

Minnesota Child Care Assistance Program Application

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

You may be eligible to get help for your child care expenses so you can work, look for work, or attend school. Child care assistance can pay any legal child care provider who registers with the Department of Children, Youth, and Families. This includes licensed, certified, and unlicensed providers, 18 years of age or older. If you do not have a child care provider, you can apply for child care assistance and ask for help finding a child care provider.

To qualify, your family must:

- Be income eligible;
- Meet employment and training requirements:
 - Work at least an average of 20 hours per week (10 hours per week if a full-time student) at minimum wage, *or*
 - Participate in job search, attend school or training classes, *or*
 - Comply with the activities of an approved Minnesota Family Investment Program (MFIP)/Diversionary Work Program (DWP) employment plan.
- Cooperate with child support enforcement for all children in the family who have an absent parent.

Read these instructions before you fill out the application.

The Child Care Assistance Program booklet [Paying for child care \(DHS-3551\)](#) gives you information about the program and choosing a child care provider.

Please follow these instructions as you complete your application.

- Print using black ink.
- Read all instructions and answer all questions completely.
- If you need more room, use space on page 18 or attach additional sheets of paper.
- **Provide proof of all requested information.** This includes proof of:
 - Identity for each adult in your family
 - Residence/Address
 - Age and relationship to you for each child in your family
 - Citizenship or immigration status for each child in your family who needs child care
 - School schedule and program completion date for each adult in your family
 - All counted earned and unearned income and work schedules
 - Allowable deductions such as insurance premiums and child/spousal support paid
- The county or tribe must ask for your Social Security number. You are not required to provide this to be eligible for assistance.
- Read the "Penalty warning" section of this form.
- Read [Client Responsibilities and Rights \(DHS-4163\)](#), [Notice of Privacy Practices \(DHS-3979\)](#), and [The Child Care Assistance Program and fraud: Questions and answers for families \(DHS-3943B\)](#) at the end of this form. These documents are on tear-off pages for you to keep.
- Sign and date the application.
- Mail, fax or bring the completed application and all other needed items to the address listed below.
- **If you have questions or have problems getting the information you need, contact the county or tribal human services office where you live.**

Once your application is received, you will receive a written notice about your eligibility within 30 calendar days, or 45 days if needed. A child care worker will write or call you if more information is needed.

Mail application to: →

AFFIX COUNTY LABEL HERE

**If you want help, please
call this phone number.**

NO ENGLISH



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

ማሳሰቢያ:- ስለ ዶክመንቱ ነፃ ገለፃ ከፈለጉ፣ ወራተኛዎን ያነጋግሩ። Amharic

Arabic. انتباه. إذا احتجت الى مساعدة مجانية في ترجمة هذه الوثيقة، اتصل بالرقم الموجود في المربع أعلاه.

মনোযোগ দিন। যদি আপনি বিনামূল্যে এই নথিটির ব্যাখ্যার জন্যে সহায় চান তাহলে উপরোক্ত বাক্সে থাকা নম্বরটিতে কল করুন। Bengali

သတိပြုရန်။ ဤစာတမ်းကို ဘာသာပြန်ဆိုရန်အတွက် အခမဲ့အကူအညီ လိုအပ်ပါက, အထက်ဖော်ပြပါ အကွက်ရှိ နံပါတ်ကို ခေါ်ဆိုပါ။ Burmese

ការយកចិត្តទុកដាក់។
ប្រសិនបើអ្នកត្រូវការជំនួយឥតគិតថ្លៃក្នុងការបកស្រាយឯកសារនេះ សូមហៅទូរសព្ទទៅលេខក្នុងប្រអប់ខាងលើ។ Cambodian

注意!如果您需要免費的口譯支持,請撥打上方方框中的電話號碼。 Cantonese (Traditional Chinese)

wąŋ. héčínhanj niyé wačínjyAnj wayúiyeska ki de wówapi sutá, ečíyA kinj wóiyawa ed ophíye wanj. Dakota

Paunawa. Kung kailangan mo ng libreng tulong sa pag-unawa sa kahulugan ng dokumentong ito, tawagan ang numero sa kahon sa itaas. Filipino (Tagalog)

Attention. Si vous avez besoin d'aide gratuite pour interpréter ce document, appelez le numéro indiqué dans la case ci-dessus. French

સાવધાન. જો તમને આ દસ્તાવેજને સમજવા માટે નિ:શુલ્ક મદદની જરૂર હોય, તો ઉપરના બોક્સ પૈકીના નંબર પર કોલ કરો. Gujarati

ध्यान दें। यदि आपको इस दस्तावेज़ की व्याख्या में नि:शुल्क सहायता की आवश्यकता है, तो ऊपर बॉक्स में दिए गए नंबर पर कॉल करें। Hindi

NO ENGLISH



Lus Ceeb Toom. Yog tias koj xav tau kev pab txhais lus dawb ntawm cov ntaub ntawv no, ces hu rau tus nab npawb xov tooj nyob hauv lub npov plaub fab saum toj no. Hmong

ဟ်သုဉ်ဟ်သး. နမ့ၢ်လိဉ်ဘဉ် တၢ်မၤစၢၤကလီၤလၢ ကကိၣ်းထံလံာ်တီၤလံာ်မိတဖဉ်အယိ, ကိးနီၣ်ဂံၢ်လၢ အအိဉ်ဖဲတၢ်လွံၢ်နၢၣ် လၢတၢ်ဖိခိဉ်အပူၤတက့ၢ်. Karen

이 문서의 내용을 이해하는 데 도움이 필요하시면 위에 있는 전화번호로 연락해 무료 통역 서비스를 받으실 수 있습니다. Korean

تکایه سهرنج بده. نهگهر بو وهرگیرانی ئەم بەلگەنامەیه پێویستت بە یارمەتی بێبەر امبەرە، ئەوا پەهیوهندی بهو ژمارهیهوه بکه که له بۆکسهکهی سهر هودایه Kurdish Sorani

Baldarî. Ger ji bo wergerandina vê belgeyê hewcedariya we bi alîkariya belaş hebe, ji kerema xwe bi hejmara li qutiya jorîn re telefon bikin. Kurdish Kurmanji

Hoŋpín. Tóhán wanǝ́ǝ́ thí wíyukčanpi kin yuhá níyungspe héčha čhéya, lé tkíčhuŋ kin k'é nánpa opáwiŋyan. Lakota

