DHS-4740-ENG 10-11

Minnesota Family Planning Program Application

(Part of Minnesota Health Care Programs)

Who is this program for?

- Men and women between the ages of 15 and 50 who are not enrolled in Medical Assistance or MinnesotaCare.

Can I get coverage right away?

- Some clinics use this application to see if you can get short-term coverage. Short-term coverage begins right away and lasts for up to two months.
- For a list of clinics that can give short-term coverage call the Minnesota Family Planning Program at the numbers below.

What do I need to do with this form?

- Read the Rights and Responsibilities on the colored pages A and B. Tear off the colored pages and keep them.
- Answer all of the questions on the white pages 1 through 6. Use blue or black ink. Print clearly.
- Use one application for each person who is applying.
- Sign and date the application.
- Mail or fax the completed application with proofs to:

  Minnesota Department of Human Services
  PO Box 64960
  St. Paul, MN 55164-0960
  Fax: (651) 431-7532 or (800) 204-0639

Questions

If you have questions or need help, call the Minnesota Family Planning Program at (651) 431-3480 (Twin Cities metro area) or (888) 702-9968 (outside Twin Cities metro area).

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

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

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

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

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

ໂປຼດຊາບ. ຖ້າຫາກທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປຂໍ້ຄວາມດັ່ງກ່າວນີ້ຟຣີ, ຈົ່ງຖາມພນັກງານຊ່ວຍວຽກຂອງທ່ານຫຼືໂທຣ໌ຫາຕາມເລກໂທຣ໌ 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)

ADA3 (5-09)

This information is available in alternative formats to individuals with disabilities by calling (651) 431-2670 or (800) 657-3739. 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.

Minnesota Department of **Human Services**

DHS-4740-ENG 10-11

Minnesota Health Care Programs

Minnesota Family Planning Program Application

Provider Use Only (If PE approved, complete the information below and fax page 1 to (651) 431-7532 or (800) 204-0639.)

PROVIDER NAME	PROVIDER ADDRESS	
NPI NUMBER	PROVIDER PHONE	DATE PE APPROVED

1. Write your information below.

FIRST NAME	MI	LAST NAME

DATE OF BIRTH (MM/DD/YYYY)	SOCIAL SECURITY NUMBER	DAYTIME PHONE NUMBER	GENDER ☐ M ☐ F	ARE YOU PREGNANT? ☐ YES ☐ NO

☐ Check this box if you are homeless. ☐ Check this box if you are a migrant worker.

HOME STREET ADDRESS			APT. NUMBER
CITY	STATE	ZIP	COUNTY

MAILING ADDRESS (where you would like notices sent if different from the address above)		APT. NUMBER
CITY	STATE	ZIP

Full-time or part-time high school student? ☐ FULL-TIME ☐ PART-TIME ☐ NOT A STUDENT

If you are a high school student, do you expect to graduate by age 19? ☐ YES ☐ NO

SPOKEN LANGUAGE ☐ ENGLISH ☐ SPANISH ☐ OTHER: ______

WRITTEN LANGUAGE ☐ ENGLISH ☐ SPANISH ☐ OTHER: ______

If you do not speak English well, do you need someone who speaks your language to help you? ☐ YES ☐ NO

Are you Latino or Hispanic? (optional) ☐ YES ☐ NO

What is your race? (optional) ☐ WHITE ☐ ASIAN ☐ AMERICAN INDIAN OR ALASKAN NATIVE ☐ BLACK/AFRICAN AMERICAN ☐ PACIFIC ISLANDER OR NATIVE HAWAIIAN

2. Do you have health insurance?

☐ No, I do not have health insurance. Go to question 3.

☐ Yes, I have or may have health insurance. But I do not want you to contact my insurance company. I have good reason for not giving you insurance information. I would be at risk of physical or emotional harm if I give it. This may happen from asking the policyholder for insurance information, or the insurance company could tell the policyholder about the services I get. Go to question 3.

☐ Yes, I have health insurance. You may contact my insurance company to see if they will pay for my services. I understand the insurance company may tell the policyholder about the services I get. Complete the information below or send us a copy of the front and back of your insurance card.

TYPE OF COVERAGE	POLICYHOLDER'S NAME	POLICY NUMBER	GROUP NUMBER
☐ INDIVIDUAL ☐ GROUP ☐ PRESCRIPTION DRUG ☐ MEDICARE ☐ OTHER	INSURANCE COMPANY NAME		DATE INSURANCE COVERAGE STARTED
	INSURANCE COMPANY ADDRESS		

3. Do you live with your spouse? ☐ No ☐ Yes – fill in below

Include a spouse who is living away from home for a short time.

