You have the right to get a record of some of the people or organizations with whom we have shared your information. This record was started on April 14, 2003. You must ask for a copy of this record in writing to our privacy official.
- If you do not understand the information, ask your worker to explain it to you. You may ask the Minnesota Department of Human Services or MNsure for another copy of this notice.

What are our responsibilities?

- We must protect the privacy of your personal, health care and other private information according to the terms of this notice.
- We may not use your information for reasons other than the reasons listed on this form or share your information with individuals and agencies other than those listed on this form unless you tell us in writing that we can.
- We will not sell any data collected, created or maintained as part of this application.
- We must follow the terms of this notice, but we may change our privacy policy because privacy laws change. We will put changes to our privacy rules on our website at https://edocs.dhs.state.mn.us/lfserver/Public/DHS-4839K-ENG and www.mnsure.org

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 – MNsure
Attn: Privacy Official
PO Box 64998
St. Paul, MN 55164-0998

Attachment A – Keep this page for your records.

Notice of Rights and Responsibilities

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

Your household's eligibility and enrollment in individual market qualified health plans (with or without advanced premium tax credits) are managed by MNsure with coordination through the health insurance carrier that you select.

Your household's eligibility and enrollment in Medical Assistance and MinnesotaCare are managed by the Minnesota Department of Human Services and Minnesota county agencies.

Rights and Responsibilities for All Programs

Changes

If you have Medical Assistance (MA), you must report a change within 10 days of the change happening. Call your county or tribal agency to report the change. If you have MinnesotaCare, you must report a change within 30 days of the change happening. If everyone in your household receives MinnesotaCare, call MinnesotaCare Operations at 800-657-3672 or 651-297-3862 to report the change. If anyone in your household has MA, call your county agency to report the change.

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

If you do not report changes, you may have to pay money back to the state or federal government for benefits that you received but were not eligible for. If you are not sure whether to report a change, call and explain what is happening. Examples of changes you need to report include the following:

Income changes when you

- Start a new job, change jobs or stop a job
- Start to get, 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

Tax Filing

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

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

You Have the Right to Ask for a Hearing

If you feel your health care eligibility or benefits are wrong or your application was not processed correctly, you may ask for an appeal hearing. By requesting an appeal hearing, you are requesting a fair review of your case. You can represent yourself or use an attorney, advocate, authorized representative, relative, friend or other person. You will find specific appeal instructions on all eligibility notices that you receive. Learn more about the appeals process and how to ask for a hearing at the MNsure appeals website at www.mnsure.org/help/appeals or at the DHS website at www.dhs.state.mn.us/appeals/faqs.

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

You can also print the form available at the address above and submit the completed form by fax to 651-431-7523 or by mail to this address:

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

Immigration

Immigration information you give to us is private. We use it to see whether you can get coverage. We share it only when the law allows it or requires it, such as to verify identity. In most cases, applying will not affect your immigration status unless you are applying for payment of long-term-care services.

You do not have to give us your immigration information if you are a pregnant woman living in the United States without the knowledge or approval of the United States Citizenship

and Immigration Services (USCIS). You also do not have to give us your immigration information if you are:

- Applying for emergency medical care only
- Helping someone else apply
- Not applying for yourself

Genetic Information

MNsure does not collect, maintain or use genetic information.

Record Retention

Information provided in an application for coverage through MNsure is subject to the False Claims Act and may be kept for up to 10 years. MNsure 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, MNsure 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.

Your Civil Rights

Civil Rights Notice

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

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

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

Free language assistance services. If you speak limited English and need translated documents or spoken language interpreting to have meaningful access to information and services, MNsure and DHS will provide them timely and free of charge.

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

To request these free services from DHS, call the DHS Minnesota Health Care Programs (MHCP) Member Help Desk at 651-431-2670 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 four 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)
http://www.hhs.gov/ocr/office/file/index.html

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

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)

MNsure and DHS

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

- race
- color

- national origin
- creed
- religion
- sexual orientation
- public assistance status
- marital status
- age
- disability
- sex, including sex stereotypes and gender identity

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

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

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

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

Deputy General Counsel
The MNsure Accessibility and Equal Opportunity (AEO) Office
81 7th Street East, Suite 300
St. Paul, MN 55101-2211
855-366-7873 (voice) or use your preferred relay service
AEO@MNsure.org (email)

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

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

Rights and Responsibilities for Medical Assistance and MinnesotaCare Only

Reviews

The state or federal agency's health care program auditors may look at your case. They will review the information you gave us and check to make sure we processed your case correctly. They will let you know if they need to ask you questions.

