DEPARTMENT OF HUMAN SERVICES

DHS-1958-ENG 2-21

Application for child support services

FOR OFFICE USE ONLY	
REQUESTED	SENT
RETURNED	

Welcome to Minnesota's child support program! Child support is money parents pay to their child's other parent or caregiver to support their child. Before completing this application, please read the Understanding Child Support handbook (https://edocs.dhs.state.mn.us/lfserver/Public/DHS-3393-ENG) to learn more about the program.

Please provide as much information as possible, including a daytime phone number to help us better serve you. The child support program will use this information to help you collect or pay support. Complete a separate application for each parent with whom you have a child.

Child support services include:

- Locating parents
- Establishing paternity and court orders for child support
- Enforcing child support orders
- Processing payments made by one parent and sending them to the other parent
- Reviewing, modifying, and adjusting orders for child support
- Working with other states to establish and enforce child support orders.

If you have questions about filling out this application, contact your local county child support agency.

The child support program will keep secure any information we collect about you from this application. A complete notice of our privacy practices is included in this document and available online at https://edocs.dhs.state.mn.us/lfserver/Public/DHS-3979-ENG.

The Minnesota child support program asks for demographic information like race, ethnicity, and gender for use in data collection and analysis of differences in program services and outcomes. Collection of this data will aid the program in designing and implementing more effective, inclusive, and equitable practices statewide. In addition, it will help ensure compliance with state and federal civil rights and anti-discrimination laws.

*Required field **********ATTENTION**********The box below must be filled out!**********

*The Minnesota child support program takes the safety of families receiving child support services seriously, and we can modify some of our processes to help with safety concerns. Do you have concerns that seeking to establish, modify or enforce a parentage or child support order will create a risk of harm to you or your child?

◯ Yes ◯ No

If you checked "Yes" above, a county child support worker will contact you to discuss your concerns upon processing this application.

1. Applicant information

*YOUR NAME - LAST	*FIRST	MIDDLE
MAIDEN OR OTHER	SOCIAL SECURITY NUMBER	*DATE OF BIRTH (MM/DD/YYYY)
MARITAL STATUS	GENDER	RACE/ETHNICITY
What is your preferred language?	Do you need an interpreter? ◯ Yes ◯ No	*PHONE NUMBER
EMAIL ADDRESS		

*MAILING ADDRESS - STREET	*CITY	*STATE	*ZIP CODE
*COUNTY	YOUR RELATIONSHIP TO THE CHILD(REN) ON THIS APPLICATION ◯ Mother ◯ Father ◯ Other – Specify: _____		

DO YOU RECEIVE:

☐ Social Security ☐ Unemployment insurance ☐ Worker's compensation ☐ Public assistance

☐ Veterans benefits ☐ Other – Describe: _____

Are you a tribal member? ◯ Yes ◯ No	NAME OF TRIBE	
Are you on active military service? ◯ Yes ◯ No	NAME OF MILITARY BRANCH	Are you a veteran? ◯ Yes ◯ No
Are you a student? ◯ Yes ◯ No	WHERE	EXPECTED GRADUATION DATE (MM/DD/YYYY)

2. Applicant employment information

Are you currently employed? ◯ Yes ◯ No

CURRENT EMPLOYER				
STREET ADDRESS		CITY	STATE	ZIP CODE
EMPLOYER PHONE	OCCUPATION			
START WORK DATE (MM/DD/YYYY)	END WORK DATE (MM/DD/YYYY)	WORK STATUS ☐ Active ☐ Temporary ☐ Laid off	HOURLY INCOME	HOURS PER WEEK
UNION NAME			LOCAL NUMBER	

Do you have a second employer? ◯ Yes ◯ No

SECOND EMPLOYER				
STREET ADDRESS		CITY	STATE	ZIP CODE
EMPLOYER PHONE	OCCUPATION			
START WORK DATE (MM/DD/YYYY)	END WORK DATE (MM/DD/YYYY)	WORK STATUS ☐ Active ☐ Temporary ☐ Laid off	HOURLY INCOME	HOURS PER WEEK
UNION NAME			LOCAL NUMBER	

