Clear Form

DEPARTMENT OF HUMAN SERVICES

DHS-2780A-ENG 7-26

BEHAVIORAL HEALTH ADMINISTRATION

# Behavioral Health Fund (BHF)

## Eligibility Application Form

### What is the Behavioral Health Fund?

The Behavioral Health Fund (BHF) is a Minnesota state program that helps pay for substance use disorder (SUD) treatment. BHF is designed for people who:

- Do not have health insurance, or
- Have insurance that does not cover SUD treatment, or
- Have insurance that does not cover the full cost of SUD treatment.

To qualify, your household income must also fall below program income limits. You can view the income limits chart here: https://mn.gov/dhs/people-we-serve/adults/health-care/alcohol-drugs-addictions/programs-and-services/ccdtf.jsp If approved, BHF will pay for 60 consecutive calendar days of SUD treatment. If you need additional treatment beyond the initial 60 days, you may reapply using this form for additional BHF coverage. You are also encouraged to apply for Minnesota Health Care Programs (Medical Assistance / Medicaid), which can provide comprehensive health care coverage — including SUD treatment coverage — on an ongoing basis. Apply for Medical Assistance online at: https://www.mnsure.org/

### How to Submit This Form

You may submit this application using either of the two methods below. Online submission is preferred — it is the fastest way to get a decision.

| Online (Preferred) | Mail |
|---|---|
| You can complete and submit the request form using our online completion tool at:<br><br>**https://mn.gov/dhs/people-we-serve/adults/health-care/alcohol-drugs-addictions/programs-and-services/ccdtf.jsp**<br><br>Online submission is the fastest way to receive a decision. | Print this completed form and mail it to:<br><br>**Minnesota Department of Human Services**<br>**Attn: BHF Request**<br>**540 Cedar St. St. Paul, MN 55101- 0977** |

### Questions?

- Learn more about the Behavioral Health Fund at: mn.gov/dhs/people-we-serve/adults/health-care/alcohol-drugs-addictions/programs-and-services/ccdtf.jsp
- Contact DHS with questions about BHF eligibility by email at dhs.BHF@state.mn.us.
- Free language assistance and auxiliary aids: contact DHS Health Care Consumer Support at 651-297-3862 or 800-657-3672.

**Required fields are marked with a red asterisk (*).** You must answer all required questions. If you provide false or incomplete information, you may be responsible for the full cost of your treatment.

## Section 1 - Medical Assistance (Medicaid) Status

This section helps us check whether you may already have coverage that can pay for your treatment. Answer as best you can — it is okay if you are unsure.

**Are you currently enrolled — or have you ever been enrolled — in Minnesota Medicaid (Medical Assistance)?**

◯ Yes, I am currently enrolled
◯ Yes, I have been enrolled in the past but am not currently enrolled
◯ No, I have never been enrolled
◯ Unknown

**If you have ever been enrolled, do you know your Medical Assistance number (PMI / Person Master Index number)?**

◯ Yes
◯ No

| Medical Assistance Number (PMI) 8-digit number found on your Minnesota Health Care ID Card (answer only if known). |
|---|
| |

## Section 2 - Your Name

| LEGAL LAST NAME | MIDDLE INITIAL | LEGAL FIRST NAME |
|---|---|---|
| | | |

**Have you ever been known by other name(s)?**
For example: a maiden name, nickname, or name used before a legal name change.

◯ Yes
◯ No

| OTHER LAST NAME | OTHER FIRST NAME | OTHER MIDDLE INITIAL |
|---|---|---|
| | | |
| ADDITIONAL LAST NAME | ADDITIONAL FIRST NAME | ADDITIONAL MIDDLE INITIAL |
| | | |

## Section 3 - Your Residence

### Open Social Services Case

**Do you currently have an open social services case with a county agency?**

◯ Yes
◯ No

**If yes - with which county social services agency?**

| Enter the name of the county (e.g., Hennepin County Social Services) |
|---|
| |

### Permanent Residence

**Do you have a permanent (long-term) residence?**

◯ Yes
◯ No

**How would you describe your PERMANENT residence? Answer only if you have a permanent residence.**

◯ Private residence (house or apartment)
◯ Nursing home or long-term care facility
◯ Foster care home (adult or child)
◯ Group home
◯ Sober home
◯ Correctional facility (jail or prison)
◯ I am unhoused (homeless, couch-hopping)
◯ Other, describe here: _____

| **If a named facility, what is the facility name?** | | | | |
|---|---|---|---|---|
| PERMANENT RESIDENCE STREET ADDRESS | CITY | STATE | ZIP CODE | COUNTY (IF MINNESOTA) |
| | | | | |

**Are you currently staying at your permanent residence?**

◯ Yes - If Yes, skip to Section 4 — How to Reach You.
◯ No - If No, complete the Current Residence fields below.

# Current Residence

**How would you describe your CURRENT residence? Complete only if your current address differs from your permanent address above.**

◯ Private residence (house or apartment)
◯ Nursing home or long-term care facility
◯ Foster care home (adult or child)
◯ Group home
◯ Sober home
◯ Intensive Residential Treatment Services (IRTS)
◯ Treatment program
◯ Hospital
◯ Correctional facility (jail or prison)
◯ I am unhoused (homeless, couch-hopping)
◯ Other, describe here: _____

| **If a named facility, what is the facility name?** | | | | |
|---|---|---|---|---|
| CURRENT RESIDENCE STREET ADDRESS | CITY | STATE | ZIP CODE | COUNTY (IF MINNESOTA) |
| | | | | |

**If 'Correctional Facility':**

| INCARCERATION START DATE | ANTICIPATED RELEASE DATE |
|---|---|
| | |
| ☐ UNKNOWN | ☐ UNKNOWN |

**If you are in a facility listed above — what county did you live in BEFORE entering the facility?**

| Select your county of residence prior to entering this facility. |
|---|
| |

## Section 4 — How to Reach You

We will contact you with a decision about your application. Please provide at least one way to reach you. You may also give permission for us to contact a provider or other person on your behalf.

