Service Agency Name
Service Agency Address Line 1
Service Agency Address Line 2
City, State, Zip Code

DEPARTMENT OF HUMAN SERVICES

Date & Time Printed
Case Number: XXXXXXXX

Primary Client Name
Client Address Line 1
Client Address Line 1
City, State, Zip Code

Medical Assistance or MinnesotaCare Discrepancy Notice

Important: Action Needed

We have received information about you or members of your household that is different from what you reported. **You must confirm or update the information on this notice within 30 days from the date on this notice. If you do not respond, health care coverage for some or all household members may end.** Contact the agency listed above or complete the enclosed form and send it to the agency listed above.

We will use the information you give us to redetermine your eligibility. This may result in:

- Your health care program staying the same
- Your health care program changing
- Your health care program closing

If you would like to call the agency listed above and do not know the phone number, call the DHS Member Help Desk at 651-431-2670 or 800-657-3739 for assistance.

Medicare Discrepancy

Information from electronic sources indicates that the following people have Medicare Part A.

[Name]

Death Discrepancy

Information from electronic sources indicates that [Person Name] is deceased. This person's death may affect health care coverage for the following people:

[Name]

Income Discrepancy

Income information received from electronic sources indicates that the following people may no longer meet the income limit for their health care program. You must confirm the income information for your household.

[Name]

Medical Assistance or MinnesotaCare Discrepancy Response Form

Review the information below. You must tell us if this information is correct or if it is incorrect and needs to be changed.

If you know the information below is complete and correct:

- Call the agency listed on the first page of this notice to confirm the information; or
- Enter your name below, review and send this form to the agency listed on the first page of this notice.

If you know the information below is incomplete or incorrect:

- Call the agency listed on the first page of this notice to provide updated information; or
- Enter your name below and provide updated information in the boxes below. Send this form to the agency listed on the first page of this notice.

Name of person completing this form:

_____.

You must respond within 30 days from the date on this notice. If you do not respond, health care coverage for some or all household members may end.

Medicare Information

The information below is complete and correct unless you enter a change in the box below.

Name	Type of insurance	Start date
[Person Name]	[Insurance type]	[Start date]

If the information above is not correct, clarify in the box below:

Death Information

If the information below is correct, **enter the date of death** for the deceased individual.

Name of deceased	Gender	Date of birth	**Date of Death**
[Person Name]	[Gender]	[DOB]	

If the information above is not correct, clarify in the box below:

Income Information

1. Income you reported

This is the income you have reported for your household. Information we have from electronic sources is now showing this income may not be correct.

You must confirm or update this information within 30 days from the date on this notice.

Review the income information below and:

- Contact the agency listed on the first page of this notice to confirm or change what is reported below OR
- Send this form to the agency listed on the first page of this notice to confirm or change what is reported below

Name	Source of income	Check here if this income source has ended	Amount	Frequency	Amount of interest received or Social Security benefit that is tax exempt
[Person Name]	[Income Source]		[Amount]	[Frequency]	[Tax exempt amount?]

If any of the information reported above is no longer correct and complete, you must report the change, even if it is the same source of income. If you have **new income** to report, add this information as well.

Name	Type of income	Amount	Frequency	Amount of interest received or Social Security benefit that is tax exempt

2. Income Adjustments

Below are income adjustments you reported. They are expenses you can subtract from your income on the IRS 1040 tax form. Some examples include alimony paid and student loan interest. For a complete list of allowable income adjustments, see lines 23–35 on the 1040 tax form. You can list adjustments even if you don't file a tax return.

Name	Type of income adjustment	Amount of income adjustment	Frequency of income adjustment
[Person Name]	[Adjustment Type]	[Adjustment Amount]	[Adjustment Frequency]

The information above is complete and correct unless you enter a change below:

Name	Type of income adjustment	Amount of income adjustment	Frequency of income adjustment

3. Projected Annual Income

Projected annual income (PAI) is the income your household expects to have for the calendar year (January through December). If you file taxes, it is the modified adjusted gross income your household expects to have for the tax year.

What is PAI?

