Health Care Renewal Notice

It is time to renew coverage for the people listed in this section. This notice tells you how to renew your coverage.

Health Care Results

<table>
<thead>
<tr>
<th>Member Name</th>
<th>MNsure ID Number</th>
<th>Health Care Program Type</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client's Name</td>
<td>MNsure ID</td>
<td>MA or MCRE</td>
<td>Need to Renew</td>
</tr>
</tbody>
</table>

Coverage will end on [last day of current certification period] unless we can confirm eligibility. **You must complete and sign the renewal form included with this notice. You must return the form within 45 days from the date printed on the first page of this notice. We cannot guarantee continued coverage if your form is received after 45 days.** *(Code of Federal Regulations, title 42, sections 435.916(a) and 600.340(e); Minnesota Statutes, sections 256B.056, subdivision 7a, and 256L.05, subdivision 3a)*
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Renewal Form

This is the information we have about your household. You must review the information on the notice and this form, including the address listed on the notice. You must tell us if any of the information is not correct. Send the signed form to the servicing agency listed on the top of the notice. If you need more space to write, attach a sheet of paper. You must return the form within 45 days of the date printed on the first page of your health care renewal notice. Call your county agency or MinnesotaCare Operations to add a new person to your household. See the enclosed Agency Addresses form to get the address and phone number for your servicing agency.

Household Information

<table>
<thead>
<tr>
<th>Name</th>
<th>Gender</th>
<th>Date of Birth</th>
<th>Marital Status</th>
<th>Pregnant?</th>
<th>Receiving coverage?</th>
</tr>
</thead>
</table>

All this information is correct unless a change is entered below. If you are reporting a pregnancy, please provide the number of unborn child(ren) and the due date.

Relationships

| Name | Client is the [Relationship Type] of Other Household Member's Name |

All this information is correct unless a change is entered below:

Residency

<table>
<thead>
<tr>
<th>Name</th>
<th>Lives in Minnesota?</th>
<th>Plans to make Minnesota home?</th>
<th>Visiting Minnesota for medical care or personal reasons?</th>
<th>Is home address the same as mailing address?</th>
<th>Home address, if different from mailing address</th>
</tr>
</thead>
</table>

All this information is correct unless a change is entered below:

Social Security Number (SSN)

<table>
<thead>
<tr>
<th>Name</th>
<th>SSN provided?</th>
<th>If no, has person applied for SSN?</th>
</tr>
</thead>
</table>
All this information is correct unless a change is entered below:

Citizenship Status

<table>
<thead>
<tr>
<th>Name</th>
<th>United States Citizen?</th>
<th>United States National?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

All this information is correct unless a change is entered below. If citizenship information has changed, please provide the effective date, Naturalization ID number and new name, if available.

Noncitizen Information

<table>
<thead>
<tr>
<th>Name</th>
<th>Immigration status (examples: asylee, legal permanent resident, refugee)</th>
<th>Entered US before August 22, 1996?</th>
<th>Lived in US for 5 or more years in a qualified status?</th>
<th>Honorably discharged veteran or active-duty military member?</th>
<th>Spouse or dependent child of an honorably discharged veteran or active-duty military member?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

All this information is correct unless a change is entered below. If noncitizen information has changed, please provide the date the new status began, the type of document you have, the Alien ID number, and the card number.

Expected Tax Filing Information – Review the following information and report any tax filing status changes for any member in your household in the box after the tables.

<table>
<thead>
<tr>
<th>Name</th>
<th>Expected Tax Status</th>
<th>Tax Relationship</th>
<th>Married Filing Jointly?</th>
<th>Tax dependent of someone outside the household?</th>
<th>Expected to be claimed as a tax dependent by a noncustodial parent?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

SAMPLE
<table>
<thead>
<tr>
<th>Name</th>
<th>Had or expects a change in family size?</th>
<th>Had or expects a decrease in annual household income?</th>
<th>Had or expects a change in tax-filing status?</th>
<th>Filed an application for unemployment benefits?</th>
<th>Had or expects a change in the number of people on tax return?</th>
</tr>
</thead>
</table>