# Phone

### Primary Phone

**Do you have a phone number?**

◯ Yes
◯ No

| PRIMARY PHONE NUMBER |
|---|
| |

**Can you receive text messages at this number?**

◯ Yes
◯ No

☐ I agree to receive text messages about my BHF eligibility at my primary phone number.

### Secondary Phone

**Do you have a secondary phone number?**

◯ Yes
◯ No

| SECONDARY PHONE NUMBER |
|---|
| |

**Can you receive text messages at this secondary number?**

◯ Yes
◯ No

☐ I agree to receive text messages about my BHF eligibility at my secondary phone number.

### Email

**Do you have an email address?**

◯ Yes
◯ No

| PRIMARY EMAIL ADDRESS |
|---|
| |

☐ I agree to receive emails about my BHF eligibility at my email address above.

### Mailing Address

**Do you have a mailing address?**

◯ Yes
◯ No

| PRIMARY MAILING ADDRESS | CITY | STATE | ZIP CODE | COUNTY |
|---|---|---|---|---|
| | | | | |

☐ I agree to receive US Mail about my BHF eligibility at my primary mailing address.

| SECONDARY MAILING ADDRESS (IF DIFFERENT) | CITY | STATE | ZIP CODE | COUNTY |
|---|---|---|---|---|
| | | | | |

☐ I agree to receive US Mail about my BHF eligibility at my secondary mailing address.

## Section 5 — Financially Responsible Person

A 'financially responsible person' (FRP) is someone other than you who is legally responsible for your finances — for example, a parent or legal guardian for a minor.

**Is there someone other than you who is financially responsible for you?**

◯ Yes
◯ No

**If yes, complete the fields below:**

| FRP LAST NAME | FRP FIRST NAME | MI | FRP PHONE NUMBER |
|---|---|---|---|
| | | | |

| FRP MAILING ADDRESS | CITY | STATE | COUNTY (IF MINNESOTA) | ZIP CODE |
|---|---|---|---|---|
| | | | | |

## Authorization to Share Information with Financially Responsible Person

If someone else is financially responsible for you, you may authorize us to share information about your BHF eligibility with them. This may include, but is not limited to, information such as your name, date of birth, Social Security Number, insurance and income information, and eligibility determination.

**This authorization is valid for one year. You may revoke this authorization at any time by submitting a written request to: Minnesota Department of Human Services, Attn: BHF Request, 540 Cedar St., St. Paul, MN 55101-0977.**

Do you authorize the Minnesota Department of Human Services to share information about your BHF eligibility with the financially responsible person named above?

◯ Yes
◯ No

### Option 1 — Electronic signature

By typing my name below, I agree that I am electronically signing this form. I attest and certify that the information provided is true and accurate. I understand that my electronic signature has the same legal effect and can be enforced in the same way as a handwritten signature (Minn. Stat. Ch. 325L.07).

| TYPE FULL LEGAL NAME | DATE |
|---|---|
| | |

### Option 2 — Handwritten signature

(For printed forms — sign above the line below)

Signature Date

## Permission to Contact Another Person or Provider

If you did not provide a contact method in section 4 (text, email, or mailing address), you must complete this section. You may also complete it voluntarily if you would like a provider or trusted person to receive information about your eligibility.

**Note: Giving permission means sharing your Protected Health Information (PHI). This may include, but is not limited to, information such as your name, date of birth, Social Security Number, insurance and income information, and eligibility determination. This authorization is valid for one year. You may revoke this authorization at any time by submitting a written request to: Minnesota Department of Human Services, Attn: BHF Request, 540 Cedar St., St. Paul, MN 55101-0977.**

**Would you like to give permission for another person, organization, or provider to receive information about your BHF eligibility?**

◯ Yes
◯ No

| **Name of person, organization, or provider** |
|---|
| |

**How should we contact this person/organization/provider?**

◯ US Mail

◯ Email

| MAILING ADDRESS (IF US MAIL) | | | CITY |
|---|---|---|---|
| STATE | ZIP CODE | COUNTY (IF MINNESOTA) | EMAIL ADDRESS (IF EMAIL) |

By signing below, I give permission to share my PHI and BHF eligibility determination with the person/organization/provider named above.

### Option 1 — Electronic signature

By typing my name below, I agree that I am electronically signing this form. I attest and certify that the information provided is true and accurate. I understand that my electronic signature has the same legal effect and can be enforced in the same way as a handwritten signature (Minn. Stat. Ch. 325L.07).

| TYPE FULL LEGAL NAME | DATE |
|---|---|
| | |

### Option 2 — Handwritten signature

(For printed forms — sign above the line below)

Signature Date

## Section 6 - Personal Information

**Do you know your date of birth?**

◯ Yes

◯ No

DATE OF BIRTH

**How would you describe your race? (Check all that apply)**

☐ White / Caucasian

☐ Black / African American

☐ American Indian / Native Person / Indigenous Person / Alaska Native

☐ Asian / Pacific Islander

☐ Multiple races

☐ Other, describe here: _____

☐ Unknown

☐ I prefer not to answer

**Do you identify as Hispanic or Latino/a/x?**

◯ Yes

◯ No

**Do you have a Social Security Number?**

◯ Yes

◯ No

**Social Security Number**

###-##-#### (ANSWER ONLY IF YOU HAVE AND KNOW YOUR SSN)

**What is your preferred language?**

LANGUAGE YOU UNDERSTAND BEST — WE CAN PROVIDE INTERPRETATION SERVICES.

