Minnesota Department of **Human Services**

Combined Application Form

For Supplemental Nutrition Assistance Program, Cash Assistance and Health Care Programs

The **Supplemental Nutrition Assistance Program (SNAP)** helps Minnesotans with low incomes get the food they need for sound nutrition and well-balanced meals. In Minnesota, this program was known as Food Support or Food Stamps.

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

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

How to fill out this form

Fill out this form in black or dark blue ink.

- **Complete and turn in this application form as soon as possible.** We can set your application date if we have your name, address and signature (page 1), but we must have the complete form to decide if you can get help.
- **For your application to be complete,** answer the questions on the application and have certain information verified. The SNAP and cash programs also require an interview with a county worker. For SNAP this can be a phone interview. If you are required to have an interview and you miss your interview appointment, you must reschedule. If you do not reschedule, we may stop or not approve your SNAP benefits and/or cash.
- **You may need to provide proof of the information on this form.** Refer to the Instructions for Completing the Combined Application Form (CAF) information sheet (DHS-2989). You cannot get help until we get proof of this information. **Bring the proofs with you to the interview or send them to your worker as soon as you can.**
- **List the names of all people who live with you on pages 3 and 4.** Include everyone, even if you are not asking for assistance for them. If your household has more than five people or if more space is needed to write the information for other questions, use additional sheets of paper.
- **For recertifications** report **all** changes in the past 12 months. You may need to provide proof of the reported information.
- The county human services agency will use this form to decide if you can get help. For **each** person check **each** program that person is applying for (if unsure, talk to your county worker). Program rules require some people to get benefits together.
- If you have child care needs, ask your worker how to apply for the Child Care Assistance Program.
- **For SNAP and Health Care Programs only:** Household members may choose not to apply. The amount of SNAP benefits will depend on the number of people who apply. The Social Security number and citizenship or immigration fields do not need to be completed for those who do not apply. Household members who do apply must provide this information. Household members who are not applying must give information on their income and, in some cases, assets because this information is needed to see if the persons who are applying can get help.

Tell someone if you need help filling out this form.

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

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

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

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

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

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

ໂປດຊາບ. ຖ້າຫາກທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປຂໍ້ຄວາມດັ່ງກ່າວນີ້ຟຣີ, ຈົ່ງຖາມນຳພນັກງານຊ່ວຍວຽກ ຂອງທ່ານຫຼືໂທຣ໌ຫາຕາມເລກໂທຣ໌ 1-888-487-8251.

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

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

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

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

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

LB2-0001 (10-09)

ADA5 (3-12)

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

Agency use:

Provide client with the following documents.

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

Clear Form

DHS-5223-ENG 9-12

Minnesota Department of Human Services

Combined Application Form

For SNAP, Cash Assistance and Health Care Programs

CASE NUMBER

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

How many people live in your household? Adults ___ Children ___

PERSON 1 APPLICANT'S LEGAL NAME (last/first/middle)	OTHER NAMES YOU USE (maiden name, nickname, etc.)	BIRTH DATE	GENDER ☐ M ☐ F
ADDRESS WHERE YOU LIVE (If you do not have an address, write "homeless.")			APT. NUMBER
CITY	COUNTY	STATE	ZIP CODE
MAILING ADDRESS (If different from address where you live)			
CITY	COUNTY	STATE	ZIP CODE

DO YOU LIVE ON A RESERVATION? ☐ Yes ☐ No If yes, which one?_____

PHONE NUMBER WHERE YOU CAN BE REACHED (include area code) Home Other

DO YOU NEED AN INTERPRETER? ☐ Yes ☐ No

WHAT IS YOUR PREFERRED SPOKEN LANGUAGE?

WHAT IS YOUR PREFERRED WRITTEN LANGUAGE?

MARITAL STATUS*

SOCIAL SECURITY NUMBER**

MOST RECENTLY MOVED TO MINNESOTA (mm/dd/yy) Date: _____ From: _____

ETHNICITY (optional) Hispanic? ☐ Yes ☐ No

RACE (optional)*

U.S. CITIZEN OR U.S. NATIONAL?** ☐ Yes ☐ No

LIST CITY, STATE AND COUNTRY OF BIRTH

WHAT PROGRAMS IS THIS PERSON APPLYING FOR? ☐ SNAP (food) ☐ Cash ☐ Emergency help ☐ Health care ☐ None

LAST SCHOOL GRADE COMPLETED

***See MARITAL and RACE codes on the top of page 3.** ****See note on back of cover page (above).**

Do you need help right away? Some people can get SNAP quickly. **Questions 1-4** below will help us decide if you can get help with food right away.