Other Health Care

You and your household members enrolled in MA must tell us about any other health insurance that you have or that is available to you, including employer-sponsored coverage, private health insurance, long-term-care insurance, and any limited health coverage, such as dental or accident coverage. You must tell us whether your employer offers insurance and whether you accepted it.

You and your household members enrolled in MA may need to accept and keep a health insurance policy when the policy is found to be cost effective. If you have a good reason for not doing that, you may ask the state to approve the reason. If you do not give us information about your health insurance policy, you may not get coverage.

You must also tell us when you have become eligible for Medicare. MA pays for the Medicare premiums of some low-income people.

Consent for Sharing of Medical Information

By accepting or receiving MA or MinnesotaCare, I give my consent to the following agencies and people to share between them medical information about me only for the limited purposes indicated:

- Health providers, including health plans, insurance agencies, MA or MinnesotaCare, county advocates, school districts, my county or state case workers, and their contractors and subcontractors, for these purposes:
  - To determine who should pay for my 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 my minor children I applied for on this application.

I can stop this consent at any time by asking in writing for it to end. The written notice to stop this consent will not affect information the agency has already given to others. This consent is good while I am enrolled in MA or MinnesotaCare, up to one year or longer if the law permits.

However, it does not end after one year for records given to consulting providers or for payment of my bills, fraud investigations or quality-of-care review and studies.

An agency or person who gets my information through this consent could give the information to others.

MA Medical Support

If you are applying for yourself and your children and you do not live with the other parent, the law says you may have to give information to child support staff if both you and your child are eligible for MA. This includes helping the state prove who the father of your children is and helping the state to get the other parent to help pay the children's medical expenses. If you do not help child support staff, your children will still get coverage, but your coverage will end, unless you are pregnant.

If you are afraid the other parent may cause harm to you or your child, you can give your county or tribal agency proof that supports your fears. The agency will review your proof and tell you whether you still must give information to child support staff.

MA Estate Claims and Liens

In certain circumstances, federal and state law require the Minnesota Department of Human Services and local agencies to recover costs that the MA program paid for its members. This recovery process is done through Minnesota's MA estate recovery and lien program.

If you are enrolled in MA when you are 55 years old or older, then, after you die, Minnesota must try to recover the total cost of all MA services that MA paid for your health care between your 55th birthday and December 31, 2013. For the period from January 1, 2014, to the day your coverage ends, Minnesota must recover only the costs of long-term services and supports (LTSS). LTSS include:

- Nursing home services
- Home and community-based services
- Related hospital and prescription drug costs

If you turned 55 years old on or after January 1, 2014, Minnesota must recover only the costs of LTSS you received.

Even after you die, Minnesota cannot start recovery of these costs if your spouse survives you, you have a child under 21 years old, or you have a child who is permanently disabled. Once your spouse dies, Minnesota must try to recover your MA costs from your spouse's estate. However, recovery is further delayed if you still have a child who is under 21 or permanently disabled. Your children do not have to use their assets to reimburse the state for any MA services you received.

Also, Minnesota must try to recover the costs of all MA services an MA member received at any age while permanently living in a medical institution. However, MA members who qualify for services under modified adjusted gross income (MAGI) eligibility criteria are not subject to recovery for services received before the age of 55.

The state may file an MA lien against your real property to recover MA costs before your death, but only if you are permanently living in a medical institution. The state also may file a notice of potential claim, which is a form of lien, against real property to recover MA costs after death. Liens to recover MA costs may be filed against the following:

- Your life estate or joint tenancy interest in real property
- Your real property that you own solely
- Your real property that you own with someone else

You have the right to speak with a legal-aid group or a private attorney if you have specific questions about how MA estate recovery and liens may affect your circumstance and estate planning. The Minnesota Department of Human Services cannot provide you with legal advice. For more information, go to http://mn.gov/dhs/ma-estate-recovery/.

Assignment of Medical Payments

By accepting MA, 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.

Attachment A – Keep this page for your records.