ເອົາໃຈໃສ່. ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອພຣີໃນການຕີຄວາມເອກະສານນີ້, ໃຫ້ໂທຫາເບີທີ່ຢູ່ໃນບ່ອງຂ້າງເທິງ. Lao

注意！如果您需要免费的口译帮助，请拨打上方方框中的电话号码。
Mandarin (Simplified Chinese)

P̄alɛ rɔ piny: Mi gööri luäk lɔrä ke luɔc kä mɛmɛ, ɣɔtni nämbär ɛmɔ tää nhial guäth ɛmɛ. Nuer

Mah Biz'sin'dan.
Keesh'pin nan'deh'dam'mun chi'wee'chi'goo'yan chi'nis'too'ta'man
oo'weh ooshii'be'kan.
Ishi'kidoon ah'kin'das'soon ka'ooshi'bee'kadehk ish'peh'mik ka'shi
ka'ka'kak. Ojibwe

NO ENGLISH



Hubachiisa:-Yoo barreeffama kana hiikuuf gargaarsa bilisaa barbaaddan, lakkoofsa saanduqa armaan olii keessa jirun bilbilaa Oromo

Atenção. Se você precisar de ajuda gratuita para interpretar este documento, ligue para o número na caixa acima. Portuguese

Внимание! Если Вам нужна бесплатная помощь в переводе этого документа, позвоните по телефону, указанному в рамке выше. Russian

Pažnja. Ukoliko vam je potrebna besplatna pomoć u tumačenju ovog dokumenta, pozovite broj naveden u kvadratu iznad. Serbian

Fiiro gaar ah. Haddii aad u baahan tahay caawimo bilaash si laguugu turjumo dukumiintigan, wac lambarka ku jira sanduuqa sare. Somali

Atención. Si necesita ayuda gratuita para interpretar este documento, llame al número que aparece en el recuadro superior. Spanish

Zingatia. Iwapo unahitaji msaada usio na malipo wa kutafsiri hati hii, piga simu kwa namba iliyo kwenye kisanduku hapo juu. Swahili


ልቢ በሉ፡ ነዚ ሰነድ ንምትርጓም ነፃ ሓገዝ እንተ ደልዮም፣ በቲ ኣብ ላዕሊ ኣብ ውሽጢ ሰደጅ ተቐጥሊጡ ዘሎ ቁጽሪ ይደውሉ። Tigrinya

Увага! Якщо Вам потрібна безкоштовна допомога в перекладі цього документа, зателефонуйте за номером, вказаним у рамці вище. Ukrainian

Xin lưu ý: Hãy liên hệ theo số điện thoại trong ô trên nếu bạn cần bất kỳ sự hỗ trợ miễn phí nào để hiểu rõ về tài liệu này. Vietnamese

Àkíyèsí. Tí o bá nílò irànlówọ pẹ̀lú tí tú mọ̀ àkòṣẹ̀ yìí, pe nọmbà tó wà nínú àpótí tí wà ló kẹ̀. Yoruba

LB (7-24)



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

Minnesota Child Care Assistance Program Application

Child care assistance staff only				
CASE NUMBER	CCAP WORKER NAME	MFIP WORKER NAME		COUNTY DATE STAMP
MFIP BEGIN DATE	MFIP END DATE	EMPLOYMENT SERVICES AGENCY	EMPLOYMENT SERVICES WORKER	

1. Applicant

Tell us about you and where you live.

- Include *proof of your identity*, such as a copy of your driver's license, state identification card, passport, school identification card, or birth certificate.
- Include *proof of your residence/address*, such as a copy of a driver's license, state identification card, recent utility bill, rental lease, mortgage document or mail you have received. If you are experiencing homelessness, you can provide a letter from a shelter or friend, or your own signed statement.

PERSON 1				
LAST NAME		FIRST NAME		MIDDLE NAME
OTHER NAMES YOU MIGHT BE KNOWN AS		GENDER <input type="radio"/> Male <input type="radio"/> Female	DATE OF BIRTH	SOCIAL SECURITY NUMBER
ADDRESS		CITY		STATE ZIP CODE
MAILING ADDRESS (if different)		CITY		STATE ZIP CODE
HOME PHONE NUMBER		WORK PHONE NUMBER		OTHER PHONE NUMBER
MARITAL STATUS <input type="radio"/> Married <input type="radio"/> Divorced <input type="radio"/> Separated <input type="radio"/> Single		Is anyone in your household pregnant? <input type="radio"/> No <input type="radio"/> Yes – who? _____		
What is your preferred spoken language?		What is your preferred written language?		Do you need an interpreter? <input type="radio"/> Yes <input type="radio"/> No
ETHNICITY (optional) Hispanic? <input type="radio"/> Yes <input type="radio"/> No	RACE (optional) <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Pacific Islander or Native Hawaiian <input type="checkbox"/> White			
Have you ever received or requested child care assistance? <input type="radio"/> Yes <input type="radio"/> No				
IF YES, WHEN?		WHERE? (MN CITY)		MN COUNTY
Do you get a housing or Section 8 subsidy? <input type="radio"/> Yes <input type="radio"/> No				
Do you want to register to vote or update your registration? <input type="radio"/> Yes <input type="radio"/> No				

Living situation: (optional, choose one)

- Own housing; lease, mortgage or roommate Family/friends due to economic hardship (answer question below) Emergency shelter
 Service provider - foster care, group home Hospital, treatment facility, detox center or nursing home Unknown
 Jail, prison or juvenile detention facility Hotel or motel Declined
 Place not meant for housing (anywhere outside, a vehicle, an abandoned building, or bus/train/airport)

If you chose "Family/friends due to economic hardship", are you temporarily sharing housing due to loss of housing, lack of affordable housing or similar reasons? Yes No

Information regarding texts and emails

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

Is it OK to communicate with you via text? No Yes – which number should receive texts? _____

Is it OK to communicate with you via email? No Yes – email address: _____

2. Family members

Tell us about all the other people living in your home.

Include all household members, both adults and children. Include family members who do not live with you, but are expected to return to your home.

Adults:

- Include your spouse, the parents of children in your family who live with you, and all other adults living with you whether or not they are family members.
- Include proof of identity for each adult in your family, such as a copy of a driver's license, state identification card, passport, school identification card, or birth certificate.