1. How much income (cash or checks) did or will your household get **this month?**
2. How much does your household (including children) have in **cash, checking or savings**? $
3. How much does your household pay for **Rent/mortgage?** $

   What **utilities** do you pay? ☐ Heat ☐ Air conditioning ☐ Electricity ☐ Phone ☐ None
4. Is anyone in your household a **migrant or seasonal farm worker**? ☐ Yes ☐ No

Agency use:

Eligible for expedited SNAP? ☐ Yes ☐ No
Same-day interview offered? ☐ Yes ☐ No Declined? ☐ Yes ☐ No
Next-day interview offered? ☐ Yes ☐ No Declined? ☐ Yes ☐ No

Intends to reside in MN? ☐ Yes ☐ No
Has sponsor? ☐ Yes ☐ No
Immigration status** _____
Verification: ☐ *requested* ☐ *attached*

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

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

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

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

SIGNATURE OF APPLICANT OR AUTHORIZED REPRESENTATIVE	DATE	AGENCY SIGNATURE	DATE RECEIVED

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

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

You can ask more than one person(s) to help you with the items listed above.The authorized person may be a friend, relative, conservator acting on your behalf, a person authorized by the courts, or a person with your power of attorney. This person(s) can act for you until you notify your worker that you want this to end. Ask your worker for more information about authorized representatives.

I want the person named to:

☐ Fill out forms
☐ Get notices
☐ Get and use my SNAP benefits

NAME	RELATIONSHIP	PHONE NUMBER
ADDRESS		
CITY	STATE	ZIP CODE

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

ORGANIZATION/AGENCY NAME

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

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

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

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

DESIGNATED PWE	SIGNATURE OF APPLICANT

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

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

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

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

☐ Other

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

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

☐ Yes ☐ No Has anyone in your household ever been in the United States military?

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

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

List in this order: Your spouse, other adult(s), children, all other people, anyone temporarily away from home. If anyone is pregnant, list unborn child(ren) as "unborn child" and the due date.

The RACE and ETHNICITY questions are optional and used to assure that race, color or national origin do not affect eligibility or the level of benefits issued. Note: Special asset and Health Care premium rules may apply to American Indians applying for Health Care programs.

Marital status: (choose one)	**N** = Never married	**M** = Married living with spouse	**S** = Separated (married, living apart)
	L = Legally separated	**D** = Divorced	**W** = Widowed
Race: (choose all that apply)	**N** = American Indian/ Alaska Native	**A** = Asian	**B** = Black or African American
	P = Pacific Islander/ Native Hawaiian	**W** = White	

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

BIRTH DATE (mm/dd/yy) | MARITAL STATUS | SOCIAL SECURITY NUMBER** | MOST RECENTLY MOVED TO MINNESOTA (mm/dd/yy) Date _____ From: _____

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

WHAT PROGRAMS IS THIS PERSON APPLYING FOR? ☐ SNAP (food) ☐ Cash ☐ Emergency help ☐ Health care ☐ None | LAST SCHOOL GRADE COMPLETED

Agency use:
Intends to reside in MN? ☐ Yes ☐ No
Has sponsor? ☐ Yes ☐ No
Immigration status** _____
Verification: ☐ *requested* ☐ *attached*

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

BIRTH DATE (mm/dd/yy) | MARITAL STATUS | SOCIAL SECURITY NUMBER** | MOST RECENTLY MOVED TO MINNESOTA (mm/dd/yy) Date _____ From: _____

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

WHAT PROGRAMS IS THIS PERSON APPLYING FOR? ☐ SNAP (food) ☐ Cash ☐ Emergency help ☐ Health care ☐ None | LAST SCHOOL GRADE COMPLETED

Agency use:
Intends to reside in MN? ☐ Yes ☐ No
Has sponsor? ☐ Yes ☐ No
Immigration status** _____
Verification: ☐ *requested* ☐ *attached*

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

BIRTH DATE (mm/dd/yy) | MARITAL STATUS | SOCIAL SECURITY NUMBER** | MOST RECENTLY MOVED TO MINNESOTA (mm/dd/yy) Date _____ From: _____

