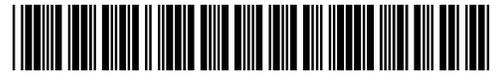


STEP 1

People to include on this application



DHS-6696-ENG

11-25

Tell us about all the family members that live with you. If you file taxes, we need to know about everyone on your tax return.

DO include:

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

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

DO NOT include:

- Your children or your spouse's children 19 or older if you do not expect to claim them as tax dependents
- Your unmarried partner, if you have no children together and do not file taxes together
- Your unmarried partner's children, if they are not related to you and you do not expect to claim them as tax dependents
- Other people that live with you but are not your spouse or children and that you do not file taxes with
- Your parents, if you are 19 or older and they do not expect to claim you as a tax dependent, and you do not expect to claim them as tax dependents

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

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

Complete Step 2 for each person in your family. Start with yourself; then add other adults and children. If you have more than four people in your family, make copies of pages 14-17. You do not need to provide immigration status or a Social Security number (SSN) for people that are not applying for health care coverage. Providing an SSN for all household members can speed up the application process. We use SSNs to check income and other information to see who is eligible for help with health coverage costs. If someone wants help getting an SSN, call 800-772-1213 or visit www.ssa.gov. If you are a TTY user, call 800-325-0778, or use your preferred relay service.

Other family members. If you have other family members that were not included in Step 2 of this application that would like to have coverage under a family health plan, see Step 7 of this application (page 21).

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 county you live in and your home zip code. Write your Safe at Home Program address in the Mailing Address spaces.

Check this box if this application includes someone who is pregnant*.
*Your application may be processed faster if you or someone in your household is pregnant.

STEP 2: PERSON 1

Start with yourself

Complete Step 2 for yourself and others you need to include on this application. See Step 1 for information about the people to include. Person 1 should be the contact person for the application.

1. FIRST NAME		MIDDLE NAME	LAST NAME		SUFFIX
2. DATE OF BIRTH _____/_____/_____ (MM/DD/YYYY)			3. SEX <input type="radio"/> Male <input type="radio"/> Female		4. MARITAL STATUS <input type="radio"/> Legally separated <input type="radio"/> Married <input type="radio"/> Divorced <input type="radio"/> Widowed <input type="radio"/> Never married
If under the age of 18, are you under the legal control of a parent? <input type="radio"/> Yes <input type="radio"/> No					
5. Do you have a Social Security number (SSN)? <input type="radio"/> Yes – what is your SSN? _____ <input type="radio"/> No – have you applied for an SSN? <input type="radio"/> Yes <input type="radio"/> No – check box for reason: <input type="checkbox"/> Noncitizen who is not eligible for SSN <input type="checkbox"/> Noncitizen who is not authorized to work <input type="checkbox"/> Religious objection <input type="checkbox"/> Other <input type="radio"/> I am not applying for health coverage for myself and choose not to answer. (Your SSN is optional if you are not applying. Choosing to tell us your SSN may help speed up the application process.)					



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STEP 2: PERSON 1

(Continue with yourself)