Children:

- List all children under the age of 18 who live with you. List children in order from oldest to youngest.
- Include children 18 or older if they are full-time students and you provide 50% or more of their financial support.
- Include proof of each child's relationship to you, such as a birth certificate, adoption record, legal guardianship statement or baptismal record.
- Include proof of each child's age, such as one of the items listed above or a school or immunization record.
- Include proof of citizenship or immigration status for each child in need of child care assistance, such as a birth certificate, an adoption record or a USCIS (United States Citizenship and Immigration Services) card.

Note: Proof of citizenship or immigration status will not be used for immigration purposes.

***RACE codes** (list all that apply)

A = Asian B = Black or African American N = American Indian or Alaska Native P = Pacific Islander or Native Hawaiian W = White

PERSON 2				
LAST NAME		FIRST NAME		MIDDLE NAME
DATE OF BIRTH	GENDER <input type="radio"/> Male <input type="radio"/> Female	SOCIAL SECURITY NUMBER	ETHNICITY (optional) Hispanic? <input type="radio"/> Yes <input type="radio"/> No	RACE (optional) <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> N <input type="checkbox"/> P <input type="checkbox"/> W
RELATIONSHIP TO YOU		CITIZENSHIP If this person is a child who needs child care, is the child a U.S. citizen? <input type="radio"/> Yes <input type="radio"/> No		
Do you need an interpreter? <input type="radio"/> Yes <input type="radio"/> No	What is your preferred spoken language?		What is your preferred written language?	

PERSON 3				
LAST NAME		FIRST NAME		MIDDLE NAME
DATE OF BIRTH	GENDER <input type="radio"/> Male <input type="radio"/> Female	SOCIAL SECURITY NUMBER	ETHNICITY (optional) Hispanic? <input type="radio"/> Yes <input type="radio"/> No	RACE (optional) <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> N <input type="checkbox"/> P <input type="checkbox"/> W
RELATIONSHIP TO YOU		CITIZENSHIP If this person is a child who needs child care, is the child a U.S. citizen? <input type="radio"/> Yes <input type="radio"/> No		
Do you need an interpreter? <input type="radio"/> Yes <input type="radio"/> No	What is your preferred spoken language?		What is your preferred written language?	

PERSON 4				
LAST NAME		FIRST NAME		MIDDLE NAME
DATE OF BIRTH	GENDER <input type="radio"/> Male <input type="radio"/> Female	SOCIAL SECURITY NUMBER	ETHNICITY (optional) Hispanic? <input type="radio"/> Yes <input type="radio"/> No	RACE (optional) <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> N <input type="checkbox"/> P <input type="checkbox"/> W
RELATIONSHIP TO YOU		CITIZENSHIP If this person is a child who needs child care, is the child a U.S. citizen? <input type="radio"/> Yes <input type="radio"/> No		
Do you need an interpreter? <input type="radio"/> Yes <input type="radio"/> No	What is your preferred spoken language?		What is your preferred written language?	

PERSON 5				
LAST NAME		FIRST NAME		MIDDLE NAME
DATE OF BIRTH	GENDER <input type="radio"/> Male <input type="radio"/> Female	SOCIAL SECURITY NUMBER	ETHNICITY (optional) Hispanic? <input type="radio"/> Yes <input type="radio"/> No	RACE (optional) <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> N <input type="checkbox"/> P <input type="checkbox"/> W
RELATIONSHIP TO YOU		CITIZENSHIP If this person is a child who needs child care, is the child a U.S. citizen? <input type="radio"/> Yes <input type="radio"/> No		
Do you need an interpreter? <input type="radio"/> Yes <input type="radio"/> No	What is your preferred spoken language?		What is your preferred written language?	

PERSON 6				
LAST NAME		FIRST NAME		MIDDLE NAME
DATE OF BIRTH	GENDER <input type="radio"/> Male <input type="radio"/> Female	SOCIAL SECURITY NUMBER	ETHNICITY (optional) Hispanic? <input type="radio"/> Yes <input type="radio"/> No	RACE (optional) <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> N <input type="checkbox"/> P <input type="checkbox"/> W
RELATIONSHIP TO YOU		CITIZENSHIP If this person is a child who needs child care, is the child a U.S. citizen? <input type="radio"/> Yes <input type="radio"/> No		
Do you need an interpreter? <input type="radio"/> Yes <input type="radio"/> No	What is your preferred spoken language?		What is your preferred written language?	

For additional household members, use the blank page at the end of the application.

3. Child Support and custody arrangement

List all children in your family who have a parent who does not live in your home. If your child spends time with his or her other parent, please describe the schedule or shared custody arrangements.

CHILD 1		
CHILD'S NAME	NAME OF PARENT NOT LIVING IN YOUR HOME	Do you receive child support? <input type="radio"/> Yes <input type="radio"/> No

Shared Custody/Visitation Schedule – List time child spends with parent who is not in the home.							
	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
START TIME							
END TIME							

CHILD 2		
CHILD'S NAME	NAME OF PARENT NOT LIVING IN YOUR HOME	Do you receive child support? <input type="radio"/> Yes <input type="radio"/> No

Shared Custody/Visitation Schedule – List time child spends with parent who is not in the home.							
	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
START TIME							
END TIME							

CHILD 3		
CHILD'S NAME	NAME OF PARENT NOT LIVING IN YOUR HOME	Do you receive child support? <input type="radio"/> Yes <input type="radio"/> No

Shared Custody/Visitation Schedule – List time child spends with parent who is not in the home.							
	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
START TIME							
END TIME							

CHILD 4		
CHILD'S NAME	NAME OF PARENT NOT LIVING IN YOUR HOME	Do you receive child support? <input type="radio"/> Yes <input type="radio"/> No

Shared Custody/Visitation Schedule – List time child spends with parent who is not in the home.							
	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
START TIME							
END TIME							

CHILD 5		
CHILD'S NAME	NAME OF PARENT NOT LIVING IN YOUR HOME	Do you receive child support? <input type="radio"/> Yes <input type="radio"/> No

Shared Custody/Visitation Schedule – List time child spends with parent who is not in the home.							
	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
START TIME							
END TIME							

4. Student information – children

Complete this section for all children in your family who are **now in school or plan to go to school within the next 12 months**.