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

WHAT PROGRAMS IS THIS PERSON APPLYING FOR? ☐ SNAP (food) ☐ Cash ☐ Emergency help ☐ Health care ☐ None | LAST SCHOOL GRADE COMPLETED

Agency use:
Intends to reside in MN? ☐ Yes ☐ No
Has sponsor? ☐ Yes ☐ No
Immigration status** _____
Verification: ☐ *requested* ☐ *attached*

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

Agency use:

Intends to reside in MN? ☐ Yes ☐ No
Has sponsor? ☐ Yes ☐ No
Immigration status** _____
Verification: ☐ *requested* ☐ *attached*

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

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

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

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

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

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

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

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

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

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

☐ Yes ☐ No **5.** Is **anyone** blind, or does anyone have a physical or mental health condition that limits the ability to work or perform daily activities?

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

☐ Yes ☐ No **6.** Is **anyone** unable to work for reasons other than illness or disability?

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

☐ Yes ☐ No **7.** In the last 60 days did **anyone** in the household:
- Stop working or quit a job?
- Ask to work fewer hours?
- Refuse a job offer?
- Go on strike?

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

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

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

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

☐ Yes ☐ No **Bring or send proof.**

9. Does **anyone** in the household have a job or expect to get income from a job this month or next month?
Note: Include income from Work Study and paid internships.
Include free benefits or reduced expenses received for work (shelter, food, clothing, etc.).

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

☐ Yes ☐ No **Bring or send proof.**

10. Is **anyone** in the household self-employed or does anyone expect to get income from self-employment this month or next month? Examples:
- Product sales
- Paper route
- Property rental
- Conservation Reserve Program (CRP)
- In-home day care
- Taxi driver
- Personal services
- Roomers/boarders
- Other
- Farming

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

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

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

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

Check yes or no for each item. **Bring or send proof.** ➤

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

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

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

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

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

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

Check yes or no for each item.

Bring or send proof. ➤

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

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

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

Check yes or no for each item.

Bring or send proof. ➤

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

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

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

☐ Yes ☐ No **16.** Do **you or anyone living with you** have costs for care of a **child** or an **ill or disabled adult** because you or they were working, looking for work or going to school?
Note: The Child Care Fund may pay child care costs. Ask your financial worker for more information.

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

☐ Yes ☐ No **17.** Does **anyone** in the household **pay** court-ordered child support, spousal support, child care support, medical support or contribute to a tax dependent who does not live in your home?

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

☐ Yes ☐ No **18.** Does **anyone** in the household have medical expenses?

Bring proof of medical expenses.

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

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

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

☐ Yes ☐ No **19. For General Assistance only:** Does **anyone** in the household have expenses related to work, training or job search, such as transportation, meals or uniforms? Ask your financial worker if these expenses apply to the programs you are requesting.

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

What do you own? (Answer questions below.)

Check yes or no for each item.

Bring or send proof. ➤

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

☐ Yes ☐ No Cash
☐ Yes ☐ No Bank accounts (savings, checking, etc.)
☐ Yes ☐ No Vehicles (cars, trucks, motorcycles, etc.)
☐ Yes ☐ No Other assets (tools, boats, livestock, etc.)
☐ Yes ☐ No Life or burial insurance
☐ Yes ☐ No Stocks bonds, annuities, etc.
☐ Yes ☐ No Real estate property (house, land, etc.)

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

☐ Yes ☐ No **21.** Has **anyone** in the household given away, sold or traded anything of value **in the past 60 months?** (for example: real estate property, bank accounts, annuities, vehicles, etc.)

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

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

Note: You do not have to answer questions 22-26 if you are only applying for SNAP benefits.

☐ Yes ☐ No **22.** Does **anyone** currently get medical benefits from another state?

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

23. If any household member is employed:

☐ Yes ☐ No **a.** Can **anyone** get health insurance through a current employer or union?
☐ Yes ☐ No **b.** Did **anyone** turn down or drop health insurance from a current employer or union?
☐ Yes ☐ No **c.** Did **anyone's** current employer or union stop offering health insurance in the last 18 months?

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

☐ Yes ☐ No **24.** Did **anyone** have health insurance that ended during the last four months?