All this information is correct unless a change is entered below:

<table>
<thead>
<tr>
<th>Name</th>
<th>Has health insurance through an employer?</th>
<th>Has access to health insurance through an employer?</th>
<th>Is employer making changes for new plan year?</th>
<th>Has Medicare or other nonemployer health insurance?</th>
<th>Type of nonemployer health insurance</th>
</tr>
</thead>
</table>

All this information is correct unless a change is entered below. If you are reporting that someone is enrolled in an employer insurance plan or has access to one, we will need a completed **Appendix A: Health Coverage from Jobs** with your completed renewal form. Access the appendix at https://edocs.dhs.state.mn.us/lfservlet/Public/DHS-6696D-ENG. Or have one mailed to you by calling your county agency or MinnesotaCare Operations at 800-657-3672.

<table>
<thead>
<tr>
<th>Name</th>
<th>Name of Employer</th>
<th>Employee claims this person on a tax return?</th>
<th>Does employer offer a plan that meets the minimum</th>
<th>Employee contribution for self-only coverage for the lowest-cost plan that meets</th>
<th>Frequency of contribution</th>
</tr>
</thead>
</table>

Information about Health Insurance Available through an Employer
All this information is correct unless a change is entered below. If you are reporting that someone is enrolled in an employer insurance plan or has access to one, we will need a completed Appendix A: Health Coverage from Jobs with your completed renewal form. Access the appendix at https://edocs.dhs.state.mn.us/lfsrserver/Public/DHS-6696D-ENG. Or have one mailed to you by calling your county agency or MinnesotaCare Operations at 800-657-3672.

### Income Information

This is the income we have for your household. It includes your taxable income plus nontaxable Title II Social Security benefits, interest income, and foreign earned income. Title II Social Security benefits include retirement, disability and railroad retirement benefits. Supplemental Security Income (SSI) is not Title II income.

**How to complete this section:** Review all the details for each income source listed on this form. Follow these steps:

1. If the type of income is still current, cross out any details of the income that are not correct and enter the corrections in the space(s) provided in the table.
2. Cross out all income that ended.
3. Cross out duplicate income information (income information listed more than once).

**IMPORTANT:** If you report a change in income, make sure you review and update all three sections on this form: Income Information, Adjustments to Income and Projected Annual Income.

<table>
<thead>
<tr>
<th>Name</th>
<th>Type of income and employer name (for wage jobs)</th>
<th>Seasonally employed? Yes or No</th>
<th>Gross Amount</th>
<th>Frequency Weekly? Bi-weekly? Semi-monthly? Monthly?</th>
<th>Amount of interest received or part of Social Security benefit amount that is tax-exempt?</th>
</tr>
</thead>
</table>

**Report new income:** Complete this section for any household members that have new income to report that is not listed in the previous table. If you need more space, write “Report new income” on a separate piece of paper and include your case number and the information from the table. Return it with this form.
Adjustments to Income

Adjustments to income are the types of expenses you would list on Schedule 1 of the 1040 federal tax return. Your gross income minus any adjustments is your “adjusted gross income.” For a complete list of allowable adjustments, see the Schedule 1 of the 1040 federal tax return.

**How to complete this section:** Review all the details for each adjustment listed on this form. Follow the steps below:

1. If the adjustment is still current and correct, do not make any changes.
2. Cross out any detail that is not correct and enter the corrections in the space provided.
3. Cross out all adjustments that ended.

If no changes are made, we will use all of the information in the table to determine eligibility for your household.

<table>
<thead>
<tr>
<th>Name</th>
<th>Type of Adjustment</th>
<th>Amount of Adjustment</th>
<th>Frequency of Adjustment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Report new adjustments to income:** Complete this section if any household members have new adjustments to income not listed in the previous table. If you need more space, write “New adjustments to income” on a separate piece of paper and include your case number and the information from the table. Return it with this form.