Attachment B

Instructions for completing this application

SOCIAL SECURITY NUMBER

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

Reasons for not applying for an SSN:

A. Not eligible for an SSN
B. Can be issued for nonwork reason only
C. No SSN because of religious objections
D. No SSN as newborn or newly adopted
E. Other

IMMIGRATION STATUS

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

A. American Indian born in Canada (Immigration and Nationality Act [INA], section 289)
B. Amerasian noncitizen
C. Asylee*
D. Conditional entrant*
E. Cuban or Haitian entrant*
F. 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

Attachment C

Agency Addresses

(Effective Date: September 2016)

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

Anoka County
2100 Third Avenue
Anoka, MN 55303-2264
763-422-7200
Fax: 763-422-6987

Becker County
712 Minnesota Avenue
Detroit Lakes, MN 56501
218-847-5628
Fax: 218-847-6738

Beltrami County
616 America Ave NW
Bemidji, MN 56601
218-333-8300
Fax: 218-333-4150

Benton County
531 Dewey Street
Foley, MN 56329-0740
320-968-5087 / 800-530-6254
Fax: 320-968-5330

Big Stone County
340 2nd Street NW
PO Box 338
Ortonville, MN 56278-0338
320-839-2555
Fax: 320-839-3966

Blue Earth County
410 S 5th Street
Mankato, MN 56002-3526
507-304-4335
Fax: 507-304-4336

Brown County
1117 Center Street
New Ulm, MN 56073-0788
507-354-8246 / 800-450-8246
Fax: 507-359-6542

Carlton County
14 N 11th Street, Suite 200
Cloquet, MN 55720-0660
218-879-4583 / 800-642-9082
Fax: 218-878-2500

Carver County
602 East Fourth Street
Chaska, MN 55318-2102
952-361-1600
Fax: 952-361-1660

Cass County
400 Michigan Avenue W
Walker, MN 56484-0519
218-547-1340
Fax: 218-547-1448

Chippewa County
719 N Seventh Street, Suite 200
Montevideo, MN 56265-1397
320-269-6401 / 877-450-6401
Fax: 320-269-6405

Chisago County
313 North Main Street, Rm 239
Center City, MN 55012-9665
651-213-5640 / 888-234-1246
Fax: 651-213-5685

Clay County
715 North 11th Street, Suite 502
Moorhead, MN 56560-2095
218-299-5200 / 800-757-3880
Fax: 218-299-7515

Clearwater County
216 Park Avenue NW
Bagley, MN 56621-9500
218-694-6164 / 800-245-6064
Fax: 218-694-6163

Cook County
411 West Second Street
Grand Marais, MN 55604-2307
218-387-3620
Fax: 218-387-3020

Cottonwood County
DVHHS
11 Fourth Street
Windom, MN 56101-0009
507-831-1891
Fax: 507-831-0126

Crow Wing County
204 Laurel Street
Brainerd, MN 56401-0686
218-824-1140 / 888-772-8212
Fax: 218-824-1305

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

Dodge County
MNPrairie
22 Sixth Street East, Dept. 401
Mantorville, MN 55955
507-923-2900 / 888-850-9419
Fax: 507-635-6186

Douglas County
809 Elm Street, Suite 1186
Alexandria, MN 56308
320-762-2302
Fax: 320-762-3833

Faribault County
FMCHS
412 Nicollet Street North
Blue Earth, MN 56013
507-526-3265
Fax: 507-526-2039

Fillmore County
902 Houston Street NW, #1
Preston, MN 55965-1080
507-765-2175
Fax: 507-765-3895

Freeborn County
203 W Clark Street
Albert Lea, MN 56007-1246
507-377-5400
Fax: 507-377-5498

Goodhue County
426 West Avenue
Red Wing, MN 55066
651-385-3200
Fax: 651-267-4879

Grant County
28 Central Avenue S
Elbow Lake, MN 56531-1006
218-685-8200 / 800-291-2827
Fax: 218-685-4978

Hennepin County
330 South 12th Street
Minneapolis, MN 55404
PO Box 107
Minneapolis, MN 55440-0107
612-596-1300
Fax: 612-288-2981

Houston County
304 S. Marshall Street, Rm 104
Caledonia, MN 55921-0310
507-725-5811
Fax: 507-725-3990

Hubbard County
205 Court Avenue
Park Rapids, MN 56470
218-732-1451 / 877-450-1451
Fax: 218-732-3231

Isanti County
1700 E Rum River Dr S, Suite A
Cambridge, MN 55008-2547
763-689-1711
Fax: 763-689-9877

Itasca County
1209 SE Second Avenue
Grand Rapids, MN 55744-3983
218-327-2941 / 800-422-0312
Fax: 218-327-5548