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

☐ Yes ☐ No **25.** Is **anyone** getting medical care for an accident or injury that happened in the last six years?

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

☐ Yes ☐ No **26.** Does **anyone** currently have or expect to have any of the following types of insurance?

- ■ Medicare
- ■ Health insurance
- ■ Dental insurance
- ■ Vision insurance
- ■ Long term care insurance

Agency use:

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

Other information: (Answer questions below.)

☐ Yes ☐ No **27. For recertifications:** Did anyone move in or out of your home in the past 12 months.

Agency use:

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

☐ Yes ☐ No **28.** Are **both** parents of **each** child under age 19 living in the home?

Agency use:

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

☐ Yes ☐ No **29. For Minnesota Supplemental Aid recipients only:** Is **anyone** in the household on a diet prescribed by a doctor?

Agency use:

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

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

Penalty warnings and qualification questions

If you get cash, SNAP, child care or health care benefits, you must follow the rules listed below.

- **Do not give false information** or hide information to get or continue to get cash, SNAP, child care, or medical benefits. If you get cash or SNAP benefits and give false information or hide information about your **identity** and/or **residence** to get multiple benefits for the same period of time, you may be barred for 10 years.
- **Do not trade or sell** SNAP benefits, electronic benefits transfer (EBT) access cards or health care membership cards. **The trade or sale of benefits valued at over $500 may result in permanent ineligibility**.
- **Do not use cash or SNAP benefits to buy ineligible items**, such as alcohol and tobacco.
- **Do not help others get medical services or child care assistance benefits** that you know they should not get.
- **Do not use someone else's EBT access cards or health care membership cards** to get cash, SNAP or medical benefits for your household.

The state may bar household members who break any of these rules.

- **For cash, SNAP or MinnesotaCare for adults without children** the bar lasts one year for the first fraud, two years for the second fraud and is permanent for the third fraud. The months you are barred from MFIP for breaking the rules may count toward your 60-month lifetime limit.
- **For child care** the bar lasts three months for the first fraud, six months for the second fraud, two years for the third fraud and is permanent for the fourth fraud.

You can also be prosecuted for fraud if you break the rules and additional fines and penalties may apply.

- **For the cash and SNAP programs**, the maximum penalty is a fine of $250,000 or a jail term of 20 years, or both.
- **For child care** the maximum penalty is a fine of $100,000 or a jail term of 20 years, or both.

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

- **Controlled substances**, that household member will be barred from getting SNAP for 24 months for the first offense and permanently for the second offense.
- **Firearms, ammunition or explosives**, that household member will be barred from getting SNAP permanently.

If you admit committing a drug felony in the past 10 years, the county agency may ask you to take random drug tests. The first time you fail a drug test, the county agency will reduce your household's MFIP or SNAP benefits by 30 percent. If you fail the test a second time, you will be permanently disqualified.

☐ Yes	☐ No	1.	Has a court or any other civil or administrative process in Minnesota or any other state found anyone in the household guilty or has anyone been disqualified from receiving public assistance for breaking any of the rules above?
☐ Yes	☐ No	2.	Has anyone in the household been convicted of making fraudulent statements about their place of residence to get cash, SNAP or medical benefits from more than one state?
☐ Yes	☐ No	3.	Is anyone in your household hiding or running from the law to avoid prosecution, being taken into custody, or to avoid going to jail for a felony?
☐ Yes	☐ No	4.	Has anyone in your household been convicted of a drug felony in the past 10 years?
☐ Yes	☐ No	5.	Is anyone in your household currently violating a condition of parole, probation or supervised release?

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

QUESTION NO.	HOUSEHOLD MEMBER	QUESTION NO.	HOUSEHOLD MEMBER

Employment services registration

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

Assignments

Medical: I give my rights to all medical payments for me and anyone else I apply for to the State of Minnesota. This includes medical payments from all other persons or companies. For MA for Long Term Care, this includes my right to support from my spouse under Minnesota Statutes, section 256B.14, subd. 3. This begins as soon as health care coverage starts. I agree to help the State to get paid back for medical expenses that should have been paid by others. I may not have to help the State if I have a good reason for not doing so and the State approves the reason. If I have Medicare Part B, Medicare can pay my health providers for the care I get while I am on a Minnesota Health Care Program.

MFIP and Child Care: I understand that when I get MFIP or Child Care Assistance I must assign my rights to child support and maintenance to the state of Minnesota.

