Household Report Form

Case number: _____

Mille Lacs Band of Ojibwe
AanjiBimaadizing
Tribal TANF Program
43408 Oodena Drive
Onamia, MN 56359

How to fill out this form:

1. Your report month is: _____
2. Fill out and return this form or your benefits may be late or stop.
3. Answer Yes or No to each question.*
4. If there is not enough room on the form to answer a question, attach your own pages.
5. Sign and date the form **on or after**: _____
6. Return this form **no later than**: _____
7. If you need help with the form, call: _____

*If you receive Medical Assistance ONLY and live in a long-term care facility (LTCF) or an Intermediate Care Facility for People with Developmental Disabilities (ICF-DD), complete ONLY questions 4 and 5 and send in your health care expenses.

Important - Read this

- **Your right to file a complaint:** If you feel the county or the Minnesota Department of Human Services treated you differently in the handling of your public assistance application or benefits because of race, color, national origin, political beliefs, religion, creed, sex, sexual orientation, public assistance status, age, or disability, including physical access to government buildings, you may file a complaint with the county, state or federal agencies.
- **How we use this information:** Our public assistance staff and other agencies allowed by law use the information on this form. We also use it to refer you to other benefit programs. If you move to another state or county, we will send certain information to them.
- **Your right to a fair hearing:** You have the right to a fair hearing if you do not agree with an action taken by the county agency. Request a fair hearing by calling or writing your county human services agency or the Minnesota Department of Human Services, State Appeals Office, P.O. Box 64941, St. Paul, MN 55164-0941.
- **Denial and notice actions:** We may deny or change your cash or health care and/or food benefits because of information you give on this form. We can make changes without giving you 10 days advance notice. We will send you written notice of any change no later than the date the change takes effect or the date you would receive benefits, whichever is earlier.
- **False information:** If you give false information, we may try you for fraud and you could lose your benefits.

DEPARTMENT OF HUMAN SERVICES

DHS-2120-ENG 9-17

Household Report Form

1. Address change

Did you move during the report month(s)? ◯ Yes ◯ No

If yes, fill in below.

DATE OF LAST MOVE	NEW PHONE NUMBER

NEW ADDRESS WHERE YOU LIVE (if you did not have an address, write "homeless")	APT. NUMBER	CITY	STATE	ZIP CODE
NEW MAILING ADDRESS (if different from where you live)	APT. NUMBER	CITY	STATE	ZIP CODE

Living situation: *(optional, choose one)*

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

2. Rent subsidy

Did you have a new rent subsidy or change in your rent subsidy during the report month(s)? ◯ Yes ◯ No

If yes, fill in below.

SUBSIDY AMOUNT

Send proof.

3. Household members

Did anyone move out of your home in the report month(s)? ◯ Yes ◯ No

Did anyone move in with you in the report month(s) (include newborns)? ◯ Yes ◯ No

Have you either moved on to a reservation or left a reservation in the last month? ◯ Yes ◯ No

If yes for any question in #3, complete the section below for **each person who moved in or out**:

Name	Relation to you or your children	Date of change	Was change for 30 days or less?	Does person buy or fix food with you?
			◯ Yes ◯ No	◯ Yes ◯ No
			◯ Yes ◯ No	◯ Yes ◯ No

4. Unearned income

Did you or anyone living with you receive **any** unearned income during the report month(s)? ◯ Yes ◯ No

If yes, list who got the money, how much they got **each** month, and date they got it. **Send proof.**

Income type	Answer Yes or No	Amount	Who got it	Date received
School loans, grants, scholarships	◯ Yes ◯ No			
RSDI (Social Security) ***The agency will verify this income for you.	◯ Yes ◯ No			
SSI (Supplemental Security Income) ***The agency will verify this income for you.	◯ Yes ◯ No			
VA (Veteran's Benefits)	◯ Yes ◯ No			
Unemployment Insurance	◯ Yes ◯ No			
Workers' Compensation	◯ Yes ◯ No			
Retirement benefits	◯ Yes ◯ No			
Child or spousal support	◯ Yes ◯ No			
Other types, such as gifts or loans, contract for deed income, rental income, lottery winnings, lawsuit settlements, inheritance, disability payments, etc.				
	◯ Yes ◯ No			
	◯ Yes ◯ No			
	◯ Yes ◯ No			

5. Earned income

Did you or anyone living with you get income from a job or self-employment during the report month(s)?
◯ Yes ◯ No

Does your household have more than one job to report? ◯ Yes ◯ No

Send Pay Stubs or other proof of gross earnings for each job. Your employer may also use the Employers Statement in Section A.

