

County WG # _____

Previous w/ _____

Application for Foster Care / Child Care Licensure

This information is available in other forms to people with disabilities by calling your county worker. For TDD users, contact your county worker through the Minnesota Relay at 711 or (800)627-3529. For the Speech-to-Speech relay, call (877)627-3848.

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

Applicant: (Applicant information should be in reference to the adult head-of-household. In circumstances where there is both a male and female head-of-household, please list the female's information only on page 1.)

Applicant's Full Legal Name (Last, First, MI):		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status: <input type="checkbox"/> Never married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Married, living w/ spouse <input type="checkbox"/> Legally separated <input type="checkbox"/> Widowed	Race: <input type="checkbox"/> Am. Indian/Alaska native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Pacific Islander/Native Hawaiian <input type="checkbox"/> White
Previous Legal Name(s) - Please include all former name(s):				
Physical Location Address: Street _____ City _____ State _____ Zip _____		Home Phone: _____		
Mailing Address: Street _____ City _____ State _____ Zip _____		Work Phone: _____		
Do you have access to the Internet? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list your email address: _____		Cell Phone: _____		
Date of Birth: _____		***Disability (see bottom of page 2 for selections): _____		
Have you received services from another county? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list previous county(ies) and type of service(s) received: _____		Social Security number: _____		
What is your preferred spoken language? _____		Hispanic heritage? <input type="checkbox"/> Yes <input type="checkbox"/> No		
What is your preferred written language? _____		Do you need an interpreter? <input type="checkbox"/> Yes <input type="checkbox"/> No		
For confidentiality purposes, are you related to a Wright County employee? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list the individual(s) you are related to: _____ (The purpose of this question is to ensure any data concerning employee relatives is retained confidentially within the agency.)				
Are you currently employed? <input type="checkbox"/> Yes <input type="checkbox"/> No Employer Name: _____ Schedule: _____ Employment Address: _____ Start Date: _____ <input type="checkbox"/> FT or <input type="checkbox"/> PT				
Request for: <input type="checkbox"/> Adult Foster Care Licensure (check all that apply) <input type="checkbox"/> Child Foster Care Licensure <input type="checkbox"/> Child Care Provider Licensure				
My worker has explained my <i>responsibilities and rights</i> and my <i>privacy rights</i> to me and I have received a copy of them. I understand that my income may be related to eligibility for social services. The agency may review my income at least every six months. I agree to notify the agency of any changes in my financial situation which may affect eligibility for services. I declare that I have examined all information on this application and, to the best of my knowledge and belief, it is a true and correct statement of every material point.				
Applicant Signature (explain if unable to sign)		Date:	Applicant has received:	
			<ul style="list-style-type: none"> • Copy of application page 1 given to applicant: <input type="checkbox"/> Yes <input type="checkbox"/> No • R&R given to applicant <input type="checkbox"/> Yes <input type="checkbox"/> No • Notice of Privacy Practices given to applicant: <input type="checkbox"/> Yes <input type="checkbox"/> No 	

<u>Applicant's authorized representative (if applicable)</u>	Date:	
<u>Agency Representative</u>	Date:	

Other household members:

Note to Agency Licensing Worker: Household members who are not an Applicant or Co-applicant are entered into SSIS as collaterals.

Household Member Name:	Relationship to Applicant (from page 1)	Date of Birth

Co-Applicant Information (If Applicable):

Instructions: Please list all information for co-applicants. All other household members should be listed under the "Household Member" section above.

