DEPARTMENT OF HUMAN SERVICES

Minnesota Family Planning Program (MFPP) Application and Renewal Form

(Part of Minnesota Health Care Programs)

What is this form for?

Use this form to apply for, or renew MFPP.

- To apply for MFPP short-term coverage, fill out pages 1-2 and sign page 7.
- To apply for ongoing MFPP (with or without short-term coverage) or to renew MFPP, fill out the entire form.

Can I get coverage right away?

- Some clinics use this form to see whether you can get short-term MFPP coverage. Short-term MFPP coverage starts right away and lasts for up to two months.
- Call MFPP at 651-431-3480 or 888-702-9968 (outside the Twin Cities metro area) to find a clinic that can give short-term MFPP coverage.

What do I need to do with this form?

- Read the Notice of Privacy Practices and Notice of Rights and Responsibilities on Attachment A. Tear off these pages and keep them.
- Answer all questions on pages 1-6. If you are filling this out by hand, use blue or black ink. Print clearly.
- Sign and date the form on page 7.
- Mail or fax the completed form to this address:

  Minnesota Department of Human Services
  PO Box 64960
  St. Paul, MN 55164-0960
  Fax: 651-431-7532

How do I apply for health coverage beyond family planning?

You can apply for health coverage and help paying costs in the following ways:

- Apply online at www.mnsure.org
- Fill out the Application for Health Coverage and Help Paying Costs (DHS-6696) (PDF). Find this application at www.mnsure.org. Or have one mailed to you by calling 651-539-2099 (855-366-7873 outside the Twin Cities).
- In person: There may be a navigator or broker in your area that can help. Visit www.mnsure.org, or call 651-539-2099 (855-366-7873 outside the Twin Cities) for more information.

Questions?

If you have questions or need help filling out this form, call 651-431-3480 or 888-702-9968 (outside Twin Cities metro area).

651-297-3862 or 800-657-3672

Attention. If you need free help interpreting this document, call the above number.

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ملاحظة: إذا أردت مساعدة مجانية لترجمة هذه الوثيقة، اتصل على الرقم أعلاه.

သတိ။ ဤစာရွက်စာတမ်းအားအခမဲ့ဘာသာပြန်ပေးခြင်း အကူအညီလိုအပ်ပါက၊ အထက်ပါဖုန်းနံပါတ်ကိုခေါ်ဆိုပါ။

កំណត់សំគាល់ ។ បើអ្នកត្រូវការជំនួយក្នុងការបកប្រែឯកសារនេះដោយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទតាមលេខខាងលើ ។

請注意，如果您需要免費協助傳譯這份文件，請撥打上面的電話號碼。

Attention. Si vous avez besoin d'une aide gratuite pour interpréter le présent document, veuillez appeler au numéro ci-dessus.

Thov ua twb zoo nyeem. Yog hais tias koj xav tau kev pab txhais lus rau tsab ntaub ntawv no pub dawb, ces hu rau tus najnpawb xov tooj saum toj no.

ဟ်သူဉ်ဟ်သးဘဉ်တက့်.ဖဲနမ့်လိဉ်ဘဉ်တ်မၤစၢၤကလီလၢတ်ကကျိးထံဝဲဒဉ်လံာ်တီလံာ်မိတခါအံၤနူဉ်,ကိးဘဉ်လီတဲစိနိုဂ်ံလၢထးအံၤနူဉ်တက့်.

알려드립니다. 이 문서에 대한 이해를 돕기 위해 무료로 제공되는 도움을 받으시려면 위의 전화번호로 연락하십시오.

ໂປຣດຊາບ. ຖ້າຫາກ ທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປເອກະສານນີ້ຟຣີ, ຈົ່ງໂທຣໄປທີ່ໝາຍເລກຂ້າງເທິງນີ້.

Hubachiisa. Dokumentiin kun tola akka siif hiikamu gargaarsa hoo feete, lakkoobsa gubbatti kenname bilbili.

Внимание: если вам нужна бесплатная помощь в устном переводе данного документа, позвоните по указанному выше телефону.

Digniin. Haddii aad u baahantahay caawimaad lacag-la'aan ah ee tarjumaadda (afcelinta) qoraalkan, lambarka kore wac.

Atención. Si desea recibir asistencia gratuita para interpretar este documento, llame al número indicado arriba.

Chú ý. Nếu quý vị cần được giúp đỡ dịch tài liệu này miễn phí, xin gọi số bên trên.

LB2 (10-20)

ADA Advisory

For accessible formats of this information or assistance with additional equal access to human services, write to DHS.info@state.mn.us, call 800-657-3672, or use your preferred relay service. ADA1 (2-18)

Clear Form

DEPARTMENT OF HUMAN SERVICES

DHS-4740-ENG 2-23

MINNESOTA HEALTH CARE PROGRAMS (MHCP)

Minnesota Family Planning Program Application

Provider Use Only (If PE is approved, complete the information here and fax pages 1-2 and 7 to 651-431-7532.)			
☐ PE ONLY ☐ FULL APPLICATION OR RENEWAL			
PROVIDER NAME			
STREET ADDRESS	CITY	STATE	ZIP CODE
NPI	PROVIDER PHONE NUMBER	DATE PE APPROVED	

1. Tell us about yourself. Use a separate form for each person applying.

FIRST NAME	MIDDLE NAME	LAST NAME
DATE OF BIRTH (MM/DD/YYYY)	SEX ◯ Male ◯ Female	Are you pregnant? ◯ Yes ◯ No
PHONE NUMBER where we can call you ◯ Cell ◯ Home ◯ Work	OTHER PHONE NUMBER where we can call you ◯ Cell ◯ Home ◯ Work	
SOCIAL SECURITY NUMBER (SSN) You do not need to give us your SSN if you are applying for short-term coverage only.*	☐ Check here if you are homeless. If you checked this box, in which county do you live?	