If unemployed:

NAME OF LAST EMPLOYER			
STREET ADDRESS	CITY	STATE	ZIP CODE
EMPLOYER PHONE	OCCUPATION	START WORK DATE (MM/DD/YYYY)	END WORK DATE (MM/DD/YYYY)

OTHER SOURCES OF INCOME

3. Other parent information

*NAME - LAST	*FIRST	MIDDLE
MAIDEN OR OTHER	SOCIAL SECURITY NUMBER	DATE OF BIRTH
MARITAL STATUS	GENDER	RACE/ETHNICITY

What is the other parent's preferred language?	Does the other parent need an interpreter? ◯ Yes ◯ No	PHONE NUMBER

EMAIL ADDRESS

MAILING ADDRESS - STREET	CITY	STATE	ZIP CODE
OTHER ADDRESS - STREET	CITY	STATE	ZIP CODE

RESIDES WITH	OTHER PARENT'S RELATIONSHIP TO CHILD(REN) ON THIS APPLICATION ◯ Mother ◯ Father ◯ Other (alleged father)	EYE COLOR	HAIR COLOR

HEIGHT ____ FT. ____ IN.	WEIGHT	GLASSES ◯ Yes ◯ No	IDENTIFYING MARKS

OTHER PARENT RECEIVES:

☐ Social Security ☐ Unemployment insurance ☐ Worker's compensation ☐ Public assistance
☐ Veterans benefits ☐ Other – Describe: _____

Is the other parent a tribal member? ◯ Yes ◯ No	NAME OF TRIBE

Is the other parent on active military service? ◯ Yes ◯ No	NAME OF MILITARY BRANCH	Is the other parent a veteran? ◯ Yes ◯ No

Has the other parent been to inpatient treatment? ◯ Yes ◯ No	START DATE	END DATE

Has the other parent been incarcerated? ◯ Yes ◯ No	WHERE?

CITY	STATE	DATE FROM	DATE TO

Is the other parent a student? ◯ Yes ◯ No	WHERE?	EXPECTED GRADUATION DATE

DRIVER'S LICENSE STATE

VEHICLE – LICENSE PLATE NUMBER	MAKE	MODEL	YEAR

NAME OF OTHER PARENT'S PARENT ONE	ADDRESS
NAME OF OTHER PARENT'S PARENT TWO	ADDRESS

4. Other parent employment information

Is the other parent currently employed? ◯ Yes ◯ No

CURRENT EMPLOYER				
STREET ADDRESS		CITY	STATE	ZIP CODE
EMPLOYER PHONE	OCCUPATION			
START WORK DATE (MM/DD/YYYY)	END WORK DATE (MM/DD/YYYY)	WORK STATUS ☐ Active ☐ Temporary ☐ Laid off	HOURLY INCOME	HOURS PER WEEK
UNION NAME			LOCAL NUMBER	

Does the other parent have a second employer? ◯ Yes ◯ No

SECOND EMPLOYER				
STREET ADDRESS		CITY	STATE	ZIP CODE
EMPLOYER PHONE	OCCUPATION			
START WORK DATE (MM/DD/YYYY)	END WORK DATE (MM/DD/YYYY)	WORK STATUS ☐ Active ☐ Temporary ☐ Laid off	HOURLY INCOME	HOURS PER WEEK
UNION NAME			LOCAL NUMBER	

If unemployed:

NAME OF LAST EMPLOYER			
STREET ADDRESS	CITY	STATE	ZIP CODE
EMPLOYER PHONE	OCCUPATION	START WORK DATE (MM/DD/YYYY)	END WORK DATE (MM/DD/YYYY)

OTHER SOURCES OF INCOME

5. Minor children

Provide information about the minor child(ren) living with you whose parent you list in section three. **If you have not established parentage for your child(ren), the child support agency will ask you to give more information to help establish parentage.**

Minor Child 1

*NAME - LAST	*FIRST	MIDDLE

*DATE OF BIRTH (MM/DD/YYYY)	GENDER	SOCIAL SECURITY NUMBER	PLACE OF BIRTH (COUNTY/STATE)