**How would you describe your marital status?**

- ☐ Divorced
- ☐ Legally separated
- ☐ Living apart
- ☐ Married
- ☐ Never married
- ☐ Widowed
- ☐ Unknown
- ☐ Other, describe here: _____

**What is your legal sex / sex assigned at birth?**

- ◯ Male
- ◯ Female
- ◯ Other

**How would you describe your gender? (Check all that apply)**

- ☐ Agender
- ☐ Cisgender man
- ☐ Cisgender woman
- ☐ Demi-gender
- ☐ Gender fluid
- ☐ Gender queer
- ☐ Man
- ☐ Non-binary
- ☐ Pan-gender
- ☐ Transgender man
- ☐ Transgender woman
- ☐ Two-spirit
- ☐ Woman
- ☐ Other, describe here: _____
- ☐ Prefer not to answer

**Are you a member of a federally recognized Tribe?**

- ◯ Yes
- ◯ No

**If yes — which Tribe(s) are you a member of? (Check all that apply)**

- ☐ Bois Forte Band of Chippewa: Zagaakwaandagowiniwag — "The men of the dense forest"
- ☐ Fond du Lac Band of Lake Superior Chippewa: Nahgahchiwanong — "Where the water stops"
- ☐ Grand Portage Band of Lake Superior Chippewa: Gichi Onigaming — "The great carrying place"
- ☐ Leech Lake Band of Ojibwe: Gaa-zagaskwaajimekaag — "Leech Lake"
- ☐ Lower Sioux Indian Community: Cansa'yapi — "Where they mark the trees red"
- ☐ Mille Lacs Band of Ojibwe: Misi-zaaga'iganiing — "The lake that spreads all over"
- ☐ Prairie Island Indian Community: Tinta Wita — "Prairie Island"
- ☐ Red Lake Nation: Miskwaagamiiwi-Zaagaiganing — "Red Lake"
- ☐ Shakopee Mdewakanton Sioux Community: Mdewakanton — "Dwellers of the Spirit Lake"
- ☐ Upper Sioux Community: Pezihutazizi Oyate — "Where they dig for yellow medicine"
- ☐ White Earth Nation: Gaa-waabaabiganikaag — "The place with abundance of white clay"
- ☐ Other, describe here: _____

## Permission to Contact Tribe

If you are a member of a federally recognized Tribe, you may authorize the Minnesota Department of Human Services to contact the tribe(s) indicated above regarding your BHF eligibility. This may include, but is not limited to, information such as your name, date of birth, Social Security Number, insurance and income information, and eligibility determination.

**This authorization is valid for one year. You may revoke this authorization at any time by submitting a written request to: Minnesota Department of Human Services, Attn: BHF Request, 540 Cedar St., St. Paul, MN 55101-0977.**

**Do you authorize the Minnesota Department of Human Services to contact the tribe(s) indicated above regarding your BHF eligibility?**

◯ Yes

◯ No

By signing below, I grant permission for the Minnesota Department of Human Services to contact the tribe(s) indicated above and share my Protected Health Information (PHI) and BHF eligibility determination with them.

### Option 1 — Electronic signature

By typing my name below, I agree that I am electronically signing this form. I attest and certify that the information provided is true and accurate. I understand that my electronic signature has the same legal effect and can be enforced in the same way as a handwritten signature (Minn. Stat. Ch. 325L.07).

| TYPE FULL LEGAL NAME | DATE |
|---|---|
| | |

### Option 2 — Handwritten signature

(For printed forms — sign above the line below)

Signature _____ Date _____

## Section 7 - Household Size and Income

BHF eligibility is based on your household income and size. Income is calculated prospectively - meaning we look at what your household expects to earn over the next 12 months starting from the date you are requesting funding.

**Which of the following best describes you? ***

◯ I am an adult (18 or older)

◯ I am a minor (under 18) and a parent or guardian is applying on my behalf

◯ I am a minor giving effective consent (Minnesota law allows minors to consent to SUD treatment - Minn. Stat. § 144.343)

### Household Size

- When counting household members, include anyone in out-of-home placement if someone in the household is contributing to the cost of that placement.
- For each currently pregnant household member, add one (+1) to your household size.

**Adults:** Count yourself, your spouse, your minor-aged children, and your spouse's minor-aged children living in the same home/dwelling.
**Minors:** Count yourself, your parents (birth or adoptive), and your minor-aged siblings living in the same home/dwelling.
**Minors giving effective consent:** Count only yourself (household size = 1).

| WHAT IS YOUR HOUSEHOLD SIZE?* |
|---|
| |

Enter a whole number — see instructions above.

## Household Income

Income is calculated as the **1-year prospective income** — the total amount your household expects to earn during the next 12 months starting from the date you are requesting BHF funding.

**Whose income counts depends on your status:**

- **Adults:** Count the combined income of all members of your household (yourself, your spouse, and your minor-aged children and your spouse's minor-aged children).
- **Minors:** Count the combined income of your household members excluding your own income (count income of your parents and minor-aged siblings only).
- **Minors giving effective consent:** Count **only your own income.**

**Income INCLUDES:** cash wages or salaries, self-employment income (net after allowable IRS deductions), Social Security, SSI, Railroad Retirement, Retirement/Pension, General Assistance, unemployment compensation, training stipends, union funds, alimony received, veteran's benefits, military family allotments, MFIP, child support received, and dividends, interest, rent, or royalties.

**Income does NOT include:** gifts, cash drawn from a bank, tax refunds, earnings from the sale of a house or car, inheritances, capital gains, savings, non-cash benefits, Cobell Settlement amounts, worker's compensation, compensation for injury while on active military duty, or court-ordered child support and health insurance premium payments made by the applicant (these are deductions from household income).

| WHAT IS YOUR EXPECTED HOUSEHOLD INCOME FOR THE NEXT 12 MONTHS? * |
|---|
| |

Enter a dollar amount (whole numbers only). Example: 18000. Count only the income described above for your status.

**Income confirmation** *

☐ I understand that if the information I provided is found to be false or incomplete, I may be responsible for the total cost of treatment provided — including costs already paid by the Behavioral Health Fund.

## Optional: Documentation of Income and Household Size

You are not required to provide documentation of your household members or household income as part of this application. If your application is approved, you may be required to provide documents to verify the information you provided on this application.

**Program Integrity Notice:** Every 10th approved BHF request is selected for a program integrity audit. If your application is selected, you will be required to submit documentation verifying your household income and household size. Submitting documentation voluntarily now may help avoid delays if your case is selected.

If you would like to voluntarily include documentation now, you may complete the household member information below and attach income documentation to this form when you submit. Acceptable documents include pay stubs, benefit letters, or a signed statement that your household has no income.