6. <input type="checkbox"/> Check here if you are homeless. If you checked the box, in which county do you usually stay? _____			
7a. HOME ADDRESS (Do not write a post office box number here. Include any post office box number in question 12.)			7b. APARTMENT OR SUITE NUMBER
8. CITY	9. STATE	10. ZIP CODE	11. COUNTY
12. MAILING ADDRESS (if different from home address)			13. APARTMENT OR SUITE NUMBER
14. CITY	15. STATE	16. ZIP CODE	17. COUNTY
18. PHONE NUMBER where we can call you: <input type="radio"/> Cell <input type="radio"/> Home <input type="radio"/> Work		19. OTHER PHONE NUMBER where we can call you: <input type="radio"/> Cell <input type="radio"/> Home <input type="radio"/> Work	
20a. YOUR PREFERRED SPOKEN LANGUAGE	20b. YOUR PREFERRED WRITTEN LANGUAGE	21. Do you need an interpreter? <input type="radio"/> Yes <input type="radio"/> No	
22. SELECT YOUR PREFERRED METHOD OF CONTACT ABOUT THIS APPLICATION <input type="checkbox"/> U.S. Postal Mail <input type="checkbox"/> Email Address: _____			
23. Do you want someone to act on your behalf as an authorized representative? <input type="radio"/> Yes – Complete Appendix C <input type="radio"/> No <i>(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 signing it on your behalf)</i>			
24. Do you plan to file a federal income tax return next year ? <i>(You can still apply even if you do not file a federal income tax return.)</i> <input type="radio"/> Yes – answer questions a, b and c. <input type="radio"/> No – go to question c. a. Will you file jointly with a spouse? <input type="radio"/> Yes – name of spouse: _____ <input type="radio"/> No – Will you file as Married Filing Separately because of domestic abuse or spousal abandonment (spouse left household) or file as Head of Household? <input type="radio"/> Yes <input type="radio"/> No b. Will you claim any dependents on your tax return? <i>(If you claim any dependents on your tax return, you must list them on the application, even if they are not applying.)</i> <input type="radio"/> Yes – list names: _____ <input type="radio"/> No c. Will you be claimed as a dependent on someone else's tax return? <input type="radio"/> Yes – name of tax filer: _____ <input type="radio"/> No			
25. Are you pregnant? <input type="radio"/> No <input type="radio"/> Yes – how many babies are expected? _____ Due date: _____ (MM/DD/YYYY) a. Were you pregnant in the past three months? <input type="radio"/> No <input type="radio"/> Yes – what date did the pregnancy end? _____ (MM/DD/YYYY)			
26. Are you applying for health care coverage for yourself? <i>(Even if you have insurance, there might be a program with better coverage or lower costs.)</i> <input type="radio"/> Yes – go to question 27. <input type="radio"/> No – go to the job and income questions on page 4. ➔			
27. Answer yes or no to the following four questions. a. Do you plan to make Minnesota your home? <input type="radio"/> Yes <input type="radio"/> No b. Did you move to Minnesota in the last three months? <input type="radio"/> Yes – what date? _____ (MM/DD/YYYY) <input type="radio"/> No c. Did you enter Minnesota with a job commitment or to seek employment? <input type="radio"/> Yes <input type="radio"/> No d. Are you visiting Minnesota to get medical care or for personal reasons? <input type="radio"/> Yes <input type="radio"/> No			



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STEP 2: PERSON 1

(Continue with yourself)

28. 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 Yes – check all that apply

Cuban Mexican, Mexican American or Chicano/a Puerto Rican 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

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

(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 born in the Northern Mariana Islands who chose to be a U.S. national.)

Yes – go to question 32. No – go to question 30.

30. Do you want help paying for a medical emergency?

No Yes – what was the begin and end date (if it has ended) for the medical emergency?

_____ (MM/DD/YYYY) to _____ (MM/DD/YYYY)

31. Do you have an immigration status listed here? (Health care coverage may still be available if you do not have an immigration status.)

No – go to question 32. Yes – check the box for your current status and answer the following questions.

Lawful Permanent Resident (LPR) or conditional resident* Refugee Asylee Asylum applicant (see page 21)

Paroled for at least one year* Paroled for less than one year Parolee from Ukraine entry before 9-30-24

Parolee from Afghanistan entry before 9-30-23 Temporary nonimmigrant (ex. visitor, student, worker and U visas)

Temporary Protected Status Deferred Action for Childhood Arrivals (DACA) Deferred Action excluding DACA

Cuban or Haitian Entrant Withholding of removal or deportation Victim of severe trafficking

Battered noncitizen* American Indian born in Canada Special Iraqi or Afghan immigrant

Amerasian noncitizen Citizen of Marshall Islands, Micronesia or Palau Conditional entrant before 1981

Granted Employment Authorization Document (work permit) excluding DACA Other (Choose from page 21) _____

a. A-number or ID number: _____ b. Date of entry (MM/DD/YYYY): _____

c. Immigration document type: _____ Document no. _____ Expiration date: _____

*Answer questions d-g if your current status is an LPR, conditional resident, paroled for at least one year, or battered noncitizen. If not, go to Question 32.

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

e. Have you had your current status for five years or more? No Yes

f. Have you previously had a different status? (example: refugee or asylee) No Yes – What status? _____

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

Answer question h only if you are an LPR or conditional resident. If not, go to Question 32.

h. Do you have an I-864 sponsor? No Yes – sponsor's name: _____

32. Do you want help from Medical Assistance (MA) to pay for medical bills from the past three months?

Yes – answer questions a and b. No – go to question 33.

a. Which months before the month of application do you want help for? (Check all that apply)

One month ago Two months ago Three months ago

b. Is everything you told us on the application the same for the selected months? (For example, income and family size)

Yes No



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STEP 2: PERSON 1

(Continue with yourself)

Recent Job Changes

33. IN THE PAST SIX MONTHS, DID YOU DO ANY OF THESE THINGS? (Check all that apply)

- Change jobs Stop working Start working fewer hours or have a salary cut

Optional: If you changed jobs or stopped working in the last 6 months, providing the name and Employer Identification Number (EIN) of your former employer may help speed up the application process.