- Include start date if not currently in school.
- Include children 18 or older if they are full-time students and you provide 50% or more of their financial support. Include proof of their school status, such as a fee statement or registration confirmation, the expected completion date of their program, and your financial support.
- For preschool age children: Indicate "Head Start" or "preschool" in the "GRADE" field if child attends one of those programs.
- Include proof of school enrollment status for children with earned income.

STUDENT 1							
STUDENT NAME		START DATE	END DATE	SCHOOL NAME			GRADE
Days and times student attends school							
	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
START TIME							
END TIME							

STUDENT 2							
STUDENT NAME		START DATE	END DATE	SCHOOL NAME			GRADE
Days and times student attends school							
	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
START TIME							
END TIME							

STUDENT 3							
STUDENT NAME		START DATE	END DATE	SCHOOL NAME			GRADE
Days and times student attends school							
	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
START TIME							
END TIME							

STUDENT 4							
STUDENT NAME		START DATE	END DATE	SCHOOL NAME			GRADE
Days and times student attends school							
	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
START TIME							
END TIME							

STUDENT 5							
STUDENT NAME		START DATE	END DATE	SCHOOL NAME			GRADE
Days and times student attends school							
	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
START TIME							
END TIME							

5. Income

List all income received by you and all members of your family.

- Include income received by family members temporarily absent from your home.
- Report self-employment income in question 5.B. *Self-employment income*.
- Include proof of work schedule and all income for the most current 30 days, such as wages, tips, commissions and bonuses.

A. Earned income (wages)

Is anyone employed? No Yes

Income #1				
EMPLOYEE'S NAME		EMPLOYER NAME		EMPLOYER PHONE NUMBER
EMPLOYER ADDRESS		CITY	STATE	ZIP CODE
WORK ADDRESS (if different)		CITY	STATE	ZIP CODE
HOURLY PAY RATE	NUMBER OF HOURS PER WEEK	HOW OFTEN PAID? <input type="radio"/> Daily <input type="radio"/> Weekly <input type="radio"/> Every other week <input type="radio"/> Two times a month <input type="radio"/> Other _____		
TOTAL AMOUNT PAID BEFORE DEDUCTIONS	WORK START DATE	DATE OF FIRST PAY CHECK	DATE OF LAST PAY CHECK	

Income #2				
EMPLOYEE'S NAME		EMPLOYER NAME		EMPLOYER PHONE NUMBER
EMPLOYER ADDRESS		CITY	STATE	ZIP CODE
WORK ADDRESS (if different)		CITY	STATE	ZIP CODE
HOURLY PAY RATE	NUMBER OF HOURS PER WEEK	HOW OFTEN PAID? <input type="radio"/> Daily <input type="radio"/> Weekly <input type="radio"/> Every other week <input type="radio"/> Two times a month <input type="radio"/> Other _____		
TOTAL AMOUNT PAID BEFORE DEDUCTIONS	WORK START DATE	DATE OF FIRST PAY CHECK	DATE OF LAST PAY CHECK	

B. Self-employment income

Is anyone self-employed? No Yes

Complete this section if you or someone in your family is **self-employed**. Examples of self-employment income include product sales, real estate sales, personal services, farming, in-home child care, and rental property.

There are two options used to calculate self-employment income:

- Using taxable self-employment income as determined from a federal tax return filed with the IRS for the most recent year, with certain expenses not allowed to reduce income. To use this method, you must have filed a tax return for the most recent tax year and must submit it, including schedules.
- Using 50% of current gross self-employment income. To use this method, you must provide documentation of current gross self-employment income that is reflective of expected future income, such as business ledgers or tax returns and applicable schedules.

The amount of self-employment income calculated impacts income eligibility, family copayment, ability to meet employment requirements and the amount of care that can be authorized. For either method, include proof of work schedule, such as a calendar with work hours. Contact the CCAP agency for more information and to discuss your options.

Income #1			
ADULT'S NAME		TYPE OF BUSINESS	
START DATE	NUMBER OF HOURS WORKED PER WEEK	MONTHLY INCOME BEFORE EXPENSES	MONTHLY EXPENSES

Income #2			
ADULT'S NAME		TYPE OF BUSINESS	
START DATE	NUMBER OF HOURS WORKED PER WEEK	MONTHLY INCOME BEFORE EXPENSES	MONTHLY EXPENSES

C. Unearned income

Complete this section for each type of **unearned income** you or someone in your family receives.

- Include proof of all unearned income, such as a check stub, an award letter, a financial aid form, or a written statement from the source of the income for the most current 30 days.

Type	Yes	No	Name of person receiving income	How often received	Amount
Public assistance (MFIP, DWP, GA, Tribal TANF)	<input type="radio"/>	<input type="radio"/>			
Child support/Spousal support	<input type="radio"/>	<input type="radio"/>			
Unemployment Insurance	<input type="radio"/>	<input type="radio"/>			
Insurance payments (short- or long-term disability, etc.)	<input type="radio"/>	<input type="radio"/>			
RSDI (Retirement, Survivors, Disability Insurance)	<input type="radio"/>	<input type="radio"/>			
Supplemental Security Income (SSI)	<input type="radio"/>	<input type="radio"/>			
Veteran benefits (VA)	<input type="radio"/>	<input type="radio"/>			
Contract for deed	<input type="radio"/>	<input type="radio"/>			
Trust income	<input type="radio"/>	<input type="radio"/>			
Interest/dividends	<input type="radio"/>	<input type="radio"/>			
Tribal payments	<input type="radio"/>	<input type="radio"/>			
Cost-effective health care reimbursement	<input type="radio"/>	<input type="radio"/>			
Worker's Compensation	<input type="radio"/>	<input type="radio"/>			
Other (lottery or gambling winnings, cash prizes, capital gains, etc.) - list below:	<input type="radio"/>	<input type="radio"/>			

D. Do you expect any changes to work hours or income listed in A, B, or C above?

Yes No

IF YES, DESCRIBE IN DETAIL

6. Deductions

Complete this section if you or someone in your family has any of the expenses listed for which you are not reimbursed.

- These expenses may be deducted from your gross income in determining your co-payment.
- Include proof of deductions, such as check stubs, benefit statements or premium statements.