<table>
<thead>
<tr>
<th>Name</th>
<th>Type of Adjustment</th>
<th>Amount of Adjustment</th>
<th>Frequency of Adjustment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Projected Annual Income

Projected annual income (PAI) is the income you expect to receive in [YYYY]. Eligibility for some health insurance is based on your expected household income for the year you want coverage, not last year’s income. You must provide your projected annual income to qualify for the correct program.

How do you figure out PAI?
1. Start with the gross income you will report in [YYYY] on your federal tax return. Do not count income that is not included on a federal tax return. Examples of income that are not included are child support and worker’s compensation.
2. Subtract any adjustments to income that you would report on Schedule 1 of your federal tax return.
3. Add any of the following sources of income as part of your PAI. Even though these sources of income may not be taxed when you file your federal tax return, you must add them when projecting your annual income.
   • Title II Social Security benefits
   • Tax-exempt interest income
   • Foreign earned income

We used the information we have on file and calculated the [YYYY] PAI for everyone in your household as shown in the second column of this table. Follow these steps:

1. Answer the question ‘Is this amount correct?’ by selecting yes or no in the table for each person in your household. You must answer this question for each household member.
2. If the [YYYY] calculated PAI is not correct for any person, enter the amount you expect will be the person’s [YYYY] PAI in the New or Correct [YYYY] PAI Amount column.

<table>
<thead>
<tr>
<th>Name</th>
<th>PAI Amount</th>
<th>Is this amount correct?</th>
<th>New or Correct [YYYY] PAI Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Yes or No</td>
<td></td>
</tr>
</tbody>
</table>
Other Information
Review each question below. If the answer is yes for you or anyone in your household, use the box below to explain which question the answer is yes for. Also write the name of the person answering yes.

- Stopped working or had hours, wages or salary decrease in the last six months?
- Has ongoing medical bills to meet a spenddown?
- Is seeking Medical Assistance payment of long-term-care services to reside in a long-term-care facility?
- Is seeking services to help a person stay in his or her home through a Medical Assistance home and community-based waiver program?
- Has a physical or mental health condition that limits the ability to work or perform daily activities?
- Is blind?
- Is getting services from the Center for Victims of Torture?
- Is in jail or prison?

Full Medical Assistance Determination
Some people may be eligible for Medical Assistance (MA) under different categories. These categories include people with disabilities, people who are blind, people who receive services from the Center for Victims of Torture, people seeking payment of long-term-care services, and people seeking community-based waiver services. In addition, people who have outstanding medical bills at application may qualify for coverage for three months before application, and people with excess income may qualify with a spenddown. We will screen you to see if you may be eligible for MA under a different category, using the information you gave us on this form or when you applied. We will contact you for more information if we think you might qualify. If one of these categories applies to you, but you have not reported information about that, call and tell your worker. If you want us to make a full MA determination for you, call your worker for more information.

Renewing Coverage in the Future
Each year, MNsure renews eligibility for help paying for health coverage. MNsure needs consent to use information from tax returns to renew your financial assistance for coverage. If you do not give consent to use this information, your financial assistance cannot be renewed. You can change your consent at any time. If you do not check a box, you are agreeing to the use of your information for 5 years.

I agree to the use of tax return information to renew my eligibility for help paying for health coverage for:

- [ ] 5 years
- [ ] 4 years
- [ ] 3 years
- [ ] 2 years
- [ ] 1 year
- [ ] Do not use information from tax returns to renew my eligibility for help paying for health coverage.
By signing below:

I received and reviewed the Notice of Privacy Practices and the Notice of Rights and Responsibilities. I know that I must report changes to the information listed on this renewal form.

I understand that if I am providing information on behalf of other people in my household, I must have consent to provide and view information about all the people that I have listed on this renewal form and agree to safeguard their information.

I declare under the penalties of perjury that this renewal form has been examined by me and to the best of my knowledge 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 to payment of a fine of not more than $10,000, or both. I understand that there may be other penalties for not telling the truth.

Additional Agreements for Medical Assistance and MinnesotaCare:

- If anyone on this renewal form is eligible for Medical Assistance or MinnesotaCare, I consent to the release of my Minnesota Health Care Programs health records to the parties listed in the Consent for Sharing of Medical Information section of the Notice of Rights and Responsibilities.

