

m MINNESOTA

Combined Application Form

Apply online at
<https://mnbenefits.mn.gov>

This application can be used to apply for any of the following programs:

Supplemental Nutrition Assistance Program (SNAP)

SNAP helps low income Minnesotans get the food they need for good nutrition and well-balanced meals. If you are age 60 and older and are applying for SNAP only, please use the "Supplemental Nutrition Assistance Program (SNAP) Application for Seniors" (DHS-5223F).

Cash assistance programs

Cash assistance programs are provided to help families and individuals meet their basic needs until they can support themselves. Cash assistance programs include:

- Emergency Assistance (EA)*
- General Assistance (GA)
- Housing Support (HSP)
- Minnesota Family Investment Program (MFIP)
- Minnesota Supplemental Aid (MSA)
- Refugee Cash Assistance (RCA).

Need help paying for child care?

If you need help paying for child care, ask your worker how to apply for the Child Care Assistance Program.

Need to apply for Health Care coverage?

Apply for free or low-cost coverage at MNsure, Minnesota's online health insurance marketplace. Go to www.mnsure.org or call 855-366-7873.

Did You Know?

If you are approved for SNAP or MFIP, children in your household between the ages of 7-17, will be automatically enrolled in the SUN Bucks program. For more information visit <https://dcyf.mn.gov/sun-bucks>.

How to fill out this application

Read all of the information in this application. Contact your county or Tribal Nation if you need help filling out this application. Complete and turn in pages 1–12 as soon as possible to your agency. We can set your application date if we have your name, address and signature (page 1), but we must have the complete application to determine if you can get benefits.

For your application to be complete, you must answer all questions and have certain information verified. SNAP and cash programs require an interview with a worker. This can be a phone or in-person interview.

To answer the marital status and race questions, please refer to page 2 of this application.

Attached to this application is information that will be discussed and reviewed with you during the interview. Review these pages prior to the interview and let your worker know if you have questions about these forms.

If you miss your interview appointment, you must reschedule. If you do not reschedule, we may stop or not approve your benefits.

You may need to provide proof of the information you report on this application. Your worker may ask for additional proof. You may not get help until we get proof of this information. Bring the required information with you to the interview or send the information to your worker as soon as you can.

Most programs require that you must report changes immediately while your application is pending.

Submit your completed application to your county or Tribal Nation agency where you reside.

Recertifications

You may use this form to recertify eligibility. Report all changes in the past 12 months on this application. You may need to provide proof of the reported information.

Important Information

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.

Denial or changes

The state may deny or change your cash or SNAP assistance because of information you give on the application. The state may make changes without giving you 10 days advance notice for cash assistance and SNAP. The state will send you written notice no later than the effective date of the change for cash assistance and no later than the date you receive or would receive your SNAP benefits.

Interim Assistance Programs

General Assistance (GA) and Housing Support (HSP) can help you while you apply for other benefits, like Supplemental Security Income (SSI), Social Security or Worker's Compensation.

If you get those other benefits for the same time you receive GA or HSP, you need to pay that money back.

Social Security numbers (SSN)

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

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

If you are not a U.S. citizen and are applying for Refugee Cash Assistance you do not have to provide an SSN.

Non-Citizen Applicants

To get help from most public assistance programs, you must be in the United States (U.S.) with permission from a federal immigration agency. Members of your household who are non-citizens, and those who are naturalized or derived U.S. citizens, and are applying for help must show proof of their immigration status by presenting immigration documents. You can apply and get help for other household members, even if you are not applying or if you are not eligible because of immigration status.

For non-citizen members of your household who apply and are eligible for help, your worker is required to verify the immigration documents submitted with a federal immigration agency to make sure the documents you give us are valid. You do not have to give us your immigration information if you are:

- Only helping someone else apply
- Applying for your children or other household members, but not yourself.

When you sign this application, you give us permission to contact federal immigration agencies to verify the immigration documents submitted. If you do not sign this form, you are not eligible to receive public benefits. If you have concerns about sharing information required on this application or how receipt of benefits may impact your immigration status, talk to an immigration attorney for advice on your situation before applying.

Domestic violence and vulnerable adults

Violence or abuse is what someone says or does to make you feel afraid or to control you. People who are elderly, frail, have a disability, or who depend on others for assistance may not be able to protect themselves from domestic violence or abuse. Minnesota has a law to protect and assist adults who are vulnerable to abuse or who are not able to care for themselves. The law can help vulnerable adults get the protection and safety that they need.

Domestic violence

For more information on domestic violence, read the "Domestic Violence Information brochure" (DHS-3477). If domestic violence makes it hard for you to follow program rules, talk to your worker. If you are in danger from domestic violence and need help, call the National Domestic Violence hotline at 1-800-799-7233; 1-800-787-3224 (TTY) or Minnesota Coalition for Battered Women at 1-866-223-1111.

Vulnerable adults

To report suspected maltreatment of a vulnerable adult call the Minnesota Adult Abuse Reporting Center at 1-844-880-1574.

* The collection of this information, including the social security number (SSN) of each household member, is authorized under the Food Stamp Act of 1977, as amended, 7 U.S.C. 2011-2036. The information will be used to determine whether your household is eligible or continues to be eligible to participate in the Food Stamp Program. We will verify this information through computer matching programs. This information will also be used to monitor compliance with program regulations and for program management. This information may be disclosed to other Federal and State agencies for official examination, and to law enforcement officials for the purpose of apprehending persons fleeing to avoid the law. If a food stamp claim arises against your household, the information on this application, including all SSNs, may be referred to Federal and State agencies, as well as private claims collection agencies, for claims collection action. Providing the requested information, including the SSN of each household member, is voluntary. However, failure to provide an SSN will result in the denial of food stamp benefits to each individual failing to provide an SSN. Any SSNs provided will be used and disclosed in the same manner as SSNs of eligible household members.



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 परारूपों में जानकारी परदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ निशुल्क और समय पर उपलब्ध हैं। कृपया ऊपर दिए गए नंबर पर कॉल करें या अपने परदाता 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

ဟ်သုဉ်ဟ်သး- နမ့ၢ်ကတိၤကညိၣ်ကိၣ်အဟိ, နမ့ၢ်န့ၢ် ကိၣ်တၢ်ဆိၣ်ထွဲမၤစၢၤ လၢတလၢ်ဘျုးလၢ်စ့ၤ ဒီးတအိၣ်ဒီး တၢ်မၤယံၢ်မၤနီၣ်သးဘၣ်န့ၣ်လီၤ. အါန့ၢ်အန့ၣ်, တၢ်အိၣ်စ့ၢ်ကိးဒီး တၢ်မၤစၢၤတၢ်န့ၢ်ဟ့ၣ်ဒီး တၢ်မၤစၢၤတၢ်မၤတဖၣ် လၢကဟ့ၣ်တၢ်ဂ့ၢ်တၢ်ကိၣ် လၢပုၤအါဂၢၢ်ဟ်အီၤသ့ လၢတအိၣ်ဒီးအဘူးအလဲ ဒီးချူးဆါချူးကတိၢ်န့ၣ်လီၤ. ဝံသးစ့ၤ ကိးနီၣ်ဂံၢ်လၢထး မ့တမ့ၢ် တဲသကိးတၢ်ဒီး ပုၤလၢအဟ့ၣ်န့ၢ်တၢ်မၤစၢၤ တက့ၢ်. ကညိၣ်ကိၣ် 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

ناگاداری: ئەگەر تۆ بە زمانی کو ئید سۆزانی قسه دهکەیت، ئەوا خزمەتگوزاری هاوکاری زمان بە بێبهرامبەر و بەبێ دواکهوتنی ناپیویست لهبهر دهستندایه جگه لهو ههش، هاوکاری و خزمەتگوزارییه پارمهتیده هه گونجاو مکان بو دابینهکردنی زانیاری به شیوهی گونجاو بهبێ بهرامبەر و هاوکات بهر دهستن. تکایه پهیوهندی بهو ژمارهیه ههسه مهوه بکه یان لهگهڵ دابینهکەر ههتندا قسه بکهن. Kurdish Sorani