HOME ADDRESS (Address where you live)**			APARTMENT OR SUITE NUMBER
CITY	STATE	ZIP CODE	COUNTY
MAILING ADDRESS (If different from home address)			APARTMENT OR SUITE NUMBER
CITY	STATE	ZIP CODE	COUNTY

Answer yes or no to the following questions:

a. Do you plan to make Minnesota your home? ◯ Yes ◯ No

b. Did you enter Minnesota with a job commitment or to seek employment? ◯ Yes ◯ No

YOUR PREFERRED SPOKEN LANGUAGE	YOUR PREFERRED WRITTEN LANGUAGE	Do you need an interpreter? ◯ Yes ◯ No
SELECT YOUR PREFERRED METHOD OF CONTACT ABOUT THIS FORM EMAIL ◯ Yes ◯ No U.S. POSTAL MAIL ◯ Yes ◯ No	EMAIL ADDRESS	

* SSN. See the Notice of Privacy Practices and Notice of Rights and Responsibilities (Attachment A) for information about SSNs.

** 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.

ETHNICITY AND RACE: You do not have to answer these questions to get health care. We use this information to identify groups of people who have health concerns and try to find ways to improve their care.

a. Are you of Hispanic, Latino or Spanish origin?

◯ No, not Hispanic, Latino or Spanish origin ◯ Yes – check all that apply

☐ Yes, Cuban ☐ Yes, Mexican, Mexican American or Chicano/a ☐ Yes, Puerto Rican

☐ Yes, other: _____ ☐ I choose not to answer

b. Race (check all that apply):

☐ American Indian or Alaska Native ☐ Asian Indian ☐ Black or African American ☐ Chinese

☐ Filipino ☐ Guamanian or Chamorro ☐ Japanese ☐ Korean

☐ Native Hawaiian ☐ Other Asian ☐ Other Pacific Islander ☐ Samoan

☐ Vietnamese ☐ White ☐ Other: _____

☐ I choose not to answer

2. Tell us about your household and income information

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

a. How many family members live in your household? _____

Include yourself, your spouse, your children under 19, and your spouse's children under 19. If you are under age 19, include your parents and your siblings under age 19. You may include family members who live with you but are temporarily away from home.

b. How much is the total income for your household? Please provide your best estimate here. If you are under age 21, count only your own income. (Choose one and fill in the amount.)

◯ Yearly amount $ _____ ◯ Monthly amount $ _____ ◯ Weekly amount $ _____

STOP HERE IF YOU ARE APPLYING FOR SHORT-TERM COVERAGE ONLY: GO TO PAGE 7 TO SIGN THE APPLICATION

Fill out the rest of the form if you are applying for ongoing coverage or renewing coverage.

3. Tell us about your household

a. What is your marital status? ◯ Legally separated ◯ Married ◯ Divorced ◯ Widowed ◯ Never Married

b. If you are married, do you live with your spouse? ◯ No – go to question c ◯ Yes – fill in spouse's name
Include a spouse who is living away from home for a short time.
Name of spouse: _____

c. Do you live with your children or stepchildren (under age 19)? ◯ No – go to question d ◯ Yes – fill in name(s)
Include children who are living away from home for a short time.
Names of children: _____

d. Do you live with your siblings (under age 19)? ◯ No – go to question e ◯ Yes – fill in name(s)
Names of siblings: _____

e. Is anyone you listed pregnant? ◯ No – go to question 4 ◯ Yes – fill in information
If yes, who? _____ How many babies are expected? _____

4. Tell us about your federal income tax filing status

(You can still apply for MFPP even if you do not file a federal income tax return.)

Do you plan to file a federal income tax return next year? ◯ Yes – answer questions a-c ◯ No – go to question c

a. Will you file jointly with a spouse? ◯ Yes ◯ No
If yes, name of spouse: _____

b. Will you claim any dependents on your tax return? ◯ Yes ◯ No
If yes, list name(s) of dependent(s): _____
What is your relationship to the dependent(s)? _____

c. Will you be claimed as a dependent on someone else's tax return? ◯ Yes ◯ No
If yes, list the name of the tax filer: _____
How are you related to the tax filer? _____

5. Do you, or does anyone you listed in question 3, have a job?

◯ No – go to question 6 ◯ Yes – fill in the information

Note: If you are under age 21, include only your own income.

Name	Employer name	Is this a seasonal or temporary job?	How often paid? (weekly, every two weeks, monthly, other)	Gross income per pay period	Date of most recent paycheck
		◯ Yes ◯ No		$	
		◯ Yes ◯ No		$	
		◯ Yes ◯ No		$	
		◯ Yes ◯ No		$	

You must give us proof of this income. Proof can be recent pay stubs, a statement from your employer, or your most recent federal tax return if your income has not changed.

6. Are you, or is anyone you listed in question 3, self-employed?

◯ No – go to question 7 ◯ Yes – fill in the information

Note: If you are under age 21, include only your own income.

Include income or loss from farming, fishing or other business.

Name of person	Name of business	Yearly income or loss amount
		$
		$

You must give us proof of this income. Proof can be your most recent federal income tax return (including all related schedules and forms) or your business records if you do not file a tax return.

7. Do you, or does anyone you listed in question 3, get money from sources other than work or self-employment?

◯ No – go to question 8 ◯ Yes – fill in the information

Note: If you are under age 21, include only your own income.

Do not include child support, workers' compensation, Supplemental Security Income (SSI) benefits, or veterans' benefits. Include any one-time lump-sum income; unemployment benefits; pension or other retirement income; Social Security disability or retirement benefits; alimony received; net rental or royalty income; and interest and dividends.

Name	Type of income	Start date	Amount	How often received	Date payment last received
			$		
			$		
			$		
			$		

You must give us proof of this income. Proof can be a statement from the place that sends the income or a direct deposit statement from your bank.