If you choose to provide household member information, list each member below. Attach an additional sheet if you have more than 5 household members.

### Household Member 1 — You (the applicant) ☐ Currently Pregnant

You are Household Member 1. Your personal information was already collected earlier in this form — you do not need to list yourself again here.

### Household Member 2 ☐ Currently Pregnant

| LAST NAME | FIRST NAME | MIDDLE INITIAL |
|---|---|---|
| DATE OF BIRTH MM/DD/YYYY | SOCIAL SECURITY NUMBER ###-##-#### | |

### Household Member 3 ☐ Currently Pregnant

| LAST NAME | FIRST NAME | MIDDLE INITIAL |
|---|---|---|
| DATE OF BIRTH MM/DD/YYYY | SOCIAL SECURITY NUMBER ###-##-#### | |

### Household Member 4 ☐ Currently Pregnant

| LAST NAME | FIRST NAME | MIDDLE INITIAL |
|---|---|---|
| DATE OF BIRTH MM/DD/YYYY | SOCIAL SECURITY NUMBER ###-##-#### | |

**Household Member 5** ☐ Currently Pregnant

| LAST NAME | FIRST NAME | MIDDLE INITIAL |
|---|---|---|
| | | |
| DATE OF BIRTH MM/DD/YYYY | SOCIAL SECURITY NUMBER ###-##-#### | |
| | | |

If you have more than five (5) household members, attach a separate sheet with additional household members.

## Section 8 - Health Insurance

BHF pays for treatment when other insurance does not. We need to know about any health insurance you currently have so we can coordinate benefits correctly. If you have insurance cards, please include copies with this application.

**Do you currently have any kind of health insurance? ***

◯ Yes

◯ No

If No, skip to Section 9 - Prior BHF History.

**What type of health insurance do you have? (Check all that apply)**

☐ Employer group health insurance (through my job or a family member's job)

☐ Medicare

☐ Minnesota Health Care Program (Medical Assistance / MA, MinnesotaCare, Prepaid Medical Assistance Program / PMAP)

☐ Medicaid from a state other than Minnesota

☐ Unknown

☐ Other, describe here: _____

### Policy Holder Information

The policy holder is the person whose name is on the insurance plan (may be you or a family member).

| POLICY HOLDER'S FULL NAME |
|---|
| |

**Relationship of policy holder to you:**

◯ Self (I am the policy holder)

◯ Spouse

◯ Parent

◯ Child

◯ Other

| POLICY HOLDER'S ADDRESS | | | |
|---|---|---|---|
| | | | |
| CITY | STATE | ZIP CODE | COUNTY (IF MINNESOTA) |
| | | | |

### Employer Group Insurance Details (complete if applicable)

| NAME OF EMPLOYER THAT PROVIDES THE INSURANCE | | | |
|---|---|---|---|
| | | | |
| EMPLOYER'S ADDRESS | | | |
| | | | |
| CITY | STATE | ZIP CODE | COUNTY (IF MINNESOTA) |
| | | | |

| HEALTH INSURANCE COMPANY NAME | | |
|---|---|---|
| POLICY / CERTIFICATE NUMBER | GROUP NAME OR NUMBER | PRE-CERTIFICATION NUMBER (IF APPLICABLE) |

### Medicare (complete if applicable)

| MEDICARE CLAIM NUMBER |
|---|

### Minnesota Health Care Program (complete if applicable)

| MEMBER ID NUMBER / PMI NUMBER | |
|---|---|
| GROUP NUMBER (IF APPLICABLE) | MANAGED CARE ORGANIZATION (IF APPLICABLE) |

### Out-of-State Medicaid (complete if applicable)

| STATE YOUR MEDICAID PLAN IS FROM | MEDICAID POLICY / MEMBER NUMBER |
|---|---|

### Other / Secondary Insurance (complete if applicable)

| HEALTH INSURANCE COMPANY NAME | |
|---|---|
| POLICY / CERTIFICATE NUMBER | GROUP NAME OR NUMBER |

## Section 9 - Prior BHF History

**Have you previously applied for the Behavioral Health Fund (BHF) to pay for substance use disorder (SUD) treatment?** *

◯ Yes
◯ No
◯ Unknown

**If yes — were you approved for BHF funding in the past?**

◯ Yes
◯ No
◯ Unknown

**If yes — were you approved for BHF funding within the last 12 months?**

◯ Yes
◯ No

**If yes — in the last 12 months, have any of the following applied to you? (Check all that apply)**

☐ I submitted a completed application for Minnesota Health Care Programs (Medical Assistance, MnSure, etc.)
☐ My application for Minnesota Health Care Programs was denied.
☐ I was incarcerated in a county, state, or federal jail or prison.
☐ I experienced a systemic barrier to accessing alternative funding for SUD treatment.
☐ I experienced barriers to participating in SUD treatment during a previously funded period.
☐ None of the above apply to me.

## Section 10 - Treatment Start Date and Eligibility Criteria

**Are you requesting BHF funding to cover Substance Use Disorder services that have already occurred (before today's date)? This includes a Comprehensive Assessment for Substance Use Disorder.** *

◯ Yes

◯ No

WHAT IS THE FIRST DATE OF SUD SERVICES YOU WANT BHF TO COVER? *

MM/DD/YYYY — This is the date of the first service or assessment.

**Select all statements that apply to you: (Check all that apply)** *

☐ I am a pregnant person.

☐ I am within 12 months of my most recent pregnancy.

☐ I am between 2 and 18 years of age.

☐ I am a parent or relative caretaker of a child under age 19.

☐ I am between 19 and 20 years of age.

☐ I am over the age of 20.

☐ I receive Supplemental Security Income (SSI).

☐ I am certified as disabled by the Social Security Administration and/or the Minnesota State Medical Review Team (SMRT).

## Section 11 - Acknowledgements and Legal Notices

Please read each statement below carefully and check the box to acknowledge that you have read and understood it.

