1.2.1
Minnesota Health Care Programs
Application Forms
Tell us about all the family members that live with you. If you file taxes, you need to know about everyone on your tax return.

DO include:
- Yourself
- Your spouse
- Your children under 19 that live with you
- Your spouse’s children under 19 that live with you
- Your unmarried partner, if you have children together
- Anyone you include on your tax return, even if that person does not live with you
- Anyone else under 19 who takes care of and lives with you

Include the people listed here, even if they do not need health care coverage.

DO NOT include:
- Your children 19 years old or older that you do not expect to claim as tax dependents
- Your spouse’s children 19 years old or older that you do not expect to claim as tax dependents
- Your unmarried partner’s children, if you are not related to you and you do not expect to claim them as tax dependents
- Other people that live in your home but are not your spouse or children and that you do not file taxes with
- Your parents, if you are 19 years old or older, your parents do not expect to claim you as a tax dependent, and you do not expect to claim them as tax dependents

These people may file a separate application for health care coverage.

The health coverage and help you qualify for depends on the number of people in your family and their incomes. This information helps us make sure everyone gets the best coverage he or she can.

Complete Step 2 for each person in your family. Start with yourself, then add other adults and children. If you have more than four people in your family, make copies of pages 14-17. You do not need to provide immigration status or a Social Security number (SSN) for people that are not applying for health care coverage. Filling in the SSN for all household members can speed up the application process. We use SSNs to check income and other information to see who is eligible for help with health care costs. If someone wants help getting an SSN, call 888-777-1213 or visit www.socialsecurity.gov. If you are a TTY user, call 800-325-0778, or use your preferred relay service.

Other family members. If you have other family members that were not included in Step 2 of this application that would like to have coverage under a family health plan, see Step 2 of this application (page 19).

Safe at Home Program. If your household is in Minnesota’s Safe at Home Program, you do not need to give us your full home address. In the Home Address spaces, you only need to provide the name of the county you live in and your home zip code. Write your Safe at Home Program address in the Mailing Address spaces.

Medical Assistance for Families, Children and Adults

MinnesotaCare

Advanced Premium Tax Credit
• Real time determination
• MA-FCA, Minnesota Care, APTC
• Applicants who are potentially eligible for other types of MA are referred for a further eligibility determination
Application for Certain Populations

All Applicants must fall into one of the populations:

- 65 years of age or older
- Medicare Savings Programs
- Older than 21 with no dependents and Medicare
- An adult receiving Supplemental Security Income (SSI)
- Applying for MA for Employed Persons with Disabilities (MA-EPD)
Application for Medical Assistance for Long-Term-Care Services (MA-LTC)

1. Information for the person living in or planning to live in a long-term-care facility or requesting services to help the person live at home or other settings in the community

<table>
<thead>
<tr>
<th>FIRSTNAME</th>
<th>MIDDLENAME</th>
<th>LASTNAME</th>
<th>DATE OF BIRTH</th>
</tr>
</thead>
</table>

- **Gender:**
  - Male
  - Female
  - Married
  - Widowed

- **Social Security Number:** Yes/No

- **Waivers:**
  - Choose a reason from the list on attachment.

- **Occupation of Next of Kin:**
  - Yes/No

- **Phone Number:**

- **Are you a veteran or the spouse of a veteran?:** Yes/No

- **Are you blind or do you have a physical or mental health condition that limits your ability to work or perform daily activities?:** Yes/No

- **Have you had a long-term-care consultation?:** Yes/No

- **What language do you speak most of the time?:**
  - Arabic
  - Black or African American
  - Amurican Indian or Alaskan Native
  - Asian
  - Hispanic
  - Native Hawaiian
  - Guamanian or Chamorro
  - Hawaiian
  - Other Pacific Islander
  - Other

- **Ethnicity:**
  - Mexican
  - Mexican American
  - Chicano or Chicana
  - Puerto Rican
  - Cuban
  - Other

- **Optional Information:**

Applicant:  
Date:  
}

Application for Medical Assistance for Long-Term-Care Services

- Long term care facilities
- Nursing facilities
- Waivers
### Application for Medical Assistance for Women with Breast and Cervical Cancer

1. **Tell us about yourself.**

   **First Name**: [Blank]
   **Last Name**: [Blank]
   **Date of Birth**: [Blank]
   **Do you have a Social Security number (SSN)?**
   - [ ] Yes
   - [ ] No
   **If you have a Social Security number (SSN), do you also have a Medicare number?**
   - [ ] Yes
   - [ ] No
   **If you have a Medicare number, have you ever been denied coverage by Medicare?**
   - [ ] Yes
   - [ ] No