Jackson County
DVHHS
407 5th Street, Suite 101
Jackson, MN 56143-0067
507-847-4000
Fax: 507-847-5616

Kanabec County
905 Forest Avenue East, #150
Mora, MN 55051-1316
320-679-6350
Fax: 320-679-6351

Kandiyohi County
2200 23rd Street NE, Suite 1020
Willmar, MN 56201-9423
320-231-7800 / 877-464-7800
Fax: 320-231-6285

Kittson County
410 South Fifth Street, Suite 100
Hallock, MN 56728
218-843-2689 / 800-672-8026
Fax: 218-843-2607

Koochiching County
1000 Fifth Street
Int'l Falls, MN 56649-2485
218-283-7000 / 800-950-4630
Fax: 218-283-7013

Lac qui Parle County
930 First Avenue
Madison, MN 56256-0007
320-598-7594
Fax: 320-598-7597

Lake County
616 Third Avenue
Two Harbors, MN 55616-1560
218-834-8400
Fax: 218-834-8412

Lake of the Woods County
206 8th Avenue SE, Suite 200
Baudette, MN 56623
218-634-2642
Fax: 218-634-4520

Le Sueur County
88 South Park Avenue
Le Center, MN 56057-1646
507-357-8288
Fax: 507-357-6122

Lincoln County
SWMHHS
319 N Rebecca Street
Ivanhoe, MN 56142
507-694-1452 / 800-657-3781
Fax: 507-694-1859

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

McLeod County
1805 Ford Avenue North, #100
Glencoe, MN 55336
320-864-3144 / 800-247-1756
Fax: 320-864-5265

Mahnomen County
311 N Main Street
Mahnomen, MN 56557-0460
218-935-2568
Fax: 218-935-5459

Marshall County
208 East Colvin Avenue, Suite 14
Warren, MN 56762-1695
218-745-5124 / 800-642-5444
Fax: 218-745-5260

Martin County
FMCHS
115 West First Street
Fairmont, MN 56031
507-238-4757
Fax: 507-238-1574

Meeker County
114 North Holcombe Ave, #180
Litchfield, MN 55355-2273
320-693-5300 / 877-915-5300
Fax: 320-693-5344

Mille Lacs County
525 Second Street SE
Milaca, MN 56353
320-983-8208 / 888-270-8208
Fax: 320-983-8306

MinnesotaCare Operations
540 Cedar Street
PO Box 64252
St. Paul, MN 55164-0252
651-297-3862 / 800-657-3672
Fax: 651-431-7750

Morrison County
213 SE First Avenue
Little Falls, MN 56345-3196
320-632-2951 / 800-269-1464
Fax: 320-632-0225

Mower County
201 1st Street NE, Suite 18
Austin, MN 55912-3405
507-437-9700
Fax: 507-437-9721

Murray County
SWMHHS
3001 Maple Road, Suite 100
Slayton, MN 56172
507-836-6144 / 800-657-3811
Fax: 507-836-8841

Nicollet County
622 South Front Street
St. Peter, MN 56082-2106
507-934-8559
Fax: 507-934-8552

Nobles County
318 9th Street
PO Box 189
Worthington, MN 56187-0189
507-295-5213
Fax: 507-372-5094

Norman County
15 Second Avenue East, Room 108
Ada, MN 56510-1389
218-784-5400
Fax: 218-784-7142

Olmsted County
2117 Campus Drive SE, Suite 200
Rochester, MN 55904
507-328-6500
Fax: 507-328-6339

Otter Tail County
535 Fir Avenue W
Fergus Falls, MN 56537
218-998-8230
Fax: 218-998-8270

Pennington County
318 N Knight Avenue
Thief River Falls, MN 56701-0340
218-681-2880
Fax: 218-683-7013

Pine County
315 Main Street S, Suite 200
Pine City, MN 55063
320-591-1570
Fax: 320-591-1601

Or

1610 Highway 23 N
Sandstone, MN 55072-5009
Fax: 320-591-1601

Pipestone County SWMHHS
1091 North Hiawatha Avenue
Pipestone, MN 56164
507-825-6720 / 888-632-4325
Fax: 507-825-5649

Polk County
612 N Broadway, Room 302
Crookston, MN 56716
218-281-3127 / 877-281-3127
Fax: 218-281-3926