EMPLOYER NAME(S)	EIN
------------------	-----

Current Job and Income Information (Check all that apply)

- Employed** **Self-employed** **Seasonally employed** **Not employed**
Start with question 34. Answer question 38. Answer question 39. Go to question 40.

Current Job 1

34. EMPLOYER NAME AND ADDRESS: Write the name of the employer that appears on your paycheck or pays you in cash.	EMPLOYER IDENTIFICATION NUMBER (EIN)
35. TAXABLE WAGES AND TIPS: List the amount before taxes are deducted. Do not include amounts deducted from wages by the employer for childcare, health insurance or retirement plans that are not taxable (sometimes called "pre-tax deductions"). Choose one frequency and fill in the dollar amount. If work hours and wages vary, write the total wages expected for the next 12 months using the "Yearly" frequency. Include wages and tips paid by cash, personal check or other methods of payment. a. Amount: \$ _____ b. Average hours worked each week: _____ c. Frequency: <input type="radio"/> Hourly <input type="radio"/> Weekly <input type="radio"/> Every two weeks <input type="radio"/> Twice a month <input type="radio"/> Monthly <input type="radio"/> Yearly	

Current Job 2

(If you have more jobs and need more space, attach another sheet of paper and include that information.)

36. EMPLOYER NAME AND ADDRESS: Write the name of the employer that appears on your paycheck or pays you in cash.	EMPLOYER IDENTIFICATION NUMBER (EIN)
37. TAXABLE WAGES AND TIPS: List the amount before taxes are deducted. Do not include amounts deducted from wages by the employer for childcare, health insurance or retirement plans that are not taxable (sometimes called "pre-tax deductions"). Choose one frequency and fill in the dollar amount. If work hours and wages vary, write the total wages expected for the next 12 months using the "Yearly" frequency. Include wages and tips paid by cash, personal check or other methods of payment. a. Amount: \$ _____ b. Average hours worked each week: _____ c. Frequency: <input type="radio"/> Hourly <input type="radio"/> Weekly <input type="radio"/> Every two weeks <input type="radio"/> Twice a month <input type="radio"/> Monthly <input type="radio"/> Yearly	
38. SELF-EMPLOYED: INCOME OR LOSS FROM FARMING, FISHING OR OTHER BUSINESS. Answer the following questions: a. Type of work _____ b. How much income or loss do you expect from self-employment for the next 12 months? Income amount \$ _____ or Loss amount \$ _____	
39. SEASONAL INCOME: Complete only if you are seasonally employed. Your total seasonal income for the next 12 months: \$ _____ Your total expected unemployment benefits for the next 12 months: \$ _____	
EMPLOYER NAME AND ADDRESS: Write the name of the employer that appears on your paycheck or pays you in cash.	EMPLOYER IDENTIFICATION NUMBER (EIN)



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STEP 2: PERSON 1

(Continue with yourself)

40. **OTHER INCOME:** Check all that apply. List the amount before taxes and deductions. If you do not receive any other type of income, leave this question blank.

Note: Do not list child support, nontaxable veteran's payments, money from an Achieving a Better Life Experience (ABLE) account or Supplemental Security Income (SSI).

- Unemployment benefits \$ _____ weekly
- Taxable Minnesota Paid Leave benefits \$ _____ weekly
- Taxable pensions or retirement \$ _____ monthly
- Social Security benefits* \$ _____ monthly
- Alimony received, if your divorce or separation agreement is dated before 1/1/2019 \$ _____ monthly
- Net rental or royalty \$ _____ yearly
- Interest \$ _____ yearly

How much of this interest amount is not taxable? \$ _____

- Lottery or gambling winnings greater than \$80,000 since January of 2018
Total amount of winnings: \$ _____ Month and year winnings were received: _____
- Other taxable income that is expected within the next 12 months (Taxable income is income you would list on the Income section of IRS Form 1040).
Type: _____ \$ _____ How often? _____
- Other taxable income this month
Type: _____ \$ _____ How often? _____

*Social Security benefits include retirement, disability and Railroad Retirement benefits. SSI is not a Social Security benefit. List the gross amount before any deductions. Include both taxable and nontaxable Social Security benefits.

41. **ADJUSTMENTS TO INCOME:** Check all that apply. List the amount you expect to pay over the next 12 months.

If you pay for certain things that can be subtracted from gross income on a federal income tax return, telling us about them could lower the cost of your health coverage. **Note:** Do not list an expense already included in your self-employment income or loss (question 38b).

See the instructions for Schedule 1 of the IRS 1040 form for more information about these adjustments.