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

Á, LÉ YAWÁ PO! Lakhól'iyaye héçi, iyápi-wóokiye išíçhola yanké. Nahán nakún wanáñ'unpi-wóokiye išíçhola yanké. Héçhel wónañ'unj kin iyóhiphiča yeló. Wóokiye kin lená išíçhola ičúphiča nahán yut'héhanšniyan ičúphiča yeló. Wičhóiyé kin lená iwánkab, wóiyawa wan yanké kin mas'ákip'hapi na wóokiye-wiçháša kíchí wóglaka po. Lakota

ໝາຍເຫດ: ຖ້າທ່ານເວົ້າພາສາລາວ, ທ່ານຈະໄດ້ຮັບບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໂດຍບໍ່ເສຍຄ່າ ແລະ ບໍ່ມີການຊັກຊ້າ ທີ່ບໍ່ຈຳເປັນ. ບອກກາກນັ້ນ, ເຄື່ອງມືຊ່ວຍເຫຼືອແລະ ບໍລິການເສີມທົ່ວໄປເພື່ອໃຫ້ຂໍ້ມູນໃນຮູບແບບທີ່ເຂົ້າເຖິງໄດ້ ໂດຍບໍ່ເສຍຄ່າໃຊ້ຈ່າຍ ແລະ ທັນເວລາ. ກະລຸນາໃຫ້ທາດປີໂທລະສັບຂ້າງເທິງ 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)

PALE RO PINY: Mi ruaci ke thok Nuärä, luäk mi lor ke kuic thuok kene lä t in jiëke tëë thin baan a thiel mi yuor ke piny kä thiele mi gaal je. Min dëë nyok ke mat thin, e luäk mi dödien kene lä t in kökien tin nöön ke läri ke duop min jiëke keë tëë ke thin baan thile mi yuorke piny ke kuicdien ke guath mi gwa. Mi nhok i je yotni nämbär emo tëë nhial o ikä kie ruacni ke ram min luäkdu. Nuer

MAH BIZ'SIN'DAN: Keesh'pin, keen Ojibwe'mo, kaa'ween ina'gin'de wiji'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



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 waqigeeda. 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


መተሓሰስ:- ትግርኛ ተዛራቢ እገተኝይኖም ፤ ናጻ ናይ ቋንቋ ሓገዝ ግልጋሎታት ብዘይምድንጓይ ምርካብ ይኸእሉ እዮም። ብተወሳኺ ሓበሬታ ብቐሊሉ ምርካብ ብዝከኣል ቅርጽታት ንምቕራብ ፤ ግቡእ ናይ ምስግቦ ሓገዝን ግልጋሎታትን ካብ ክፍሊት ናጻ ብዝኸነን ግዚኡ ብዝተለወገ መልክዑ ይርከቡ። ቢይዝኦም ኣብ ላዕሊ ናብ ዘሎ ቐጽሪ ይደውሉ ወይደማ መቐረቢኦም የዘራርቡ። Tigriynya

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 ìrànlọ́wọ́ èdè wà fún ọ ní ọfẹ́ tí kò sì ní idènà nínú. Ní àfikún, àwọn ilàṅà isé àti ohun èlò ìrànlọ́wọ́ tó pé ye wá ní èkúnrẹ́rẹ́ láti pèsè àlàyẹ̀ èyíkẹyíí tí o bá nilò ní ọfẹ́ àti ní òrèkòdòrè. Jọwọ́, pe ẹ̀rọ̀ l̀bànisọ̀rọ̀ tó wà lóké̀ tàbí kí o bá aṣọ́jú ẹ̀ sọ̀rọ̀. Yoruba

LB (7-25)



For accessible formats of this information, ask your county worker. For assistance with additional equal access to human services, contact your county's ADA coordinator. ADA4 (2-18)

Combined Application Form

 Apply online at: <https://mnbenefits.mn.gov>
If you need help filling out this application contact your local county or Tribal Nation office. Sign and date the application on pages 1 and 12.

CASE NUMBER

PERSON 1					
APPLICANT'S LEGAL NAME – LAST		FIRST NAME		MIDDLE NAME	
OTHER NAMES YOU USE (family name, nickname, etc.)			SOCIAL SECURITY NUMBER (only if applying for help)		
DATE OF BIRTH		GENDER <input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> Rather not say		MARITAL STATUS* <input type="radio"/> N <input type="radio"/> M <input type="radio"/> S <input type="radio"/> L <input type="radio"/> D <input type="radio"/> W	
ADDRESS OF CURRENT RESIDENCE			APT. NUMBER	CITY	STATE
MAILING ADDRESS (If different from address where you live)			APT. NUMBER	CITY	STATE
Do you consider yourself homeless? <input type="radio"/> Yes <input type="radio"/> No		Do you live within the boundaries of a Tribal Nation? <input type="radio"/> No <input type="radio"/> Yes – which one? _____			
PRIMARY PHONE NUMBER	OTHER PHONE NUMBER	Is anyone in your household pregnant? <input type="radio"/> No <input type="radio"/> Yes – who? _____			
Do you need an interpreter? <input type="radio"/> Yes <input type="radio"/> No	What is your preferred spoken language?		What is your preferred written language?		
What program(s) are you applying for? <input type="checkbox"/> SNAP (food) <input type="checkbox"/> Cash programs <input type="checkbox"/> Emergency Assistance <input type="checkbox"/> None					
Are you applying for Housing Support Program (HSP) benefits? <input type="radio"/> Yes <input type="radio"/> No			HSP VENDOR NAME AND NUMBER (if known)		
Has anyone in your household ever received cash assistance, commodities or SNAP benefits before? <input type="radio"/> Yes <input type="radio"/> No If yes, Who? _____ When? _____ Where? _____ What? _____					

***Marital status** (choose one)
N = Never married **M** = Married living with spouse **S** = Separated (married, living apart) **L** = Legally separated **D** = Divorced **W** = Widowed

Do you need help with food right away? Answer questions 1-6. If you can get help right away, you will be contacted within 24 hours for an interview.

1. How much income did or will your household get **this month**? \$ _____
- 1a. Are you self-employed? Yes No
2. How much does your household (including children) have in **cash, checking or savings**? \$ _____
3. What utilities do you pay? Heat Air conditioning Electricity Phone None
4. How much does your household pay for housing costs other than utilities? \$ _____
5. Have you received energy assistance in the past year? Yes No
6. Is anyone in your household a **migrant or seasonal farm worker**? Yes No

I have looked over my answers and believe they are all true and correct to the best of my knowledge.

SIGNATURE OF APPLICANT OR AUTHORIZED REPRESENTATIVE 	DATE	AGENCY/TRIBAL NATION SIGNATURE	DATE RECEIVED
---	------	--------------------------------	---------------

What is your living situation? *(optional)*

- | | |
|---|--|
| <input type="checkbox"/> In housing that you own or rent. (Have a lease, mortgage, roommate etc.) | <input type="checkbox"/> Family/friends due to economic hardship |
| <input type="checkbox"/> Emergency shelter | <input type="checkbox"/> Service provider - foster care, group home |
| <input type="checkbox"/> Hospital, treatment facility, detox center or nursing home | <input type="checkbox"/> Jail, prison or juvenile detention facility |
| <input type="checkbox"/> Place not meant for housing (anywhere outside, a vehicle, an abandoned building, or bus/train/airport) | <input type="checkbox"/> Hotel or motel |
| | <input type="checkbox"/> Other: _____ |
| | <input type="checkbox"/> Declined to answer |

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

If yes:		PERSON'S FULL NAME	ORGANIZATION
DO YOU PAY A FEE?	IF YES, AMOUNT	HOW OFTEN?	
<input type="radio"/> Yes <input type="radio"/> No			

Attach copies of legal documents.**Information regarding texts and emails**

Minnesota invites you to get electronic communications about your benefits and resources available to you. By selecting yes, you consent to get electronic communications and agree to Minnesota terms and conditions and privacy policy. Message and data rates may apply. Message frequency varies. Terms and conditions at <https://mn.gov/dhs/text-economic-assistance>. Privacy policy at <https://edocs.dhs.state.mn.us/lfserver/Public/DHS-3979-ENG>.