- If anyone on this renewal form is eligible for Medical Assistance, I give the Medical Assistance agency our rights to pursue and get any money from other health insurance, legal settlements, or other third parties.

- If I am a parent that is eligible for Medical Assistance, I know I will be asked to cooperate with the agency that collects medical support from an absent parent. If I think that cooperating to collect medical support will harm me or my children, I can tell the agency, and I may not have to cooperate. I give to the Medical Assistance agency the rights to medical support paid for my children.

- If anyone on this renewal form is eligible for Medical Assistance, I have read and understand that the state may claim repayment for the cost of medical care, or the cost of the premiums paid for care, from my estate or my spouse's estate.

- If anyone on this renewal form is eligible for Medical Assistance, I agree and understand that my information, and information about me shared from third parties, will be shared for fraud prevention investigations as stated in the Notice of Privacy Practices.

- If I or anyone in my household already receives Medical Assistance or MinnesotaCare, I understand that the state may stop or change benefits because of the information I give on this form. I understand that the state may make changes without 10 days’ advance notice. However, the state will send written notice no later than the effective date of the change.

If an enrollee is unable to sign, provide copies of legal documents of conservatorship or power of attorney.
How do I use my health care coverage?

If you qualify for Medical Assistance:

• You will get a Minnesota Health Care Programs (MHCP) member ID card showing your Medical Assistance ID number. Give your MHCP member ID card or Medical Assistance ID number to your health care providers.

• If you have medical bills for services received since the date you qualified for coverage, contact the health care provider and ask the provider to bill the State of Minnesota. The provider may be able to pay you back for bills you have already paid.

• You may be enrolled in a health plan. You will get information in the mail about choosing a health plan. Once you are enrolled, the health plan will send you an ID card and information telling you how to get services.

If you qualify for MinnesotaCare:

• If you have a MinnesotaCare premium: You must make a full payment for coverage to start. Your coverage starts on the first day of the month after you make your first payment. If you have not gotten it already, you will get your first premium notice in the mail. Send the payment to us as soon as you can.

• If you do not have a MinnesotaCare premium: Your coverage will start on the first day of the month after you were approved.

• You must enroll in a health plan: You will get information in the mail about choosing a health plan. You may be enrolled in an assigned health plan until we get your enrollment form. Once we get your enrollment form and you are enrolled, the health plan will send you an ID card and information telling you how to get services. You will also get an MHCP member ID card.

What if I have questions about this notice?

Call us if you have questions.

• For questions about Medical Assistance, call your county or tribal agency.

• For questions about MinnesotaCare, call MinnesotaCare Operations at 800-657-3672 or 651-297-3862.

• For general questions about Medical Assistance or MinnesotaCare, call the MHCP Member Help Desk at 651-431-2670 or 800-657-3739.

If you have hearing or speech disabilities, contact us using your preferred telecommunications relay service.

You can also visit us in person:

• For in-person help about Medical Assistance, go to your county or tribal agency.

• For in-person help about MinnesotaCare, go to the MinnesotaCare walk-in office.

• See the enclosed Agency Addresses form to get the address and phone number for your servicing agency.
Do I have to pay back the costs of my health care if I am receiving government assistance?

In certain circumstances, federal and state law require the Minnesota Department of Human Services and local agencies to recover costs that the MA program paid for its members. This recovery process is done through Minnesota’s MA estate recovery and lien program. Read the following if you are enrolled in MA.

If you are enrolled in MA, then, after you die, Minnesota must try to recover the costs of any long-term services and supports (LTSS) you received at 55 years old or older. LTSS include:

- Nursing home services
- Home and community-based services
- Related hospital and prescription drug costs

Even after you die, Minnesota cannot recover these costs if your spouse survives you, you have a child under 21 years old, or you have a child who is blind or permanently disabled. Once your spouse dies, Minnesota must try to recover your MA LTSS costs from your spouse’s estate. However, recovery is further delayed if you still have a child who is under 21 years old, blind, or permanently disabled. Your children do not have to use their assets to reimburse the state for any MA services you received.