SPOUSE'S FIRST NAME	MI	LAST NAME	If you live with your wife, is she pregnant? ☐ No ☐ Yes

4. Do you live with your children or stepchildren? ☐ No ☐ Yes – fill in below

Include children who are living away from home for a short time.

NUMBER OF CHILDREN UNDER AGE 21

5. What is your monthly gross income?

If you are under age 21, include only your income. If you are age 21 or older, include your income and your spouse's income.

- If you have income, go to question 6.
- If you do not have income, explain in the box below how you pay for your living expenses (food, housing, clothing). Go to question 10.

GROSS MONTHLY INCOME
$

6. Do you have a job?

☐ No, go to question 7.

☐ Yes, fill out the information below. Attach additional pieces of paper if necessary.

EMPLOYER NAME	START DATE	DO YOU WORK LESS THAN 37½ HOURS PER WEEK? ☐ YES ☐ NO
☐ THIS IS A SEASONAL OR TEMPORARY JOB	HOW OFTEN ARE YOU PAID? ☐ EVERY WEEK ☐ EVERY TWO WEEKS ☐ ONCE A MONTH ☐ OTHER:	
GROSS WAGES $	CASH OR TIPS $	DATE OF MOST RECENT PAYCHECK

You must give us proof of this income. Proof can be pay stubs from the last 30 days or a statement from the employer.

7. Does your spouse have a job?

☐ No, go to question 8.

☐ Yes, fill out the information below. Attach additional pieces of paper if necessary.

EMPLOYER NAME			START DATE
☐ THIS IS A SEASONAL OR TEMPORARY JOB	HOW OFTEN IS HE OR SHE PAID? ☐ EVERY WEEK ☐ EVERY TWO WEEKS ☐ ONCE A MONTH ☐ OTHER:		
GROSS WAGES $	CASH OR TIPS $	DATE OF MOST RECENT PAYCHECK	

You must give us proof of this income. Proof can be pay stubs from the last 30 days or a statement from the employer.

8. Are you or your spouse self-employed?

☐ No, go to question 9.

☐ Yes, fill out the information below.

Name of person	Name of business	Start date of business	Gross yearly income
			$
			$

You must give us proof of this income. Proof can be your most recent income tax returns and all related schedules, or business records if taxes are not filed.

9. Are you or your spouse getting or expecting to get other types of income?

Other income may include: Child support, spousal support, unemployment, worker's compensation, Social Security, SSI, pensions, Veteran's benefits, retirement, rent, annuities, trusts, interest, dividends, contracts for deed, property agreements, public assistance payments and other types of income.

☐ No, go to question 10.

☐ Yes, fill out the information below. Attach additional pieces of paper if necessary.

Name of person	Where is this income from?	Amount	How often is it received?	Date of last payment received
		$		
		$		
		$		

You must give us proof of this income. Proof can be a statement from the place that sends the income or a direct deposit statement from your bank from the last 30 days.

10. Are you a U.S. citizen or national?

☐ Yes, if you are a U.S. citizen or national, fill out the information below.

CITY AND STATE WHERE YOU WERE BORN	FULL NAME AT BIRTH

☐ No, if you are not a U.S. citizen or national, fill out the information below.

IMMIGRATION STATUS	DATE OF U.S. ENTRY	DO YOU HAVE A SPONSOR? ☐ YES ☐ NO

You must give us proof of your immigration status or citizenship and identity.

- **If you are not a citizen, give us copies of your immigration documents.**
- **If you are a citizen, give us a copy of one of the following:**
  - U.S. passport
  - Certificate of Naturalization
  - Certificate of U.S. Citizenship
  - PASS card
  - Tribal enrollment or membership card
  - Certificate of Indian blood issued by a federally recognized Indian tribe

If you do not have one of the above documents, give us a copy of one citizenship document and one identity document listed below:

Citizenship documents:

- U.S. birth certificate
- Report of Birth Abroad of a U.S. citizen
- U.S. citizen ID card
- Hospital record of birth in one of the 50 states or U.S. territories.

Identity documents:

- State driver's license with picture
- Minnesota ID card with picture
- School ID card with picture, report card, or clinic, doctor, hospital or day care records also proves identity for children under age 16.

You do not have to send proof of citizenship or identity if you are eligible for Medicare, receiving Supplemental Security Income (SSI), or receiving Social Security Disability.

Sign and date the application on the signature page.

Signature Page

(Effective Date: October 1, 2011)

Read the following information and sign.

