MNsure℠
Where you choose health coverage

Application for Health Coverage and Help Paying Costs

THINGS TO KNOW

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 $94,000 a year (for a family of 4).**

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, please complete Appendix B when filling out this application.

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!

What you may need to apply

- Social security numbers (or document numbers for any legal immigrants who 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 on page 16. 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 **1-855-366-7873**.
- **In person:** There may be a navigator or broker in your area who can help. Visit our website or call **1-855-366-7873** 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.

Attention. If you need free help interpreting this document, ask your worker or call the number below for your language.

ملاحظة: إذا أردت مساعدة مجانية لترجمة هذه الوثيقة، اطلب ذلك من مشرفك أو اتصل على الرقم 1-800-358-0377.

កំណត់សំគាល់ ។ បើអ្នកត្រូវការជំនួយក្នុងការបកប្រែឯកសារនេះដោយឥតគិតថ្លៃ សូមសួរអ្នកកាន់សំណុំរឿង របស់អ្នក ឬហៅទូរស័ព្ទមកលេខ 1-888-468-3787 ។

Pažnja. Ako vam treba besplatna pomoć za tumačenje ovog dokumenta, pitajte vašeg radnika ili nazovite 1-888-234-3785.

Thov ua twb zoo nyeem. Yog hais tias koj xav tau kev pab txhais lus rau tsab ntaub ntawv no pub dawb, ces nug koj tus neeg lis dej num los sis hu rau 1-888-486-8377.

ໂປຣດຊາບ. ຖ້າຫາກ ທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປເອກະສານນີ້ຟຣີ, ຈົ່ງຖາມພະນັກງານກ່ຽວກັບການຊ່ວຍເຫຼືອ ຂອງທ່ານ ຫຼື ໂທຣໄປທີ່ 1-888-487-8251.

Hubachiisa. Dokumentiin kun bilisa akka siif hiikamu gargaarsa hoo feete, hojjettoota kee gaafadhu ykn afaan ati dubbattuuf bilbilli 1-888-234-3798.

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

Digniin. Haddii aad u baahantahay caawimaad lacag-la'aan ah ee tarjumaadda qoraalkan, hawlwadeenkaaga weydiiso ama wac lambarka 1-888-547-8829.

Atención. Si desea recibir asistencia gratuita para interpretar este documento, comuníquese con su trabajador o llame al 1-888-428-3438.

Chú ý. Nếu quý vị cần được giúp đỡ dịch tài liệu này miễn phí, xin gọi nhân viên xã hội của quý vị hoặc gọi số 1-888-554-8759.

LB1-0001 (3-13)

ADA2 (12-12)

This information is available in accessible formats for individuals with disabilities by calling our Contact Center at 1-855-366-7873 or by using your preferred relay service. For other information on disability rights and protections, contact the agency's ADA coordinator.

Clear Form

DHS-6696-ENG 10-13

STEP 1 Tell us about yourself.

(We need one adult in the family to be the contact person for your application.)

1. FIRST NAME, MIDDLE NAME, LAST NAME, & SUFFIX			
2. HOME ADDRESS (LEAVE BLANK IF YOU DO NOT HAVE ONE.)			3. APARTMENT OR SUITE NUMBER
4. CITY	5. STATE	6. ZIP CODE	7. COUNTY
8. MAILING ADDRESS (if different from home address)			9. APARTMENT OR SUITE NUMBER
10. CITY	11. STATE	12. ZIP CODE	13. COUNTY
14. PHONE NUMBER where we can call you: ◯ Cell ◯ Home ◯ Work		15. OTHER PHONE NUMBER where we can call you: ◯ Cell ◯ Home ◯ Work	
16. Do you plan to make Minnesota your home? ◯ Yes ◯ No			
17a. YOUR PREFERRED SPOKEN LANGUAGE	17b. YOUR PREFERRED WRITTEN LANGUAGE	17c. Do you need an interpreter? ◯ Yes ◯ No	
18. SELECT YOUR PREFERRED METHOD OF CONTACT ABOUT THIS APPLICATION			
Email: ◯ Yes ◯ No US Postal Mail: ◯ Yes ◯ No	EMAIL ADDRESS		

STEP 2 Who do you need to include on this application?

Tell us about all the family members who 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 21 who live with you
- Your unmarried partner who needs health coverage
- Anyone you include on your tax return, even if they do not live with you
- Anyone else under 21 who you take care of and lives with you

You DO NOT have to include:

- Your unmarried partner who does not need health coverage
- Your unmarried partner's children
- Your parents who live with you, but file their own tax return (if you are over 21)
- Other adult relatives who file their own tax return

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 they can.

Complete Step 2 for each person in your family. Start with yourself, then add other adults and children. If you have more than 4 people in your family, make copies of Step 2, Person 4 (pages 11-13). You do not need to provide immigration status or a Social Security number (SSN) for family members who do not need health coverage. We will keep all the information you provide private and secure as required by law. We will use personal information only to check if 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 who would like to have coverage under a family health plan, please see Step 6 of this application (page 14).