Is it OK to communicate with you via text? No Yes – which number should receive texts? _____Is it OK to communicate with you via email? No Yes – email address: _____**Information regarding receiving your benefits**1. Have you had an Electronic Benefit Transfer (EBT) card in the past? Yes No2. Would you like more information on having your benefits directly deposited into your bank account, if available?
 Yes No**AGENCY USE**

1. EBT account still open in MONY/DISB? Yes No
1a. If yes, was the client referred to EBT customer service to request a new card if they no longer have the old one? Yes No
2. Direct Deposit brochure provided Yes No

PERSON 1 – Additional Information

LAST SCHOOL GRADE COMPLETED	MOST RECENTLY MOVED TO MINNESOTA (mm/dd/yyyy) Date: _____ From: _____
CITIZENSHIP <input type="radio"/> U.S. Citizen or U.S. National <input type="radio"/> Naturalized U.S. Citizen or Derived U.S. Citizen <input type="radio"/> Not a U.S. Citizen	
IMMIGRATION STATUS (only if applying for help)	U.S. Military Service (regardless of discharge status?) <input type="radio"/> Yes <input type="radio"/> No
ETHNICITY <i>(optional)</i> Hispanic? <input type="radio"/> Yes <input type="radio"/> No	RACE** <i>(optional)</i> <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> N <input type="checkbox"/> P <input type="checkbox"/> W

****Race** *(check all that apply)***A** = Asian **B** = Black or African American **N** = American Indian or Alaska Native **P** = Pacific Islander or Native Hawaiian **W** = White**NOTE:** This information will not affect eligibility or level of benefits and is to assure that program benefits are distributed without regard to race, color, or national origin.

AGENCY USE: MEMB, MEMI, TYPE, PROG, IMIG, SPON			
Eligible for expedited SNAP? <input type="radio"/> Yes <input type="radio"/> No	Same-day interview offered? <input type="radio"/> Yes <input type="radio"/> No		Declined? <input type="radio"/> Yes <input type="radio"/> No
Next-day interview offered? <input type="radio"/> Yes <input type="radio"/> No	_____ children		_____ adults
Intends to reside in MN? <input type="radio"/> Yes <input type="radio"/> No		Does person have sponsor? <input type="radio"/> Yes <input type="radio"/> No	
Verification: <input type="radio"/> requested <input type="radio"/> attached			

Additional people

List all of the people living in your home, even those temporarily living away from you, even if you are not applying for them and/or the person is not asking for assistance. Program rules require some people to get benefits together. For example, list your spouse, other adults, children, all other people and those temporarily away from your home.

PERSON 2			
LEGAL NAME - LAST	FIRST NAME	MIDDLE NAME	OTHER NAMES (maiden name, nickname, etc.)
SOCIAL SECURITY NUMBER (only if applying for help)	DATE OF BIRTH	GENDER <input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> Rather not say	RELATIONSHIP TO YOU
MARITAL STATUS* <input type="radio"/> N <input type="radio"/> M <input type="radio"/> S <input type="radio"/> L <input type="radio"/> D <input type="radio"/> W	LAST SCHOOL GRADE COMPLETED	MOST RECENTLY MOVED TO MINNESOTA Date (mm/dd/yyyy): _____ From: _____	
CITIZENSHIP <input type="radio"/> U.S. Citizen or U.S. National <input type="radio"/> Naturalized U.S. Citizen or Derived U.S. Citizen <input type="radio"/> Not a U.S. Citizen			
IMMIGRATION STATUS (only if applying for help)	U.S. Military Service (regardless of discharge status)? <input type="radio"/> Yes <input type="radio"/> No		
WHAT PROGRAM(S) IS THIS PERSON APPLYING FOR? <input type="checkbox"/> SNAP (food) <input type="checkbox"/> Cash programs <input type="checkbox"/> Emergency Assistance <input type="checkbox"/> None		ETHNICITY (optional) Hispanic? <input type="radio"/> Yes <input type="radio"/> No	RACE** (optional) <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> N <input type="checkbox"/> P <input type="checkbox"/> W
AGENCY USE: MEMB, MEMI, TYPE, PROG, IMIG, SPON			
Intends to reside in MN? <input type="radio"/> Yes <input type="radio"/> No		RELATIONSHIP VERIFICATION <input type="radio"/> requested <input type="radio"/> attached	IMMIGRATION VERIFICATION <input type="radio"/> requested <input type="radio"/> attached
Does person have sponsor? <input type="radio"/> Yes <input type="radio"/> No			

PERSON 3			
LEGAL NAME - LAST	FIRST NAME	MIDDLE NAME	OTHER NAMES (maiden name, nickname, etc.)
SOCIAL SECURITY NUMBER (only if applying for help)	DATE OF BIRTH	GENDER <input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> Rather not say	RELATIONSHIP TO YOU
MARITAL STATUS* <input type="radio"/> N <input type="radio"/> M <input type="radio"/> S <input type="radio"/> L <input type="radio"/> D <input type="radio"/> W	LAST SCHOOL GRADE COMPLETED	MOST RECENTLY MOVED TO MINNESOTA Date (mm/dd/yyyy): _____ From: _____	
CITIZENSHIP <input type="radio"/> U.S. Citizen or U.S. National <input type="radio"/> Naturalized U.S. Citizen or Derived U.S. Citizen <input type="radio"/> Not a U.S. Citizen			
IMMIGRATION STATUS (only if applying for help)	U.S. Military Service (regardless of discharge status)? <input type="radio"/> Yes <input type="radio"/> No		
WHAT PROGRAM(S) IS THIS PERSON APPLYING FOR? <input type="checkbox"/> SNAP (food) <input type="checkbox"/> Cash programs <input type="checkbox"/> Emergency Assistance <input type="checkbox"/> None		ETHNICITY (optional) Hispanic? <input type="radio"/> Yes <input type="radio"/> No	RACE** (optional) <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> N <input type="checkbox"/> P <input type="checkbox"/> W
AGENCY USE: MEMB, MEMI, TYPE, PROG, IMIG, SPON			
Intends to reside in MN? <input type="radio"/> Yes <input type="radio"/> No		RELATIONSHIP VERIFICATION <input type="radio"/> requested <input type="radio"/> attached	IMMIGRATION VERIFICATION <input type="radio"/> requested <input type="radio"/> attached
Does person have sponsor? <input type="radio"/> Yes <input type="radio"/> No			