Also, Minnesota must try to recover the costs of all MA services an MA member received at any age while permanently living in a medical institution. However, MA members who qualify for services under modified adjusted gross income (MAGI) eligibility criteria are not subject to recovery for services received before the age of 55.

The state may file an MA lien against your real property to recover MA costs before your death, but only if you are permanently living in a medical institution. The state also may file a notice of potential claim, which is a form of lien, against real property to recover MA costs after death. Liens to recover MA costs may be filed against the following:

- Your life estate or joint tenancy interest in real property
- Your real property that you own solely
- Your real property that you own with someone else

You have the right to speak with a legal-aid group or a private attorney if you have specific questions about how MA estate recovery and liens may affect your circumstance and estate planning. The Minnesota Department of Human Services cannot provide you with legal advice. For more information, go to http://mn.gov/dhs/ma-estate-recovery/.
What if I do not agree with the action MNsure or DHS took on my health care coverage?

If you think the decision in your health care notice is wrong, you have the right to appeal. An appeal is a legal process where a human services judge holds a hearing and reviews (1) a decision made by MNsure about qualified health plan (QHP) coverage, cost-sharing reductions, or advanced premium tax credits; (2) a decision by the Minnesota Department of Human Services (DHS) about MinnesotaCare coverage; or (3) a decision by a county or tribal agency about Medical Assistance coverage. You can learn more about how this works at www.mnsure.org/help/appeals and www.dhs.state.mn.us/appeals/faqs.

How do I appeal?
You can appeal by submitting your own written request, filling out a MNsure or DHS appeal form, or getting help by phone or in person. The MNsure Contact Center or your county or tribal agency can help you file your appeal.

<table>
<thead>
<tr>
<th>1. Internet</th>
<th>2. Phone (for help filing an appeal)</th>
<th>3. Mail</th>
<th>4. In person (appeals help only)</th>
</tr>
</thead>
</table>
| • Log in to your account at www.mnsure.org  
• Or fill out the DHS-0033 form at https://edocs.dhs.state.mn.us/lfserver/Public/DHS-0033-ENG and submit it electronically. | • Call the MNsure Contact Center at 855-366-7873.  
• Or call your county or tribal agency. | • Mail your request to MNsure 81 Seventh Street East Suite 300 St. Paul, MN 55101-2211.  
• Or mail it to Minnesota Department of Human Services Appeals Division PO Box 64941 St. Paul, MN 55164-0941. | Get appeals help in person at Minnesota Department of Human Services Information Desk 444 Lafayette Road North St. Paul, MN 55155. |

What can I appeal?
You can appeal any of these:

- MNsure, the county or tribal agency, or DHS failed to act on your request about health care coverage.
- MNsure, the county or tribal agency, or DHS processed your request too slowly.
- MNsure, the county or tribal agency, or DHS took an action you do not agree with (examples of actions: denial of Medical Assistance coverage, approval of coverage for a program you do not think you are eligible for, the amount of advanced premium tax credits you qualify for, a change in your MinnesotaCare benefits).
When must I appeal?
If your appeal involves Medical Assistance or MinnesotaCare, you must file your appeal within **30 days** of receiving your health care notice. If you show good cause for not appealing a Medical Assistance or MinnesotaCare action within **30 days**, you may be able to appeal up to **90 days** after the date of your health care notice. See below for more important information about time limits for Medical Assistance and MinnesotaCare appeals.

If your appeal involves QHPs, an advanced premium tax credit or cost-sharing reductions, you must file an appeal within **90 days** after the date of your health care notice.

*Important:* An appeal decision for one household member may affect the eligibility of other household members. Household eligibility may need to be redetermined.

Will my benefits continue during my appeal?
You may be able to continue to get the same benefits you were receiving at the time you got the health care notice. But you may have to file your appeal within a certain time limit:

- For Medical Assistance and MinnesotaCare enrollees, we usually must send you an advance notice 10 days or more before the effective date of an action, or we may send you a notice five days before an action, depending on the situation. Your benefits will automatically continue if you file your appeal by the effective date of the action on the advance health care notice. In a few situations we may send you a notice less than five days before an action, or on the effective date of an action. Your benefits will continue if you file an appeal within 15 days from the date of that health care notice. You must pay your monthly MinnesotaCare premium to get continued coverage during your appeal. Tell DHS in writing if you do not want your benefits to continue.