NEED HELP WITH YOUR APPLICATION? Visit **www.mnsure.org** or call us at **1-855-366-7873**. 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 (Start with yourself)

Complete step 2 for yourself, your spouse/partner and children who live with you and/or anyone on your same federal income tax return if you file one. See page 1 for more information about who to include. If you do not file a tax return, remember to still add family members who live with you.

1. FIRST NAME, MIDDLE NAME, LAST NAME, & SUFFIX	2. RELATIONSHIP TO YOU
3. DATE OF BIRTH (MM/DD/YYYY)	4. SEX

5. SOCIAL SECURITY NUMBER (SSN)

We need this if you want health coverage and have an SSN. Providing your SSN can be helpful if you do not want health coverage too since it 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 1-800-772-1213 or visit **socialsecurity.gov**. TTY users should call 1-800-325-0778.

6. 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 – please answer questions a–c. ◯ No – skip 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 dependents: _____

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

7. Are you pregnant? ◯ Yes ◯ No If yes, how many babies are expected during this pregnancy? _____

8. Do you need health coverage?
(Even if you have insurance, there might be a program with better coverage or lower costs.)
◯ Yes – answer ALL of the questions below. ◯ No – SKIP to the income questions on page 4.

9. Are you a U.S. citizen or U.S. national?
◯ Yes – go to Question 11. ◯ No – go to Question 10.

10. What is your immigration status? _____
a. Immigration Document Type : _____
b. Document ID Number _____
c. Do you have a sponsor? ◯ Yes ◯ No
d. Are you, or your spouse or parent a veteran or active-duty member of the military? ◯ Yes ◯ No
e. Did you enter into the U.S. prior to August 22, 1996? ◯ Yes ◯ No
f. Do you want help paying for a medical emergency? ◯ Yes ◯ No
g. Are you getting services from the Center for Victims of Torture? ◯ Yes ◯ No

11a. Health care coverage through MNsure begins January 1, 2014. Do you want help from Medical Assistance (MA) for health care coverage for October, November or December 2013? ◯ Yes ◯ No

11b. Do you want help from Medical Assistance (MA) to pay for medical bills from the last 3 months? ◯ Yes ◯ No

NEED HELP WITH YOUR APPLICATION? Visit **www.mnsure.org** or call us at **1-855-366-7873**. 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. Were you in foster care in Minnesota at age 18 or older? ◯ Yes ◯ No

13. Please answer Yes or No to the following two questions.
    a. Are you blind or do you have a physical, mental, or emotional health condition that limits your activities (like bathing, dressing, daily chores, etc.)? ◯ Yes ◯ No
    b. Do you need help staying in your home or help paying for care in a long-term facility such as a nursing home? ◯ Yes ◯ No

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

15. Your answers to the two tobacco questions listed below do not affect your eligibility for health care coverage.
    15a. Within the past 6 months, have you used tobacco regularly (4 or more times per week on average)? Do not count religious or ceremonial uses. ◯ Yes ◯ No
    15b. When was the last time you used tobacco regularly? (MM/DD/YYYY) _____

16. If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)
    ☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

17. 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 _____		

Now, tell us about your income on the next page

STEP 2: PERSON 1 (Continue with yourself)

Current Job & Income Information

◯ **Employed**
If you are currently employed, tell us about your income. Start with question 18.

◯ **Not employed**
Skip to question 28.

◯ **Self-employed**
Skip to question 27.

Current Job 1

18. EMPLOYER NAME AND ADDRESS	19. EMPLOYER PHONE NUMBER

20. WAGES/TIPS (BEFORE TAXES)

$ ◯ Hourly ◯ Weekly ◯ Every 2 weeks ◯ Twice a month ◯ Monthly ◯ Yearly

21. AVERAGE HOURS WORKED EACH WEEK

Current Job 2 (If you have more jobs and need more space, attach another sheet of paper.)

22. EMPLOYER NAME AND ADDRESS	23. EMPLOYER PHONE NUMBER

24. WAGES/TIPS (BEFORE TAXES)

$ ◯ Hourly ◯ Weekly ◯ Every 2 weeks ◯ Twice a month ◯ Monthly ◯ Yearly

25. AVERAGE HOURS WORKED EACH WEEK

26. IN THE PAST 6 MONTHS, DID YOU:

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

27. IF SELF-EMPLOYED, INCLUDING FROM FARMING AND FISHING, ANSWER THE FOLLOWING QUESTIONS:

27a. Type of work

27b. How much net income (profits once business expenses are paid) will you get from this self-employment this month?

$

28. **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 $ _____ How often? _____
☐ Other Retirement $ _____ How often? _____
☐ Alimony Received $ _____ How often? _____
☐ Net rental/royalty $ _____ How often? _____

☐ Other income that is expected within the next 12 months TYPE: _____
$ _____ How often? _____

☐ Other income this month TYPE: _____
$ _____ How often? _____

29. **DEDUCTIONS:** Check all that apply, and give the amount and how often you pay it.

If you pay for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower. See lines 23-35 on the 1040 Form or lines 16-19 on the 1040-A Form. **NOTE:** You should not include a cost that you already considered in your answer to net self-employment (question 27b).