PERSON 4					
LEGAL NAME - LAST	FIRST NAME	MIDDLE NAME	OTHER NAMES (maiden name, nickname, etc.)		
SOCIAL SECURITY NUMBER (only if applying for help)	DATE OF BIRTH	GENDER <input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> Rather not say		RELATIONSHIP TO YOU	
MARITAL STATUS* <input type="radio"/> N <input type="radio"/> M <input type="radio"/> S <input type="radio"/> L <input type="radio"/> D <input type="radio"/> W	LAST SCHOOL GRADE COMPLETED	MOST RECENTLY MOVED TO MINNESOTA Date (mm/dd/yyyy): _____ From: _____			
CITIZENSHIP <input type="radio"/> U.S. Citizen or U.S. National <input type="radio"/> Naturalized U.S. Citizen or Derived U.S. Citizen <input type="radio"/> Not a U.S. Citizen					
IMMIGRATION STATUS (only if applying for help)	U.S. Military Service (regardless of discharge status)? <input type="radio"/> Yes <input type="radio"/> No				
WHAT PROGRAM(S) IS THIS PERSON APPLYING FOR? <input type="checkbox"/> SNAP (food) <input type="checkbox"/> Cash programs <input type="checkbox"/> Emergency Assistance <input type="checkbox"/> None		ETHNICITY (optional) Hispanic? <input type="radio"/> Yes <input type="radio"/> No	RACE** (optional) <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> N <input type="checkbox"/> P <input type="checkbox"/> W		
AGENCY USE: MEMB, MEMI, TYPE, PROG, IMIG, SPON					
Intends to reside in MN? <input type="radio"/> Yes <input type="radio"/> No		RELATIONSHIP VERIFICATION <input type="radio"/> requested <input type="radio"/> attached		IMMIGRATION VERIFICATION <input type="radio"/> requested <input type="radio"/> attached	
Does person have sponsor? <input type="radio"/> Yes <input type="radio"/> No					

PERSON 5					
LEGAL NAME - LAST	FIRST NAME	MIDDLE NAME	OTHER NAMES (maiden name, nickname, etc.)		
SOCIAL SECURITY NUMBER (only if applying for help)	DATE OF BIRTH	GENDER <input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> Rather not say		RELATIONSHIP TO YOU	
MARITAL STATUS* <input type="radio"/> N <input type="radio"/> M <input type="radio"/> S <input type="radio"/> L <input type="radio"/> D <input type="radio"/> W	LAST SCHOOL GRADE COMPLETED	MOST RECENTLY MOVED TO MINNESOTA Date (mm/dd/yyyy): _____ From: _____			
CITIZENSHIP <input type="radio"/> U.S. Citizen or U.S. National <input type="radio"/> Naturalized U.S. Citizen or Derived U.S. Citizen <input type="radio"/> Not a U.S. Citizen					
IMMIGRATION STATUS (only if applying for help)	U.S. Military Service (regardless of discharge status)? <input type="radio"/> Yes <input type="radio"/> No				
WHAT PROGRAM(S) IS THIS PERSON APPLYING FOR? <input type="checkbox"/> SNAP (food) <input type="checkbox"/> Cash programs <input type="checkbox"/> Emergency Assistance <input type="checkbox"/> None		ETHNICITY (optional) Hispanic? <input type="radio"/> Yes <input type="radio"/> No	RACE** (optional) <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> N <input type="checkbox"/> P <input type="checkbox"/> W		
AGENCY USE: MEMB, MEMI, TYPE, PROG, IMIG, SPON					
Intends to reside in MN? <input type="radio"/> Yes <input type="radio"/> No		RELATIONSHIP VERIFICATION <input type="radio"/> requested <input type="radio"/> attached		IMMIGRATION VERIFICATION <input type="radio"/> requested <input type="radio"/> attached	
Does person have sponsor? <input type="radio"/> Yes <input type="radio"/> No					

If more than 5 people, complete DHS-5223S or attach a separate sheet.

1. Does *everyone* in your household buy, fix **or eat food with you?**

Yes No

AGENCY USE: EATS
<input type="checkbox"/> Confirmed response
VERIFICATION: <input type="radio"/> requested <input type="radio"/> attached

2. Is *anyone* in the household, who is age 60 or over and disabled, unable to buy or fix food due to a disability?

Yes No

AGENCY USE: EATS, DISA, WREG
<input type="checkbox"/> Confirmed response
VERIFICATION: <input type="radio"/> requested <input type="radio"/> attached

3. Is **anyone** in the household attending school (any level/age)?

Yes No

AGENCY USE: SCHL
<input type="checkbox"/> Confirmed response
VERIFICATION: <input type="radio"/> requested <input type="radio"/> attached

4. Is there **anyone** who normally lives with you that is temporarily not living with you?

Yes No

AGENCY USE: REMO
<input type="checkbox"/> Confirmed response
VERIFICATION: <input type="radio"/> requested <input type="radio"/> attached

5. Does **anyone** have a physical or mental health condition, including blindness, that limits the ability to work or perform daily activities?

Yes No

AGENCY USE: DISA, EMPS, PBEN, UNEA, WREG
<input type="checkbox"/> Confirmed response
VERIFICATION: <input type="radio"/> requested <input type="radio"/> attached
For GA/HSP - IAAs Needed: <input type="radio"/> requested <input type="radio"/> attached <input type="radio"/> N/A

6. Is **anyone** unable to work for any reason other than an illness or disability?

Yes No

AGENCY USE: EMPS, WREG
<input type="checkbox"/> Confirmed response
VERIFICATION: <input type="radio"/> requested <input type="radio"/> attached

7. Do all children under the age of 19 have both parents living in the home? If no children under the age of 19 are living with you, leave this question blank.

Yes No

AGENCY USE: INFC/CSIA, ABPS
<input type="checkbox"/> Confirmed response
VERIFICATION: <input type="radio"/> requested <input type="radio"/> attached

8. **For recertifications only:** Did **anyone** move in or out of your home in the past 12 months?

Yes No

AGENCY USE: ADME, REMO
<input type="checkbox"/> Confirmed response
VERIFICATION: <input type="radio"/> requested <input type="radio"/> attached

9. **What kinds of income do you have?**

Yes No **A job?** (Examples: employment, work study, paid internships)

Yes No **Self-employment?** (Examples: Selling products, farming, rental income, driving or delivery services)

Yes No **Any other source?** (Examples: Social Security (RSDI/SSI), disability, retirement, child or spousal support, foster or adoption payments, unemployment, workers' compensation, veterans' benefits, investment income, gambling winnings, money from others, or **any other** income)

AGENCY USE: JOBS, STIN, SPON, BUSI, RBIC, PBEN, UNEA, DISA, WREG
<input type="checkbox"/> Confirmed response
VERIFICATION: <input type="radio"/> requested <input type="radio"/> attached
<input type="radio"/> 50% <input type="radio"/> taxable

If yes to any of the above:

1.	Who receives this income?
Type of income <input type="radio"/> Job EMPLOYER: _____ <input type="radio"/> Self-employment: _____ <input type="radio"/> Other SOURCE: _____	
Do you expect this income to: <input type="radio"/> Continue at the same amount <input type="radio"/> Change <input type="radio"/> End	If this income will change or end, what is the expected date? _____ If changing, what will the new amount or hours be? _____
Comments (optional) _____ _____	
If work, average hours per week	Gross amount received (amount before taxes/deductions)
How often received? <input type="radio"/> Weekly <input type="radio"/> Every 2 weeks <input type="radio"/> Twice a month <input type="radio"/> Monthly <input type="radio"/> Other	
2.	Who receives this income?
Type of income <input type="radio"/> Job EMPLOYER: _____ <input type="radio"/> Self-employment: _____ <input type="radio"/> Other SOURCE: _____	
Do you expect this income to: <input type="radio"/> Continue at the same amount <input type="radio"/> Change <input type="radio"/> End	If this income will change or end, what is the expected date? _____ If changing, what will the new amount or hours be? _____
Comments (optional) _____ _____	
If work, average hours per week	Gross amount received (amount before taxes/deductions)
How often received? <input type="radio"/> Weekly <input type="radio"/> Every 2 weeks <input type="radio"/> Twice a month <input type="radio"/> Monthly <input type="radio"/> Other	

3.	Who receives this income?	
Type of income		
<input type="radio"/> Job EMPLOYER: _____ <input type="radio"/> Self-employment: _____ <input type="radio"/> Other SOURCE: _____		
Do you expect this income to:		If this income will change or end, what is the expected date?
<input type="radio"/> Continue at the same amount <input type="radio"/> Change <input type="radio"/> End		If changing, what will the new amount or hours be?
Comments (optional)		
If work, average hours per week		Gross amount received (amount before taxes/deductions)
How often received?		
<input type="radio"/> Weekly <input type="radio"/> Every 2 weeks <input type="radio"/> Twice a month <input type="radio"/> Monthly <input type="radio"/> Other		

Bring or send proof.