Expense	How often do you pay?	Amount
Medical insurance premiums		
Dental insurance premiums		
Vision insurance premiums		
Child support paid for a child not living in the home		
Court ordered spousal support		

7. Assets

Assets include cash, bank accounts, vehicles, investments, and real estate (other than your home). Do not include the home you live in, personal belongings, or self-employment assets (if used only for business purposes). How much are your family's assets?

- My family's assets are **LESS THAN \$1 million** (or equal to \$1 million), **OR**
- My family's assets are **MORE THAN \$1 million** (your worker will contact you for more information)

8. Request for child care assistance

Complete the sections that apply to adult members of your family.

A. List all *adult* family members who need help paying for child care to attend school or training classes.

- Include family members participating in GED or ESL classes.
- Include proof of school schedules that show the days and times classes meet, including school breaks.

ADULT 1							
ADULT'S NAME				NAME OF SCHOOL OR TRAINING SITE			
SCHOOL PROGRAM ATTENDING						START DATE	
Days and times this adult attends school or training							
	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
START TIME							
END TIME							

ADULT 2							
ADULT'S NAME				NAME OF SCHOOL OR TRAINING SITE			
SCHOOL PROGRAM ATTENDING						START DATE	
Days and times this adult attends school or training							
	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
START TIME							
END TIME							

B. List all *adult* family members who need help paying for child care to be able to work.

- Include proof of all work schedules, such as a time card or a letter from employer.
If the work schedule varies, please provide this information for the past two months.

ADULT 1							
ADULT'S NAME				EMPLOYER'S NAME			
Days and times this adult works							
	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
START TIME							
END TIME							

ADULT 2							
ADULT'S NAME				EMPLOYER'S NAME			
Days and times this adult works							
	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
START TIME							
END TIME							

C. List all *adult* family members who need help paying for child care to look for work.

ADULT'S NAME	NUMBER OF HOURS PER WEEK REQUESTED (up to 20)
ADULT'S NAME	NUMBER OF HOURS PER WEEK REQUESTED (up to 20)

D. List all *adult* family members who need help paying for child care to attend MFIP orientations or other MFIP/DWP activities in an approved employment plan.

ADULT'S NAME	JOB COUNSELOR ASSIGNED? <input type="radio"/> Yes <input type="radio"/> No	JOB COUNSELOR'S NAME	JOB COUNSELOR'S PHONE NUMBER
ADULT'S NAME	JOB COUNSELOR ASSIGNED? <input type="radio"/> Yes <input type="radio"/> No	JOB COUNSELOR'S NAME	JOB COUNSELOR'S PHONE NUMBER

E. List all *adult* family members who need help paying for child care to support their mental health needs.

- The child must be receiving MFIP and be under 7.
- Include proof of mental health diagnoses and need for child care as recommended by a mental health professional.

ADULT'S NAME	NUMBER OF HOURS PER WEEK REQUESTED (up to 20)
ADULT'S NAME	NUMBER OF HOURS PER WEEK REQUESTED (up to 20)

9. Child care needs

List all children who are attending or are in need of child care.

- Child care assistance is available for children under age 13 and for children with disabilities under age 15.
- Complete the provider questions if you currently use or have chosen a child care provider(s) for your child.
- Contact your county or tribal human services office if your child has special needs and needs specialized care.
- Child care assistance can only pay two providers per child, one primary and one secondary provider.

CHILD 1							
CHILD'S NAME							
Days and hours child care is needed with child's primary provider							
	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
START TIME							
END TIME							
PRIMARY CHILD CARE PROVIDER'S NAME					PHONE NUMBER		START DATE
PRIMARY CHILD CARE PROVIDER'S ADDRESS				CITY		STATE	ZIP CODE
WHERE IS CARE PROVIDED? <input type="radio"/> Provider's home <input type="radio"/> Child care center <input type="radio"/> Child's home				IS PROVIDER RELATED TO THE CHILD? <input type="radio"/> Yes <input type="radio"/> No			
IF RELATED, PROVIDER IS CHILD'S: <input type="radio"/> Sibling <input type="radio"/> Aunt/Uncle <input type="radio"/> Grandparent <input type="radio"/> Other: _____							
Days and hours child care is needed with child's secondary provider							
	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
START TIME							
END TIME							
SECONDARY CHILD CARE PROVIDER'S NAME					PHONE NUMBER		START DATE
SECONDARY CHILD CARE PROVIDER'S ADDRESS				CITY		STATE	ZIP CODE
WHERE IS CARE PROVIDED? <input type="radio"/> Provider's home <input type="radio"/> Child care center <input type="radio"/> Child's home				IS PROVIDER RELATED TO THE CHILD? <input type="radio"/> Yes <input type="radio"/> No			
IF RELATED, PROVIDER IS CHILD'S: <input type="radio"/> Sibling <input type="radio"/> Aunt/Uncle <input type="radio"/> Grandparent <input type="radio"/> Other: _____							

CHILD 2

CHILD'S NAME

Days and hours child care is needed with child's primary provider

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
START TIME							
END TIME							

PRIMARY CHILD CARE PROVIDER'S NAME PHONE NUMBER START DATE

PRIMARY CHILD CARE PROVIDER'S ADDRESS CITY STATE ZIP CODE

WHERE IS CARE PROVIDED? Provider's home Child care center Child's home IS PROVIDER RELATED TO THE CHILD? Yes No

IF RELATED, PROVIDER IS CHILD'S: Sibling Aunt/Uncle Grandparent Other: _____

Days and hours child care is needed with child's secondary provider

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
START TIME							
END TIME							

SECONDARY CHILD CARE PROVIDER'S NAME PHONE NUMBER START DATE

SECONDARY CHILD CARE PROVIDER'S ADDRESS CITY STATE ZIP CODE

WHERE IS CARE PROVIDED? Provider's home Child care center Child's home IS PROVIDER RELATED TO THE CHILD? Yes No

IF RELATED, PROVIDER IS CHILD'S: Sibling Aunt/Uncle Grandparent Other: _____

CHILD 3

CHILD'S NAME

Days and hours child care is needed with child's primary provider

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
START TIME							
END TIME							

PRIMARY CHILD CARE PROVIDER'S NAME PHONE NUMBER START DATE

PRIMARY CHILD CARE PROVIDER'S ADDRESS CITY STATE ZIP CODE

WHERE IS CARE PROVIDED? IS PROVIDER RELATED TO THE CHILD?
 Provider's home Child care center Child's home Yes No