8. Do you, or does anyone you listed in question 3, have income adjustments?

◯ No – go to question 9 ◯ Yes – fill in the information

Note: If you are under age 21, include only your own income adjustments.

If you pay for certain things that can be subtracted from gross income on a federal income tax return, telling us about them could help you qualify for MFPP. (See the list of allowed income adjustments on Attachment B.)

Type of adjustment	Amount	How often?
	$	
	$	
	$	

You must give us proof of these adjustments. Proof can be your most recent federal income tax return that shows these adjustments or other statements or receipts for these expenses.

9. Is any part of the income you reported in questions 5, 6 and 7 educational funds or American Indian or Alaska Native income?

Educational funds are scholarships, awards or grants that are used for educational purposes.

American Indian or Alaska Native income is:

- per-capita or other payments from a tribe that come from natural resources, usage rights, leases, or royalties;
- payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations); and
- student financial assistance provided under the Bureau of Indian Affairs education programs.

◯ No, none of the income I listed is from these sources ◯ Yes – fill in the information

Amount of educational funds used for educational purposes	$
Amount of American Indian or Alaska Native income from the sources above	$

You must give us proof of these adjustments. Proof can be your most recent federal income tax return that shows these adjustments or other statements or receipts for these expenses.

10. Do you have health insurance?

◯ No, I do not have health insurance.

◯ Yes, I have or may have health insurance. But I do not want you to contact my insurance company. I have good reason for not giving you insurance information. I would be at risk of physical or emotional harm if I gave it. The risk could come from asking the policyholder for insurance information, or from the insurance company telling the policyholder about the services I get.

◯ Yes, I have health insurance. You may contact my insurance company. I understand the insurance company may tell the policyholder about my health coverage. Complete the following information or send us a copy of the front and back of your insurance card.

TYPE OF COVERAGE ◯ Individual ◯ Group ◯ Prescription drug ◯ Medicare ◯ Other			
POLICYHOLDER'S NAME			POLICY HOLDER DATE OF BIRTH
INSURANCE COMPANY NAME			
START DATE	END DATE	GROUP NUMBER	NAME OF INSURANCE POLICY

11. If you did not provide a Social Security number (SSN) on page 1, please answer the following questions. Go to question 12 if you already provided your SSN.

Do you have an SSN?

◯ Yes – what is your SSN? _____

◯ No – have you applied for an SSN? ◯ Yes ◯ No

If no, why not?

◯ Not eligible for an SSN ◯ Can be issued for non-work reason only ◯ Religious objections ◯ Other reason

*See the Notice of Privacy Practices and Notice of Rights and Responsibilities (Attachment A) for information about SSNs.

12. Are you a U.S. citizen or U.S. national?

◯ Yes – go to question 14 ◯ No – go to question 13

You do not need to answer this question if you are renewing your coverage.

(A U.S national is a person born in American Samoa or Swains Island, a person born outside the U.S with one or both parents who are U.S nationals, or a person in the Northern Mariana Islands who chose to be a U.S. national.)

13. What is your current immigration status?

Choose a status code from the list in Attachment B, or write in your status if it is not on the list.

Code or Status: _____

a. Immigration Document Type: _____

b. Alien ID Number: _____

c. Card Number: _____

d. Did you enter the United States before August 22, 1996? ◯ Yes ◯ No

e. Have you lived in the United States for five years or more in a qualified status? (See Attachment B to determine whether you have a qualified status.)
◯ Yes ◯ No

f. Do you have a sponsor? ◯ Yes ◯ No

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

h. Did you ever have an immigration status different from your current status (example: refugee or asylee)?
◯ No ◯ Yes – What is your previous immigration status?

(Choose a status code from Attachment B, or write in your previous status below if it is not on the list.)

Code or status: _____ Original date of entry: _____ (MM/DD/YYYY)

14. Do you want help from MFPP to pay for family planning medical bills from the past three months?

You do not need to answer this question if you are renewing your coverage. (The start date for MFPP can go back up to three months from your initial application date if you have family planning medical bills from that time and meet the MFPP requirements.)

◯ No – go to question 15 ◯ Yes – answer questions a and b.

a. How many months? ◯ One ◯ Two ◯ Three

b. Is everything you told us on the application the same for the past month(s)? ◯ Yes ◯ No

15. Do you want someone to act on your behalf as an authorized representative?

You can give a trusted person permission to talk about this application with us, see your information and act for you on matters related to this application, including getting information about your application and signing your application on your behalf.

◯ Yes – complete Attachment C ◯ No

Signature Page

(Effective Date: January 2023)

Read the following information and sign.

Please read this page and the Notice of Privacy Practices and Notice of Rights and Responsibilities in Attachment A before signing and giving the date on this page.

By signing here:

- I received and reviewed the Notice of Privacy Practices and the Notice of Rights and Responsibilities (Attachment A). I know that I must report changes to the information listed on this application.
- I understand that my information will be released to the parties listed in the Notice of Privacy Practices (Attachment A) and the Notice of Rights and Responsibilities (Attachment A) to verify eligibility for MFPP.
- I agree to the release of my MFPP records to the parties listed in the "Consent for Sharing of Medical Information" section of the Notice of Rights and Responsibilities.
- 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 the application and agree to safeguard their information.
- I agree to assign my medical benefits as stated in the "Assignment of Medical Payments" section of the Notice of Rights and Responsibilities, when applicable.
- I understand that I am required to report changes to my worker within 10 days of a change happening as stated in the "Changes" section of the Notice of Rights and Responsibilities.
- I understand that the state may make certain changes without 10 days advance notice. However, the state will send me written notice no later than the effective date of the change.

I declare under the penalties of perjury that this application 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 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.

Renewing Coverage

Enrollees in MFPP must have eligibility renewed every 12 months.