☐ I understand that providing true and accurate information as part of this request for the Behavioral Health Fund is expected. I understand that if the information provided is false or incomplete, I may be responsible for the total cost of treatment provided. *

☐ I understand that by submitting this application, the information contained in this application — as well as the eligibility determination — will be shared with the Minnesota County Human Services agency or tribal agency identified as financially responsible. *

### Privacy of Alcohol and Drug Abuse Records

State laws and federal rules protect your placement and treatment records. The federal rule is Title 42, Part 2 of the Code of Federal Regulations. The state laws are Minnesota Statutes, Chapter 13 and Section 254A.09. The agency must not identify you to others without your written consent. You do not have to answer the questions on this form; however, the state will not pay for your treatment unless you answer the questions. Your records are private — only agency employees working on your case and DHS workers have access. Records may be released outside the agency only with your consent or under specific legal conditions (court order, medical emergency, child abuse report, or agency administrative need). Breaking the federal privacy rule is a crime. You have the right to see and copy your record.

☐ **I acknowledge that I have read and understood the Privacy of Alcohol and Drug Abuse Records statement.** *

## Section 12 - Signature

By signing below, you certify that all information provided in this application is true and accurate to the best of your knowledge. You authorize access to medical information needed to determine your health care benefits. You authorize payment of any third-party benefits directly to the Department of Human Services. This authorization expires one year from the date services were rendered. You may revoke this authorization at any time, except to the extent that actions have already been taken — if revoked, you may be responsible for the total cost of treatment.

**Applicant Signature** *

### Option 1 — Electronic signature

By typing my name below, I agree that I am electronically signing this form. I attest and certify that the information provided is true and accurate. I understand that my electronic signature has the same legal effect and can be enforced in the same way as a handwritten signature (Minn. Stat. Ch. 325L.07).

| TYPE FULL LEGAL NAME | DATE |
|---|---|
| | |

### Option 2 — Handwritten signature

(For printed forms — sign above the line below)

Signature Date

**Financially Responsible Person Signature (if applicable)**

### Option 1 — Electronic signature

By typing my name below, I agree that I am electronically signing this form. I attest and certify that the information provided is true and accurate. I understand that my electronic signature has the same legal effect and can be enforced in the same way as a handwritten signature (Minn. Stat. Ch. 325L.07).

| TYPE FULL LEGAL NAME | DATE |
|---|---|
| | |

### Option 2 — Handwritten signature

(For printed forms — sign above the line below)

Signature Date

# Your Civil Rights

Discrimination is against the law. The Minnesota Department of Human Services (DHS) does not discriminate on the basis of any of the following: race, color, national origin, creed, religion, public assistance status, marital status, age, disability, sex (including sexual orientation and gender identity) or political beliefs.

## Free Services

### Auxiliary aids

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

### Language assistance

If you have difficulty understanding English and need language help to access information and services, DHS will provide language assistance services timely and free of charge. These services include translated documents and interpreting spoken language.

**To request these free services from DHS,** call DHS Health Care Consumer Support at 651-297-3862 or 800-657-3672. Or use your preferred relay service.

## Civil Rights Complaints

You have the right to file a discrimination complaint if you believe you were treated in a discriminatory way by a human services agency.

You may contact any of the following three agencies directly to file a discrimination complaint.

### U.S. Department of Health and Human Services' Office for Civil Rights (OCR)

You have a right to file a complaint with the OCR, a federal agency, if you believe you have been discriminated against because of any of the following: race, color, national origin, age, disability, or sex (including sexual orientation and gender identity).

Contact the **OCR** directly to file a complaint:

Centralized Case Management Operations
U.S. Department of Health and Human Services
200 Independence Avenue SW
Room 509F, HHH Building
Washington, DC 20201
800-368-1019 (voice), 800-537-7697 (TDD)
202-619-3818 (fax)
OCRComplaint@hhs.gov (email)
https://ocrportal.hhs.gov/

## Minnesota Department of Human Rights (MDHR)

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

Contact the **MDHR** directly to file a complaint:

Minnesota Department of Human Rights
540 Fairview Avenue North, Suite 201
St. Paul, MN 55104
651-539-1100 (voice) or 800-657-3704 (toll free)
711 or 800-627-3529 (MN Relay)
651-296-9042 (fax)
Info.MDHR@state.mn.us (email)
https://mn.gov/mdhr/intake/consultationinquiryform/

## DHS

You have a right to file a complaint with DHS if you believe you have been discriminated against in our health care programs because of any of the following: race, color, national origin, creed, religion, public assistance status, marital status, age, disability, sex (including sexual orientation and gender identity), or political beliefs.

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

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

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

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

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

**NO ENGLISH**  **651-431-4945** **TRS: 711**

ATTENTION: If you speak English, free language assistance services are available to you free of charge and without unnecessary delay. Additionally, appropriate auxiliary aids and services to provide information in accessible formats are available free of charge and in a timely manner. Please call the number above or speak to your provider. English

ማሳሰቢያ፦ አማርኛ ተናጋሪ ከሆኑ ፤ ነጻ የቋንቋ ድጋፍ አገልግሎቶች ካለምንም ክፍያ እና ካለአላስፈላጊ መዘግየት ማግኘት ይችላሉ። በተጨማሪም መረጃን በቀላሉ ለማግኘት በሚያስችል ቅርጸት ለማቅረብ ተገቢ የሆኑ የመስማት ድጋፍ እና አገልግሎቶች ከክፍያ ነጻ በሆነ እና ግዜውን በጠበቀ መልኩ ማግኘት ይችላሉ። እባክዎ ከላይ ባለው ቁጥር ይደውሉ ወይም አቅራቢዎን ያነጋግሩ። Amharic

**تنبيه:** نقدم لمتحدثي اللغة العربية خدمات مساعدة لغوية مجانية وفورية، بالإضافة إلى وسائل وخدمات مساعدة مناسبة، وبصيغة معلومات سهلة بدون تكلفة وبشكل سريع. يرجى التواصل على الرقم الموضح أعلاه أو مراجعة مقدم الخدمة المباشرة. Arabic