- For QHP-related appeals, tell MNsure that you want to continue your benefits when you file your appeal.

*Important:* If you lose your appeal, you may have to pay back the benefits you got while your appeal was pending.

*Important:* You have the right to apply for Medical Assistance or MinnesotaCare again if your benefits stop.

What if I need a hearing right away?
You have the right to ask for an expedited (sped-up) appeal. If you need a hearing right away, tell MNsure or DHS the reason when you file your appeal. To ask for a sped-up appeal for Medical Assistance or MinnesotaCare, contact the DHS Appeals Office at 800-657-3510 (outstate) or 651-431-3600 (metro).
What do I do after I file my appeal?
Gather information related to the action you are appealing that you think will prove or explain the reason you think the action was wrong.

You will get a letter telling you the date and time of the appeal hearing. Many hearings are done over the phone.

Continue to report changes (such as the start or stop of a job or changes in who lives with you) within these time frames:
- **30 days** if you have MinnesotaCare, a QHP, an advanced premium tax credit or cost-sharing reductions
- **10 days** if you have Medical Assistance

If you have Medical Assistance, report changes by calling your county or tribal agency. If you have MinnesotaCare, report changes by calling MinnesotaCare Operations at 800-657-3672 or 651-297-3862. If you have a QHP, report changes by calling the MNsure Contact Center at 855-366-7873.

Can I get help with my appeal?
You may speak for yourself at the hearing. You may also have someone else speak for you. You can let us know that you want someone else to speak for you at the hearing when you file your appeal. If your income is below a certain limit, you may be able to get legal advice or help with your appeal from your local legal aid office.
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
- creed
- public assistance status
- disability
- color
- religion
- marital status
- sex (including sex stereotypes and gender identity)
- national origin
- sexual orientation
- age
- political beliefs

Auxiliary Aids and Services: DHS provides auxiliary aids and services, like qualified interpreters or information in accessible formats, free of charge and in a timely manner to ensure an equal opportunity to participate in our health care programs. Contact the Minnesota Health Care Programs (MHCP) Member Help Desk at dhs.info@state.mn.us or 800-657-3739, 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 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
- age
- color
- disability
- national origin
- sex

Contact the OCR directly to file a complaint:

Director, U.S. Department of Health and Human Services’ Office for Civil Rights
200 Independence Avenue SW, Room 509F
HHH Building
Washington, DC 20201
800-368-1019 (voice) 800-537-7567 (TDD)
Complaint Portal: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

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
- religion
- sexual orientation
- color
- creed
- marital status
- national origin
- sex
- public assistance status
- disability

Contact the MDHR directly to file a complaint:

Minnesota Department of Human Rights
Freeman Building, 625 North Robert Street
St. Paul, MN 55155
651-539-1100 (voice) 800-657-3704 (toll free)
711 or 800-627-5529 (MN Relay)
651-296-9042 (fax) info.MDHR@state.mn.us (email)

Language Assistance Services: DHS provides translated documents and spoken language interpreting, free of charge and in a timely manner, when language assistance services are necessary to ensure limited English speakers have meaningful access to our information and services. Contact the Minnesota Health Care Programs (MHCP) Member Help Desk at dhs.info@state.mn.us or 800-657-3739, or use your preferred relay service.

DHS
You have the 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
- sexual orientation
- public assistance status
- sex (including sex stereotypes and gender identity)
- color
- marital status
- creed
- age
- religious
- disability

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
P.O. Box 64977
St. Paul, MN 55164-0997
651-431-3040 (voice) or use your preferred relay service
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 flurry: ከአማርኛ ከም ይህ ይህ የአማርኛ በማስ蒈ር ከተርጠ ከአማርኛ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይህ ይ hiểm