CHILD'S LEGAL RELATIONSHIP TO THE OTHER PARENT

◯ Established by court order ◯ Legally adopted ◯ Parent married at child's birth
◯ Not established ◯ Recognition of Parentage ◯ Other state acknowledgement of paternity

Does the child receive Social Security benefits?	Does the child receive Veterans benefits?
◯ Yes ◯ No	◯ Yes ◯ No

Minor Child 2

NAME - LAST	FIRST	MIDDLE

DATE OF BIRTH (MM/DD/YYYY)	GENDER	SOCIAL SECURITY NUMBER	PLACE OF BIRTH (COUNTY/STATE)

CHILD'S LEGAL RELATIONSHIP TO THE OTHER PARENT

◯ Established by court order ◯ Legally adopted ◯ Parent married at child's birth
◯ Not established ◯ Recognition of Parentage ◯ Other state acknowledgement of paternity

Does the child receive Social Security benefits?	Does the child receive Veterans benefits?
◯ Yes ◯ No	◯ Yes ◯ No

Minor Child 3

NAME - LAST	FIRST	MIDDLE

DATE OF BIRTH (MM/DD/YYYY)	GENDER	SOCIAL SECURITY NUMBER	PLACE OF BIRTH (COUNTY/STATE)

CHILD'S LEGAL RELATIONSHIP TO THE OTHER PARENT

◯ Established by court order ◯ Legally adopted ◯ Parent married at child's birth
◯ Not established ◯ Recognition of Parentage ◯ Other state acknowledgement of paternity

Does the child receive Social Security benefits?	Does the child receive Veterans benefits?
◯ Yes ◯ No	◯ Yes ◯ No

Minor Child 4

NAME - LAST	FIRST	MIDDLE

DATE OF BIRTH (MM/DD/YYYY)	GENDER	SOCIAL SECURITY NUMBER	PLACE OF BIRTH (COUNTY/STATE)

CHILD'S LEGAL RELATIONSHIP TO THE OTHER PARENT

◯ Established by court order ◯ Legally adopted ◯ Parent married at child's birth
◯ Not established ◯ Recognition of Parentage ◯ Other state acknowledgement of paternity

Does the child receive Social Security benefits?	Does the child receive Veterans benefits?
◯ Yes ◯ No	◯ Yes ◯ No

Are you pregnant? ◯ Yes ◯ No

IF YES, EXPECTED DATE OF BIRTH (MM/DD/YYYY)	Is the parent in section three of this application the biological parent of the unborn child? ◯ Yes ◯ No ◯ Unknown

Do you have minor child(ren) whose parent is not listed on this application? ◯ Yes ◯ No

If yes, provide information about the other minor children whose parent is not listed in section three.

Other Minor Child 1

NAME - LAST	FIRST	MIDDLE
DATE OF BIRTH (MM/DD/YYYY)	GENDER	Does this child live with you? ◯ Yes ◯ No
Do you pay child support for this child? ◯ Yes ◯ No	If you pay child support, what is the monthly amount you pay?	

Other Minor Child 2

NAME - LAST	FIRST	MIDDLE
DATE OF BIRTH (MM/DD/YYYY)	GENDER	Does this child live with you? ◯ Yes ◯ No
Do you pay child support for this child? ◯ Yes ◯ No	If you pay child support, what is the monthly amount you pay?	

6. Child(ren) health care coverage information

Do you have health care coverage for the child(ren)?

◯ Yes, available but not in place ◯ Yes, in place ◯ No, not available

CHILD(REN) HEALTH INSURANCE TYPE

☐ Employer sponsored health insurance ☐ Private health insurance ☐ Public health insurance

Does the other parent have health care coverage for the child(ren)?