☐ Alimony Paid $ _____ How often? _____
☐ Student loan interest $ _____ How often? _____

☐ Other deduction TYPE: _____
$ _____ How often? _____

30. **YEARLY INCOME: Complete only if your income changes from month to month or you are seasonally employed. If you do not expect changes to your monthly income, skip to the next person.**

YOUR TOTAL INCOME **THIS YEAR**	YOUR TOTAL INCOME **NEXT YEAR** (if you think it will be different)
$	$

NEED HELP WITH YOUR APPLICATION? Visit **www.mnsure.org** or call us at **1-855-366-7873**. 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

Complete step 2 for yourself, your spouse/partner and children who live with you and/or anyone on your same federal income tax return if you file one. See page 1 for more information about who to include. If you do not file a tax return, remember to still add family members who live with you.

1. FIRST NAME, MIDDLE NAME, LAST NAME, & SUFFIX	2. RELATIONSHIP TO YOU
3. DATE OF BIRTH (MM/DD/YYYY)	4. SEX

5. SOCIAL SECURITY NUMBER (SSN)

We need this if PERSON 2 wants health coverage and has an SSN.

6. Does PERSON 2 live at the same address as you?

◯ Yes ◯ No – list address:

7. 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 – please answer questions a–c. ◯ No – skip 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 dependents: _____

c. Will PERSON 2 be claimed as a dependent on someone else's tax return? ◯ Yes ◯ No

If yes, please list the name of the tax filer: _____

How is PERSON 2 related to the tax filer? _____

8. Is PERSON 2 pregnant? ◯ Yes ◯ No If yes, how many babies are expected during this pregnancy? _____

9. Does PERSON 2 need health coverage?

(Even if PERSON 2 has insurance, there might be a program with better coverage or lower costs.)

◯ Yes – answer ALL of the questions below. ◯ No – SKIP to the income questions on page 7.

10. Is PERSON 2 a U.S. citizen or U.S. national?

◯ Yes – go to Question 12. ◯ No – go to Question 11.

11. What is PERSON 2's immigration status? _____

a. Immigration Document Type : _____

b. Document ID Number _____

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

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

e. Did PERSON 2 enter into the U.S. prior to August 22, 1996? ◯ Yes ◯ No

f. Does PERSON 2 want help paying for a medical emergency? ◯ Yes ◯ No

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

12a. Health care coverage through MNsure begins January 1, 2014. Does PERSON 2 want help from Medical Assistance (MA) for health care coverage for October, November or December 2013? ◯ Yes ◯ No

12b. Does PERSON 2 want help from Medical Assistance (MA) to pay for medical bills from the last 3 months? ◯ Yes ◯ No

STEP 2: PERSON 2 (Continue with PERSON 2)

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

14. Please answer Yes or No to the following two questions.
   a. Is PERSON 2 blind or 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
   b. Does PERSON 2 need help staying in his or her home or help paying for care in a long-term facility such as a nursing home? ◯ Yes ◯ No

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

16. The answers to the two tobacco questions listed below do not affect PERSON 2's eligibility for health care coverage.
   16a. Within the past 6 months, has PERSON 2 used tobacco regularly (4 or more times per week on average)? Do not count religious or ceremonial uses. ◯ Yes ◯ No
   16b. When was the last time PERSON 2 used tobacco regularly? (MM/DD/YYYY) _____

17. If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)
☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

18. 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 _____		

Now, tell us about any income from PERSON 2 on the next page

STEP 2: PERSON 2 (Continue with PERSON 2)

Current Job & Income Information

◯ **Employed**
If PERSON 2 is currently employed, tell us about his or her income income. Start with question 19.

◯ **Not employed**
Skip to question 29.

◯ **Self-employed**
Skip to question 28.

Current Job 1

19. EMPLOYER NAME AND ADDRESS	20. EMPLOYER PHONE NUMBER

21. WAGES/TIPS (BEFORE TAXES)

$ ◯ Hourly ◯ Weekly ◯ Every 2 weeks ◯ Twice a month ◯ Monthly ◯ Yearly

22. AVERAGE HOURS WORKED EACH WEEK

Current Job 2 (If PERSON 2 has more jobs and need more space, attach another sheet of paper.)

23. EMPLOYER NAME AND ADDRESS	24. EMPLOYER PHONE NUMBER

25. WAGES/TIPS (BEFORE TAXES)

$ ◯ Hourly ◯ Weekly ◯ Every 2 weeks ◯ Twice a month ◯ Monthly ◯ Yearly

26. AVERAGE HOURS WORKED EACH WEEK

27. IN THE PAST 6 MONTHS, DID PERSON 2:

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

28. IF SELF-EMPLOYED, INCLUDING FROM FARMING AND FISHING, ANSWER THE FOLLOWING QUESTIONS:

28a. Type of work

28b. How much net income (profits once business expenses are paid) will PERSON 2 get from this self-employment this month?