- | | Yearly amount |
|--|---------------|
| <input type="checkbox"/> Educator expenses (up to \$300) | \$ _____ |
| <input type="checkbox"/> Certain business expenses of reservists, performing artists, and fee-basis government officials | \$ _____ |
| <input type="checkbox"/> Health savings account deduction | \$ _____ |
| <input type="checkbox"/> Moving expenses for active duty military members | \$ _____ |
| <input type="checkbox"/> Deductible part of self-employment tax | \$ _____ |
| <input type="checkbox"/> Self-employed SEP, SIMPLE and qualified plans | \$ _____ |
| <input type="checkbox"/> Self-employed health insurance deduction | \$ _____ |
| <input type="checkbox"/> Penalty on early withdrawal of savings | \$ _____ |
| <input type="checkbox"/> Alimony paid, if your divorce or separation agreement is dated before 1/1/2019 | \$ _____ |
| <input type="checkbox"/> IRA deduction | \$ _____ |
| <input type="checkbox"/> Student loan interest | \$ _____ |

42. **PROJECTED ANNUAL INCOME FOR 2026:** Do you expect your total annual income for 2026 to be the same as the income you listed on this application?

- Yes – My total income expected for 2026 will be the same as the income I listed on this application.
- No – My total income expected for 2026 will be: \$ _____

Add up all of the income you received from January 1 until now, and all of the income you expect to receive through December 31.

See page 21 for more information about how to calculate your projected annual income.



STEP 2: PERSON 2

Complete the remaining pages for Step 2 for any others you need to include on this application. See Step 1 on page 1 for information about the people to include. If you have no more people to include, go to Step 3 on page 18.

1. FIRST NAME	MIDDLE NAME	LAST NAME	SUFFIX	2. MARITAL STATUS <input type="radio"/> Legally separated <input type="radio"/> Married <input type="radio"/> Divorced <input type="radio"/> Widowed <input type="radio"/> Never married
3. RELATIONSHIP TO YOU	4. DATE OF BIRTH _____ (MM/DD/YYYY) If under the age of 18, is this person under the legal control of a parent? <input type="radio"/> Yes <input type="radio"/> No		5. SEX <input type="radio"/> Male <input type="radio"/> Female	
6. Does PERSON 2 have a Social Security number (SSN)? <input type="radio"/> Yes – what is PERSON 2's SSN? _____ <input type="radio"/> No – has PERSON 2 applied for an SSN? <input type="radio"/> Yes <input type="radio"/> No – check box for reason: <input type="checkbox"/> Noncitizen who is not eligible for SSN <input type="checkbox"/> Noncitizen who is not authorized to work <input type="checkbox"/> Religious objection <input type="checkbox"/> Other <input type="radio"/> PERSON 2 is not applying for health coverage and chooses not to answer. (PERSON 2's SSN is optional if PERSON 2 is not applying. Choosing to tell us PERSON 2's SSN may help speed up the application process.)				
7. Does PERSON 2 live at the same address with you? <input type="radio"/> Yes <input type="radio"/> No – list address: _____				
8. Does PERSON 2 plan to file a federal income tax return next year ? (PERSON 2 can still apply even if PERSON 2 does not file a federal income tax return.) <input type="radio"/> Yes – answer questions a, b and c. <input type="radio"/> No – go to question c. a. Will PERSON 2 file jointly with a spouse? <input type="radio"/> Yes – name of spouse: _____ <input type="radio"/> No – Will PERSON 2 file as Married Filing Separately because of domestic abuse or spousal abandonment (spouse left household) or file as Head of Household? <input type="radio"/> Yes <input type="radio"/> No b. Will PERSON 2 claim any dependents on PERSON 2's tax return? <input type="radio"/> Yes – list names: _____ <input type="radio"/> No c. Will PERSON 2 be claimed as a dependent on someone else's tax return? <input type="radio"/> Yes – name of tax filer: _____ How is PERSON 2 related to the tax filer: _____ <input type="radio"/> No				
9. Is PERSON 2 pregnant? <input type="radio"/> No <input type="radio"/> Yes – how many babies are expected? _____ Due date: _____ (MM/DD/YYYY) a. Was PERSON 2 pregnant in the past three months? <input type="radio"/> No <input type="radio"/> Yes – what date did the pregnancy end? _____ (MM/DD/YYYY)				
10. Does PERSON 2 want to apply for health care coverage? (Even if PERSON 2 has insurance, there might be a program with better coverage or lower costs.) <input type="radio"/> Yes – go to question 11. <input type="radio"/> No – go to the job and income questions on page 8. 				
11. Answer yes or no to the following four questions: a. Does PERSON 2 plan to make Minnesota home? <input type="radio"/> Yes <input type="radio"/> No b. Did PERSON 2 move to Minnesota in the last three months? <input type="radio"/> Yes – what date? _____ (MM/DD/YYYY) <input type="radio"/> No c. Did PERSON 2 enter Minnesota with a job commitment or to seek employment? <input type="radio"/> Yes <input type="radio"/> No d. Is PERSON 2 visiting Minnesota to get medical care or for personal reasons? <input type="radio"/> Yes <input type="radio"/> No				