Or

1424 Central Avenue NE
East Grand Forks, MN 56721
218-773-2431
Fax: 218-773-3602

Or

104 N. Kaiser Avenue
Fosston, MN 56542
218-435-1585
Fax: 218-435-1552

Pope County
211 East MN Avenue, Suite 200
Glenwood, MN 56334-1629
320-634-7755
Fax: 320-634-0164

Ramsey County
160 East Kellogg Boulevard
St. Paul, MN 55101-1494
651-266-4444
Fax: 651-266-4439

Red Lake County
125 Edward Avenue SW
Red Lake Falls, MN 56750-0356
218-253-4131 / 877-294-0846
Fax: 218-253-2926

Redwood County
SWMHHS
266 E Bridge Street
Redwood Falls, MN 56283
507-637-4050 / 888-234-1292
Fax: 507-637-4055

Renville County
105 S 5th Street, Suite 203H
Olivia, MN 56277
320-523-2202
Fax: 320-523-3565

Rice County
320 NW Third Street, #2
Faribault, MN 55021-0718
507-332-6115
Fax: 507-332-6247

Rock County
SWMHHS
2 Roundwind Road
Luverne, MN 56156-0715
507-283-5070
Fax: 507-283-5074

Roseau County
208 6th Street SW
Roseau, MN 56751-1451
218-463-2411 / 866-255-2932
Fax: 218-463-3872

St. Louis County
320 West 2nd Street
Duluth, MN 55802-1495
218-726-2101 / 800-450-9777
Fax: 218-726-2163

Or

307 S 1st Street – PO Box 1148
Virginia, MN 55792-1148
218-749-7137
Fax: 218-742-9503

Or

320 Miners Drive E
Ely, MN 55731-1402
218-365-8220
Fax: 218-365-8217

Or

1814 14th Avenue East
Hibbing, MN 55746-1314
218-262-6000
Fax: 218-262-6049

Scott County
200 4th Avenue W
Shakopee, MN 55379
952-496-8686
Fax: 952-496-8685

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

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

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

Steele County MNPrairie
630 Florence Avenue
Owatonna, MN 55060-0890
507-431-5600
Fax: 507-635-6186

Stevens County
400 Colorado Avenue, Suite 104
Morris, MN 56267-1235
320-208-6600 / 800-950-4429
Fax: 320-589-3972

Swift County
410 21st Street South
Benson, MN 56215-0208
320-843-3160
Fax: 320-843-4582

Todd County
212 Second Avenue South
Long Prairie, MN 56347-1640
320-732-4500 / 888-838-4066
Fax: 320-732-4540

Traverse County
202 8th Street North
Wheaton, MN 56296
320-422-7777 / 855-735-8916
Fax: 320-563-4230

Wabasha County
411 Hiawatha Drive E
Wabasha, MN 55981-1573
651-565-3351 / 888-315-8815
Fax: 651-565-3084

Wadena County
124 First Street SE
Wadena, MN 56482-1553
218-631-7605 / 888-662-2737
Fax: 218-631-7616

Waseca County MNPrairie
299 Johnson Avenue SW, Suite 160
Waseca, MN 56093-2498
507-837-6600
Fax: 507-635-6186

Washington County
14949 62nd Street North
PO Box 30
Stillwater, MN 55082-0030
651-430-6455
Fax: 651-430-6605

Watonwan County
715 Second Avenue S
St. James, MN 56081-1741
507-375-3294 / 888-299-5941
Fax: 507-375-7359

Wilkin County
227 6th Street North
PO Box 369
Breckenridge, MN 56520-0369
218-643-7161
Fax: 218-643-7175

Winona County
202 West Third Street
Winona, MN 55987-3146
507-457-6200
Fax: 507-454-9381

Wright County
1004 Commercial Drive
Buffalo, MN 55313-1736
763-682-7414 / 800-362-3667
Fax: 763-682-7701

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

White Earth Human Services
2531 310th Avenue, PO Box 70
Naytahwaush, MN 56566
218-935-5554

Attachment C – Keep this page for your records.

APPENDIX A Health Coverage from Jobs

You **do not** need to answer these questions unless someone in the household is eligible for health coverage from a job. Attach a copy of this page for each job that offers coverage. Take this form to your employer that offers coverage to help you answer these questions. You can use this information to complete your application.