- It includes income your household already received this year, even if that income has stopped.
- It includes all taxable income.
- It also includes Social Security benefits, interest income and foreign earned income your household expects to receive this year, even if it is not taxable.
- It doesn't include Supplemental Security Income (SSI), child support or workers compensation.
- It includes adjustments that you expect to claim on your federal tax return if you file one. Some common adjustments are alimony you pay and student loan interest.
- You can use your most recently filed federal tax return (1040 tax form), if you filed one, as a guide. The income is listed on lines 7–21. The adjustments are listed on lines 23–35.

This is the PAI we have for people in your household. If you need help with your PAI, please contact your county agency or MinnesotaCare Operations.

Name	PAI for [Current Tax Year]	PAI for [Next Tax Year]
[Person Name]	[Current Year PAI]	[Next Year PAI]

The information above is complete and correct unless you enter a change below:

Name	PAI for [Current Tax Year]	PAI for [Next Tax Year]

What if I have questions about this notice?

Call us if you have questions.

- For questions about Medical Assistance, call your county or tribal agency.
- For questions about MinnesotaCare, call Healthcare Consumer Support at 800-657-3672 or 651-297-3862.
- For general questions about Medical Assistance or MinnesotaCare, call Healthcare Consumer Support at 651-431-2670 or 800-657-3739.

If you have hearing or speech disabilities, contact us using your preferred telecommunications relay service.

You can also visit us in person:

- For in-person help about Medical Assistance, go to your county or tribal agency.
- For in-person help about MinnesotaCare, go to the MinnesotaCare walk-in office. The walk-in office is on the first floor of the Elmer L. Andersen Human Services Building in St. Paul. It is next to the security desk in the lobby.

Location:	Elmer L. Andersen Human Services Building 540 Cedar Street St. Paul, MN 55101
Hours:	8:00 a.m. to 5:00 p.m., Monday–Friday

Who can help me resolve a discrepancy?

If you have Medical Assistance, your county or tribal agency has workers who can help you. If you have MinnesotaCare, you can get help from workers at Healthcare Consumer Support. The Department of Human Services (DHS) also partners with trusted organizations across the state. People from these organizations, called navigators, are trained to provide free face-to-face help. To find a navigator near you, use the MNsure Assister Directory at www.mnsure.org.

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 (including sex stereotypes and gender identity)
- political beliefs

Auxiliary Aids and Services: DHS provides 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 our health care programs. Contact the Minnesota Health Care Programs (MHCP) Member Help Desk at dhs.info@state.mn.us or 800-657-3739, or use your preferred relay service.

Language Assistance Services: DHS provides 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 our information and services. Contact the Minnesota Health Care Programs (MHCP) Member Help Desk at dhs.info@state.mn.us or 800-657-3739, or use your preferred relay service.

Civil Rights Complaints

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

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

You have 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

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

651-431-2670 or 800-657-3739

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

ያስተውሉ: ካለምንም ክፍያ ይህንን ዶኩመንት የሚተረጉምሎ አስተርጓሚ ከፈለጉ ከላይ ወደተጻፈው የስልክ ቁጥር ይደውሉ።

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

သတိ။ ဤစာရွက်စာတမ်းအားအခမဲ့ဘာသာပြန်ပေးခြင်း အကူအညီလိုအပ်ပါက၊
အထက်ပါဖုန်းနံပါတ်ကိုခေါ်ဆိုပါ။

កំណត់សំគាល់ ។ បើអ្នកត្រូវការជំនួយក្នុងការបកប្រែឯកសារនេះដោយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទតាមលេខខាងលើ ។

請注意，如果您需要免費協助傳譯這份文件，請撥打上面的電話號碼。

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

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

ဟ်သူဉ်ဟ်သးဘဉ်တကွ်. ဖဲနမ့်လိဉ်ဘဉ်တ်မၤစၢၤကလီလၢတ်ကကျိးထံဖဲဒုဉ်လ်ာ် တီလ်ာ်ဓိတခါဆံၤန္တဉ်,ကိးဘဉ်လီတဖိနိာ်ဂ်ါလၢထးဆံၤန္တဉ်တကွ်.

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

ໂປຣດຊາບ. ຖ້າທ່ານ ທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປເອກະສານນີ້ຟຣີ,
ຈົ່ງໂທຣໄປທີ່ໝາຍເລກຂ້າງເທິງນີ້.

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

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

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

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

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