STEP 2: PERSON 2

(Continue with PERSON 2)

12. Ethnicity and Race for PERSON 2: 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. Is PERSON 2 of Hispanic, Latino or Spanish origin? No Yes – check all that apply

Cuban Mexican, Mexican American or Chicano/a Puerto Rican 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

13. Is PERSON 2 a U.S. citizen or U.S. national?

(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 born in the Northern Mariana Islands who chose to be a U.S. national.)

Yes – go to question 16. No – go to question 14.

14. Does PERSON 2 want help paying for a medical emergency?

No Yes – what was the begin and end date (if it has ended) for the medical emergency?

_____ (MM/DD/YYYY) to _____ (MM/DD/YYYY)

15. Does PERSON 2 have an immigration status listed here? (Health care coverage may still be available without an immigration status.)

No – go to question 16. Yes – check the box for PERSON 2's current status and answer the following questions.

Lawful Permanent Resident (LPR) or conditional resident* Refugee Asylee Asylum applicant (see page 21)

Paroled for at least one year* Paroled for less than one year Parolee from Ukraine entry before 9-30-24

Parolee from Afghanistan entry before 9-30-23 Temporary nonimmigrant (ex. visitor, student, worker and U visas)

Temporary Protected Status Deferred Action for Childhood Arrivals (DACA) Deferred Action excluding DACA

Cuban or Haitian Entrant Withholding of removal or deportation Victim of severe trafficking

Battered noncitizen* American Indian born in Canada Special Iraqi or Afghan immigrant

Amerasian noncitizen Citizen of Marshall Islands, Micronesia or Palau Conditional entrant before 1981

Granted Employment Authorization Document (work permit) excluding DACA Other (Choose from page 21) _____

a. A-number or ID number: _____ b. Date of entry (MM/DD/YYYY): _____

c. Immigration document type: _____ Document no. _____ Expiration date: _____

*Answer questions d - g if PERSON 2 is an LPR, conditional resident, paroled for at least one year, or a battered noncitizen. If not, go to Question 16.

d. Did PERSON 2 enter the United States before August 22, 1996? No Yes

e. Has PERSON 2 had their current status for five years or more? No Yes

f. Has PERSON 2 previously had a different status? (example: refugee or asylee) No Yes – What status? _____

g. Is PERSON 2, or is the spouse or parent of PERSON 2, a veteran or active-duty member of the military? No Yes

Answer question h only if PERSON 2 is an LPR or conditional resident. If not, go to Question 16.

h. Does PERSON 2 have an I-864 sponsor? No Yes – sponsor's name: _____

16. Does PERSON 2 want help from Medical Assistance (MA) to pay for medical bills from the past three months?

Yes – answer questions a and b. No – go to question 17.

a. Which months before the month of application does PERSON 2 want help for? (Check all that apply)

One month ago Two months ago Three months ago

b. Is everything you told us on the application the same for the selected months? (For example, income and family size)

Yes No



STEP 2: PERSON 2

(Continue with PERSON 2)

Recent Job Changes

17. In the past six months, did PERSON 2 do any of these things? (Check all that apply)

- Change jobs Stop working Start working fewer hours or have a salary cut

Optional: If PERSON 2 changed jobs or stopped working in the last 6 months, providing the name and Employer Identification Number (EIN) of PERSON 2's former employer may help speed up the application process.

EMPLOYER NAME(S)	EIN
------------------	-----

Current Job and Income Information (Check all that apply)

- Employed** **Self-employed** **Seasonally employed** **Not employed**
Start with question 18. Answer question 22. Answer question 23. Go to question 24.