$

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 $ _____ How often? _____

☐ Other Retirement $ _____ How often? _____

☐ Alimony Received $ _____ How often? _____

☐ Net rental/royalty $ _____ How often? _____

☐ Other income that is expected within the next 12 months TYPE: _____
$ _____ How often? _____

☐ Other income this month TYPE: _____
$ _____ How often? _____

30. **DEDUCTIONS:** 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 deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower. See lines 23-35 on the 1040 Form or lines 16-19 on the 1040-A Form. **NOTE:** PERSON 2 should not include a cost that he or she already considered in his or her answer to net self-employment (question 28b).

☐ Alimony Paid $ _____ How often? _____

☐ Student loan interest $ _____ How often? _____

☐ Other deduction TYPE: _____
$ _____ How often? _____

31. **YEARLY INCOME: Complete only if PERSON 2's income changes from month to month or PERSON 2 is seasonally employed.**

PERSON 2'S TOTAL INCOME **THIS YEAR**	PERSON 2's TOTAL INCOME **NEXT YEAR** (if PERSON 2 thinks it will be different)
$	$

NEED HELP WITH YOUR APPLICATION? Visit **www.mnsure.org** or call us at **1-855-366-7873**. 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 3

Complete step 2 for yourself, your spouse/partner and children who live with you and/or anyone on your same federal income tax return if you file one. See page 1 for more information about who to include. If you do not file a tax return, remember to still add family members who live with you.

1. FIRST NAME, MIDDLE NAME, LAST NAME, & SUFFIX	2. RELATIONSHIP TO YOU
3. DATE OF BIRTH (MM/DD/YYYY)	4. SEX

5. SOCIAL SECURITY NUMBER (SSN)

We need this if PERSON 3 wants health coverage and has an SSN.

6. Does PERSON 3 live at the same address as you?

◯ Yes ◯ No – list address:

7. 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 – please answer questions a–c. ◯ No – skip 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 dependents: _____

c. Will PERSON 3 be claimed as a dependent on someone else's tax return? ◯ Yes ◯ No

If yes, please list the name of the tax filer: _____

How is PERSON 3 related to the tax filer? _____

8. Is PERSON 3 pregnant? ◯ Yes ◯ No If yes, how many babies are expected during this pregnancy? _____

9. Does PERSON 3 need health coverage?

(Even if PERSON 3 has insurance, there might be a program with better coverage or lower costs.)

◯ Yes – answer ALL of the questions below. ◯ No – SKIP to the income questions on page 7.

10. Is PERSON 3 a U.S. citizen or U.S. national?

◯ Yes – go to Question 12. ◯ No – go to Question 11.

11. What is PERSON 3's immigration status? _____

a. Immigration Document Type : _____

b. Document ID Number _____

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

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

e. Did PERSON 3 enter into the U.S. prior to August 22, 1996? ◯ Yes ◯ No

f. Does PERSON 3 want help paying for a medical emergency? ◯ Yes ◯ No

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

12a. Health care coverage through MNsure begins January 1, 2014. Does PERSON 3 want help from Medical Assistance (MA) for health care coverage for October, November or December 2013? ◯ Yes ◯ No

12b. Does PERSON 3 want help from Medical Assistance (MA) to pay for medical bills from the last 3 months? ◯ Yes ◯ No

NEED HELP WITH YOUR APPLICATION? Visit **www.mnsure.org** or call us at **1-855-366-7873**. 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 3 (Continue with PERSON 3)

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

14. Please answer Yes or No to the following two questions.
    a. Is PERSON 3 blind or 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
    b. Does PERSON 3 need help staying in his or her home or help paying for care in a long-term facility such as a nursing home? ◯ Yes ◯ No

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

16. The answers to the two tobacco questions listed below do not affect PERSON 3's eligibility for health care coverage.
    16a. Within the past 6 months, has PERSON 3 used tobacco regularly (4 or more times per week on average)? Do not count religious or ceremonial uses. ◯ Yes ◯ No
    16b. When was the last time PERSON 3 used tobacco regularly? (MM/DD/YYYY) _____

17. If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)
    ☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

18. 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 _____		

Now, tell us about any income from PERSON 3 on the next page

STEP 2: PERSON 3 (Continue with PERSON 3)

Current Job & Income Information

◯ **Employed**
If PERSON 3 is currently employed, tell us about his or her income income. Start with question 19.

◯ **Not employed**
Skip to question 29.

◯ **Self-employed**
Skip to question 28.

Current Job 1

19. EMPLOYER NAME AND ADDRESS	20. EMPLOYER PHONE NUMBER

21. WAGES/TIPS (BEFORE TAXES)

$ ◯ Hourly ◯ Weekly ◯ Every 2 weeks ◯ Twice a month ◯ Monthly ◯ Yearly

22. AVERAGE HOURS WORKED EACH WEEK

Current Job 2 (If PERSON 3 has more jobs and need more space, attach another sheet of paper.)