***Married codes:** N-Never M-Married living with spouse S-Separated L-Legally separated D-Divorced W-Widowed

****Race codes:** N-Am. Indian/Alaska native A-Asian B-Black or African American P-Pacific Island/Native Hawaiian W-White

Full Legal Name (Last, First, MI):		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Married* (circle) N M S L D W
Previous Legal Name(s) or Nickname(s):	Date of birth: (or estimated age)	Primary Language:	Race** (circle) N A B P W
Social Security number:		Hispanic heritage <input type="checkbox"/> Yes <input type="checkbox"/> No	Phone:
Relationship to Head of Household (from page 1):		***Disability (see bottom of page for selections):	
Place of Employment:	<input type="checkbox"/> FT <input type="checkbox"/> PT	Employment Schedule:	
School Attending:	Grade:	School Schedule:	
Does this person have an address, phone number or email address different from what is listed on page 1? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list:			

*****Disability Selections:**

Adult Mental Illness - Acute Adult Mental Illness - Other Adult Mental Illness - Serious & Persistently Mentally Ill Chemical Dependency - Alcohol Chemical Dependency - Drugs Fetal Alcohol Syndrom (FAS)	Emotional Disturbance, less than age 18, Not Severe Emotional Disturbance, less than age 18, Severe Developmental Disability, Mental Retardation w/other DD Developmental Disability, Without Mental Retardation Developmental Disability, Mental Retardation Only Hearing Impairment Physical Disability - Ambulation Limited	Physical Disability - Ambulation Not Limited Speech Impairment Specific Learning Disability Traumatic Brain Injury (TBI) Visual Impairment HIV/AIDS Other: _____
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Health History Information:

Do you or any household members have a known disability or diagnosed condition? Yes No

If yes, please list each household member’s name and explain their disability or diagnosis:

Applicant/Household Member Name:	Please explain briefly each disability or diagnosed condition:

If you answered “Yes” to the disability/diagnosis question above, please complete the following Healthcare Provider Information:

INSTRUCTIONS:

Please list all of the primary healthcare providers who work with you and your family/household members:

Provider Name, Title & Field of Practice:	Clinic Name:	Clinic Address:	Phone Number:	Family members served by this provider:

Financial Information

1. Do you receive assistance from the Minnesota Family Investment Project (MFIP)? Yes No
2. Are you an adult caretaker of children who receive MFIP? _____ Yes No
3. Do you receive Supplemental Security Income (SSI)? Yes No
4. Do you receive Minnesota Supplemental Aid (MSA)? Yes No
5. Do you receive Medical Assistance (MA)? Yes No

The above information is completed accurately to the best of my knowledge: _____
 Signature of Applicant or Authorized Representative

Client notified of eligibility or ineligibility on _____ by _____
 Date (Social Worker)

For Agency Use Only

Method of contacting the agency: <input type="checkbox"/> Document <input type="checkbox"/> Email <input type="checkbox"/> External Referral <input type="checkbox"/> Internal Referral <input type="checkbox"/> Fax <input type="checkbox"/> Phone <input type="checkbox"/> Walk-in					
Intake Source: <input type="checkbox"/> Internal Referral <input type="checkbox"/> Mandated Reporter <input type="checkbox"/> Other <input type="checkbox"/> Professional Referral <input type="checkbox"/> Self Referral <input type="checkbox"/> Voluntary Reporter					
Source Detail:					
<input type="checkbox"/> Alleged Offender	<input type="checkbox"/> Alleged Victim	<input type="checkbox"/> Anonymous	<input type="checkbox"/> Babysitter	<input type="checkbox"/> Chemical Dependency Practitioner	
<input type="checkbox"/> Child Care Provider	<input type="checkbox"/> Clergy	<input type="checkbox"/> Coroner/medical Examiner	<input type="checkbox"/> Court/Court Services		
<input type="checkbox"/> DHS/Birth Match	<input type="checkbox"/> Facility Staff	<input type="checkbox"/> Foster Parent	<input type="checkbox"/> Friend/Acquaintance/Neighbor		
<input type="checkbox"/> Hospital/Clinic	<input type="checkbox"/> Human/Social Services Staff (county & other)		<input type="checkbox"/> Law Enforcement	<input type="checkbox"/> Mental Health Practitioner	
<input type="checkbox"/> Other Health Practitioner	<input type="checkbox"/> Other Mandated		<input type="checkbox"/> Other non-mandated	<input type="checkbox"/> Other relative in home	
<input type="checkbox"/> Other relative out of home	<input type="checkbox"/> Other School Personnel		<input type="checkbox"/> Parent in home	<input type="checkbox"/> Parent out of home	
<input type="checkbox"/> Private Physician	<input type="checkbox"/> PHN	<input type="checkbox"/> School Nurse	<input type="checkbox"/> Teacher		