Note to those using this Minnesota Family Planning Program Application and Renewal Form (DHS-4740) to renew coverage: Mail or fax this completed renewal and proofs to the address or fax on this page. The form is due before the renewal date.

YOUR SIGNATURE	DATE

Submit your completed and signed application or renewal form to:

Minnesota Department of Human Services
PO Box 64960
St. Paul, MN 55164-0960
Fax: 651-431-7532

If you have questions or need help filling out this form, call 651-297-3862 or 800-657-3672 (outside Twin Cities metro area).

If you want to register to vote in Minnesota, you can complete a voter registration form at sos.state.mn.us.

MINNESOTA DEPARTMENT OF HUMAN SERVICES

Notice of Privacy Practices and Notice of Rights and Responsibilities

(Effective Date: December 2022)

Notice of Privacy Practices

This notice informs you of the privacy practices of the Minnesota Department of Human Services, and your rights and responsibilities when applying for and enrolling in health insurance coverage through this agency.

The Minnesota Department of Human Services manages eligibility and enrollment in the Minnesota Family Planning Program (MFPP).

This part of the notice describes how private or confidential information about you and your family may be used and disclosed.

Why do we ask for this 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 and mental health services and decide whether you can pay for some services
- To make reports, do research, do audits, and evaluate our programs
- To investigate reports of people that may lie about the help they need or to get assistance they may not be entitled to receive
- 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

Why do we ask you for your Social Security number?

We need a Social Security number (SSN) for every person applying for health care coverage, if they have one. (See 42 CFR § 435.910.)

You do not have to give us the SSN for people in your home that are not applying for coverage, but providing an SSN may help speed up the application process.

We use SSNs to verify identity and prevent duplication of state and federal benefits. Additionally, SSNs are used to conduct computer data matches with federal and local agencies to verify income, resources and other information that may affect your eligibility or benefits. We will keep all the information you provide private and secure, as required by law. We will use personal information only to check if you're eligible for health coverage.

If someone who is applying does not have an SSN, he or she may be required to apply for one to get Medical Assistance. There are exceptions to this for people who:

- are not eligible for a Social Security number,
- can only get a Social Security number for a valid non-work reason, or
- refuse to get a Social Security number due to a well-established religious objection.

If you want help getting an SSN, visit socialsecurity.gov, or call 800-772-1213. TTY users should call 800-325-0778.

Why do we ask for your income information?

We ask for income information and check state and federal sources to confirm your income and family size. We will use this information only for the purposes authorized by law, such as verifying eligibility or determining eligibility for the advanced premium tax credit and cost-sharing reductions, and the amount of the credit or reduction. We will not share this information with any other person or entity.

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 share information about you only as needed and as allowed or required by law. For all programs, we may share your information with the following agencies or people that need the information to do their jobs:

- Employees or volunteers with other state, county, local, federal, and partner nonprofit and private agencies
- Researchers, auditors, investigators, and others that do quality-of-care reviews and studies or begin prosecutions or legal actions related to managing the human services programs
- Court officials, county attorneys, attorneys general, other law enforcement officials, fraud investigators, and fraud prevention investigators
- Health care insurers, health care agencies, managed care organizations and others that pay for your care
- Guardians, conservators or people with power of attorney who are authorized representatives
- Certified application counselors, in-person assisters, and navigators and anyone else the law says we must or can give the information to

What are our responsibilities?

- We must protect the privacy of your personal, health care and other 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 will not sell any data collected, created or maintained as part of this application.
- We must follow the terms of this notice and give you a copy of it, but we may change our privacy policy. Those changes will apply to all information we have about you. The new notice will be available on request, and we will put changes to it on our website at https://edocs.dhs.state.mn.us/ lfserver/ Public/DHS-4839K-ENG and www.mnsure.org.
- The law requires us to keep your private information private and secure.
- As the law requires, if something happens that causes your private information to no longer be private and secure, we will let you know.

This part of the notice describes how medical or other information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

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, such as health and claims records. You may have to pay for the copies.
- You can choose someone to act for you with a medical power of attorney or as a legal guardian. That person can exercise your rights and make choices about your information.

Ask us to correct health or other records about you

You may question whether 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 anytime information is shared.

Request confidential communications

- You have the right to ask us in writing to share health information with you in a certain way or in a certain place.
- We will consider all reasonable requests. We must say yes if you tell us you would be in danger if we did not. 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.

Ask us to limit what we use or share

You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say no if it would affect your care.

Get a list of those with whom we've shared information

- This list will not include disclosures for treatment, payment, and health care operations. It will also not include certain other disclosures, such as any you asked us to make.
- We will provide one list a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
- If you do not understand the information, ask your worker to explain it to you. You may ask the Minnesota Department of Human Services or MNsure for another copy of this notice.