23. EMPLOYER NAME AND ADDRESS	24. EMPLOYER PHONE NUMBER

25. WAGES/TIPS (BEFORE TAXES)

$ ◯ Hourly ◯ Weekly ◯ Every 2 weeks ◯ Twice a month ◯ Monthly ◯ Yearly

26. AVERAGE HOURS WORKED EACH WEEK

27. IN THE PAST 6 MONTHS, DID PERSON 3:

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

28. IF SELF-EMPLOYED, INCLUDING FROM FARMING AND FISHING, ANSWER THE FOLLOWING QUESTIONS:

28a. Type of work

28b. How much net income (profits once business expenses are paid) will PERSON 3 get from this self-employment this month?

$

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 $ _____ How often? _____

☐ Other Retirement $ _____ How often? _____

☐ Alimony Received $ _____ How often? _____

☐ Net rental/royalty $ _____ How often? _____

☐ Other income that is expected within the next 12 months TYPE: _____
$ _____ How often? _____

☐ Other income this month TYPE: _____
$ _____ How often? _____

30. **DEDUCTIONS:** 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 deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower. See lines 23-35 on the 1040 Form or lines 16-19 on the 1040-A Form. **NOTE:** PERSON 3 should not include a cost that he or she already considered in his or her answer to net self-employment (question 28b).

☐ Alimony Paid $ _____ How often? _____

☐ Student loan interest $ _____ How often? _____

☐ Other deduction TYPE: _____
$ _____ How often? _____

31. **YEARLY INCOME: Complete only if PERSON 3's income changes from month to month or PERSON 3 is seasonally employed.**

PERSON 3'S TOTAL INCOME **THIS YEAR**	PERSON 3's TOTAL INCOME **NEXT YEAR** (if PERSON 3 thinks it will be different)
$	$

NEED HELP WITH YOUR APPLICATION? Visit **www.mnsure.org** or call us at **1-855-366-7873**. 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 4

Complete step 2 for yourself, your spouse/partner and children who live with you and/or anyone on your same federal income tax return if you file one. See page 1 for more information about who to include. If you do not file a tax return, remember to still add family members who live with you.

1. FIRST NAME, MIDDLE NAME, LAST NAME, & SUFFIX	2. RELATIONSHIP TO YOU
3. DATE OF BIRTH (MM/DD/YYYY)	4. SEX

5. SOCIAL SECURITY NUMBER (SSN)

We need this if PERSON 4 wants health coverage and has an SSN.

6. Does PERSON 4 live at the same address as you?

◯ Yes ◯ No – list address:

7. 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 – please answer questions a–c. ◯ No – skip 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 dependents: _____

c. Will PERSON 4 be claimed as a dependent on someone else's tax return? ◯ Yes ◯ No

If yes, please list the name of the tax filer: _____

How is PERSON 4 related to the tax filer? _____

8. Is PERSON 4 pregnant? ◯ Yes ◯ No If yes, how many babies are expected during this pregnancy? _____

9. Does PERSON 4 need health coverage?

(Even if PERSON 4 has insurance, there might be a program with better coverage or lower costs.)

◯ Yes – answer ALL of the questions below. ◯ No – SKIP to the income questions on page 7.

10. Is PERSON 4 a U.S. citizen or U.S. national?

◯ Yes – go to Question 12. ◯ No – go to Question 11.

11. What is PERSON 4's immigration status? _____

a. Immigration Document Type : _____

b. Document ID Number _____

c. Does PERSON 4 have a sponsor? ◯ Yes ◯ No

d. Is PERSON 4, his or her spouse or parent a veteran or active-duty member of the military? ◯ Yes ◯ No

e. Did PERSON 4 enter into the U.S. prior to August 22, 1996? ◯ Yes ◯ No

f. Does PERSON 4 want help paying for a medical emergency? ◯ Yes ◯ No

g. Is PERSON 4 getting services from the Center for Victims of Torture? ◯ Yes ◯ No

12a. Health care coverage through MNsure begins January 1, 2014. Does PERSON 4 want help from Medical Assistance (MA) for health care coverage for October, November or December 2013? ◯ Yes ◯ No

12b. Does PERSON 4 want help from Medical Assistance (MA) to pay for medical bills from the last 3 months? ◯ Yes ◯ No

STEP 2: PERSON 4 (Continue with PERSON 4)

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

14. Please answer Yes or No to the following two questions.
   a. Is PERSON 4 blind or 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
   b. Does PERSON 4 need help staying in his or her home or help paying for care in a long-term facility such as a nursing home? ◯ Yes ◯ No

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

16. The answers to the two tobacco questions listed below do not affect PERSON 4's eligibility for health care coverage.
   16a. Within the past 6 months, has PERSON 4 used tobacco regularly (4 or more times per week on average)? Do not count religious or ceremonial uses. ◯ Yes ◯ No
   16b. When was the last time PERSON 4 used tobacco regularly? (MM/DD/YYYY) _____

17. If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)
☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

18. 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 _____		

Now, tell us about any income from PERSON 4 on the next page

STEP 2: PERSON 4 (Continue with PERSON 4)

Current Job & Income Information

◯ **Employed**
If PERSON 4 is currently employed, tell us about his or her income income. Start with question 19.