মনোযোগ: আপনি যদি বাংলায় কথা বলেন, তাহলে আপনার জন্য ভাষা সহায়তা পরিষেবা বিনামূল্যে এবং অপর্যোজনীয় বিলম্ব ছাড়াই পাওয়া যায়। এছাড়াও, একটি সহজলভ্য ফমর্যাটে তথ্য পর্দানের জন্য উপযুক্ত সহায়ক সরঞ্জাম এবং পরিষেবা বিনামূল্যে এবং সময়োপযোগীভাবে পাওয়া যায়। উপরের নমব্রে কল করুন অথবা আপনার পের্াভাইডারের সাথে কথা বলুন। Bengali

သတိပြုရန် – အကယ်၍ သင်သည် မြန်မာဘာသာစကား ပြောဆိုသူဖြစ်လျှင် အခမဲ့ ဘာသာစကားဆိုင်ရာ ပံ့ပိုးထောက်ပံ့ပေးမှု ဝန်ဆောင်မှုများအား မလိုအပ်သည့် နှောင့်နှေးကြန့်ကြာမှုများ မရှိစေဘဲ သင် အခမဲ့ ရရှိနိုင်မည် ဖြစ်သည်။ ထို့ပြင် အချက်အလက်များအား အလွယ်တကူ ဝင်ရောက်ရယူနိုင်စေသော ဖောမတ်ပုံစံများဖြင့် ထောက်ပံ့ပေးထားသည့် သက်ဆိုင်ရာ ဖြည့်စွက် ထောက်ပံ့မှုများနှင့် ဝန်ဆောင်မှုများကိုလည်း အခမဲ့၊ အချိန်မီ ရရှိနိုင်စေရန် စီမံပေးထားပါသည်။ ကျေးဇူးပြုပြီး အထက်ဖော်ပြပါ ဖုန်းနံပါတ်သို့ ခေါ်ဆိုပါ သို့မဟုတ် သင်၏ ထောက်ပံ့သူဖြင့် ပြောဆိုဆွေးနွေးပါ။ မြန်မာဘာသာစကား Burmese

យកចិត្តទុកដាក់៖ ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ (ខ្មែរ)
សេវាកម្មជំនួយភាសាឥតគិតថ្លៃមានផ្តល់ជូនអ្នកដោយមិនគិតថ្លៃ និងដោយគ្មានការពន្យារពេលមិនចាំបាច់ឡើយ។
លើសពីនេះ ជំនួយ និងសេវាកម្មដែលសមស្របក្នុងការផ្តល់ព័ត៌មានក្នុងទម្រង់ដែលអាចចូលប្រើ
បានគឺអាចរកបានដោយឥតគិតថ្លៃ និងទាន់ពេលវេលា។ សូមហៅទូរសព្ទទៅលេខខាងលើ
ឬនិយាយជាមួយអ្នកផ្តល់សេវារបស់អ្នក។ ភាសាខ្មែរ (ខ្មែរ) Cambodian (Khmer)

注意：如果您說簡體中文，您可以免費獲得語言協助服務，且不會有不必要的延誤。此外，還能免費及時獲取以無障礙格式提供資訊的適當輔助工具和服務。請撥打上面的電話號碼，或與您的服務提供商溝通。
Cantonese (Traditional Chinese)

Á, DÉ YAWÁ PO! Dakhód'iyaye héčiŋhaŋ, iyápi-wóokiye išíčhona yaŋké. Ka nakúŋ wanáȟ'uŋpi-wóokiye išíčhona yaŋké. Héčhed wónaȟ'uŋ kiŋ iyóhiphiča dó. Wóokiye kiŋ dená išíčhona ičúphiča naháŋ yuthéhaŋšniyaŋ ičúphiča dó. Wičhóiye kiŋ dená iwáŋkab, wóiyawa waŋ yaŋké kiŋ mas'ákiphapi na wóokiye-wičháša kičhí wóhdaka po. Dakota

PAUNAWA: Kung nagsasalita ka ng Filipino, ang mga libreng serbisyo ng tulong sa wika ay magagamit sa iyo nang walang bayad at walang hindi kinakailangang pagkaantala. may mga angkop na pantulong na kagamitan at serbisyo upang maibigay ang impormasyon sa naaangkop na anyo, nang libre at sa tamang oras. Mangyaring tawagan ang numero sa itaas o makipag-usap sa iyong provider. Filipino

ATTENTION: Si vous parlez français, des services d'assistance linguistique gratuits sont à votre disposition, sans frais et sans délai. En outre, des aides et services auxiliaires appropriés pouvant fournir des informations dans des formats accessibles sont disponibles gratuitement et rapidement. Veuillez appeler le numéro ci-dessus ou contacter votre fournisseur. French

સાવધાન: જો તમે ગુજરાતી બોલો છો, તો ભાષા સહાયની મફત સેવાઓ તમારા માટે નિ:શુલ્ક અને બિનજરૂરી વિલંબ વગર ઉપલબ્ધ છે. વધુમાં, સુલભ પ્રારૂપમાં માહિતી પ્રદાન કરવા માટે યોગ્ય સહાયક મદદ અને સેવાઓ નિ:શુલ્ક અને સમયસર ઉપલબ્ધ છે. કૃપા કરીને ઉપરના નંબર પર કૉલ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો. Gujarati

**NO ENGLISH** ☎ **651-431-4945** **TRS: 711**

ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निशुल्क भाषा सहायता सेवाएँ निशुल्क और बिना किसी अनावश्यक देरी के उपलब्ध हैं। इसके अतिरिक्त, सुलभ पर्यारूपों में जानकारी पर्दान करने के लिए उपयुक्त सहायक साधन और सेवाएँ निशुल्क और समय पर उपलब्ध हैं। कृपया ऊपर दिए गए नंबर पर कॉल करें या अपने पर्दाता से बात करें। Hindi

CEEB TOOM: Yog koj hais lus Hmoob, muaj kev pab txhais lus dawb rau koj siv. Koj tsis tas them nqi thiab yuav tsis qeeb. Kuj muaj cuab yeej thiab kev pab los pab koj nyeem cov ntaub ntawv kom yooj yim nkag siab. Koj hu tau rau tus xov tooj saum toj no lossis nrog koj tus kws kho mob tham. Hmong

