Clear Form

Minnesota Department of **Human Services**

DHS-2140-ENG 11-14

Application for Social Services

Purpose

This is an application for social services. It allows you to tell the agency what you need help with and how you would like the agency to help you meet those needs.

Applicant

NAME (Last, First, MI)			GENDER ◯ Male ◯ Female	MARRIED* (check one) ◯ N ◯ M ◯ S ◯ L ◯ D ◯ W
ADDRESS			HISPANIC HERITAGE *(optional)* ◯ Yes ◯ No	RACE** *(optional)* (check all that apply) ☐ N ☐ A ☐ B ☐ P ☐ W
CITY	STATE	ZIP CODE	PHONE NUMBER	SOCIAL SECURITY NUMBER
DATE OF BIRTH	DISABILITY			

What is your preferred spoken language? _____ Do you need an interpreter? ◯ Yes ◯ No

What is your preferred written language? _____

***Married codes**: **N**–Never **M**–Married living with spouse **S**–Separated **L**–Legally separated **D**–Divorced **W**–Widowed
****Race codes:** **N**–American Indian/Alaska Native **A**–Asian **B**–Black or African American **P**–Pacific Island/Native Hawaiian **W**–White

Why did you come to the agency and what help do you need?

What kind of help do you expect from the agency?

By signing below:

- I acknowledge my worker gave me a copy of the "Notice of Privacy Practices" information sheet and the "Your responsibilities" and "Your rights" pages from this form and explained them to me.
- I understand that my eligibility for social services may be related to my income.
- I understand the agency may review my income at least every six months. I agree to notify the agency of any changes in my financial situation which may affect eligibility for services.
- I declare that I have examined all information on this application and, to the best of my knowledge and belief, it is a true and correct statement of every material point.

APPLICANT SIGNATURE (explain if unable to sign)	DATE	**Applicant has received:**
APPLICANT'S AUTHORIZED REPRESENTATIVE (if applicable)	DATE	Copy of application page one given to applicant. ◯ Yes ◯ No R&R given to applicant. ◯ Yes ◯ No Notice of Privacy Practices given to applicant. ◯ Yes ◯ No
AGENCY REPRESENTATIVE	DATE	

Attention. If you need free help interpreting this document, ask your worker or call the number below for your language.

ملاحظة: إذا أردت مساعدة مجانية لترجمة هذه الوثيقة، اطلب ذلك من مشرفك أو اتصل على الرقم 1-800-358-0377.

កំណត់សំគាល់ ។ បើអ្នកត្រូវការជំនួយក្នុងការបកប្រែឯកសារនេះដោយឥតគិតថ្លៃ សូមសួរអ្នកកាន់សំណុំរឿង របស់អ្នក ឬហៅទូរស័ព្ទមកលេខ 1-888-468-3787 ។

Pažnja. Ako vam treba besplatna pomoć za tumačenje ovog dokumenta, pitajte vašeg radnika ili nazovite 1-888-234-3785.

Thov ua twb zoo nyeem. Yog hais tias koj xav tau kev pab txhais lus rau tsab ntaub ntawv no pub dawb, ces nug koj tus neeg lis dej num los sis hu rau 1-888-486-8377.

ໂປຣດຊາບ. ຖ້າຫາກ ທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປເອກະສານນີ້ຟຣີ, ຈົ່ງຖາມພະນັກງານກ່ຽວກັບການຊ່ວຍເຫຼືອ ຂອງທ່ານ ຫຼື ໂທຣໄປທີ່ 1-888-487-8251.

Hubachiisa. Dokumentiin kun bilisa akka siif hiikamu gargaarsa hoo feete, hojjettoota kee gaafadhu ykn afaan ati dubbattuuf bilbilli 1-888-234-3798.

Внимание: если вам нужна бесплатная помощь в устном переводе данного документа, обратитесь к своему социальному работнику или позвоните по телефону 1-888-562-5877.

Digniin. Haddii aad u baahantahay caawimaad lacag-la'aan ah ee tarjumaadda qoraalkan, hawlwadeenkaaga weydiiso ama wac lambarka 1-888-547-8829.

Atención. Si desea recibir asistencia gratuita para interpretar este documento, comuníquese con su trabajador o llame al 1-888-428-3438.

Chú ý. Nếu quý vị cần được giúp đỡ dịch tài liệu này miễn phí, xin gọi nhân viên xã hội của quý vị hoặc gọi số 1-888-554-8759.

LB1-0001 (3-13)

ADA5 (12-12)

This information is available in accessible formats for individuals with disabilities by contacting your county worker. For other information on disability rights and protections to access human services programs, contact the agency's ADA coordinator.

Other household members

***Married codes**: **N**–Never **M**–Married living with spouse **S**–Separated **L**–Legally separated **D**–Divorced **W**–Widowed
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SOCIAL SECURITY NUMBER	DATE OF BIRTH	HISPANIC HERITAGE *(optional)* ◯ Yes ◯ No	RACE** *(optional)* (check all that apply) ☐ N ☐ A ☐ B ☐ P ☐ W
RELATIONSHIP	DISABILITY		

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RELATIONSHIP	DISABILITY		

Financial information

Do you receive assistance from:

- Diversionary Work Program (DWP)/Minnesota Family Investment Program (MFIP)? ◯ Yes ◯ No
  Are you an adult caretaker of children who receive DWP/MFIP? ◯ Yes ◯ No
- General Assistance (GA)? ◯ Yes ◯ No
- Minnesota Supplemental Aid (MSA)? ◯ Yes ◯ No
- Medical Assistance/MinnesotaCare? ◯ Yes ◯ No
- Supplemental Security Income (SSI)? ◯ Yes ◯ No
  If yes, check the reason: ☐ Aged ☐ Blind ☐ Disabled

Complete the information below on income for **all** family members (including yourself) who are 14 years of age or older.