We can use and share your health care information to

- **Help manage the health care treatment you receive**
  - We can use your health information and share it with professionals who are treating you.
    Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.
  - We can also share your information with guardians, conservators or people with power of attorney who are authorized representatives.
- **Run our organization**
  - We can use and share your information to run our organization and contact you when necessary. This includes sharing your information with employees or volunteers with other state, county, local, federal, and partner nonprofit and private agencies, including child support offices.
  - We can share your information with these people and groups:
    - Auditors, investigators, and others that do quality-of-care reviews and studies
    - Credit bureaus, creditors or collection agencies if you do not pay fees you owe to us for services, in limited situations
    - Certified application counselors, in-person assisters, and navigators and anyone else the law says we must or can give the information to
  - We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long-term-care plans.
    Example: We use health information about you to develop better services for you.
- **Pay for your health services**
  - We can use and share your health information as we pay for your health services.
    Example: We share information about you with your dental plan to coordinate payment for your dental work.
- **Help with public health and safety issues**
  - We can share health information about you for purposes like these:
    - Preventing disease
    - Helping with product recalls
    - Reporting adverse reactions to medications
    - Reporting suspected abuse, neglect, or domestic violence
    - Preventing or reducing a serious threat to anyone's health or safety
- **Do research**
  - We can use or share your information for health research.
- **Comply with the law**
  - We will share information about you if state or federal laws require it. This includes sharing information with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
- **Respond to organ and tissue donation requests and work with a medical examiner or funeral director**
  - We can share health information about you with organ procurement organizations.
  - We can share health information with a coroner, medical examiner, or funeral director when a person dies.
- **Address workers' compensation, law enforcement, and other government requests**
  - For workers' compensation claims
  - For law enforcement purposes or with a law enforcement official
  - With health oversight agencies for activities authorized by law
  - With governmental agencies in other states administering public benefits programs
  - For special government functions, such as military, national security, and presidential protective services
- **Respond to lawsuits and legal actions**
  - We can share health information about you in response to a court order. We may share the information with court officials, county attorneys, attorneys general, other law enforcement officials, child support officials, child protection and fraud investigators, and fraud prevention investigators.

What are your choices?

For certain health information, you can tell us your choices about what we share.

You have both the right and choice to tell us to:

- Share health information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

Tell us what you want us to do, and we will follow your instructions. If you are not able to tell us your preference, for example, if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

What privacy rights do children have?

If you are under 18, when parental consent for medical treatment is not required, information will be provided to parents only when the medical provider believes that your health is at risk if the information is not shared. 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?

You may complain if you believe your privacy rights have been violated. You cannot be denied service or treated badly because you have made a complaint. If you believe that your medical privacy was violated by your doctor or clinic, a health insurer, a health plan, or a pharmacy, you may send a written complaint to either the county agency, the organization or the federal civil rights office at:

U.S. Department of Health and Human Services
Office for Civil Rights, Region V
233 N. Michigan Avenue, Suite 240
Chicago, IL 60601
312-886-2359 (voice)
800-368-1019 (toll free)
800-537-7697 (TTY)
312-886-1807 (fax)

If you believe the Minnesota Department of Human Services violated your privacy rights, you may also contact:

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

Whom do you contact if you need more information about privacy practices?

If you need more information about privacy practices, call DHS Health Care Consumer Support at 651-297-3862 or 800-357-3672.

Notice of Rights and Responsibilities

Changes

If you have MFPP, you must report a change within 10 days of the change happening. Call your county or tribal agency to report the change. Examples of changes you need to report include the following:

Income changes when you

- Start a new job, change jobs or stop a job
- Start to get new income or stop getting income, like Social Security or unemployment
- Have changes in the amount of income you get from your business, from farming or other types of self-employment

Residence changes when you

- Move to a new address
- Are temporarily out of Minnesota for more than 30 days

Life changes in your household when someone

- Becomes pregnant or has a baby
- Moves in or out of your home
- Dies, gets married or divorced
- Starts or stops other health insurance or Medicare
- Becomes disabled
- Goes into or gets out of jail

You Have the Right to Ask for a Hearing

If you feel your health care eligibility or benefits are wrong or your application was not processed correctly, you may ask for an appeal hearing. By requesting an appeal hearing, you are requesting a fair review of your case. You can represent yourself or use an attorney, advocate, authorized representative, relative, friend or other person. You will find specific appeal instructions on all eligibility notices that you receive. Learn more about the appeals process and how to ask for a hearing at the MNsure appeals website at www.mnsure.org/help/appeals or at the DHS website at www.dhs.state.mn.us/appeals/faqs.

You can complete and submit an appeal request online at https://edocs.dhs.state.mn.us/lfserver/Public/DHS-0033-ENG.

You can also print the form available at the address above and submit the completed form by fax to 651-431-7523 or by mail to this address:

Minnesota Department of Human Services
Appeals Division
PO Box 64941
St. Paul, MN 55164-0941

Immigration

Immigration information you give to us is private. We use it to see whether you can get coverage. We share it only when the law allows it or requires it, such as to verify identity. In most cases, applying will not affect your immigration status unless you are applying for payment of long-term-care services.

You do not have to give us your immigration information if you are a pregnant woman living in the United States without the knowledge or approval of the United States Citizenship and Immigration Services (USCIS). You also do not have to give us your immigration information if you are:

- Applying for emergency medical care only
- Helping someone else apply
- Not applying for yourself

Consent for Sharing of Medical Information

In your application for Minnesota Health Care Program coverage, you have given your written and signed consent to the following agencies and people to share between them medical information about you only for the limited purposes indicated:

- Health providers, including health plans, insurance agencies, MA or MinnesotaCare, county advocates, school districts, your county or state case workers, and their contractors and subcontractors, for these purposes:
  - To determine who should pay for your health care
  - To provide, manage and coordinate health care services
- All other agencies or people listed on this Notice of Privacy Practices and Notice of Rights and Responsibilities, for this purpose:
  - To administer Minnesota Health Care Programs, pay for services, and conduct research and investigations

This consent applies to medical information about your minor children you applied for on this application.

You can stop this consent at any time by asking in writing for it to end. The written notice to stop this consent will not affect information the agency has already given to others. This consent is good while you are enrolled in Minnesota Health Care Programs, up to one year or longer if the law permits.

However, it does not end after one year for records given to consulting providers or for payment of your bills, fraud investigations or quality-of-care review and studies.

An agency or person who gets your information through this consent could give the information to others.

If you end this consent, you cannot enroll or stay enrolled in Minnesota Health Care Programs.

Other Health Care

You and your household members enrolled in MFPP must tell us about any other health insurance that you have or that is available to you, including employer-sponsored coverage, private health insurance, long-term-care insurance, and any limited health coverage, such as dental or accident coverage. You must tell us whether your employer offers insurance and whether you accepted it.