Current Job 1

18. EMPLOYER NAME AND ADDRESS: Write the name of the employer that appears on PERSON 2's paycheck or pays PERSON 2 in cash.	EMPLOYER IDENTIFICATION NUMBER (EIN)
19. TAXABLE WAGES AND TIPS: List the amount before taxes are deducted. Do not include amounts deducted from wages by the employer for childcare, health insurance or retirement plans that are not taxable (sometimes called "pre-tax deductions"). Choose one frequency and fill in the dollar amount. If work hours and wages vary, write the total wages expected for the next 12 months using the "Yearly" frequency. Include wages and tips paid by cash, personal check or other methods of payment.	
a. Amount: \$ _____ b. Average hours worked each week: _____	
c. Frequency: <input type="radio"/> Hourly <input type="radio"/> Weekly <input type="radio"/> Every two weeks <input type="radio"/> Twice a month <input type="radio"/> Monthly <input type="radio"/> Yearly	

Current Job 2

(If PERSON 2 has more jobs and needs more space, attach another sheet of paper and include that information.)

20. EMPLOYER NAME AND ADDRESS: Write the name of the employer that appears on PERSON 2's paycheck or pays PERSON 2 in cash.	EMPLOYER IDENTIFICATION NUMBER (EIN)
21. TAXABLE WAGES AND TIPS: List the amount before taxes are deducted. Do not include amounts deducted from wages by the employer for childcare, health insurance or retirement plans that are not taxable (sometimes called "pre-tax deductions"). Choose one frequency and fill in the dollar amount. If work hours and wages vary, write the total wages expected for the next 12 months using the "Yearly" frequency. Include wages and tips paid by cash, personal check or other methods of payment.	
a. Amount: \$ _____ b. Average hours worked each week: _____	
c. Frequency: <input type="radio"/> Hourly <input type="radio"/> Weekly <input type="radio"/> Every two weeks <input type="radio"/> Twice a month <input type="radio"/> Monthly <input type="radio"/> Yearly	
22. SELF-EMPLOYED: INCOME OR LOSS FROM FARMING, FISHING OR OTHER BUSINESS. Answer the following questions:	
a. Type of work _____	b. How much income or loss does PERSON 2 expect from self-employment for the next 12 months? Income amount \$ _____ or Loss amount \$ _____
23. SEASONAL INCOME: Complete only if PERSON 2 is seasonally employed.	
PERSON 2's total seasonal income for the next 12 months: \$ _____	
PERSON 2's total expected unemployment benefits for the next 12 months: \$ _____	
EMPLOYER NAME AND ADDRESS: Write the name of the employer that appears on PERSON 2's paycheck or pays PERSON 2 in cash.	EMPLOYER IDENTIFICATION NUMBER (EIN)



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STEP 2: PERSON 2

(Continue with PERSON 2)

24. **OTHER INCOME:** Check all that apply. List the amount before taxes and deductions. If PERSON 2 does not receive any other type of income, leave this question blank.

Note: PERSON 2 does not need to list child support, nontaxable veteran's payments, money from an Achieving a Better Life Experience (ABLE) account or Supplemental Security Income (SSI).

- Unemployment benefits \$ _____ weekly
- Taxable Minnesota Paid Leave benefits \$ _____ weekly
- Taxable pensions or retirement \$ _____ monthly
- Social Security benefits* \$ _____ monthly
- Alimony received, if your divorce or separation agreement is dated before 1/1/2019 \$ _____ monthly
- Net rental or royalty \$ _____ yearly
- Interest \$ _____ yearly
How much of this interest amount is not taxable? \$ _____
- Lottery or gambling winnings greater than \$80,000 since January of 2018
Total amount of winnings: \$ _____ Month and year winnings were received: _____
- Other taxable income that is expected within the next 12 months (Taxable income is income you would list on the Income section of IRS Form 1040).
Type: _____ \$ _____ How often? _____
- Other taxable income this month
Type: _____ \$ _____ How often? _____

*Social Security benefits include retirement, disability and Railroad Retirement benefits. SSI is not a Social Security benefit. List the gross amount before any deductions. Include both taxable and nontaxable Social Security benefits.

25. **ADJUSTMENTS TO INCOME:** Check all that apply. List the amount PERSON 2 expects to pay over the next 12 months. If PERSON 2 pays for certain things that can be subtracted from gross income on a federal income tax return, telling us about them could lower the cost of PERSON 2's health coverage. **Note:** Do not list an expense already included in PERSON 2's self-employment income or loss (question 22b).

See the instructions for Schedule 1 of the IRS 1040 form for more information about these adjustments.