Authorization for release (sharing) of my protected information

I give my consent to the following agencies or individuals to share between them medical information about me only for the limited purposes indicated:

- Health providers, including school districts, health plans, insurance agencies, Minnesota Health Care Programs, county advocates, my county or state case workers, and their contractors and subcontractors:
  a. To determine who should pay for my health care, and
  b. To provide, manage, and coordinate health care services
- All other agencies or persons as listed on the Notice of Privacy Practices (DHS-3979).

This consent applies to medical information about my minor children I applied for on this application. I understand the school district needs a separate consent to share information about my children with private insurance plans. 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 Minnesota Health Care Programs, up to one year. However, it does not end after one year for records given to consulting providers, records given 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. If I do not sign or end this consent, I cannot enroll or stay enrolled in Minnesota Health Care Programs.

Authorization to share information for fraud investigation

I agree that third parties may share information about me with persons investigating fraud. This may include, but is not limited to:

- Employers and schools,
- Landlords and utility companies,
- Financial and insurance agencies, and
- Other government offices.

If I am enrolled in MinnesotaCare, the Minnesota Department of Revenue may share copies of my income tax returns with investigators.

I understand this consent is good for six months after my benefits stop.

Perjury and general declarations

I declare under the penalties of perjury that I have examined this application and to the best of my knowledge it is a true and correct statement of every material point. I understand that a person convicted of perjury may be sentenced to imprisonment of not more than five years or payment of a fine of not more than $10,000, or both. [Minn. Stat. §256.984, subd. 1]

By signing:

- I understand cash assistance is provided to help eligible families meet their basic needs.
- I understand if I give incorrect information or misuse an electronic benefits transfer (EBT) card, I may be prosecuted for fraud. [Minn. Stats. §256.98 and §609.821]
- I acknowledge that since my last application or recertification, I have received my cash and/or SNAP benefits directly or used my EBT card to get my cash and/or SNAP benefits.
- I acknowledge that my worker gave me a copy of the Notice of Privacy Practices (DHS-3979), the attached CAF Important Information sheet and the "Your responsibilities" and "Your rights" pages and explained them to me.
- I acknowledge that I have read and understand the "Penalty warnings and qualification questions" section on page 9.
- I agree to assign my support and medical benefits as stated above.
- I agree to the sharing of information as stated on the medical and fraud release information sections above, the Social Security numbers section of the "Important Information" sheet and the Notice of Privacy Practices (DHS-3979) given with this application.

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

Client Responsibilities and Rights

NOTE: Cash on an EBT card is provided to help families meet their basic needs. These basic needs include food, shelter, clothing, utilities and transportation. These funds are given until families can support themselves. It is illegal for an EBT user to buy or attempt to buy tobacco products or alcohol with the EBT card. If you do, it is fraud and you will be removed from the program. Do not use an EBT card at a gambling establishment.

Your responsibilities

- **You must report changes which may affect your benefits to the county agency within 10 days** after the change has occurred. **Applicants** - Report these changes to your worker when the change happens.

  This includes the following for everyone in your household:

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

  Note about child care providers: If you change providers, you must tell your child care worker and provider at least 15 days before the change goes into effect.

  If you have any questions or are unsure about any reporting rules, contact your worker. If your worker is not available, leave a message so the worker can get back to you.
- **The county, state or federal agency may check any of the information you give.** To get some information we must have your signed consent. If you don't allow the county to confirm your information, you might not get assistance.
- **If you give us information you know is untrue or we get information you did not report,** we will investigate you for fraud.
- **The State or Federal Quality Control agency** may randomly choose your case for review. They will review statements you made on forms. They will check to see if we figured your eligibility correctly. The state agency may seek information from other sources. The State or Federal Quality Control agency will tell you about any contact they intend to make. **If you do not cooperate, your benefits may stop.**
- **Cooperation requirements:**
  - If the county approves you for the Minnesota Family Investment Program (MFIP) or the Diversionary Work Program (DWP), you must cooperate with employment services, unless you are exempt. You must develop and sign an employment plan or your DWP application will be denied.
  - To receive Family Cash Benefits and/or Child Care Assistance (CCAP), you must cooperate with child support enforcement for all children in your household. You have the right to claim "good cause" for not cooperating with child support enforcement. You must assign your child support to the State of Minnesota for all eligible children.
    If you do not cooperate or assign your child support, benefits will be denied or terminated.
  - After the county approves your MFIP or DWP, if you get child support directly from the noncustodial parent, you must report it to your worker. You must cooperate with the child support agency in any legal action brought against a third party for payment of medical expenses, unless you claim and are granted good cause.
  - If you are applying for health care for yourself and your children and you do not live with the other parent, you may have to give information about the other parent to child support staff. Child support staff may use this information to pursue medical support for your children. You do not have to give this information if you are only applying for your children or are pregnant.
  - Household members applying for health care may need to accept and keep other health insurance that is available. This includes Medicare. If you do not give us information about your policy, you may not get coverage.