If self-employed, send proof or use the Self-Employment Report Form DHS-3336. For Supplemental Nutrition Assistance Program (SNAP) only cases, if self-employment income is from farming or rental income, you must document and verify all income and expenses.

6. Assets

Is the total value of your assets (cash, bank accounts, stocks and bonds, vehicles) **$9800 or more**? ◯ Yes ◯ No

If yes, complete Section B.

7. Child or Adult Care Expenses (SNAP only)

Did you or anyone living with you have costs for care of a child or an ill or disabled adult during the report month(s) because you or they were working, looking for work, going to school or training to prepare for work?
◯ Yes ◯ No

If yes, complete the section below for each person getting care. **Send proof.**

Name of person getting care	Name of person paying care	Amount you paid in report month(s)	Amount paid by someone else in report month(s)	Name of person giving care

8. Court-ordered expenses

Did anyone living in your household pay court-ordered expenses in the report month(s) (child/spousal support, medical, child care)? ◯ Yes ◯ No **If yes, send proof.**

PAID TO WHOM	AMOUNT PAID	TYPE OF EXPENSE (child/spousal support, medical, child care)

9. Other changes

Do you or anyone living with you have any other changes to report? ◯ Yes ◯ No

(Examples of things you may be required to report: Starting a new job, stopping work, starting or stopping school, selling or giving away assets, court ordered community service, marriage, immigration, citizenship, or disability status.)

If yes, fill in below. **Send proof.**

WHO?	DATE OF CHANGE

EXPLAIN THE CHANGE

10. Future changes

In the next two months, do you or anyone living with you expect any changes in what you reported on this form?
◯ Yes ◯ No

If yes, fill in below.

WHO?	DATE OF CHANGE

EXPLAIN THE CHANGE

Health Care Expenses

For SNAP only

To receive a medical expense deduction, send copies of medical bills by anyone in your household who is disabled or 60 years or older that were not paid (Do not provide medical bills that are being paid for by any health care program, insurance or someone not living with you).

For Long-Term Care Facility or Intermediate Care Facility for Persons with Developmental Disabilities only

If you are living in a Long-Term Care Facility or Intermediate Care Facility for Persons with Developmental Disabilities and are receiving Medical Assistance, send copies of medical bills that were not paid by Medical Assistance (MA) or were not paid in full by other insurance, including prescription copays, to your worker. Send proof of your medical bills (Do not send medical bills you already gave to your worker).

✍ Sign and date this report **on or after** the last day of the report month(s) ✍

I declare that I have examined this form and, to the best of my knowledge and belief, it is a true and correct statement of every material point.

SIGN YOUR NAME HERE	DATE	PHONE NUMBER

PRINT YOUR NAME HERE	PRINT YOUR CASE NUMBER HERE

HAVE THE SECOND ADULT SIGN HERE	DATE	PERSON WHO HELPED COMPLETE THE FORM SIGN HERE	DATE

Section A: Employer's Statement

If you do not have pay stubs or other documentation of earned income, your employer may complete this section.

HOUSEHOLD MEMBER	OCCUPATION

EMPLOYER	STREET ADDRESS	CITY

HOW MANY HOURS DID YOU WORK IN THE REPORT MONTH?	HOW OFTEN PAID
	◯ Every week ◯ Every 2 weeks ◯ Once a month ◯ Twice a month ◯ Other

	1st check	2nd check	3rd check	4th check	5th check
Date pay received					
Gross earnings					
Tips/bonuses					

EMPLOYER SIGNATURE (NEEDED IF YOU DON'T HAVE PAY STUBS)	DATE

Section B: Assets

Only complete if you answered "Yes" to question 6, and your assets total **$9,800 or more**.

List all assets (including cash, bank accounts, debit accounts, reliacard accounts, money market accounts, certificates of deposits, stocks, bonds, pensions, retirement accounts, car, truck, van, camper, motorcycle, trailer).

Send proof.