You and your household members enrolled in MFPP may need to accept and keep a health insurance policy when the policy is found to be cost effective. If you have a good reason for not doing that, you may ask the state to approve the reason. If you do not give us information about your health insurance policy, you may not get coverage.

Assignment of Medical Payments

By accepting MFPP, you give your rights to all medical payments for yourself, and anyone else you apply for and for whom you can legally assign rights, to the State of Minnesota. These include medical payments from all other people or companies, including medical support payments from an absent parent. This assignment of medical payments begins as soon as health care coverage starts.

You also agree to help the state get paid back for medical expenses that should have been paid by others. You may not have to help the state if you have a good reason for not helping and the state approves the reason.

Your Civil Rights

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

Free Services

Auxiliary aids

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

Language assistance

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

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

Civil Rights Complaints

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

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

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

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

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

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

Minnesota Department of Human Rights (MDHR)

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

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

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

DHS

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

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

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

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

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

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

Instructions for completing this application

Income Adjustments

Income adjustments are costs you can subtract from gross income on a federal income tax return. See the Adjusted Gross Income section of IRS Form 1040 Schedule 1 for more information. If you pay for any of these things, tell us about them in question 10.

- Alimony paid based on a divorce decree or agreement executed before 2019
- Student loan interest
- Educator expenses (up to $250)
- Certain business expenses of reservists, performing artists, and fee-basis government officials
- Health savings account deduction
- Deductible part of self-employment tax
- Self-employment SEP, SIMPLE and qualified plans
- Self-employed health insurance deduction
- Penalty on early withdrawal of savings
- IRA deduction
- Moving expenses for active duty military members

Immigration status

Choose an immigration status from this list and place your letter choice in question 13. The immigration statuses with an asterisk (*) are qualified statuses:

A. American Indian born in Canada (Immigration and Nationality Act [INA], section 289)*
B. Amerasian noncitizen*
C. Asylee*
D. Conditional entrant*
E. Cuban or Haitian entrant*
F. Withholding of removal or deportation being withheld under section 243(h) or 241(b)(3) of the INA*
G. Refugee*
H. Special Iraqi or Afghani immigrant*
I. Victim of severe trafficking (LPR or T Visa)*
J. Battered noncitizen*
K. Lawful permanent resident (LPR)*
L. Paroled for at least one year*
M. Temporary nonimmigrant
N. Deferred action for childhood arrivals
O. Citizen of Marshall Islands, Micronesia or Palau*

Attachment C

Authorized Representative Designation

You can choose an authorized representative.

You can give a trusted person permission to talk about this application with us, see your information and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an "authorized representative." If you ever need to change your authorized representative, contact the Minnesota Family Planning Program office at 651-431-3480 or 888-702-9968.

A legally appointed representative for someone on this application must submit proof with the application.

FIRST NAME OF AUTHORIZED REPRESENTATIVE	MIDDLE NAME	LAST NAME	RELATIONSHIP TO YOU, IF ANY

STREET ADDRESS	APARTMENT OR SUITE

CITY	STATE	ZIP CODE

PHONE NUMBER	ORGANIZATION NAME, IF ANY	ID NUMBER (if applicable)

By signing, you allow this person to sign your application, get official information about this application and act for you on all future matters with this agency.

YOUR SIGNATURE	DATE

Authorized Representative Signature

By signing, I agree to be an authorized representative for this household. I understand my responsibilities including keeping information about the people applying on this application private.

☐ I would like to get information by email at: _____

AUTHORIZED REPRESENTATIVE SIGNATURE	DATE

Attachment - Keep this page.

Attachment D

Agency Addresses

(Effective Date: August 2022)

Aitkin County
204 First Street NW
Aitkin, MN 56431-1291
218-927-7200 / 800-328-3744
Fax: 218-927-7210

Anoka County
Economic Assistance Department
1201 89th Ave NE, Suite 400
Blaine, MN 55434
763-422-7200
Fax: 763-324-3620

Becker County
712 Minnesota Avenue
Detroit Lakes, MN 56501
218-847-5628
Fax: 218-847-6738

Beltrami County
616 America Ave NW
Bemidji, MN 56601
218-333-8300
Fax: 218-333-4150

Benton County
531 Dewey Street
Foley, MN 56329-0740
320-968-5087 / 800-530-6254
Fax: 320-968-5330

Big Stone County
340 2nd Street NW, PO Box 338
Ortonville, MN 56278-0338
320-839-2555
Fax: 320-839-3966

Blue Earth County
410 S 5th Street
Mankato, MN 56002-3526
507-304-4335
Fax: 507-304-4336

Brown County
1117 Center Street, PO Box 788
New Ulm, MN 56073-0788
507-354-8246 / 800-450-8246
Fax: 507-359-4146

Carlton County
14 N. 11th Street, Suite 100
Cloquet, MN 55720-0660
218-879-4583 / 800-642-9082
Fax: 218-878-2500

Carver County
602 East Fourth Street
Chaska, MN 55318-2102
952-361-1600
Fax: 952-361-1660

Cass County
400 Michigan Avenue W
Walker, MN 56484-0519
218-547-1340
Fax: 218-547-1448

Chippewa County
719 N Seventh Street, Suite 200
Montevideo, MN 56265-1397
320-269-6401 / 877-450-6401
Fax: 320-269-6405

Chisago County
313 North Main Street, Rm 239
Center City, MN 55012-9665
651-213-5640 / 888-234-1246
Fax: 651-213-5685

Clay County
715 North 11th Street, Suite 102
Moorhead, MN 56560-2095
218-299-5200 / 800-757-3880
Fax: 218-299-7106

Clearwater County
216 Park Avenue NW
Bagley, MN 56621-9500
218-694-6164 / 800-245-6064
Fax: 218-694-3535

Cook County
411 West Second Street
Grand Marais, MN 55604-2307
218-387-3620
Fax: 218-387-3020