For Cash and SNAP:

- **Each time you use your electronic benefits transfer (EBT) card or sign your check,** you state that you have informed the county agency about any changes in your situation which may affect your benefits.
- **Each time your electronic benefits transfer (EBT)** card is used we assume you have received your cash or SNAP benefits, unless you reported your card lost or stolen to the county agency.

For Child Care:

- **You may be required to pay a co-payment fee.** If you do not pay the fee, your Child Care Assistance will be terminated until fees are paid in full or satisfactory payment agreements have been made with the county and your child care provider. Your Child Care Assistance worker will tell you whether to pay this fee to your child care provider or to the county agency.
- **You may be required to pay additional costs** when your child care provider charges a rate that is more than the maximum rate in your county.
- **You must document** the immigration or citizenship status of the children in your family for whom you are applying for child care assistance.

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

Your rights

- **Your right to privacy.** Your private information, including your health information, is protected by state and federal laws. Your worker has given you a Notice of Privacy Practices (DHS-3979) information sheet explaining these rights.
- **You have the right to reapply** at any time if your benefits stop.
- **You have the right to know why, if we have not processed your application promptly.**
  - 15 days for medical care for pregnant women
  - 30 days for cash, SNAP and child care
  - 45 days for medical care
  - 60 days for cash and medical care related to disability.
- **You have the right to know the rules of the program you are applying for** and for us to tell you how we figured your benefits.
- **You have the right to choose where and with whom you live** and, within certain limits, to choose your own doctor, hospital, etc.
- **Appeal rights.** If you are unhappy with the action taken or feel the agency did not act on your request for assistance, you may appeal. For cash, child care and health care, you may appeal **within 30 days** from the date you receive the notice by writing to the county agency, or directly to the State Appeals Office at the Minnesota Department of Human Services, PO Box 64941, St. Paul, MN 55164-0941. (If you show good cause for not appealing your cash and health care **within 30 days**, the agency can accept your appeal **for up to 90 days** from the date you receive the notice.)
  For SNAP, you may appeal **within 90 days** by writing or calling the county or the State Appeals Office. You may represent yourself at the hearing, or you may have someone (an attorney, relative, friend or another person) speak for you.
  If you wish your assistance to continue until the hearing, you must appeal before the date of the proposed action or within 10 days after the date the agency notice was mailed, whichever is later. Ask your county worker to explain how the timing of your appeal could affect your present or future assistance.
- **Access to free legal services.** Contact your worker for information on free legal services.
- **Your right to file a complaint.** If you feel the county or the Minnesota Department of Human Services treated you differently in the handling of your public assistance application or benefits because of race, color, national origin, political beliefs, religion, creed, sex, sexual orientation, public assistance status, age or disability, including physical access to government buildings, you may file a complaint with your county agency or any of the following agencies.

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

Minnesota Department of Human Rights
Freeman Building
625 Robert Street North
St. Paul, MN 55155
800-657-3704 (Voice) / 651-296-1283 (TTY)

U.S. Department of Health and Human Services
Office for Civil Rights, Region V
233 North Michigan Avenue, Suite 240
Chicago, IL 60601
312-886-2359 (Voice) / 312-353-5693 (TTY)

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U.S. Department of Agriculture
Director, Office of Adjudication
1400 Independence Avenue, S.W.
Washington D.C. 20250-9410
866-632-9992 (Voice) / 800-877-8339 (Federal Relay Service)
800-845-6136 (Spanish)

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Minnesota Department of Human Services

Combined Application Form
Important Information

Denial or changes

The State may deny or change your cash assistance, SNAP, child care assistance, and/or health care because of information you give on the application form. The State may make changes without giving you 10 days advance notice for cash assistance, SNAP, and/or health care (15 days for child care assistance). The State will send you written notice no later than the effective date of the change for cash assistance and health care or no later than the date you receive or would receive your SNAP benefits.