EMPLOYEE Information

1. EMPLOYEE NAME (FIRST, MIDDLE, LAST)	2. EMPLOYEE SOCIAL SECURITY NUMBER

EMPLOYER Information

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

10. Whom can we contact about employee health coverage at this job?

11. PHONE NUMBER (if different from above)	12. EMAIL ADDRESS

13. Are you currently eligible for coverage offered by this employer, or will you become eligible in the next three months?

◯ Yes – continue

13a. If you are in a waiting or probationary period, when can you enroll in coverage (MM/DD/YYYY)?
List the names of anyone else that is eligible for coverage from this job.

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

Tell us about the health plan offered by this employer.

14. Does the employer offer a health plan that meets the minimum value standard*? ◯ Yes ◯ No

15. For the lowest-cost plan that meets the minimum value standard* offered **only to the employee** (do not include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he or she received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on wellness programs.

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

b. How much would the employee have to pay in premiums for this plan? $ _____

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

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

☐ Employer will not offer health coverage

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much would the employee have to pay in premiums for this plan? $ _____

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

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

*An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

Employer Coverage Tool

Use this tool to help answer questions in Appendix A about any employer health coverage that you are eligible for (even if it is from another person's job, like a parent's or spouse's). The information in the numbered boxes below matches the information in the boxes on Appendix A. For example, the answer to question 14 on this page should match the answer to question 14 on Appendix A. Write your name and Social Security number in boxes 1 and 2 and ask the employer to fill out the rest of the form. Complete one tool for each employer that offers health coverage.

EMPLOYEE Information

1. EMPLOYEE NAME (FIRST, MIDDLE, LAST)	2. EMPLOYEE SOCIAL SECURITY NUMBER

EMPLOYER Information

3. EMPLOYER NAME		4. EMPLOYER IDENTIFICATION NUMBER (EIN)
5. EMPLOYER ADDRESS (The marketplace will send notices to this address)		6. EMPLOYER PHONE NUMBER
7. CITY	8. STATE	9. ZIP CODE

10. Whom can we contact about employee health coverage at this job?

11. PHONE NUMBER (if different from above)	12. EMAIL ADDRESS

13. Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next three months?

◯ Yes – continue

13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? _____ (MM/DD/YYYY)

◯ No – STOP and return form to employee

Tell us about the health plan offered by this employer.

Does the employer offer a health plan that covers an employee's spouse or dependent?

◯ Yes – which people? ☐ Spouse ☐ Dependent(s) ◯ No – go to question 14

14. Does the employer offer a health plan that meets the minimum value standard*?

◯ Yes – go to question 15 ◯ No – STOP and return form to employee

15. For the lowest-cost plan that meets the minimum value standard* offered **only to the employee** (do not include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he or she received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on wellness programs.

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

b. How much would the employee have to pay in premiums for this plan? $ _____

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

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you do not know, STOP and return form to employee.

16. What change will the employer make for the new plan year?

☐ Employer will not offer health coverage

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much would the employee have to pay in premiums for this plan? $ _____

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

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

* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

NEED HELP WITH YOUR APPLICATION? Visit **www.mnsure.org** or call us at **855-366-7873**. If you need help in a language other than English, tell us the language you need. We will get you help at no cost to you.

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

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

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

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

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

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

APPENDIX C Assistance with Completing this Application

You can choose an authorized representative.

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

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

1. NAME OF AUTHORIZED REPRESENTATIVE (First Name, Middle Name, Last Name)		RELATIONSHIP TO YOU, IF ANY	
2. ADDRESS		3. APARTMENT OR SUITE NUMBER	
4. CITY		5. STATE	6. ZIP CODE
7. PHONE NUMBER	8. ORGANIZATION NAME	9. ID NUMBER (if applicable)	
By signing, you allow this person to sign your application, get official information about this application and act for you on all future matters with this agency.			
10. YOUR SIGNATURE		11. DATE (MM/DD/YYYY)	
Authorized Representative Signature By signing, I agree to be an authorized representative for this household. I understand my responsibilities including keeping information about the people applying on this application private. ☐ I would like to get information by email at: _____			
AUTHORIZED REPRESENTATIVE SIGNATURE		DATE (MM/DD/YYYY)	

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

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

1. APPLICATION START DATE (MM/DD/YYYY)	2. NAME OF APPLICANT (First Name, Middle Name, Last Name, Suffix)
3. NAME OF ASSISTER (First Name, Middle Initial, Last Name)	4. ASSISTER PHONE NUMBER
5. ORGANIZATION NAME	6. ASSISTER ID NUMBER