ဟ်သူဉ်ဟ်သး– နမ့်ကတိၤကညီကျိာ်အဃိ, နမၤနှ်၊ ကျိာ်တ၊်ဆိဉ်ထွဲမၤစၢၤ လၢတလာ်ဘူဉ်လာ်စ့ၤ ဒီးတအိဉ်ဒီး တ၊်မၤယံာ်မၤနီ၊်သးဘဉ်နှဉ်လီၤ. အါနှ်၊အနှဉ်, တ၊်အိဉ်စ့၊်ကီးဒီး တ၊်မၤစၢၤတ၊်နှ၊်ဟူဒီး တ၊်မၤစၢၤတ၊်မၤတဖဉ် လၢကဟ့ဉ်တ၊်ဂ့၊်တ၊်ကျိၤ လၢပှၤအါဂၤန၊်ပ၊်အီၤသ့ လၢတအိဉ်ဒီးအဘူးအလဲ ဒီးချူးဆၢချူးကတြီ၊်နှဉ်လီၤ. ဝံသးစူၤ ကိးနိဉ်ဂံ၊်လၢထး မ့တမ့၊် တဲသကိးတ၊်ဒီး ပှၤလၢအဟ့ဉ်နၤတ၊်မၤစၢၤ တက့၊်. ကညီကျိာ် Karen

안내: 한국어를 사용하시는 분께는 언어 지원 서비스를 무료로, 지체 없이 제공해 드립니다. 또한, 정보 접근성을 위한 적절한 보조 기구 및 서비스가 무료로, 시의적절하게 제공됩니다. 위에 있는 번호로 전화하시거나 담당자에게 말씀해 주십시오. Korean

ئاگاداری: ئەگەر تۆ بە زمانی کو ﻭﻳ ﻳﺴﻮارنی قسە دەکەیت، ئەوا خزمەتگوزاری هاوکاریی زمان بە بێبەرامبەر و بەبێ دواکەوتنی ناپێویست لەبەردەستتدایە. جگە لەوەش، هاوکاری و خزمەتگوزارییە یارمەتیدەرە گونجاوەکان بۆ دابینکردنی زانیاری بە شێوەی گونجاو بەبێ بەرامبەر و هاوکات بەردەستن. تکایە پەیوەندی بەو ژمارەیە ﻳﺴﻮه بکە یان لەگەڵ دابینکەرەکەتدا قسە بکەن.
Kurdish Sorani کوردی سۆرانی

BALDARÎ: Heke hûn bi Kurdîya Kurmancî diaxivin, xizmetên alîkarîya ziman bêpere û bêyî derengmayîneke nehewce ji we re peyda dibin. Her wiha, hevkariyên guncaw û karûbarên alîkar bêpere û di heman demê de ji bo dabînkirina agahdariya guncaw hene. Ji kerema xwe bi jimareya jorîn re telefon bikin an jî bi dabînkerê xwe re biaxivin. Kurdish Kurmanji

Á, LÉ YAWÁ PO! Lakȟól'iyaye héči, iyápi-wóokiye išíčhola yaŋké. Naháŋ nakúŋ wanáȟ'uŋpi-wóokiye išíčhola yaŋké. Héčhel wónaȟ'uŋ kiŋ iyóhiphiča yeló. Wóokiye kiŋ lená išíčhola ičúphiča naháŋ yutȟéhaŋšniyaŋ ičúphiča yeló. Wičhóiye kiŋ lená iwáŋkab, wóiyawa waŋ yaŋké kiŋ mas'ákipȟapi na wóokiye-wičháša kičhí wóglaka po. Lakota

ໝາຍເຫດ: ຖ້າທ່ານເວົ້າພາສາລາວ, ທ່ານຈະໄດ້ຮັບບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໂດຍບໍ່ເສຍຄ່າ ແລະ ບໍ່ມີການຊັກຊ້າ ທີ່ບໍ່ຈຳເປັນ. ນອກຈາກນັ້ນ, ເຄື່ອງມືຊ່ວຍເຫຼືອແລະ ບໍລິການເສີມທີ່ເໝາະສົມເພື່ອໃຫ້ຂໍ້ມູນໃນຮູບແບບທີ່ເຂົ້າເຖິງໄດ້ ໂດຍບໍ່ເສຍຄ່າໃຊ້ຈ່າຍ ແລະ ທັນເວລາ. ກະລຸນາໂທຫາເບີໂທລະສັບຂ້າງເທິງ ຫຼື ສົນທະນາກັບຜູ້ໃຫ້ບໍລິການຂອງທ່ານ. Lao

注意：如果您说简体中文，您可以免费获得语言协助服务，且不会有不必要的延误。此外，还能免费及时获取以无障碍格式提供信息的适当辅助工具和服务。请拨打上面的电话号码，或与您的服务提供商沟通。
Mandarin (Simplified Chinese)

PALƐ RƆ PINY: Mi ruaci kɛ thok Nuärä, luäk mi lɔr kɛ kuic thuok kɛnɛ lät tin jiëkɛ tëë thin baaŋ a thiɛl mi yuɔr kɛ piny kä thiɛlɛ mi gaal jɛ. Min dëë nyɔk kɛ mat thin, ɛ luäk mi dɔdiɛn kɛnɛ lät tin kɔkiɛn tin nöön kɛ läri kɛ duɔp min jiëkɛ kɛɛ tëë kɛ thin baaŋ thilɛ mi yuɔrkɛ piny kɛ kuicdiɛn kɛ guath mi gɔa. Mi nhɔk i jɛ yɔtni nämbär ɛmɔ tëë nhial ɔ ikä kiɛ ruacni kɛ ram min luäkdu. Nuer