If there are any other collaterals that should be listed in this licensing workgroup (other than household members listed on page 2) please add them below:

Name: _____	Title/Role: _____	Name: _____	Title/Role: _____	Name: _____	Title/Role: _____
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(Tear off here)

Your Responsibilities

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

- **You must report changes which may affect your services to the county agency** after the change has occurred.
Applicants - Report these changes to your worker when the change happens.
This includes the following for everyone in your household:
 - **Household** - when a person dies, moves in or out of your home, or temporarily leaves; pregnancy; birth of a child.
 - **Income** - receipt or change in child support, Social Security, Veteran's Benefits, Unemployment Insurance, inheritance, insurance benefits and other payments.
 - **Employment** - start or stop a job or business; or change in hours, earnings or expenses.
 - **Property** - purchase, sale or transfer of a house, car, or other items of value.
 - **Address**
 - **Drug felony conviction**
 - **Housing costs/rent subsidy**
 - **Marriage or divorce**
 - **Filing a lawsuit**
 - **School attendance**
 - **Health insurance**
 - **Absent parent custody or visits**
- **The county, state or federal agency may check any of the information you give.** To get some information we must have your signed consent. If you don't allow the county to confirm your information, you might not get services.
- **If you give us information you know is untrue or we get information you did not report,** we may investigate you for fraud.
- **Contact your worker** if you have questions or are unsure about any reporting rules.

Your Rights

- **Your right to privacy.** Your private information, including your health information, is protected by state and federal laws. Your worker has given you a "Notice of Privacy Practices" information sheet. Please read it carefully.
This sheet explains:
 - Your privacy rights;
 - How we may use the health and other private information;
 - Who we can share this information with and
 - How you can get access to this information.
- **How we use information.** Our public assistance staff and other agencies the law allows will use the information to see if you are eligible. We will also use it to refer you to other benefit programs. When you applied for help, or at your last review, we gave you a sheet explaining who we would share this information with. If you move to another state or county, we will send some information on your case to them. After we close your case, we will keep your file until federal, state and county rules let us destroy it.
- **Your right to see information.** You may review all of the information we get about you, except for information that is legally classified as "confidential." (Confidential information is information such as certain psychological or medical evaluations, records which agencies use to prosecute a crime, etc. Agencies cannot share it with the person it

affects.) You have the right to disagree with information that you think is wrong. For more information about your data privacy rights, ask your financial worker.

- **You have the right to apply for** any of the agency's applicable social services.
- **You have the right to know why, if we have not processed your application promptly.**
- **You have the right to information about services.**
- **Appeal rights.** You have the right to appeal if the county denies, reduces, suspends or terminates social services or if you or your authorized representative do not agree with the services identified in your service plan. To start an appeal, send a very short letter saying you want to appeal to:

Appeals Office
Department of Human Services
444 Lafayette Road North
St. Paul, MN 55155-3813

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

- **Your right to file a complaint.** If you feel we treated you differently in the handling of a public assistance application or payment because of race, color, national origin, political beliefs, religion, sex, sexual orientation, age or disability (including access to buildings or programs), you may file a complaint with one or more of these agencies:

State Agencies

Minnesota Department of Human Services
Office for Equal Opportunity, Affirmative
Action, and Civil Rights
444 Lafayette Road
St. Paul, Minnesota 55155-3812

Minnesota Department of Human Rights
190 East 5th Street, Suite 700
St. Paul, Minnesota 55101
(800) 657-3704 (Voice)
(651) 296-1283 (TDD)

Federal Agencies

U.S. Department of Health and Human Services
Office of Civil Rights - Region V
233 North Michigan Avenue,
Suite 240
Chicago, IL 60601