◯ **Not employed**
Skip to question 29.

◯ **Self-employed**
Skip to question 28.

Current Job 1

19. EMPLOYER NAME AND ADDRESS	20. EMPLOYER PHONE NUMBER

21. WAGES/TIPS (BEFORE TAXES)

$ ◯ Hourly ◯ Weekly ◯ Every 2 weeks ◯ Twice a month ◯ Monthly ◯ Yearly

22. AVERAGE HOURS WORKED EACH WEEK

Current Job 2 (If PERSON 4 has more jobs and need more space, attach another sheet of paper.)

23. EMPLOYER NAME AND ADDRESS	24. EMPLOYER PHONE NUMBER

25. WAGES/TIPS (BEFORE TAXES)

$ ◯ Hourly ◯ Weekly ◯ Every 2 weeks ◯ Twice a month ◯ Monthly ◯ Yearly

26. AVERAGE HOURS WORKED EACH WEEK

27. IN THE PAST 6 MONTHS, DID PERSON 4:

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

28. IF SELF-EMPLOYED, INCLUDING FROM FARMING AND FISHING, ANSWER THE FOLLOWING QUESTIONS:

28a. Type of work

28b. How much net income (profits once business expenses are paid) will PERSON 4 get from this self-employment this month?

$

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 $ _____ How often? _____

☐ Other Retirement $ _____ How often? _____

☐ Alimony Received $ _____ How often? _____

☐ Net rental/royalty $ _____ How often? _____

☐ Other income that is expected within the next 12 months TYPE: _____
$ _____ How often? _____

☐ Other income this month TYPE: _____
$ _____ How often? _____

30. **DEDUCTIONS:** 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 deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower. See lines 23-35 on the 1040 Form or lines 16-19 on the 1040-A Form. **NOTE:** PERSON 4 should not include a cost that he or she already considered in his or her answer to net self-employment (question 28b).

☐ Alimony Paid $ _____ How often? _____

☐ Student loan interest $ _____ How often? _____

☐ Other deduction TYPE: _____
$ _____ How often? _____

31. **YEARLY INCOME: Complete only if PERSON 4's income changes from month to month or PERSON 4 is seasonally employed.**

PERSON 4'S TOTAL INCOME **THIS YEAR**	PERSON 4's TOTAL INCOME **NEXT YEAR** (if PERSON 4 thinks it will be different)
$	$

NEED HELP WITH YOUR APPLICATION? Visit **www.mnsure.org** or call us at **1-855-366-7873**. 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 3 American Indian or Alaska Native (AI/AN) family member(s)

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

◯ No – skip to step 4. ◯ Yes – you will need to complete and include Appendix B.

STEP 4 Your Family's Health Coverage

Answer these questions for anyone who needs health coverage.

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

◯ Yes – check the type of coverage and write the person(s)' name(s) next to the coverage they have. ◯ No

☐ Medical Assistance (MA) _____

☐ MinnesotaCare _____

☐ Medicare _____

☐ TRICARE (Do not check if you have direct care or Line of Duty)

_____

☐ VA health care programs _____

☐ Peace Corps _____

☐ Employer insurance _____

Name of health insurance _____

Policy number _____

Is this COBRA coverage? ◯ Yes ◯ No

Is this a retiree health plan? ◯ Yes ◯ No

☐ Private/Other Name of health insurance _____

Policy number _____

Is this a limited-benefit plan (like a school accident policy)? ◯ Yes ◯ No

2. 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.

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

◯ No – continue to Step 5.

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

◯ No ◯ Yes – who? _____

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: _____

STEP 6 Other Family Members

If you have other family members that were not included in Step 2 of this application who you would like to have covered under a family health plan, please call the MNsure Contact Center at 1-855-366-7873.

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

- Children who do not live with you
- Children who are not included on your federal income tax return
- Adult children ages 21-26
- Grandchildren who have resided with you continuously from birth and who are financially dependent upon you or your covered spouse
- Children for whom you or your spouse are legal guardian

NEED HELP WITH YOUR APPLICATION? Visit **www.mnsure.org** or call us at **1-855-366-7873**. 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 Please complete the information on this page and read the attached Notice of Privacy Practices before signing below.

- I have provided true answers to all the questions on this application to the best of my knowledge. I know that there may be a penalty if I am not truthful.
- I know that my information on this form will only be used to determine eligibility for health insurance and will be kept private and secure as required by law. I know that I must tell MNsure if anything changes (and is different than) what I wrote on this application. I can call MNsure at **1-855-366-7873** or visit www.**mnsure.org** to report any changes.
- I know that under federal law, discrimination is not permitted on the basis of race, color, national origin, sex, age, or disability. I can file a complaint of discrimination by visiting **www.hhs.gov/ocr/office/file**.
- By signing and submitting this application, I understand that you need this information to check my eligibility for help paying for health coverage if I choose to apply. We will check your answers using information in our electronic databases and databases from the Internal Revenue service (IRS), Social Security, the Department of Homeland Security, and/or a consumer reporting agency. If the information does not match, we may ask you to send us proof.