IF RELATED, PROVIDER IS CHILD'S:
 Sibling Aunt/Uncle Grandparent Other: _____

Days and hours child care is needed with child's secondary provider

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
START TIME							
END TIME							

SECONDARY CHILD CARE PROVIDER'S NAME PHONE NUMBER START DATE

SECONDARY CHILD CARE PROVIDER'S ADDRESS CITY STATE ZIP CODE

WHERE IS CARE PROVIDED? IS PROVIDER RELATED TO THE CHILD?
 Provider's home Child care center Child's home Yes No

IF RELATED, PROVIDER IS CHILD'S:
 Sibling Aunt/Uncle Grandparent Other: _____

CHILD 4

CHILD'S NAME

Days and hours child care is needed with child's primary provider

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
START TIME							
END TIME							

PRIMARY CHILD CARE PROVIDER'S NAME	PHONE NUMBER	START DATE
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PRIMARY CHILD CARE PROVIDER'S ADDRESS	CITY	STATE	ZIP CODE
---------------------------------------	------	-------	----------

WHERE IS CARE PROVIDED? <input type="radio"/> Provider's home <input type="radio"/> Child care center <input type="radio"/> Child's home	IS PROVIDER RELATED TO THE CHILD? <input type="radio"/> Yes <input type="radio"/> No
---	---

IF RELATED, PROVIDER IS CHILD'S: <input type="radio"/> Sibling <input type="radio"/> Aunt/Uncle <input type="radio"/> Grandparent <input type="radio"/> Other: _____

Days and hours child care is needed with child's secondary provider

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
START TIME							
END TIME							

SECONDARY CHILD CARE PROVIDER'S NAME	PHONE NUMBER	START DATE
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SECONDARY CHILD CARE PROVIDER'S ADDRESS	CITY	STATE	ZIP CODE
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WHERE IS CARE PROVIDED? <input type="radio"/> Provider's home <input type="radio"/> Child care center <input type="radio"/> Child's home	IS PROVIDER RELATED TO THE CHILD? <input type="radio"/> Yes <input type="radio"/> No
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IF RELATED, PROVIDER IS CHILD'S: <input type="radio"/> Sibling <input type="radio"/> Aunt/Uncle <input type="radio"/> Grandparent <input type="radio"/> Other: _____

CHILD 5							
CHILD'S NAME							
Days and hours child care is needed with child's primary provider							
	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
START TIME							
END TIME							
PRIMARY CHILD CARE PROVIDER'S NAME					PHONE NUMBER	START DATE	
PRIMARY CHILD CARE PROVIDER'S ADDRESS				CITY	STATE	ZIP CODE	
WHERE IS CARE PROVIDED? <input type="radio"/> Provider's home <input type="radio"/> Child care center <input type="radio"/> Child's home				IS PROVIDER RELATED TO THE CHILD? <input type="radio"/> Yes <input type="radio"/> No			
IF RELATED, PROVIDER IS CHILD'S: <input type="radio"/> Sibling <input type="radio"/> Aunt/Uncle <input type="radio"/> Grandparent <input type="radio"/> Other: _____							
Days and hours child care is needed with child's secondary provider							
	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
START TIME							
END TIME							
SECONDARY CHILD CARE PROVIDER'S NAME					PHONE NUMBER	START DATE	
SECONDARY CHILD CARE PROVIDER'S ADDRESS				CITY	STATE	ZIP CODE	
WHERE IS CARE PROVIDED? <input type="radio"/> Provider's home <input type="radio"/> Child care center <input type="radio"/> Child's home				IS PROVIDER RELATED TO THE CHILD? <input type="radio"/> Yes <input type="radio"/> No			
IF RELATED, PROVIDER IS CHILD'S: <input type="radio"/> Sibling <input type="radio"/> Aunt/Uncle <input type="radio"/> Grandparent <input type="radio"/> Other: _____							

Important! Please read and sign this application.

Authorization to share information for fraud investigation and audits.

I give permission to authorized investigators and third parties to share information about me during the course of investigations regarding fraud, fraud prevention and misrepresentation, and conducting federal or state audits. Third parties who can share information about me with investigators include but are not limited to financial institutions, credit reporting agencies, landlords, public housing agencies, schools, utility companies, insurance agencies, employers, other government agencies and others as they apply. I also understand that my permission to share information about me remains in effect for six months after my benefits stop.

Provider release.

State and federal privacy laws protect my information. If I am eligible for child care assistance, CCAP staff can share information about the hours and amount of child care assistance I get with my child care provider(s). My provider will be notified when my redetermination is due. I understand:

- This information must be shared so that my child care provider knows how much CCAP will pay for the child care provided.
- This information can be shared only if I give my written permission or if the law allows it.
- I can refuse to sign or cancel this release, but if I do, CCAP may not be able to pay my provider for the child care provided.
- I may cancel this authorization with written notice anytime. This written notice will not affect information already released.
- The person or agency who gets my information may be able to pass it on to others.
- If my information is passed on to others by CCAP agencies or the State of Minnesota, it may no longer be protected by this authorization.

This authorization will end one year from the date I sign it. Minnesota Data Privacy Act (Minn. Stat., Ch. 13).

Penalty warning.

If you get child care assistance benefits, do not give false information or hide information:

- To get or continue to get child care assistance benefits
- To help someone else to get or to continue to get child care assistance payments.

The state may bar a family with a member who breaks either of these rules from the Child Care Assistance Program. The bar lasts one year for the first fraud, two years for the second fraud, and is permanent for the third fraud. A person who supplies false information in order for them or someone else to receive Child Care Assistance may also be prosecuted criminally.

If I get child care assistance I understand:

- I must cooperate with child support enforcement and assign my child care support portion to the Minnesota Department of Children, Youth, and Families. I have the right to claim "good cause" for not cooperating with child support enforcement.
- I may be required to pay a co-payment fee.
- If my child care provider charges more than the maximum rate paid in my county, I will pay the additional costs, as well as my co-payment fee.
- I must report changes to the information I have given within 10 calendar days from the date the change occurred. These include changes in employment and activity status and schedules, family status, significant income changes, address or residence, or anyone moving in or out of my household. Refer to [Reporting Responsibilities for CCAP families \(DHS-6953\)](#) for specific requirements.
- I must give the county agency and my child care provider 15 calendar days' notice before changing my child care provider(s). This notice is not needed in cases when:
 - A provider's Minnesota child care license has been temporarily immediately suspended or
 - There is an imminent risk of harm to the health, safety, or rights of a child in the care of a provider not licensed by Minnesota.
- My eligibility for child care assistance will be redetermined every 12 months.