Type of asset	Amount or value	Owner's name	Account information (number, location)

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

ያስተውሉ: ይህንን ዶኩመንት ለመተርጎም እርዳታ የሚፈልጉ ከሆነ: የጉዳዮን ሰራተኛ ይጠይቁ ወይም በሰልክ ቁጥር 1-844-217-3547 ይደውሉ።

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

သတိ။ ဤစာရွက်စာတမ်းအားအခမဲ့ဘာသာပြန်ပေးခြင်း အကူအညီလိုအပ်ပါက၊ သင့်လူမှုရေးအလုပ်သမား အားမေးမြန်း ခြင်းသို့ မဟုတ် 1-844-217-3563 ကိုခေါ်ဆိုပါ။

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

請注意，如果您需要免費協助傳譯這份文件，請告訴您的工作人員或撥打 1-844-217-3564。

Attention. Si vous avez besoin d'une aide gratuite pour interpréter le présent document, demandez à votre agent chargé du traitement de cas ou appelez le 1-844-217-3548.

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

ဟ်သူဉ်ဟ်သးဘဉ်တက့်. ဖဲနမ့်လိဉ်ဘဉ်တ်မၤစၢၤကလီလၢတ်ကကျိးထံဝဲဒဉ်လံာ် တီလံာ်မီတခါအံၤန္ဉ်,သံကွါဘဉ်ပှၤဂ့ၢ်ဝီအပှၤမၤစၢၤတ်လၢနဂီၢ်မ့တမ့်ကီးဘဉ် 1-844-217-3549 တက့်.

알려드립니다. 이 문서에 대한 이해를 돕기 위해 무료로 제공되는 도움을 받으시려면 담당자에게 문의하시거나 1-844-217-3565으로 연락하십시오.

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

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

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

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

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

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

LB1 (8-16)

ADA Advisory

For accessible formats of this publication, ask your county worker. For assistance with additional equal access to human services, contact your county's ADA coordinator. (ADA4 [9-15])

CB6 (Food, Cash, SS, HC) 3-18

Civil Rights Notice

Discrimination is against the law. The Minnesota Department of Human Services (DHS) and local human services agencies do 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 (including sex stereotypes and gender identity)
- political beliefs

Auxiliary Aids and Services: Human services agencies provide auxiliary aids and services, like qualified interpreters or information in accessible formats, free of charge and in a timely manner to ensure an equal opportunity to participate in their programs. **Contact** your worker or agency's ADA Coordinator to get auxiliary aids and services.

Language Assistance Services: Human services agencies provide translated documents and spoken language interpreting, free of charge and in a timely manner, when language assistance services are necessary to ensure limited English speakers have meaningful access to information and services. **Contact** your worker or agency's LEP Coordinator to get language assistance services.

Civil Rights Complaints

You have the right to file a discrimination complaint if you believe you were treated in a discriminatory way by a human services agency. You may contact any of the following four agencies directly to file a discrimination complaint.

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

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

Director, U.S. Department of Health and Human Services' Office for Civil Rights
200 Independence Avenue SW, Room 509F
HHH Building
Washington, DC 20201
800-368-1019 (voice)
800-537-7697 (TDD)
Complaint Portal: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

In accordance with Federal civil rights law and **U.S. Department of Agriculture (USDA)** civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), 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. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

(1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, DC 20250-9410;

(2) fax: (202) 690-7442; or

(3) email: program.intake@usda.gov

This institution is an equal opportunity provider.

Keep this page for your records.

Minnesota Department of Human Rights (MDHR)

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

- race
- color
- national origin
- religion
- creed
- sex
- sexual orientation
- marital status
- public assistance status
- disability

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

Minnesota Department of Human Rights
Freeman Building, 625 North Robert Street
St. Paul, MN 55155
651-539-1100 (voice)
800-657-3704 (toll free)
711 or 800-627-3529 (MN Relay)
651-296-9042 (fax)
Info.MDHR@state.mn.us (email)

DHS

You have the right to file a complaint with DHS if you believe you have been discriminated against in our health care programs because of any of the following:

- race
- color
- national origin
- creed
- religion
- sexual orientation
- public assistance status
- marital status
- age
- disability
- sex (including sex stereotypes and gender identity)
- political beliefs

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

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

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

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

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