Renewal of coverage in future years

To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow MNsure to use income data, including information from tax returns. MNsure will send me a notice, let me make any changes, and I can opt out at any time.

Yes, I agree to the use of income data to renew my eligibility automatically for the next 5 years (the maximum number of years allowed), or for a shorter number of years:

☐ 4 years ☐ 3 years ☐ 2 years ☐ 1 year ☐ Do not use information from tax returns to renew my coverage.

If anyone on this application is eligible for Medical Assistance (MA):

- I am giving to the Medical Assistance (MA) agency our rights to pursue and get any money from other health insurance, legal settlements, or other third parties. I am also giving to the Medical Assistance (MA) agency rights to pursue and get medical support from a spouse or parent.
- Does any child on the application have a parent living outside of the home? ◯ Yes ◯ No
- For parents who qualify for Medical Assistance (MA): 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 Medical Assistance (MA) and my case will be reviewed.
- By signing below, I agree and understand that my information will be shared for fraud investigations and audits as stated in the attached Notice of Privacy Practices.
- By signing below, I agree to the release of my Medical Assistance (MA) health records to the parties listed in the Notice of Privacy Practices' Authorization for Release (Sharing) of My Medical Information section.

My right to appeal:

- If I think a mistake has been made, I can call the MNsure Contact Center at 1-855-366-7873. I can also appeal the action. To appeal means to tell someone that I think the action is wrong, and ask for a fair review of the action. I can find more information about appeals by going to the MNsure website and reading more about appeals. If I want to file an appeal, I can do so via internet, phone, mail, or in-person. I can learn more about these appeal options by going to the MNsure website or by calling the MNsure Contact Center at 1-855-366-7873.
- I know that I can be represented in the process by someone other than myself including an attorney, advocate, authorized representative, relative, friend, or another person. My eligibility and other important information will be explained to me. I understand that a change in my information could affect my eligibility and the eligibility of member(s) of my household. I know that additional appeals information can be read in Attachment A.

Sign this application.

SIGNATURE	DATE (mm/dd/yyyy)

STEP 8 Submit your completed and signed application.

Please submit your completed and signed application by using one of the three methods listed below.

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

How to Submit Your Completed and Signed Paper Application	
Fax Number	651-431-7750
Mailing Address	MNsure Operations PO Box 64252 St. Paul, MN 55164-0252
In-Person Submission	Elmer L. Andersen Human Services Building (First floor) 540 Cedar Street St. Paul, MN 55101

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 **1-855-366-7873**. 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

Effective Date: October 1, 2013

This notice tells how private 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 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 if you can pay for some services
- To make reports, do research, do audits, and evaluate our programs
- To investigate reports of people who may lie about the help they need
- To decide about out-of-home care and in-home care for you or your children
- To collect money from other agencies, like insurance companies, if they should pay for your care
- To decide if you or your family need protective services
- 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, or 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 collaborative, nonprofit and private agencies to verify income, resources, or other information that may affect your eligibility and/or benefits.

You do not have to give us the SSN:

- For persons in your home who are not applying for coverage
- 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, 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 verify state and federal sources to confirm your income and family size. We will only use this information for the purposes authorized by law, such as verifying enrollment eligibility or claiming a premium tax credit, cost-sharing reduction or the amount of the credit or reduction. We will not share this information to any other person or entity. You do not have to provide income information if you are not requesting a subsidy, tax credit or cost-sharing reduction.

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 only share information about you as needed and as allowed or required by law. We may share your information with the following agencies or persons who need the information to do their jobs:

- Employees or volunteers with other state, county, local, federal, collaborative, nonprofit and private agencies
- Researchers, auditors, investigators, and others who do quality of care reviews and studies or commence prosecutions or legal actions related to managing the human services programs.
- Court officials, county attorney, attorney general, other law enforcement officials, child support officials, and child protection and fraud 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 who pay for your care
- Guardians, conservators or persons with power of attorney
- 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
- Certified application counselors, in-person assistors, and navigators and anyone else to whom the law says we must or can give the information.

We may disclose your health information to a record locator service. This can help health care providers find health plans and other health care providers that have health information about you. The health care provider can then get that information to help make better decisions about your treatment.

If you prefer not to be included in the record locator service, you may "opt out" by contacting the Community Health Information Collaborative (CHIC) service desk at 877-411-CHIC (toll free), 218-625-5515 (voice), 218-625-5518 (fax).

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

- You and people you have given permission to may see and copy medical or other private information we have about you.
- You may have to pay for the copies.
- You may question if 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 any time 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 can 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 medical 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-3979-ENG and/or 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 only be provided to parents 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 either to the county agency, the organization or to 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) or toll free 800-368-1019
800-537-7697 (TTY)
312-886-1807 (Fax)

If you think that the Minnesota Department of Human Services – MNsure 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

Rights and Responsibilities

Immigration

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, 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:

- Applying for emergency medical care only.
- Helping someone else apply.
- You are a pregnant woman living in the United States without the knowledge or approval of the United States Citizenship and Immigration Services (USCIS)
- Not applying for yourself.