- | | Yearly amount |
|--|---------------|
| <input type="checkbox"/> Educator expenses (up to \$300) | \$ _____ |
| <input type="checkbox"/> Certain business expenses of reservists, performing artists, and fee-basis government officials | \$ _____ |
| <input type="checkbox"/> Health savings account deduction | \$ _____ |
| <input type="checkbox"/> Moving expenses for active duty military members | \$ _____ |
| <input type="checkbox"/> Deductible part of self-employment tax | \$ _____ |
| <input type="checkbox"/> Self-employed SEP, SIMPLE and qualified plans | \$ _____ |
| <input type="checkbox"/> Self-employed health insurance deduction | \$ _____ |
| <input type="checkbox"/> Penalty on early withdrawal of savings | \$ _____ |
| <input type="checkbox"/> Alimony paid, if your divorce or separation agreement is dated before 1/1/2019 | \$ _____ |
| <input type="checkbox"/> IRA deduction | \$ _____ |
| <input type="checkbox"/> Student loan interest | \$ _____ |

26. **PROJECTED ANNUAL INCOME FOR 2026:** Is PERSON 2's expected total annual income for 2026 the same as the income listed on this application?

- Yes – PERSON 2's total income expected for 2026 will be the same as the income listed on this application.
- No – PERSON 2's total income expected for 2026 will be: \$ _____

Add up all of the income PERSON 2 received from January 1 until now, and all of the income PERSON 2 expects to receive through December 31.

See page 21 for more information about how to calculate PERSON 2's projected annual income.



STEP 3 Your Household's Health Coverage

Answer questions 1-3 in this step for anyone that needs health coverage.

1. Is anyone now **enrolled** in health coverage?

- Yes – check the type of coverage and provide the information about the coverage. If there is more than one insurance company, please provide the same information on an attached sheet of paper.

No – Continue to question 2.

- Medical Assistance (MA) MinnesotaCare Medicare COBRA
 Employer insurance Private or other insurance VA health care programs Prescription drug coverage
 TRICARE (Do not check if you have direct care or line of duty) Peace Corps
 Long-term-care (LTC) insurance Dental Vision

POLICYHOLDER'S NAME		POLICYHOLDER'S DATE OF BIRTH		INSURANCE COMPANY NAME	
START DATE	END DATE	GROUP NUMBER	NAME OF INSURANCE POLICY		
LIST EVERYONE THAT IS COVERED BY THIS POLICY					
NAME		POLICY NUMBER		NAME	
NAME		POLICY NUMBER		NAME	

2. Is anyone listed on this application **offered**, but not currently enrolled in, health insurance from a job? Check "yes" even if the insurance is from someone else's job, such as a parent or spouse.

Yes – **Complete Appendix A.**

No – Continue to question 3.

3. Is anyone getting medical care for an accident or injury? No Yes – who? _____

STEP 4 Household Details

1. Are you or is anyone in your family American Indian or Alaska Native? No Yes – **Complete Appendix B.**

2. Is anyone temporarily outside of Minnesota for more than 30 days? No Yes – who? _____

Date left: _____ (MM/DD/YYYY) Date expected to return: _____ (MM/DD/YYYY)

Reason for being temporarily outside Minnesota: _____

3. Has anyone ever been in the United States military? No Yes – who? _____

4. Has anyone returned from a tour of active military duty in the last 24 months?

No Yes – who? _____ Date last active tour of duty ended: _____ (MM/DD/YYYY)

5. Is anyone in jail or prison? Yes – answer questions a - d No – go to question 6.

a. Who? _____

b. Is this person awaiting the court's disposition of charges? Yes No

c. In what county did this person live before entering jail or prison? _____

d. Jail or prison name and address: _____ Offender ID: _____



NEED HELP WITH THIS APPLICATION? Visit www.mnsure.org or call us at **651-539-2099** (855-366-7873 outside the Twin Cities). If you need help in a language other than English, tell us the language you need. We will get you help at no cost to you.

STEP 4

(Continue with Household Details)

6. Does any child on the application have a parent living outside of the home? *If you are a parent or caregiver that is eligible for MA, you may have to cooperate with the child support agency and provide information about yourself, your children and the other parent to establish a court order. If you are required to cooperate, you will receive more information in the mail. **Contact your county or tribal agency (see Attachment B) if you believe there is fear or risk of harm to you or your children in this process, or you have concerns about your safety.** Safety measures are available, and you may not have to cooperate.*

No Yes – which child or children? _____

7. Was anyone in foster care on that person's 18th birthday?

No Yes – who? _____

Was this person getting healthcare through Medical Assistance or another state's Medicaid program? Yes No

In what state? _____

8. Answer yes or no to the following six questions.

a. Is anyone applying blind? No Yes – who? _____

b. Does anyone applying have a physical, mental or emotional health condition that limits the person's ability to perform daily activities (like bathing, dressing, daily chores, etc.)?

No Yes – who? _____

c. Is anyone applying seeking services and supports to help with activities of daily living to stay in the person's home or community through a home and community-based services (HCBS) waiver?