Social Security numbers

For most programs, you must provide a Social Security number (SSN) for each household member applying for benefits.* If you need a SSN we can help you apply for one. The State uses your SSN:

- To check identity, prevent duplicate participation and to make mass changes
- To determine eligibility for programs such as SNAP, family cash assistance, health care programs and the school lunch program
- For program reviews and audits to determine household eligibility, including fraud investigations
- To coordinate with other programs or state agencies to provide more effective and meaningful services to you.

If you are not a U.S. citizen and are applying for Refugee Cash Assistance (RCA), Refugee Medical Assistance (RMA), or emergency health care coverage only, you do not have to provide an SSN. For Child Care Assistance, the county must ask for your SSN, but you are not required to provide this to be eligible.

* (Food Stamp Act of 1977 as amended by PL 97-98 and the Social Security Act of 1935 [section 1137] as amended by PL 98-369 and 42 CFR 435.910 [2006]; [Minn. Stat. §256D.03, subd. 3(h); Minn. Stat. §256L.04, subd. 1a])

Family cap information

If you or someone else in your family has a child while getting cash assistance, your family might not get more cash for that child. If you have questions, talk to your worker.

Important information for non-citizen applicants

To get help from most public assistance programs, you must be in the United States (U.S.) legally. Members of your household who are not citizens and are applying for help must show proof of their immigration status. Give a copy of both sides of immigration cards or other documents that show immigration status for every household member who is not a U.S. citizen and who is applying for help. (See "Immigration" section for information on when you do not have to show proof of your immigration status.) You can apply and get help for other household members, even if you are not applying or if you are not eligible because of immigration status.

For non-citizen members of your household who apply and are eligible for help, your worker may do a computer match with the U.S. Citizenship and Immigration Services (USCIS) to confirm the immigration status documents you give us are valid.

We will not share information about you with the USCIS without your permission.

If you get cash or long-term care institutional benefits (e.g., nursing home care), it may affect changes to your immigration status. If you would like more information about this or would like to know what the county might tell or ask the USCIS, talk to your worker.

Immigration

All immigration information you give to us is private. We use it to see if you can get coverage. We only share it when the law allows it or requires it. In most cases, applying will not affect your immigration status. However, it may if you are applying to pay for long-term care services.

You do not have to give us your immigration information if you are:

- Applying only for emergency medical care
- Only helping someone else apply
- A non-immigrant or undocumented person who is pregnant
- Applying for your children or other household members, but not yourself.

Family/domestic violence

Domestic violence is what someone says or does over and over again to make you feel afraid or to control you. The following are some examples of domestic violence:

- Swearing or screaming at you
- Threatening to hurt you or others you care about
- Calling you names
- Not letting you leave your house
- Forcing you to have sex
- Stalking you
- Choking, grabbing, hitting, pushing or kicking you.

For more information on domestic violence, ask your worker for the Domestic Violence Information brochure (DHS-3477). **If domestic violence makes it hard for you to follow program rules, talk to your worker.**

If you are in danger from domestic violence and need help, call the National Domestic Violence hotline at 800-799-7233; 800-787-3224 (TTY) or Minnesota Coalition for Battered Women at 800-289-6177.

Interim aid programs

General Assistance (GA) and/or Group Residential Housing (GRH) are interim aid programs. In order to receive aid you must apply for other benefits for which you may be eligible, such as Social Security or Worker's Compensation. If you receive other aid for the same period of time that you received GA or GRH, you must repay the GA or GRH.

Liens and estate claims

The state or county may try to recover the cost of medical services paid by Medical Assistance (MA) or General Assistance Medical Care (GAMC). The state may file a claim against your estate, against the estate of your surviving spouse or file a lien against your ownership interest in real property if you received:

- GAMC at any age.
- MA when you were over age 55.
- MA at any age if you lived in a long term care facility for six months or more.

Liens can be filed against:

- Your life estate interest in real property.
- Real property you own by yourself.
- Real property you own with someone else. If you own property with another person, the lien is only against your share.

You should talk to your lawyer or advisor if you have questions.