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

AGENCY USE: STWK, STRK, PBEN
<input type="checkbox"/> <i>Confirmed response</i>
ELIGIBLE FOR GOOD CAUSE: <input type="radio"/> Yes <input type="radio"/> No
VERIFICATION: <input type="radio"/> <i>requested</i> <input type="radio"/> <i>attached</i>

ADDITIONAL DETAILS

- 11a. For SNAP only:** If not currently working or self-employed, has anyone had a job or been self-employed in the past 36 months? If currently working or self-employed, leave this question blank.
- Yes No

AGENCY USE: WREG
<input type="checkbox"/> <i>Confirmed response</i>
VERIFICATION: <input type="radio"/> <i>requested</i> <input type="radio"/> <i>attached</i>

- 11b.** Does anyone in your household volunteer on a weekly or monthly basis?
- Yes No

AGENCY USE: WREG
<input type="checkbox"/> <i>Confirmed response</i>
VERIFICATION: <input type="radio"/> <i>requested</i> <input type="radio"/> <i>attached</i>

- 12. For SNAP only:** Does anyone in your household receive or expect to receive Advance Child Tax Credit payments in July through December?
- Yes No

AGENCY USE: UNEA
<input type="checkbox"/> <i>Confirmed response</i>
VERIFICATION: <input type="radio"/> <i>requested</i> <input type="radio"/> <i>attached</i>

Principal Wage Earner (PWE)

SNAP households must designate an adult as the PWE. Talk to your worker about how this designation could affect your benefits.

DESIGNATED PWE

13. Does anyone in the household have or expect to get any loans, scholarships or grants for attending college, university or other post high school? **Bring or send proof.**
 Yes No

AGENCY USE: STIN, STEC, SCHL, WREG
<input type="checkbox"/> <i>Confirmed response</i>
VERIFICATION: <input type="radio"/> <i>requested</i> <input type="radio"/> <i>attached</i>

14. What kinds of expenses do you have, including seasonal charges?
 (Check all that apply.)
Bring or send proof.

AGENCY USE: SHEL, EATS, HEST
<input type="checkbox"/> <i>Confirmed response</i>
VERIFICATION: <input type="radio"/> <i>requested</i> <input type="radio"/> <i>attached</i>

Expenses	Amount per month	Who pays?	Does this heat or cool your home?
<input type="checkbox"/> Rent			
<input type="checkbox"/> Mobile home lot rent			
<input type="checkbox"/> Mortgage/contract for deed payment			
<input type="checkbox"/> Association fees			
<input type="checkbox"/> Homeowner's insurance (if not included in the mortgage)			
<input type="checkbox"/> Real estate taxes (if not included in the mortgage)			
<input type="checkbox"/> Room and/or board			
<input type="checkbox"/> Water and sewer			
<input type="checkbox"/> Gas (Natural Gas/Propane)			<input type="radio"/> Yes <input type="radio"/> No
<input type="checkbox"/> Electricity			<input type="radio"/> Yes <input type="radio"/> No
<input type="checkbox"/> Other fuel (ex: wood, fuel oil/kerosene, coal, gasoline)			<input type="radio"/> Yes <input type="radio"/> No
<input type="checkbox"/> Phone/cell phone			

14a. Do you receive a rental subsidy (ex: Section 8)? Yes No

14b. Did you or anyone in your household receive energy assistance of more than \$20 in the past 12 months?
 Yes No

15. Do you or anyone living with you have costs for care of a **child(ren)** because you or they are working, looking for work or going to school? The Child Care Assistance Program may help pay child care costs. Ask your worker how to apply for the Child Care Assistance Program.

AGENCY USE: DCEX, FMED
<input type="checkbox"/> <i>Confirmed response</i>
VERIFICATION: <input type="radio"/> <i>requested</i> <input type="radio"/> <i>attached</i>

Yes No

If yes:	HOW MUCH?	HOW OFTEN PAID?

16. Do you or anyone living with you have costs for care of an ill or disabled adult because you or they are working, looking for work or going to school?

Yes No

If yes:	HOW MUCH?	HOW OFTEN PAID?

AGENCY USE: DCEX, FMED
<input type="checkbox"/> Confirmed response
VERIFICATION: <input type="radio"/> requested <input type="radio"/> attached

17. Does anyone in the household **pay** court-ordered child support, spousal support, child care support, medical support or contribute to a tax dependent who does not live in your home?

Yes No

If yes:	HOW MUCH?	HOW OFTEN PAID?

AGENCY USE: COEX
<input type="checkbox"/> Confirmed response
VERIFICATION: <input type="radio"/> requested <input type="radio"/> attached

18. For SNAP only: Is there a household member who has a disability OR is age 60 or older and has medical expenses? To get a medical deduction you must provide proof of all medical bills incurred by anyone in your household **who is disabled or 60 years or older. Do not** bring medical bills that are being paid for by any health care program, insurance or someone not living with you.

Yes No

AGENCY USE: FMED, DISA, WREG
<input type="checkbox"/> Confirmed response
VERIFICATION: <input type="radio"/> requested <input type="radio"/> attached

19. Does anyone in the household own any of the following? **Bring or send proof.**

Cash	<input type="radio"/> Yes <input type="radio"/> No
Bank accounts (savings, checking, debit card, etc.)	<input type="radio"/> Yes <input type="radio"/> No
Electronic payment card (Reliacard, Direct Express, etc.)	<input type="radio"/> Yes <input type="radio"/> No
Stocks, bonds, annuities, 401K, etc.	<input type="radio"/> Yes <input type="radio"/> No
Vehicles (cars, trucks, motorcycles, campers, trailers)	<input type="radio"/> Yes <input type="radio"/> No

AGENCY USE: CASH, CARS, ACCT, REST, SECU, SPON
<input type="checkbox"/> Confirmed response
EFT OFFERED? <input type="radio"/> Yes <input type="radio"/> No
VERIFICATION: <input type="radio"/> requested <input type="radio"/> attached

20. Has anyone in the household given away, sold or traded anything of value **in the past 12 months?** (For example: cash, bank accounts, stocks, bonds, vehicles)

Yes No

AGENCY USE: TRAN
<input type="checkbox"/> Confirmed response
VERIFICATION: <input type="radio"/> requested <input type="radio"/> attached

21. For Minnesota Supplemental Assistance only: Does **anyone** in the household have any of the following expenses?

Representative payee fees	<input type="radio"/> Yes <input type="radio"/> No
Guardian or conservator fees	<input type="radio"/> Yes <input type="radio"/> No
Medically-prescribed special diet	<input type="radio"/> Yes <input type="radio"/> No
High housing costs	<input type="radio"/> Yes <input type="radio"/> No

AGENCY USE: DIET, PDED
<input type="checkbox"/> Confirmed response
VERIFICATION: <input type="radio"/> requested <input type="radio"/> attached

You may authorize another person(s) to:

- Fill out forms and apply for help from the agency
- Communicate with the agency
- Get notices and information related to your case
- Get your SNAP benefits and buy food for you through your Electronic Benefit Transfer (EBT) account.