MAH BIZ'SIN'DAN: Keesh'pin, keen Ojibwe'mo, kaa'ween ina'gin'de wiiji'kaa'kii'ki'do miina'waa ke'nebe-naa'ta'maw chi'nis'too'ta'man noon'goom. Da'kon'an, wee'chi'ma'zinaa'beke'webene'kan'an ozhe'che'kan miina'waa kinah ozhee'bee'geh ma'zenah'egan'an kaa'ween ina'gin'de miina'waa da'daa'ta'be'bee'an. Da'gah'na'sa ka'noozh aseh'ge'beh'egan ish'peh'meng ge'maa kee'kidoon wii'doo'kaa'geh. Ojibwe

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HUBADHAA: Yoo Afaan Oromoo dubbattu ta'e, tajaajila gargaarsa turjumaana afaanii biliisaan akkasumas turtii barbaachisaa hin taane hambisu danda'u isiniif dhihaatee jira. Dabalataanis, odeeffannoo haala salphaan argamuu danda'an dhiyeessuuf gargaarsa fi tajaajiloota deeggarsaa qama midhamtootaaf mijatoo ta'an, kaffaltii tokko malee fi yeroo isaa eeggatee kennamu dhihaatee jira. Odeeffanno dabalataaf lakkoofsa armaan oliitti fayyadamuun namoota gargaarsa kana isiniif kennan qunnamaa. Oromo

ATENÇÃO: Se fala português, tem à sua disposição serviços de assistência linguística gratuitos e sem demoras desnecessárias. Além disso, estão disponíveis, gratuitamente e numa forma atempada, ajudas e serviços auxiliares adequados para fornecer informações em formatos acessíveis. Por favor, contacte o número acima ou fale com o seu prestador de serviços. Portuguese

ВНИМАНИЕ: Если вы разговариваете на русском языке, воспользуйтесь услугами языковой поддержки бесплатно и без лишних проволочек. Также бесплатно и незамедлительно предоставляются соответствующие вспомогательные средства и услуги по обеспечению информацией в доступных форматах. Позвоните по указанному выше номеру или обратитесь к своему поставщику услуг. Russian

PAŽNJA: Ako govorite srpski, besplatne usluge jezičke pomoći su vam dostupne besplatno i bez nepotrebnog odlaganja. Pored toga, odgovarajuća pomoćna sredstva i usluge za pružanje informacija u pristupačnim formatima dostupne su besplatno i blagovremeno. Molimo vas da pozovete gore navedeni broj ili razgovarate sa vašim pružateljem usluga. Serbian

FIIRO GAAR AH: Haddii aad ku hadasho Soomaali, waxaa si bilaash ah kuugu diyaar ah adeegyada caawinada luuqadeed oo aan lahayn daahitaan aan munaasib ahayn. Intaas waxaa dheer, waxaa la heli karaa adeegyada iyo kaabitaanka naafada ee haboon si macluumaadka loogu bixiyo qaabab la adeegsan karo oo bilaash ah laguna bixinayo waqqigeeda. Fadlan wac lambarka kore ama la hadal adeegbixiyahaaga. Somali

ATENCIÓN: si habla español, tiene a su disposición los servicios gratuitos de traducción sin costo alguno y sin demoras innecesarias. Además, se encuentran disponibles de forma gratuita y oportuna ayuda y servicios auxiliares adecuados con el fin de brindarle información en formatos accesibles. Llame al número indicado anteriormente o hable con su proveedor. Spanish

ZINGATIO: Ikiwa unazungumza Kiswahili, huduma za msaada wa lugha zinapatikana kwa ajili yako bila malipo na bila ucheleweshaji usio wa lazima. Aidha, vifaa saidizi vya mawasiliano na huduma kwa walemavu ili kutoa habari katika miundo inayofikika zinapatikana bila malipo na kwa wakati. Tafadhali piga simu kwa namba ya hapo juu au zungumza na mtoa huduma wako. Swahili

መተሓሳሰቢ:- ትግርኛ ተዛራቢ እንትኾይኖም ፤ ናጻ ናይ ቋንቋ ሓገዝ ግልጋሎታት ብዘይምድንጓይ ምርካብ ይኽእሉ እየም። ብተወሳኺ ሓበሬታ ብቐሊሉ ምርካብ ብዝከኣል ቅርጽታት ንምቐራብ ፤ ግቡእ ናይ ምስማዕ ሓገዝን ግልጋሎታትን ካብ ክፍሊት ናጻ ብዝኾነን ግዚኡ ብዝሓለወን መልክዑ ይርከቡ። በይዝኣም ኣብ ላዕሊ ናብ ዘሎ ቑጽሪ ይደውሉ ወይድማ መቐረቢኣም የዘራርቡ። Tigrinya

УВАГА: Якщо ви розмовляєте українською мовою, ви можете скористатися послугами мовної підтримки безкоштовно та без зайвих зволікань. Ви також можете безкоштовно та оперативно отримати відповідні допоміжні засоби та послуги з надання інформації у доступному форматі. Зателефонуйте за вказаним вище номером або поговоріть зі своїм постачальником послуг. Ukrainian

LƯU Ý: Nếu bạn nói tiếng Việt, bạn có thể được hỗ trợ ngôn ngữ miễn phí mà không phải chờ đợi lâu. Ngoài ra, các thiết bị hỗ trợ và dịch vụ phù hợp để cung cấp thông tin ở định dạng dễ tiếp cận cũng có sẵn miễn phí và kịp thời. Vui lòng gọi số điện thoại phía trên hoặc trao đổi với nhân viên y tế của bạn. Vietnamese

ÌKÉDE PÀTÀKÌ: Tí o bá leè sọ èdè Yorùbá, àwọn ètò ìrànlówọ́ èdè wà fún ọ ní ọ̀fẹ́ tí kò sì ní ìdènà nínú. Ní àfikún, àwọn ìlànà isẹ́ àti ohun èlò ìrànlówọ́ tó pé ye wá ní ẹ̀kúnrẹ́rẹ́ láti pèsè àlàyé èyíkéyìí tí o bá nílò ní ọ̀fẹ́ àti ní òrèkóòrè. Jọ̀wọ́, pe ẹ̀rọ Ìbánisọ̀rọ̀ tó wà lókè tàbí kí o bá aṣojú rẹ sọ̀rọ̀. Yoruba

LB (7-25)

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