I understand this is an application for the Minnesota Family Planning Program (MFPP), which covers only family planning services and supplies. I understand that if I want additional health care coverage, I must fill out a Minnesota Health Care Programs application.

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.

I also agree that 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.

Authorization for Release (Sharing) of My Medical 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, health plans, insurance agencies, Minnesota Health Care Programs, county advocates, 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 the Notice of Privacy Practices.

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 authorization is good while I am enrolled in MFPP, not to exceed one year, or longer if the law permits. 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 if I end this consent, I cannot enroll or stay enrolled in MFPP.

Medical Assignment of Benefits

I give my rights to all medical payments to the State of Minnesota. This includes medical payments from all other persons or companies. 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 have MFPP coverage.

Over ➔

By signing below:

- I agree that I have read and understand the Notice of Privacy Practices, the list of my responsibilities in that Notice, and the sections under Following the Rules and Changes.
- I agree and understand that my information will be released to the parties listed in the Notice of Privacy Practices in order to verify eligibility for MFPP.
- I agree and understand that my information will be shared for fraud investigations as stated in the Authorization to Share Information for Fraud Investigations section.
- I agree to the release of my MFPP records to the parties listed in the Authorization for Release (Sharing) of My Medical Information section.
- I agree to assign my medical benefits as stated in the Medical Assignment of Benefits.
- I understand that I am applying for the MFPP, which only covers family planning services and supplies.
- I declare that, under penalty of perjury, all parts of this application and any updates to information on this application I give during the year are true and correct statements, to the best of my knowledge. I understand what happens to people convicted of perjury (not telling the truth). They may be sentenced to prison for up to five years, a fine up to $10,000, or both.

YOUR SIGNATURE	DATE

Mail or fax this completed application and proofs to:

Minnesota Department of Human Services
PO Box 64960
St. Paul, MN 55164-0960
Fax: (651) 431-7532 or (800) 204-0639

Notice of Privacy Practices

Minnesota Department of Human Services

(Effective Date: October 1, 2011)

This notice tells how medical and other 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, mental health, financial or social 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, 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.

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
- 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 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 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: http://edocs.dhs.state.mn.us/lfserver/Public/DHS-3979-ENG

What privacy rights do children have?

If you are under 18, when parental consent for medical treatment is not required, information will not be shown to parents unless the health care provider believes not sharing the information would risk your health. 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 or (866) 282-0659
  (312) 353-5693 (TTY)
  (312) 886-1807 (Fax)

If you think that the Minnesota Department of Human Services has violated your privacy rights, you may send a written complaint to the U.S. Department of Health and Human Services at the address above or to:

- Minnesota Department of Human Services
  Attn: Privacy Official
  PO Box 64998
  St. Paul, MN 55164-0998

Rights and Responsibilities

Immigration

Immigration information you give us is private. We use it to see if you can get coverage. We only share it when the law allows or requires it. In most cases, applying will not affect your immigration status.

You Have the Right to Fair Treatment

We cannot treat you different because of your race, color, national origin, creed, religion, disability, sex, sexual orientation, and public assistance status. If you feel the State or local agency did not treat you fairly, you can file a complaint with any of the following places:

- Minnesota Department of Human Services
  Office for Equal Opportunity
  PO Box 64997
  St. Paul, MN 55164-0997
- Minnesota Department of Human Rights
  190 E. Fifth Street, Suite 700
  St. Paul, MN 55101
- U.S. Department of Health and Human Services
  Office of Civil Rights – Region V
  233 N. Michigan Avenue, Suite 240
  Chicago, IL 60601

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 a fair hearing. You can ask for a hearing by telling your worker or by writing to:

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

Following the rules

People who are enrolled in the Minnesota Family Planning Program must follow the rules listed below:

- Do not give false information or hide information to get or continue to get coverage.
- Do not trade or sell your membership cards.
- Do not help others get medical services that you know they should not get.
- Do not use someone else's membership card for yourself or other household members.

If you break the rules you may not be able to keep your coverage.

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. If you do not answer their questions, your coverage may stop.

Changes

You must report changes to your worker 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 your worker and explain what is happening. Examples of changes you need to report include:

When you or your spouse:

- Starts a new job, change jobs, or stops a job.
- Starts to get or has a change in the amount of other income you get such as Social Security, other retirement income, child support, unemployment or workers' compensation.
- Moves to a new address.
- Starts to get health insurance or Medicare.
- Starts or stops school.

When any family member in your home:

- Becomes pregnant or has a baby.
- Dies, gets married or gets a divorce.
- Moves in or out of your home.

Keep this page.

Use this space to include any additional information.

Minnesota Department of Human Services