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

AUTHORIZED PERSON 1				
I WANT THE PERSON NAMED TO: <input type="checkbox"/> Fill out forms <input type="checkbox"/> Get notices <input type="checkbox"/> Get and use my SNAP benefits <input type="checkbox"/> Communicate	NAME	RELATIONSHIP		PHONE NUMBER
	ADDRESS	CITY	STATE	ZIP CODE

AUTHORIZED PERSON 2				
I WANT THE PERSON NAMED TO: <input type="checkbox"/> Fill out forms <input type="checkbox"/> Get notices <input type="checkbox"/> Get and use my SNAP benefits <input type="checkbox"/> Communicate	NAME	RELATIONSHIP		PHONE NUMBER
	ADDRESS	CITY	STATE	ZIP CODE

*Only one authorized representative can get and use SNAP benefits on behalf of the applicant.

Other help

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

Do you need help with referrals for other areas (for example, food shelves, housing, transportation)? Yes No

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

Did an agency assist with the completion of this application? Yes No

NAME OF AGENCY	ADDRESS	PHONE NUMBER

Penalty warnings and qualification questions

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

- **Do not give false information** or hide information to get or continue to get benefits. If you get cash or SNAP benefits and give false information or hide information about your **identity** and **residency** to get multiple benefits for the same period of time, you may be barred for 10 years.
- **Do not trade or sell SNAP benefits** or Electronic Benefit Transfer (EBT) access cards. **The trade or sale of benefits valued at over \$500 may result in permanent ineligibility.**
- **Do not use cash or SNAP benefits to buy ineligible items**, such as alcohol and tobacco.
- **Do not use someone else's EBT access card(s)** to get cash or SNAP benefits for your household.

The state may bar household members who break any of these rules. The bar lasts one year for the first fraud, two years for the second fraud and is permanent for the third fraud. The months you are barred from MFIP for breaking the rules may count toward your 60-month lifetime limit.

You can also be prosecuted for fraud if you break the rules and additional fines and penalties may apply. The maximum penalty is a fine of \$250,000 or a jail term of 20 years, or both.

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

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

<input type="radio"/> Yes	<input type="radio"/> No	1. Has a court or any other civil or administrative process in Minnesota or any other state found anyone in the household guilty or has anyone been disqualified from receiving public assistance for breaking any of the rules above?	
<input type="radio"/> Yes	<input type="radio"/> No	2. Has anyone in the household been convicted of making fraudulent statements about their place of residence to get cash or SNAP benefits from more than one state?	
<input type="radio"/> Yes	<input type="radio"/> No	3. Is anyone in your household hiding or running from the law to avoid prosecution, being taken into custody, or to avoid going to jail for a felony?	
<input type="radio"/> Yes	<input type="radio"/> No	4. Has anyone in your household been convicted of a drug felony in the past 10 years?(If yes, the agency may ask you to take random drug tests).	
<input type="radio"/> Yes	<input type="radio"/> No	5. Is anyone in your household currently violating a condition of parole, probation or supervised release?	
<p>If you checked yes to any of the above questions, list the household member(s) and question number below:</p>			
QUESTION NO.	HOUSEHOLD MEMBER	QUESTION NO.	HOUSEHOLD MEMBER

Employment services registration

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

Assignments

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

Perjury and general declarations

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

Authorization to share information for fraud investigation and audits

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

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

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

By signing:

- I understand cash assistance is provided to help eligible families meet their basic needs.
- I understand that if I give incorrect information or misuse an electronic benefits transfer (EBT) card, I may be investigated and face administrative disqualification or criminal prosecution for fraud, both of which could result in disqualification from the programs.
- I acknowledge that since my last application or recertification, I have received my cash and/or SNAP benefits directly or used my EBT card to get my cash and/or SNAP benefits.
- I acknowledge that I have read and understand the "Penalty warnings and qualification questions" section.
- I acknowledge that my worker reviewed and explained the attached "Notice of Privacy Practices" (DHS-3979) and "Client Responsibilities and Rights" (DHS-4163).
- I agree to assign my child support as stated above.
- I agree to the sharing of information as stated on the fraud investigation and audits release information section above.
- I agree to the sharing of information as stated in the Social Security numbers section on page ii.

SIGNATURE OF APPLICANT OR AUTHORIZED REPRESENTATIVE 	DATE	SIGNATURE OF SPOUSE OR OTHER ADULT 	DATE
SIGNATURE OF AUTHORIZED REPRESENTATIVE 	DATE	SIGNATURE OF AUTHORIZED REPRESENTATIVE 	DATE

AGENCY USE												
PROVIDED APPLICANT WITH THE FOLLOWING DOCUMENTS: <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none;"><input type="checkbox"/> Program information for cash, food and child care programs (DHS-2920)</td> <td style="width: 50%; border: none;"><input type="checkbox"/> Notice About Income and Eligibility Verification System and Work Reporting System (DHS-2759) <i>(attached)</i></td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Domestic Violence Information brochure (DHS-3477)</td> <td style="border: none;"><input type="checkbox"/> Do you have a disability? (DHS-4133)</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Notice of Privacy Practices (DHS-3979) <i>(attached)</i></td> <td style="border: none;"><input type="checkbox"/> How to Use Your Minnesota EBT Card (DHS-3315A)</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Client responsibilities and rights (DHS-4163) <i>(attached)</i></td> <td style="border: none;"><input type="checkbox"/> Reviewed all pages of application with client</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Appeal Rights (DHS-3353) <i>(attached)</i></td> <td></td> </tr> </table>			<input type="checkbox"/> Program information for cash, food and child care programs (DHS-2920)	<input type="checkbox"/> Notice About Income and Eligibility Verification System and Work Reporting System (DHS-2759) <i>(attached)</i>	<input type="checkbox"/> Domestic Violence Information brochure (DHS-3477)	<input type="checkbox"/> Do you have a disability? (DHS-4133)	<input type="checkbox"/> Notice of Privacy Practices (DHS-3979) <i>(attached)</i>	<input type="checkbox"/> How to Use Your Minnesota EBT Card (DHS-3315A)	<input type="checkbox"/> Client responsibilities and rights (DHS-4163) <i>(attached)</i>	<input type="checkbox"/> Reviewed all pages of application with client	<input type="checkbox"/> Appeal Rights (DHS-3353) <i>(attached)</i>	
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AGENCY SIGNATURE	INTERVIEW DATE	CASE NUMBER										

Information That May Be Needed <ul style="list-style-type: none"> • Additional proofs may be needed to determine your benefits. • Proofs should be current (within the past 30 days). • Let your worker know if you need help getting proofs. 	Cash Programs	SNAP
Identity of applicant or authorized representative (driver's license, state ID, passport, school or work identification card, etc.)	✓	✓
Social Security numbers of all people applying for help.	✓	✓
Residency in Minnesota (driver's license, state ID, lease agreement, utility bills, mail sent to you at the stated address, etc.)	✓	✓
Income from the last 30 days (paystubs, unemployment insurance, pension, child support agreements, alimony, etc.) or, if you are self-employed, provide federal income taxes or business records. The agency will attempt to verify Social Security income for you.	✓	✓
Current housing costs (rent/house payment receipt, mortgage, lease, subsidized housing, property taxes, homeowners insurance, etc.)	✓*	✓*
Medical costs for people with disabilities or who are age 60 or older (prescriptions, medical equipment, medical bills, medical payment agreement etc.)		✓*
Relationship to other household members (birth certificates, marriage licenses, court documents, etc.)	✓	
Child support paid within the last 30 days (paystubs, proof of payments made, etc.)	✓	✓*
Checking and savings accounts (bank statement, direct deposit account, Reliacard and debit account statement, DHS-6054 Signed Personal Statement about Assets for Cash Programs etc.)	✓	
Value of vehicles (cars, trucks, motorcycles, trailers, campers, DHS-6054 Signed Personal Statement about Assets for Cash Programs , etc.)	✓	
Current value of stocks/bonds, certificates of deposit, trusts (account statement, DHS-6054 Signed Personal Statement about Assets for Cash Programs , etc.)	✓	
Proof of illness or disability (doctor's statement, receipt of disability benefits, award letters, DHS-2114 Medical Opinion Form , DHS-7122 Professional Statement of Need , etc.)	✓	✓
Student status (signed statement from a school official, DHS-2646 Financial Aid Information , DHS-2883 Request for verification of school attendance/progress , etc.)	✓	✓
Immigration status (immigration document, official USCIS papers, etc.)	✓	✓

* Providing this proof may increase your benefits.