No Yes – who? _____

d. Does anyone need help paying for care in a long-term care facility, such as a nursing home?

No Yes – who? _____

e. Has anyone been determined blind or disabled by the Social Security Administration (SSA) or the State Medical Review Team (SMRT)?

No Yes – who? _____

f. Does anyone applying under age 21 have a chronic condition you believe is disabling or has been certified disabled, and need additional services or supports? (If yes, your child under age 19 may be eligible for MA under the TEFRA option or under age 21 for home and community-based waiver services.)

No Yes – who? _____

9. Is anyone applying in a residential treatment program for mental illness or drug or alcohol dependency?

No Yes – who? _____

10. Does anyone applying have outstanding medical bills or ongoing medical expenses that can be used to meet a medical spenddown?

No Yes – who? _____

11. Does anyone applying get services from the Center for Victims of Torture?

No Yes – who? _____



STEP 5 Household Changes

1. Has anyone on the application applied for unemployment benefits? Yes No
2. Has your family size changed since last year, or do you think your family size will change this year (such as because of a new baby)? Yes No
3. Has the income of any tax filer included in the application decreased from last year? Yes No
4. Has your tax filing status changed, or do you think it will change in the next year? Yes No

STEP 6 Please complete this page and read the attached Notice of Privacy Practices and Notice of Rights and Responsibilities before signing.

Verifying Eligibility and Renewing Coverage

Each year, MNsure and the Department of Human Services (DHS) match data to verify and renew eligibility for help paying for health coverage. We need consent to use information from tax returns to verify and renew your financial assistance for coverage. If you do not give consent to use this information, your financial assistance cannot be verified during the year and renewed. You can change your consent at any time. **If you do not check a box, you are agreeing to the use of your information for 5 years.**

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

5 years 4 years 3 years 2 years 1 year

Do not use information from tax returns to renew my eligibility for help paying for health coverage.

Contacting You

Can we send you updates and reminders about your case in the future? By checking "yes" here, you consent to receive electronic notifications. DHS and MNsure are not responsible for any charges for electronic notifications. It is the applicant's responsibility to check with the individual carrier, as standard messaging and data rates may apply.

Is it OK to reach out to you via text message? No Yes – which number should receive texts? _____

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

Do you want us to send you or someone in your household a voter registration form? We will only send forms to household members who you said are at least 18 years old and U.S. Citizens.

No Yes

For help with voter registration, contact your county or tribal agency. Agency addresses are listed on Attachment B.

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 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 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.

Additional Agreements for Medical Assistance (MA) and MinnesotaCare:

- **If anyone on this application is eligible for MA or MinnesotaCare**, I consent to the release of medical records as described in the Consent for Sharing of Medical Information section of the Notice of Rights and Responsibilities.
- **If anyone on this application is eligible for MA**, I give the MA agency our rights to pursue and get any money from other health insurance, legal settlements, or other third parties.
- **If anyone on this application is eligible for MA**, I have read and understand that the state may claim repayment for the cost of medical care, or the cost of the premiums paid for care, from my estate or my spouse's estate.
- **If anyone on this application is eligible for MA or MinnesotaCare**, I understand that my information, and information about me shared from third parties, will be shared for fraud prevention investigations as stated in the Notice of Privacy Practices and the Notice of Rights and Responsibilities.
- **If I am a parent or caretaker that is eligible for MA**, I know I may be asked to cooperate with the child support agency that collects medical support from a parent outside of the home. If I think that cooperating to collect medical support will harm me or my children, I can tell the agency, and I may not have to cooperate. I give to the MA agency the rights to medical support paid for my children.

Remember to return with this application any appendixes you completed.

Sign this application.

SIGNATURE	DATE (MM/DD/YYYY)
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STEP 7 Other Family Members

If you have other family members that were not included in Step 2 of this application that you would like to have covered under a family health plan, call the MNsure Contact Center at 855-366-7873.

Qualified family members that may be eligible to be included under a family health plan include:

- Children that do not live with you
- Children that are not included on your federal income tax return
- Adult children 19-26 years old
- Grandchildren that have resided with you continuously from birth and that are financially dependent on you or your covered spouse
- Children under the legal guardianship of you and/or your spouse

STEP 8 Submit your completed and signed application

Submit your completed and signed application in one of these three ways:

- Fax your application for faster processing.
- Mail your application using the enclosed envelope.
- Submit your application in person.

Mail, fax, or bring your application to your county or tribal agency or DHS Health Care Consumer Support. The addresses and fax numbers are listed on Attachment B at the back of the application.