◯ Yes, available but not in place ◯ Yes, in place ◯ No, not available

OTHER PARENT HEALTH INSURANCE TYPE FOR THE CHILD(REN)

☐ Employer sponsored health insurance ☐ Private health insurance ☐ Public health insurance

Is either parent court-ordered to provide: Health care coverage for the child(ren)? ◯ Yes ◯ No

Dental care coverage for the child(ren)? ◯ Yes ◯ No

7. Child care

Do you have child care expenses? ◯ Yes ◯ No

Do you receive a Child Care Assistance Program subsidy? ◯ Yes ◯ No

Complete for each child who has child care expenses.

Child's name	**Total monthly child care expense** (include subsidy amount if applicable)

8. Applicant relationship to other parent

What is your relationship to the other parent? (check all that apply)

☐ Married ☐ Divorced ☐ Separated ☐ Other – describe: _____

DATE (MM/DD/YYYY)	COUNTY	STATE	COUNTRY

9. Court order and legal information (check all that apply)

Type of order	**County**	**State**	**Date** (MM/DD/YYYY)
☐ Separation			
☐ Divorce			
☐ Custody and Parenting Time Order			
☐ Paternity			
☐ Recognition of Parentage signed			
☐ Child support			
☐ Protective order (such as domestic abuse order (DAB), order for protection (OFP), domestic abuse no contact order (DANCO), harassment restraining order (HRO))			
☐ Cost of Living Adjustment (COLA)			
☐ Genetic test results			
☐ No order			

10. Support payment information

Has the other parent made support payments? ◯ Yes ◯ No

11. Other information

Provide any additional information that may assist the child support agency in processing your application.

Certifications and signatures

By signing my name below, I am enrolling in full child support services from Minnesota's child support program available under Title IV-D of the Social Security Act. By submitting this form, I understand:

- The services available to me and my responsibilities
- I am authorizing the Minnesota child support program to take legal action, relating to child support on behalf of the child(ren) for which I am applying
- The Minnesota child support program has discretion to determine the appropriate action to take to establish, enforce, and modify my child support order
- I must cooperate with the Minnesota child support program to receive services, which may include:
  - providing verbal or written information
  - participating in genetic testing to establish paternity
  - appearing as a witness at court hearings necessary to pursue the requested child support services, and
  - notifying the child support agency of any changes in circumstances that may affect my child support case
- My failing to cooperate may result in my case being closed
- The county attorney's office represents only the county and State of Minnesota, and does not represent me, the other parent, the child(ren) or other custodian of the child(ren)
- I have the right to my own attorney and may hire one at any time
- The child support program may verify the information I provide on this application through sources authorized by law, contact the other parent to obtain additional information, and use all information obtained to determine what action to take
- The Minnesota Child Support Payment Center will receive and distribute all child support payments. If I am a parent who receives child support, I authorize the Center to act in my name in endorsing and cashing any drafts, checks, money orders, or other negotiable instruments received by the public authority
- If I wish to close my child support case, I must tell my county child support agency verbally or in writing. The child support agency can only stop child support services if my child(ren) do not receive public assistance. If I close my case, the child support agency may continue to collect any amounts owed to the state or county due to the receipt of public assistance
- I am required to return any support amounts I receive from the Minnesota child support program by mistake
- I swear (or affirm) under penalty of perjury that I have read the entire application and that all of the information I'm providing is true
- I have received and reviewed the Understanding Child Support handbook and I agree to the terms and limitations stated in it (https://edocs.dhs.state.mn.us/lfserver/Public/DHS-3393-ENG)
- I have received and reviewed the Notice of Privacy Practices (https://edocs.dhs.state.mn.us/lfserver/Public/DHS-3979-ENG)

*SIGNATURE OF APPLICANT	*DATE (MM/DD/YYYY)

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 សូមសួរអ្នកការងារសង្គមរបស់អ្នក 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 တီလံာ်မီတခါဖၣံၤန္ဉ်,သံကွါဘဉ်ပှၤဂ့ၢ်ဝီဒုပှၤမၤစၢၤတ်လၢနဂီၢ်မ့တမ့်ကီးဘဉ် 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 information, ask your county worker. For assistance with additional equal access to human services, contact your county's ADA coordinator. ADA4 (2-18)

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 social 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
- marital status
- 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 (email)

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
Email: ocrmail@hhs.gov

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