Civil Rights Notice

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 • sexual orientation • public assistance status
- marital status • age • disability • sex • political beliefs

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.

Contact **DHS** directly only if you have a discrimination complaint:

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

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 • gender identity
- public assistance status • 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)
 1-800-657-3704 (toll free)
 711 or 1-800-627-3529 (MN Relay)
 651-296-9042 (fax)
 Info.MDHR@state.mn.us

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

You have the right to file a complaint with the OCR, a federal agency, if you believe you have been discriminated against because of any of the following:

- race • color • national origin • age • disability • sex • religion

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

Office for Civil Rights
 U.S. Department of Health and Human Services
 Midwest Region
 233 N. Michigan Avenue, Suite 240
 Chicago, IL 60601
 Customer Response Center:
 Toll-free: 1-800-368-1019
 TDD Toll-free: 1-800-537-7697
 ocrmail@hhs.gov

U.S. Department of Agriculture

In accordance with federal civil rights law and **U.S. Department of Agriculture (USDA)** civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the agency (state or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: <https://www.usda.gov/sites/default/files/documents/ad-3027.pdf>, from any USDA office, by calling (833) 620-1071, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to:

(1) mail:

Food and Nutrition Service, USDA
1320 Braddock Place, Room 334
Alexandria, VA 22314;

(2) fax:

(833) 256-1665 or (202) 690-7442; or

(3) email:

FNSCIVILRIGHTSCOMPLAINTS@usda.gov

This institution is an equal opportunity provider.

Notice of Privacy Practices

(Effective Date: November 2016)

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?

- In order to determine whether and how we can help you, we collect information:
 - To tell you apart from other people with the same or similar name
 - To decide what you are eligible for
 - To help you get medical, mental health, financial or social services and decide if you can pay for some services
 - To decide if you or your family need protective services
 - To decide about out-of-home care and in-home care for you or your children
 - To investigate the accuracy of the information in your application
- After we have begun to provide services or support to you, we may collect additional information:
 - To make reports, do research, do audits, and evaluate our programs
 - To investigate reports of people who may lie about the help they need
 - To collect money from other agencies, like insurance companies, if they should pay for your care
 - To collect money from the state or federal government for help we give you.
 - When your or your family's circumstances change and you are required to report the change (see Client Responsibilities and Rights – DHS-4163)

Why do we ask you for your Social Security number?

We need your Social Security number 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 Social Security Number to verify identity and prevent duplication of state and federal benefits. Additionally, your Social Security Number 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 Social Security Number:

- For persons in your home who are not applying for coverage
- If you have religious objections
- If you are not a United States citizen and are applying for Emergency Medical Assistance only
- If you are from another country, in the United States on a temporary basis and do not have permission from the United States Citizenship and Immigration Services to live in the United States permanently
- If you are living in the United States without the knowledge or approval of the U.S. Citizenship and Immigration Services.

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.

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

- You and people you have given permission to may see and copy private information we have about you. You may have to pay for the copies.
- You may question 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 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.
- 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 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?

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 to the address below:

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



Client responsibilities and rights

Note: Cash on an Electronic Benefit Transfer (EBT) card is provided to help families meet their basic needs, including: food, shelter, clothing, utilities and transportation. These funds are provided until families can support themselves. It is illegal for you to buy or attempt to buy tobacco products or alcohol with your EBT card. If you do, it is fraud and you will be removed from the EBT program. EBT cards also cannot be used at gambling or retail establishments that provide adult-orientated entertainment in which performers disrobe or perform in an unclothed state for entertainment.

Your responsibilities

- **If you receive child care assistance** you must report any changes that may affect your benefits to your county or Tribal Nation agency within 10 days after the change has occurred. **If you receive Supplemental Nutrition Assistance Program benefits and/or cash assistance benefits, report changes by the 10th of the following month.** Each benefits program may have different requirements for reporting changes. Talk to your caseworker about what you must report.

You may be required to report changes in:

- **Employment** – starting or stopping a job or business; a change in hours, earnings or expenses
- **Income** – receipt or change in child support, Social Security, veteran benefits, unemployment insurance, inheritance or insurance benefits
- **Property** – purchase, sale or transfer of a house, car or other items of value, or if you receive an inheritance or settlement
- **Household status** – When a person dies or becomes disabled, moves in or out of your home or temporarily leaves; pregnancy; birth of a child
- **Citizenship or immigration status**
- **Address**
- **Housing costs and/or rent subsidy**
- **Utility costs**
- **Parental custody or visitation rights**
- **Marital status**
- **School attendance**
- **Health insurance coverage and premiums.**
- **You or someone in your household wins \$4,500 or more from the lottery or gambling.**

You may also be required to report if you are party to a newly filed lawsuit, or if you have been convicted of a drug-related felony.

Note: If you are enrolled in Child Care Assistance and change child care providers, you must notify your child care worker and provider at least 15 days before the change goes into effect.

If you have questions or are unsure about any reporting rules, contact your case worker. If your case worker is not available, leave a message so they can get back to you.

- **Your county, Tribal Nation, state or federal agency** may check any of the information you provide. Your signed consent may be needed to obtain some forms of information. If you don't give your signed consent, you might not receive assistance.
- If you provide information you know is untrue, withhold information or do not report as required, or it's later discovered that your information is untrue, you may be investigated for fraud. This may result in you being disqualified from receiving benefits, charged with a criminal offense, or both.
- The state or federal quality control agency may randomly choose your case for review. They will review statements you provided and will check to see if your eligibility was determined correctly. The state may seek information from other sources and will inform you about any contact they intend to make. **If you do not cooperate, your benefits may stop.**
- **Cooperation requirements:**
 - If your county or Tribal Nation agency approves you for the Minnesota Family Investment Program or the Diversionary Work Program, you must cooperate with all required employment services, unless you are exempt. You must develop and sign an employment plan with your case worker or your Diversionary Work Program application will be denied.
 - You must cooperate with child support to receive Minnesota Family Investment Program benefits, Diversionary Work Program benefits and/or Child Care Assistance Program.

If you receive child support directly from a noncustodial parent, you must report it to your case worker.

For Cash and Supplemental Nutrition Assistance Program (SNAP) benefits:

- **Each time you use your EBT card or sign your check**, you state that you have informed your county or Tribal Nation agency about any changes in your situation that may affect your benefits.
- **Each time your EBT card is used**, it's assumed you have received your cash or SNAP benefits, unless you reported your card lost or stolen to your county or Tribal Nation agency.

Note: If you sign the application as an authorized representative of a person who is requesting or receiving assistance, **you are agreeing to assume all of the responsibilities listed above on behalf of that person.**

For child care assistance:

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

Your rights

- **You have the right to privacy.** Your private information, including your health information, is protected by state and federal laws. Your case worker has given you a Notice of Privacy Practices (DHS-3979) information sheet explaining these rights.
- **You have the right to reapply** at any time if your benefits stop.
- **You have the right to receive** a paper or electronic copy of your SNAP application. Let your case worker know if you would like to receive a copy.
- **You have the right to know why**, if we have not processed your application within:
 - Seven days for Expedited SNAP
 - Thirty days for cash, SNAP and child care assistance
 - Sixty days for cash related to disability.
- **SNAP only:** Time limits and other requirements that apply to the receipt of cash benefits do not apply to the receipt of SNAP benefits. If cash benefits end, you may still qualify for SNAP benefits.
- **You have the right to know the rules** of the program you are applying for and for the agency to tell you how your benefit amount was figured.
- **You have the right to choose** where and with whom you live.
- **You have the right to report expenses** such as shelter, utilities, child care, child support or medical costs. These expenses may affect the amount of SNAP benefits that you receive. Failure to report or verify certain expenses listed will be a statement by your household that you do not want a deduction for the unreported expenses.
- **You have the right to access free legal services.** Contact your case worker for information on free legal services.
- **You have the right to appeal.** If you are unhappy with the action taken or feel the agency did not act on your request for assistance, you may appeal. For cash, child care assistance and health care, you may appeal **within 30 days** from the date you receive the notice by writing to the county or Tribal Nation agency, or directly to the State Appeals Office at the Minnesota Department of Human Services, PO Box 64941, St. Paul, MN 55164-0941. (If you show good cause for not appealing your cash and health care **within 30 days**, the agency can accept your appeal **for up to 90 days** from the date you receive the notice.)