2. **Housing Address**

   **Street Address**: [Blank]
   **City**: [Blank]
   **State**: [Blank]
   **Zip Code**: [Blank]
   **Phone Number**: [Blank]

3. **Work Address**

   **Street Address**: [Blank]
   **City**: [Blank]
   **State**: [Blank]
   **Zip Code**: [Blank]
   **Phone Number**: [Blank]

4. **Other Information**

   - **Race and Ethnicity**
     - [ ] White
     - [ ] Black or African American
     - [ ] Asian
     - [ ] Native American or Alaska Native
     - [ ] Hawaiian or Pacific Islander
     - [ ] Other
   - **Religion**
     - [ ] Catholic
     - [ ] Jewish
     - [ ] Muslim
     - [ ] Other
   - **Spouse or Partner**
     - [ ] Male
     - [ ] Female
   - **Do you need an interpreter?**
     - [ ] Yes
     - [ ] No

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### Sage Screening Process

- [ ] Sage Screening Process
Minnesota Family Planning Program Application

1. Tell us about yourself below.

   FIRST NAME
   MIDDLE INITIAL
   LAST NAME

   U.S. CITIZENSHIP NUMBER
   SOCIAL SECURITY NUMBER
   GENDER
   M F
   ARE YOU A PARENT?
   Y N

   MOTHER'S NAME
   FATHER'S NAME

   HOME ADDRESS
   CITY
   STATE
   ZIP CODE

   Mailing Address (if you would like the notice sent to a different address)
   CITY
   STATE
   ZIP CODE

   CHECK THIS BOX IF YOU ARE HOMELESS:

   DO YOU PLAN TO MAKE MINNESOTA YOUR HOME?
   YES
   NO
   CAN'T TELL

   COUNTRY OF ORIGIN

   STATE OF ORIGIN:

   LANGUAGE(s) UNDERSTOOD
   ENGLISH
   SPANISH
   OTHER

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

   Are you Latino or Hispanic origin?
   YES
   NO

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

   *You do not need to give us your Social Security number if you are applying only for short-term MCOV coverage.

2. What is your household and income information?

   Complete these questions if you are applying for short-term MCOV coverage.

   a. How many family members live in your household? (Include yourself, parent, spouse, and children under age 18 who live with you.)

   b. How much is the income for your household? (Choose one and fill in the amount). If you are under 21, count only your own income.
   ○ Yearly amount: $__________
   ○ Monthly amount: $__________
   ○ Weekly amount: $__________
MHCP Application Supplements
Supplement to MNsure Application for Health Coverage and Help Paying Costs

• Ineligible for MA under Families, Children and Adults Basis

• Gets to Aged, Blind and Disabled Basis
Supplement to the Minnesota Health Care Programs Application for Certain Populations

Section A  Tell us about yourself.

1. FIRST NAME, MIDDLE NAME, LAST NAME, SUFFIX

2. PHONE NUMBER where we can call you:
   - Cell
   - Home
   - Work

3. DATE OF BIRTH (mm/dd/yyyy)

4. SOCIAL SECURITY NUMBER (SSN)

5. PROVIDER/contact information about this application:
   - Email
   - Yes
   - No
   - EMAIL ADDRESS

6. U.S. Postal Mail:
   - Yes
   - No
   - MAILING ADDRESS

Section B  Complete this section.

1. Do you plan to file a federal income tax return NEXT YEAR?
   - Yes — answer questions a–c
   - No — go to question e
   (You can still apply for health insurance even if you do not file a federal income tax return.)

a. Will you file jointly with a spouse?
   - Yes
   - No

b. Will you claim any dependents on your tax return?
   - Yes
   - No

c. Will you be claimed as a dependent on someone else’s tax return?
   - Yes
   - No

2. Is anyone applying pregnant?  No
   - Yes — fill in below

   NAME

   HOW MANY BABIES ARE EXPECTED DURING THIS PREGNANCY?

3. Is everyone applying a U.S. citizen or U.S. national?  No
   - Yes — go to question 4

   NAME OF NON-CITIZEN

4. Do you want help paying for a medical emergency?  No
   - Yes

   Are you, or your spouse or parent, a veteran or active-duty member of the military?  No
   - Yes

5. Are you or is anyone in your family American Indian or Alaska Native?  No
   - Yes — you need to complete and include Appendix B

- Ineligible for MA under Aged Blind and Disabled Basis
- Gets to a Families, Children and Adults Basis
Thank you