Kind of income	Person(s) receiving	Monthly gross amount	County verification
Wage or salary: Person 1		$	
Wage or salary: Person 2		$	
Wage or salary: Person 3		$	
Net self-employment income		$	
Net farm income		$	
Unemployment Insurance		$	
Workers' Compensation		$	
Social Security (RSDI)		$	
Veteran benefits (VA)		$	
Pensions and annuities		$	
Child support		$	
Alimony		$	
Other income such as: dividends/interest, rental, royalties		$	
	Total	$ 0	

(Tear off here)

Your responsibilities

NOTE: If you sign this application as an *Authorized Representative* of a person who is requesting or receiving assistance, you are agreeing to assume all of the following responsibilities on behalf of that person.

- **You must report changes which may affect your services to the county agency** after the change has occurred. ***Applicants*** – Report these changes to your worker when the change happens.

  This includes the following for everyone in your household:
  - **Household** – When a person dies, moves in or out of your home, or temporarily leaves; pregnancy; birth of a child
  - **Income** – Receipt or change in child support, Social Security, Veterans Benefits, Unemployment Insurance, inheritance, insurance benefits and other payments
  - **Employment** – Start or stop a job or business; change in hours, earnings or expenses
  - **Property** – Purchase, sale or transfer of a house, car or other items of value
  - **Address**
  - **Drug felony conviction**
  - **Housing costs/rent subsidy**
  - **Marriage or divorce**
  - **Filing a lawsuit**
  - **School attendance**
  - **Health insurance**
  - **Absent parent custody or visits**

- **The county, state or federal agency may check any of the information you give.** To get some information we must have your signed consent. If you don't allow the county to confirm your information, you might not get services.

- **If you give us information you know is untrue or we get information you did not report**, we may investigate you for fraud.

- **Contact your worker** if you have questions or are unsure about any reporting rules.

Your rights

- **Your right to privacy.** Your private information, including your health information, is protected by state and federal laws. Your worker has given you a "Notice of Privacy Practices" information sheet. Please read it carefully. This sheet explains:
  - Why we are asking you to give us your private information
  - How we may use and share private information about you
  - Why we ask for your Social Security number
  - Your rights about your private information. You can:
    - Ask about how we can use information and with whom we will share this information
    - Ask to get this information in another format
    - Ask to see your information
    - Ask whom we have given your information to
    - File a privacy complaint.
  - How we must legally protect your private information
  - Whom you can contact if you think your private information has been mishandled.

  For more information about your data privacy rights or a copy of the Notice of Privacy Practices (DHS-3979), ask your worker. You can also get a copy of this notice at https://edocs.dhs.state.mn.us/lfserver/Public/DHS-3979-ENG.

- **You have the right to apply for** any of the agency's applicable social services.

- **You have the right to know why, if we have not processed your application promptly.**

- **You have the right to information about services.**

■ **Appeal rights.** You have the right to appeal if the county denies, reduces, suspends or terminates social services or if you or your authorized representative do not agree with the services identified in your service plan. To start an appeal, send a very short letter saying you want to appeal to:

Write:
Minnesota Department of Human Services
Appeals Office
P.O. Box 64941
St. Paul, MN 55164-0941

Call:
Metro: 651-431-3600 (Voice)
Outstate: 800-657-3510
TTY: 800-627-3529
Fax: 651-431-7523

The Appeals Office will hold a hearing and allow both you and/or your authorized representative and the county to explain their positions. Shortly after the hearing the Appeals Office will issue a written decision, outlining the facts in your case and determining if the county has acted correctly.

■ **Your right to file a discrimination complaint.**

If you feel that your county human service agency or the Minnesota Department of Human Services discriminated against you in the handling of your public assistance application or benefits because of your race, color, national origin, political beliefs, religion, creed, sex, sexual orientation, public assistance status, age, or disability, you have the right to file a discrimination complaint with your county agency or any of the following agencies. Your county agency or the Department of Human Services may refer your complaint to another agency if it does not have authority over it. You can also go directly to one of the federal agencies listed below to file your discrimination complaint.

Minnesota Department of Human Services
Equal Opportunity and Access
P.O. Box 64997
St. Paul, MN 55164-0997
651-431-3040 (Voice)
866-786-3945 (TTY)
651-431-7444 (Fax)

Minnesota Department of Human Rights
Freeman Building
625 Robert Street North
St. Paul, MN 55155
651-539-1100 (Voice)
651-296-1283 (TTY)
800-657-3704 (Toll-Free Voice)
651-296-9042 (Fax)

The Minnesota Department of Human Rights prohibits discrimination in public services programs because of race, color, creed, religion, national origin, disability, sex, sexual orientation, or public assistance status.

U.S. Department of Health and Human Services
Office for Civil Rights
Region V
233 North Michigan Avenue, Suite 240
Chicago, IL 60601
312-886-2359 (Voice)
312-353-5693 (TTY)

The U.S. Department of Health and Human Services' Office for Civil Rights prohibits discrimination in its programs because of race, color, national origin, disability, age, religion, or sex.