For SNAP, you may appeal **within 90 days** by writing or calling the county or the State Appeals Office. You may represent yourself at the hearing, or you may have someone (an attorney, relative, friend or another person) speak for you.

If you wish for your assistance to continue until the hearing, you must appeal before the date of the proposed action or within 10 days after the date the agency notice was mailed, whichever is later. Ask your county or Tribal Nation case worker to explain how the timing of your appeal could affect your present or future assistance.

Appeal rights

- **Appeal rights.** An appeal is a legal process where a human services judge reviews a decision made by the agency. You may appeal a decision if:
 - You feel the agency did not act on your request for assistance.
 - You do not agree with the action taken.

You may represent yourself at the hearing, or you may have someone (an attorney, relative, friend or another person) speak for you.

- **For emergency help**, when your case is about an emergency and you need a faster decision on your appeal, you can ask for an emergency hearing in your appeal request. You can also request it by calling the Department of Human Services Appeals Division.
- **For cash, child care and health care**, you may appeal **within 30 days** from the date you received this notice by sending a written appeal request saying you do not agree with the decision. You can send this letter to the agency, or directly to the Appeals Division. If you show good cause for not appealing your cash, child care and health care **within 30 days**, the agency can accept your appeal for **up to 90 days** from the date of the notice. Good cause is when you have a good reason for not appealing on time. The Appeals Division will decide if your reason is a good cause reason. You can ask to meet informally with agency staff to try to solve the problem, but this meeting will not delay or replace your right to an appeal.
- **For the Supplemental Nutrition Assistance Program**, you may appeal **within 90 days** by writing or calling the agency or the Appeals Division.
- Submit your appeal request:
 - **Online:** <https://edocs.dhs.state.mn.us/lfserver/Public/DHS-0033-ENG>
 - **Write:** Minnesota Department of Human Services Appeals Division
P.O. Box 64941
St. Paul, MN 55164-0941
 - **Fax:** 651-431-7523
 - **Call:** Metro: 651-431-3600
Greater Minnesota: 800-657-3510
or use your preferred relay service
- **If you want to keep receiving your benefits until the hearing**, you must appeal within 10 days of the date on the agency's notice of action letter or before the proposed action takes place in order to keep benefits in place. For most programs, if you file your appeal on time, you will get your benefits until the Appeals Division decides your appeal. If you lose your appeal, you may have to pay back the benefits you got while your appeal was pending. You can ask the agency to end your benefits until the decision. If you end your benefits and then win your appeal, you will be paid back for benefits that you should have received or, for child care assistance, your provider will be reimbursed for eligible costs that you paid or incurred. Ask your agency worker to explain how the timing of your appeal could affect your present or future assistance.
- **You have the right to reapply** at any time if your benefits stop.
- **Access to free legal services.** You may be able to get legal advice or help with an appeal from your local legal aid office. To find your local legal aid office, visit www.LawHelpMN.org or call 888-354-5522.

Notice About Income and Eligibility Verification System and Work Reporting System

Read this if you are asking for or get:

- Cash Assistance:
 - Diversionary Work Program
 - Minnesota Family Investment Program
 - Refugee Cash Assistance
 - Minnesota Supplemental Aid
 - General Assistance
 - Emergency Assistance
- Supplemental Nutrition Assistance Program
- Minnesota Health Care Programs

What is the Income and Eligibility Verification System (IEVS)?

The government has a way to check income. It is the "Income and Eligibility Verification System" (IEVS).

The law has us check your income with other agencies. We have to check income for all who ask for or get cash assistance, Supplemental Nutrition Assistance Program (SNAP) benefits or Medical Assistance (MA). This includes your children.

We need Social Security Numbers (SSN) for anyone wanting help. If you have no SSN, you must apply for one. Apply with your county human services agency. You must report all SSNs to your worker.

What facts will we get? How will we use them?

We check with other agencies about your income, assets and health insurance. If you didn't tell us about all of your income or assets, we will refigure your aid. Your aid might go lower or stop. If you get aid you should not be getting, we may use these facts in civil or criminal lawsuits.

We will tell you if facts from other agencies are not the same as the facts you gave us. We will tell you what facts we got, the kind of income or assets, and the amount. We give you 10 days to respond in writing to prove if our facts are wrong.

We will ask you to show proof of income, assets, or health insurance you did not report or that we could not verify. You may need to give us permission to check the facts with the source of data. We will tell you what happens if you do not sign for permission or do not help us.

Agencies we get information from

We must trade facts with these agencies:

- United States Social Security Administration (SSA) - We get records of self-employment earnings, retirement income, survivor's benefits, disability payments, Social Security (RSDI), Supplemental Security Income (SSI).
- United States Internal Revenue Service (IRS) - We get records of unearned income (like interest and dividends).
- Minnesota Department of Employment and Economic Development (DEED) - We get records of wages and pay and facts on Unemployment Insurance.
- Minnesota Office of Child Support Division
- Agencies in other states that manage:
 - Unemployment Insurance
 - Cash assistance
 - Medical Assistance (MA)
 - SNAP
 - Child support
 - SSI state supplements

These agencies have the right to get certain facts from us about you. They have to use those facts for programs like RSDI, child support, cash assistance, SNAP, MA, Unemployment Insurance, and SSI.

What is the Work Reporting System?

Minnesota employers must tell us when they hire someone. This information is used by the Child Support Program. We also use this information to see if a new employee is getting help from any of the programs listed above.

How do we use it?

If the employee is getting help from any of these programs, the county worker gets a notice. If the client did not report the new job, the county worker will contact the client. The county worker may ask the client to show proof about the job. The client may need to give the county permission to check the facts with the employer. If a client does not help us check the information, they will lose benefits.

The law limits who gets facts about you

The law limits the facts about you that we get from other agencies and the facts we give them. Contracts with the Minnesota Department of Human Services and those agencies also protect you. Only those agencies, the state, and the county agency where you apply for and get program benefits can use the facts about you. No one else can get the facts about you without your written permission.

Your duty to report

You **must report** all of your income and assets.

- **If you receive cash assistance**, report any changes within 10 days of the change, **or**, if you report on a Household Report Form (DHS-2120), complete the form and return it by the 8th of the month.
- **If you receive SNAP**, report required changes by the 10th of the month following the month of the change. For example, if a change happens in March, you must report the change by April 10.

You **must** still report all of your income, assets and other information on redetermination forms we send you.

You **must** help the county agency check your income, assets and health insurance. IEVS is one way of proving your income, assets and health insurance amounts.

What if you do not help

You must help us check your income, assets and health insurance to get cash assistance, SNAP and MA. **If you don't, you and your family will not get help.**

Legal Authority

IEVS - 7 CFR, parts 271, 272, 273, 275; 42 CFR, parts 431, 435; 45 CFR, parts 205, 206, 233

Work Reporting - Minnesota Statutes Section 256.998, Subd. 10