- I have the right to choose any legal child care provider, including certified licensed child care centers, licensed family child care providers and legally nonlicensed child care providers that meet program requirements.
- If I choose a provider to provide child care in my home, I am considered the employer of the provider and have legal and tax responsibilities. This care must be approved by DCYF before child care assistance can be paid.

Perjury and general declarations

I declare under the penalties of perjury that I have reviewed this form 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. [Minnesota Statute, section 256.984, subd. 1]

By signing below:

- I have received a copy of the [Notice of Privacy Practices \(DHS-3979\)](#), the [Client Responsibilities and Rights \(DHS-4163\)](#), and [The Child Care Assistance Program and Fraud - Questions and Answers for Families \(DHS-3943B\)](#). I have read, and understand this information. If I have questions about this information, I will ask a worker to explain them to me.
- I agree to continue to assign my child care support to the state of Minnesota. I understand that I have the right to claim good cause for not cooperating with child support enforcement.
- I agree to the sharing of information as stated in the provider release and fraud investigation authorization information above.

SIGNATURE OF APPLICANT OR AUTHORIZED REPRESENTATIVE		DATE
SIGNATURE OF SPOUSE OR SECOND APPLICANT		DATE
AGENCY SIGNATURE	DATE	CLIENT GIVEN: <input type="checkbox"/> Client Responsibilities and Rights (DHS-4163) <input type="checkbox"/> Notice of Privacy Practices (DHS-3979) <input type="checkbox"/> The Child Care Assistance Program and fraud: Questions and answers for parents (DHS-3943B)

AGENCY NOTES

Use this space if you need additional room

Use this space if you need additional room

The Child Care Assistance Program: What to know about fraud – information for families

What is the Child Care Assistance Program?

The Child Care Assistance Program (CCAP) provides financial assistance to help families with low incomes pay for child care so that parents can work and children are well cared for.

What are the Child Care Assistance Program laws?

If you get child care assistance, you and your child care provider must follow the law. Failure to follow child care assistance laws could result in serious consequences. This document explains some of the laws. You can find more of the program's laws in the Minnesota Child Care Assistance Program (CCAP) Family Guide ([DHS-3944](https://edocs.dhs.state.mn.us/lfsrserver/Public/DHS-3944)) (<https://edocs.dhs.state.mn.us/lfsrserver/Public/DHS-3944-ENG>) (PDF). If you have questions about these laws, contact your child care assistance worker.

What do I need to tell my child care assistance worker?

You must report certain changes to your child care assistance worker within 10 calendar days of the change. For more information, see Reporting responsibilities for Child Care Assistance Program families ([DHS-6953](https://edocs.dhs.state.mn.us/lfsrserver/Public/DHS-6953)) (<https://edocs.dhs.state.mn.us/lfsrserver/Public/DHS-6953-ENG>) (PDF).

If you do not report required changes within 10 calendar days, you may have to pay back the money provided for your child care assistance.

When requested, you must submit proof of your actual income to your child care assistance worker. It is against the law to submit pay stubs that are different from what you actually earned to your child care assistance worker, employment counselor, and/or the county/tribe where you receive benefits.

Can the Child Care Assistance Program pay for days when my child does not attend child care?

Yes, but there are limits to what child care assistance can pay. If your child stops attending child care or needs less child care, tell your child care assistance worker. **It is against the law for child care providers to bill the Child Care Assistance Program for days when your child does not attend, unless the provider bills those days correctly as absent days or holidays.**

Absent days

The Child Care Assistance Program will pay 25 absent days per calendar year, per child. The Child Care Assistance Program will not pay more than 10 absent days in a row.

When absent days are all used for the year, your family, or a payment source other than child care assistance, is responsible to pay for any additional absent days.

Holidays

The Child Care Assistance Program will pay 10 holidays per calendar year, per child.

CCAP cannot pay for provider vacation days, provider sick days, or any other days that child care is not available, other than holidays.

Attendance records

Attendance records must be a true record of the days and times each child arrives at and leaves their child care provider. Records must include the date of service, each child's first and last name, and sign in and out times. Each day a child attends, the person picking up or dropping off the child should be the one to sign the child in and out.

Can I get child care assistance if I work in child care?

Yes, but the Child Care Assistance Program cannot pay:

- Licensed family or legal nonlicensed providers to receive child care subsidies for their own children, or children in their family, during the hours they are providing care or being paid to provide child care.
- More than 25 employee's children to attend a child care center where the parents work. For more information about this law, see Child Care Assistance Program Payments for Children of Center Employees – Questions and Answers for Parents ([DHS-6960C](https://edocs.dhs.state.mn.us/lfservlet/Public/DHS-6960C)) (<https://edocs.dhs.state.mn.us/lfservlet/Public/DHS-6960C-ENG>) (PDF)

You must report to your child care assistance worker within 10 days if you start working in a child care center or providing child care.

Can I get child care assistance if I'm self-employed?

Yes, child care assistance can help parents who are self-employed or who own their own businesses as long as:

- The family meets all other Child Care Assistance Program requirements, including income requirements, AND
- The parents need child care during the time they are working.

Can I get child care assistance if I work at a child care center?

Yes, but the Child Care Assistance Program cannot pay for more than 25 employees' children to attend a child care center where their parents work. This law applies to both licensed and license exempt centers. Parents may work at a child care center where their children do not attend. For more information about this law, see Child Care Assistance Program Payments for Children of Center Employees – Questions and Answers for Parents ([DHS-6960C](https://edocs.dhs.state.mn.us/lfservlet/Public/DHS-6960C)).

What if I don't follow the law?

Failure to follow Child Care Assistance Program rules could result in serious consequences, such as:

- A loss of child care assistance
- The need to pay back money paid by the Child Care Assistance Program, and/or
- A fraud determination (**see below for more information**).

What is fraud?