You Have the Right to Ask for a Hearing

If you feel your benefits are wrong or your application has not been processed correctly, you may ask for an appeal hearing. In requesting an appeal hearing, you are requesting a fair review of your benefits decision. Specific appeal instructions can be found on all notices that you receive. You can learn more by going to the MNsure appeals website. You can ask for a hearing by telling your consumer assistant or by logging into your MNsure account.

Reviews
The state or federal office may look at your case. They will review the information you gave us and check to make sure we did your case correctly. They will let you know if they need to ask you questions.

Other Health Care
You and your household members may need to accept and keep a health insurance policy. This includes Medicare. If you do not give us information about your health insurance policy, you may not get coverage.

Changes
You must report changes by contacting MNsure within 10 days of the change happening. If you do not report changes, you may have to pay money back to the State for what we paid if you were not eligible.

If you are not sure if you should report a change, call 1-855-366-7873 and explain what is happening. Examples of changes you need to report include:

Income:

- Starting a new job, changing jobs or stopping a job.
- Starting to get or changes in the amount of other income you get such as Social Security, other retirement income, child support, unemployment or workers' compensation.

When you:

- Sell your home.
- Move to a new address.
- Get an inheritance or a settlement.
- Transfer or give away assets or income.

When someone in your household:

- Starts to get health insurance or Medicare.
- Becomes pregnant or has a baby.
- Moves in or out of your home.
- Dies, gets married or gets a divorce.
- Becomes disabled.
- Starts or stops school.

For Medical Assistance Only

MA Child 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. This includes helping the state prove who the father of your children are and getting the other parent to help pay the children's medical expenses. Your children will still get coverage if you do not help Child Support, but you may not get coverage unless you are pregnant.

If you are afraid the other parent may cause harm to you or your child, you can give proof to support your fears. We will review your proof and tell you if you still need to give information about the other parent.

MA Liens and Estate Claims
The Medical Assistance (MA) program must recover medical assistance costs after the death of certain recipients.

The MA program does so by filing a claim in probate court, or against assets remaining after death. The MA program must attempt to recover costs but only for:

- Individuals who received MA at and after age 55.
- Without regard to age, individuals who resided in a long-term care facility for six months or more.

The MA program may file an MA lien against real property to recover MA costs before death, but only for people who are permanently institutionalized. Liens used to recover MA costs can be filed against:

- Your life estate or joint tenancy 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.

MA Authorization for Release (Sharing) of my Medical Information
By accepting or receiving Medical Assistance (MA), 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 health plans, insurance agencies, Medical Assistance (MA), county advocates, school districts, my county or state case workers, and their contractors and subcontractors:
  - To determine who should pay for my health care, and
  - To provide, manage, and coordinate health care services.
- All other agencies or persons as listed on this Notice of Privacy Practices:
  - For program administration, payment for services, 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 Medical Assistance (MA), 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.

Discrimination is against the law

The U.S. Department of Health and Human Services' Office for Civil Rights prohibits discrimination in its programs because of race, color, national origin, age, disability and sex, including sex stereotypes and gender identity. If you believe you have been discriminated against, you have the right to file a complaint directly with the federal agency.

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)
800-368-1019 (Toll Free)
312-353-5693 (TTY)

In Minnesota, if you believe you have been discriminated against because of race, color, national origin, religion, creed, sex, sexual orientation, public assistance status, age, or disability, you have the right to file a complaint with:

Minnesota Department of Human Services
Equal Opportunity and Access
P.O. Box 64997
St. Paul, MN 55164-0997
651-431-3040 (Voice)
711 or 800-627-3529 (MN Relay)

Minnesota Department of Human Rights
Freeman Building
625 Robert Street North
St. Paul, MN 55155
651-539-1100 (Voice)
800-657-3704 (Toll-Free)
651-296-1283 (TTY)

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.

Tell us about the job that offers coverage.

Take the Employer Coverage Tool on the next page to the employer who offers coverage to help you answer these questions. You only need to include this page when you send in your application, not the Employer Coverage Tool.

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. Who 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 3 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 who is eligible for coverage from this job.

◯ No – stop here and go to Step 5 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/she received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on wellness programs.

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

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ 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 2 weeks ☐ Twice a month ☐ 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 or spouse). The information in the numbered boxes below match the boxes on Appendix A. For example, the answer to question 14 on this page should match 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. Who 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 3 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/she received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on wellness programs.

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

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ 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 will the employee have to pay in premiums for that plan? $ _____

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ 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 **1-855-366-7873**. 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/AN)

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

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

American Indians and Alaska Natives can get services from the Indian Health Services, tribal health programs, or urban Indian health programs. They also 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 a copy of this page and attach.

	AI/AN PERSON 1	AI/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: _____ ◯ No	◯ Yes, tribe name: _____ ◯ No
3. Has this person ever gotten a service from the Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs?	◯ Yes ◯ No, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? ◯ Yes ◯ No	◯ Yes ◯ No, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? ◯ 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 1-855-366-7873.

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. ORGANIZATION NAME	5. ASSISTER ID NUMBER