Cottonwood County
DVHHS
11 Fourth Street, PO Box 9
Windom, MN 56101-0009
507-831-1891
Fax: 507-831-0126

Crow Wing County
204 Laurel Street, PO Box 686
Brainerd, MN 56401-0686
218-824-1250 / 888-772-8212
Fax: 218-824-1141

Dakota County
1 Mendota Road West, #100
West St. Paul, MN 55118-4765
651-554-5611
Fax: 651-554-5748

Dept of Human Services
Health Care Consumer Support
540 Cedar Street, PO Box 64252
St. Paul, MN 55164-0252
651-297-3862 / 800-657-3672
Fax: 651-431-7750

Dodge County
MnPrairie
22 Sixth Street East, Dept. 401
Mantorville, MN 55955
507-923-2900 / 888-850-9419
Fax: 507-635-6186

Douglas County
809 Elm Street, Suite 1186
Alexandria, MN 56308
320-762-2302
Fax: 320-762-3833

Faribault County
FMCHS
412 Nicollet Street North
Blue Earth, MN 56013
507-526-3265
Fax: 507-526-2039

Fillmore County
902 Houston Street NW, #1
Preston, MN 55965-1080
507-765-2175
Fax: 507-765-3895

Freeborn County
203 W Clark Street
Albert Lea, MN 56007-1246
507-377-5400
Fax: 507-377-5498

Goodhue County
426 West Avenue
Red Wing, MN 55066
651-385-3200
Fax: 651-267-4879

Grant County
Western Prairie Human Services
15 Central Avenue N, PO Box 1006
Elbow Lake, MN 56531-1006
218-685-8200 / 800-291-2827
Fax: 218-685-4978

Hennepin County
PO Box 107
Minneapolis, MN 55440-0107
612-596-1300
Fax: 612-288-2981

Houston County
304 S. Marshall Street, Rm 104
Caledonia, MN 55921-0310
507-725-5811
Fax: 507-725-3990

Hubbard County
205 Court Avenue
Park Rapids, MN 56470
218-732-1451 / 877-450-1451
Fax: 218-732-3231

Isanti County
1700 E Rum River Dr S, Suite A
Cambridge, MN 55008-2547
763-689-1711
Fax: 763-689-9877

Itasca County
1209 SE Second Avenue
Grand Rapids, MN 55744-3983
218-327-2941 / 800-422-0312
Fax: 218-327-5548

Jackson County
DVHHS
407 5th Street, PO Box 67
Jackson, MN 56143-0067
507-847-4000
Fax: 507-847-5616

Kanabec County
905 Forest Avenue East, #150
Mora, MN 55051-1316
320-679-6350
Fax: 320-679-6351

Kandiyohi County
2200 23rd Street NE, Suite 1020
Willmar, MN 56201-9423
320-231-7800 / 877-464-7800
Fax: 320-231-6285

Kittson County
410 South Fifth Street, Suite 100
Hallock, MN 56728
218-843-2689 / 800-672-8026
Fax: 218-843-2607

Koochiching County
1000 Fifth Street
Int'l Falls, MN 56649-2485
218-283-7000 / 800-950-4630
Fax: 218-283-7013

Lac Qui Parle County
930 First Avenue
Madison, MN 56256-0007
320-598-7594
Fax: 320-598-7597

Lake County
616 Third Avenue
Two Harbors, MN 55616-1560
218-834-8400 / 800-450-8832
Fax: 218-834-8412

Lake of the Woods County
206 8th Avenue SE, Suite 200
Baudette, MN 56623
218-634-2642
Fax: 218-634-4520

Le Sueur County
88 South Park Avenue
Le Center, MN 56057-1646
507-357-8288
Fax: 507-357-6122

Lincoln County
SWHHS
319 North Rebecca St., PO Box 44
Ivanhoe, MN 56142
507-694-1452 / 800-657-3781
Fax: 507-694-1859

Lyon County
SWHHS
607 West Main Street, Suite 100
Marshall, MN 56258
507-537-6747 / 800-657-3760
Fax: 507-537-6088

McLeod County
520 Chandler Avenue North
Glencoe, MN 55336
320-864-3144 / 800-247-1756
Fax: 320-864-5265

Mahnomen County
PO Box 460
Mahnomen, MN 56557-0460
218-935-2568
Fax: 218-935-5459

Marshall County
208 East Colvin Avenue, Suite 14
Warren, MN 56762-1695
218-745-5124 / 800-642-5444
Fax: 218-745-5260

Martin County
FMCHS
115 West First Street
Fairmont, MN 56031
507-238-4757
Fax: 507-238-1574

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Meeker County
114 North Holcombe Ave, #180
Litchfield, MN 55355-2273
320-693-5300 / 877-915-5300
Fax: 320-693-5344

Mille Lacs County
525 Second Street SE
Milaca, MN 56353
320-983-8208 / 888-270-8208
Fax: 320-983-8306

Morrison County
213 SE First Avenue
Little Falls, MN 56345-3196
320-632-2951 / 800-269-1464
Fax: 320-632-0225

Mower County
201 1st Street NE, Suite 18
Austin, MN 55912-3405
507-437-9700
Fax: 507-437-9721

Murray County
SWHHS
3001 Maple Road, Suite 100
Slayton, MN 56172
507-836-6144 / 800-657-3811
Fax: 507-836-8841

Nicollet County
622 South Front Street
St. Peter, MN 56082-2106
507-934-8559
Fax: 507-934-8552

Nobles County
318 9th Street, PO Box 189
Worthington, MN 56187-0189
507-295-5213
Fax: 507-372-5094

Norman County
15 Second Avenue East, Room 108
Ada, MN 56510-1389
218-784-5400
Fax: 218-784-7142

Olmsted County
2117 Campus Drive SE, Suite 200
Rochester, MN 55904
507-328-6500
Fax: 507-328-7956