Fraud is knowingly giving the government false information or knowingly hiding information to get public assistance for yourself or someone else. Public assistance includes programs like child care assistance, cash assistance, SNAP and Medical Assistance.

It's very important that you provide **true, complete and current information** about everyone in your household to your child care assistance worker and on paperwork you submit. Your child care assistance worker uses this information to determine the amount of benefits you should receive. If your child care assistance worker discovers any information you gave is not true, you risk losing future public assistance benefits and face other serious penalties.

Know what you are signing

Before you sign your name on an application or form, read it carefully. Be sure that you are giving true information about yourself, your situation and all changes in your life.

Fraud penalties

If you commit fraud, you may lose your right to get any future benefits. You may also have to:

- Pay back the money or public assistance benefits that you wrongfully received
- Pay additional fines to the court
- Go to jail or prison.

How can I report fraud?

People who are dishonest about information related to public assistance benefits cause serious trouble for themselves and others. If you think someone is cheating or breaking the law, please help by reporting it. To report suspected fraud, contact the Department of Human Services Fraud Hotline:

- 800-627-9977 toll-free outside the Twin Cities metropolitan area
- 651-431-3968 in the Twin Cities metropolitan
- Online at <https://fraudhotline.dhs.mn.gov>

You do not have to give your name when you report fraud.

Notice of Privacy Practices

(Effective Date: November 2016)

This notice tells how private information about you may be used and disclosed and how you can get this information. Please review it carefully.

Why do we ask for this information?

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

Why do we ask you for your Social Security number?

We need your Social Security number to give you medical assistance, some kinds of financial help, or child support enforcement services (42 CFR 435.910 [2006]; Minn. Stat. 256D.03, subd.3(h); Minn. Stat.256L.04, subd. 1a; 45 CFR 205.52 [2001]; 42 USC 666; 45 CFR 303.30 [2001]). We also need your Social Security Number to verify identity and prevent duplication of state and federal benefits. Additionally, your Social Security Number is used to conduct computer data matches with collaborative, nonprofit and private agencies to verify income, resources, or other information that may affect your eligibility and/or benefits.

You do not have to give us the Social Security Number:

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

Do you have to answer the questions we ask?

You do not have to give us your personal information. Without the information, we may not be able to help you. If you give us wrong information on purpose, you can be investigated and charged with fraud.

With whom may we share information?

We will only share information about you as needed and as allowed or required by law. We may share your information with the following agencies or persons who need the information to do their jobs:

- Employees or volunteers with other state, county, local, federal, collaborative, nonprofit and private agencies
- Researchers, auditors, investigators, and others who do quality of care reviews and studies or commence prosecutions or legal actions related to managing the human services programs.
- Court officials, county attorney, attorney general, other law enforcement officials, child support officials, and child protection and fraud investigators
- Human services offices, including child support enforcement offices
- Governmental agencies in other states administering public benefits programs
- Health care providers, including mental health agencies and drug and alcohol treatment facilities
- Health care insurers, health care agencies, managed care organizations and others who pay for your care

- Guardians, conservators or persons with power of attorney
- Coroners and medical investigators if you die and they investigate your death
- Credit bureaus, creditors or collection agencies if you do not pay fees you owe to us for services
- Anyone else to whom the law says we must or can give the information.

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

- You and people you have given permission to may see and copy private information we have about you. You may have to pay for the copies.
- You may question if the information we have about you is correct. Send your concerns in writing. Tell us why the information is wrong or not complete. Send your own explanation of the information you do not agree with. We will attach your explanation any time information is shared with another agency.
- You have the right to ask us in writing to share information with you in a certain way or in a certain place. For example, you may ask us to send health information to your work address instead of your home address. If we find that your request is reasonable, we will grant it.
- You have the right to ask us to limit or restrict the way that we use or disclose your information, but we are not required to agree to this request.
- If you do not understand the information, ask your worker to explain it to you. You can ask the Minnesota Department of Human Services for another copy of this notice.

What are our responsibilities?

- We must protect the privacy of your private information according to the terms of this notice.
- We may not use your information for reasons other than the reasons listed on this form or share your information with individuals and agencies other than those listed on this form unless you tell us in writing that we can.
- We must follow the terms of this notice, but we may change our privacy policy because privacy laws change. We will put changes to our privacy rules on our website at: <http://edocs.dhs.state.mn.us/lfserver/Public/DHS-3979-ENG>

What privacy rights do children have?

If you are under 18, when parental consent for medical treatment is not required, information will not be shown to parents unless the health care provider believes not sharing the information would risk your health. Parents may see other information about you and let others see this information, unless you have asked that this information not be shared with your parents. You must ask for this in writing and say what information you do not want to share and why. If the agency agrees that sharing the information is not in your best interest, the information will not be shared with your parents. If the agency does not agree, the information may be shared with your parents if they ask for it.

What if you believe your privacy rights have been violated?

If you think that the Minnesota Department of Human Services has violated your privacy rights, you may send a written complaint to the U.S. Department of Health and Human Services to the address below:

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



Client responsibilities and rights

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

Your responsibilities

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

You may be required to report changes in:

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

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

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

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

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

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

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

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

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

For child care assistance:

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

Your rights

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

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

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

Civil Rights Notice

Discrimination is against the law. The Minnesota Department of Human Services (DHS) does not discriminate on the basis of any of the following:

- race • color • national origin • creed • religion • sexual orientation • public assistance status
- marital status • age • disability • sex • political beliefs

Civil Rights Complaints

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

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

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

Minnesota Department of Human Rights (MDHR)

In Minnesota, you have the right to file a complaint with the MDHR if you believe you have been discriminated against because of any of the following:

- race • color • national origin • religion • creed • sex • sexual orientation • gender identity
- public assistance status • disability

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

Minnesota Department of Human Rights
 540 Fairview Avenue North, Suite 201
 St. Paul, MN 55104
 651-539-1100 (voice)
 1-800-657-3704 (toll free)
 711 or 1-800-627-3529 (MN Relay)
 651-296-9042 (fax)
 Info.MDHR@state.mn.us

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

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

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

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

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

U.S. Department of Agriculture

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

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

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

(1) mail:

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

(2) fax:

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

(3) email:

FNSCIVILRIGHTSCOMPLAINTS@usda.gov

This institution is an equal opportunity provider.