Otter Tail County
535 Fir Avenue W
Fergus Falls, MN 56537
218-998-8230
Fax: 218-998-8270

Pennington County
318 N Knight Avenue
Thief River Falls, MN 56701-0340
218-681-2880
Fax: 218-683-7013

Pine County
635 Northridge Dr NW, Suite 220
Pine City, MN 55063
320-591-1570
Fax: 320-591-1601

Or

1602 Highway 23 N
Sandstone, MN 55072-5009
320-216-4100
Fax: 320-216-4101

Pipestone County
SWHHS
1091 North Hiawatha Avenue
Pipestone, MN 56164
507-825-6720 / 888-632-4325
Fax: 507-825-6727

Polk County
612 N Broadway, Room 302
Crookston, MN 56716
218-281-3127 / 877-281-3127
Fax: 218-281-3926

Or

1424 Central Avenue NE
East Grand Forks, MN 56721
218-773-2431 / 877-281-3127
Fax: 218-773-3602

Or

250 SW Cleveland Avenue
PO Box 100
McIntosh, MN 56556
218-435-1585 / 877-281-3127
Fax: 218-435-1552

Pope County
Western Prairie Human Services
211 East MN Avenue
Glenwood, MN 56334-1629
320-634-7755 / 800-291-2827
Fax: 320-634-0164

Ramsey County
160 East Kellogg Boulevard
St. Paul, MN 55101-1494
651-266-4444
Fax: 651-266-3942

Red Lake County
125 Edward Avenue SW
Red Lake Falls, MN 56750-0356
218-253-4131 / 877-294-0846
Fax: 218-253-2926

Red Lake Nation
Oshkiimaajitahdah
15525 Mendota Ave, PO Box 416
Redby, MN 56670
218-679-3350 / 888-404-0686
Fax: 218-679-4317

Redwood County
SWHHS
266 E Bridge Street
Redwood Falls, MN 56283
507-637-4050 / 888-234-1292
Fax: 507-637-4055

Renville County
105 S 5th Street, Suite 203H
Olivia, MN 56277
320-523-2202
Fax: 320-523-3565

Rice County
320 NW Third Street, #2
Faribault, MN 55021-0718
507-332-6115
Fax: 507-332-6247

Rock County
SWHHS
2 Roundwind Road, PO Box 715
Luverne, MN 56156-0715
507-283-5070
Fax: 507-283-5074

Roseau County
208 6th Street SW
Roseau, MN 56751-1451
218-463-2411 / 866-255-2932
Fax: 218-463-3872

St. Louis County
320 West 2nd Street
Duluth, MN 55802-1495
218-726-2101 / 800-450-9777
Fax: 218-733-2975

Or

201 S 3rd Avenue W, PO Box 1148
Virginia, MN 55792-1148
218-471-7137
Fax: 218-471-7123

Or

320 Miners Drive E
Ely, MN 55731-1402
218-365-8220
Fax: 218-365-8217

Or

1814 14th Avenue East
Hibbing, MN 55746-1314
218-262-6000
Fax: 218-262-6049

Scott County
Scott County Health and Human Services
200 4th Avenue West
Shakopee, MN 55379
952-445-7751
Fax: 952-496-8685

Sherburne County
13880 Business Center Drive
Elk River, MN 55330-4600
763-765-4000 / 800-433-5239
Fax: 763-765-4096

Sibley County
111 8th Street, PO Box 237
Gaylord, MN 55334-0237
507-237-4000
Fax: 507-237-4031

Stearns County
PO Box 1107
705 Courthouse Square
St. Cloud, MN 56302-1107
320-656-6000 / 800-450-3663
Fax: 320-656-6447

Steele County
MnPrairie
PO Box 890
630 Florence Ave
Owatonna, MN 55060
507-431-5600
Fax: 507-451-5947

Stevens County
400 Colorado Avenue, Suite 104
Morris, MN 56267-1235
320-208-6600 / 800-950-4429
Fax: 320-589-3972

Swift County
410 21st Street South, PO Box 208
Benson, MN 56215-0208
320-843-3160
Fax: 320-843-4582

Todd County
212 Second Avenue South
Long Prairie, MN 56347-1640
320-732-4500 / 888-838-4066
Fax: 320-732-4540

Traverse County
202 8th Street North, PO Box 46
Wheaton, MN 56296
320-422-7777 / 855-735-8916
Fax: 320-563-4230

Wabasha County
411 Hiawatha Drive E
Wabasha, MN 55981-1573
651-565-3351 / 888-315-8815
Fax: 651-565-3084

Wadena County
124 First Street SE
Wadena, MN 56482-1553
218-631-7605 / 888-662-2737
Fax: 218-631-7616

Waseca County
MnPrairie
1000 West Elm Ave
Waseca, MN 56093-2498
507-837-6600
Fax: 507-635-6186

Washington County
14949 62nd Street North
PO Box 30
Stillwater, MN 55082-0030
651-430-6455
Fax: 651-430-6605

Watonwan County
715 Second Avenue S, PO Box 31
St. James, MN 56081-0031
507-375-3294 / 888-299-5941
Fax: 507-375-7359

White Earth Financial Services
PO Box 100
Naytahwaush, MN 56566
218-935-2359

Wilkin County
227 6th Street North
PO Box 369
Breckenridge, MN 56520-0369
218-643-7161
Fax: 218-643-7175

Winona County
202 West Third Street
Winona, MN 55987-3146
507-457-6500 / 844-317-8960
Fax: 507-454-9381

Wright County
3650 Braddock Ave NE, Suite 2100
Buffalo, MN 55313-3675
763-682-7400 / 800-362-3667
Fax: 763-682-8920

Yellow Medicine County
415 9th Avenue, Suite 202
Granite Falls, MN 56241
320-564-2211
Fax: 320-564-4165

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