

November 2026 updates to the DHS-3876, DHS-6696 and Blank Renewal form

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DEPARTMENT OF HUMAN SERVICES

Agenda

DHS-3876 November 2026

- Certain Populations Application

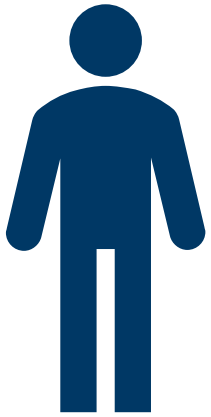
DHS-6696 November 2026

- Application for Health Coverage and Help Paying Costs

DHS-8262 November 2026

- METS Blank Renewal Form

DHS-3876 Updates



DHS-3876 Question 6



DHS-3876 Question 6
Person 2



DHS-3876 Attachment B

DHS-3876 Updates – Question 6

3876 June 2026

6. Is everyone applying a U.S. citizen or U.S. national?

◯ Yes ◯ No – fill in the information

Person 1

NAME

What is this person's current immigration status? (Choose a status from List 1 or List 2 on Attachment B and write it here. If status is not listed, write it in.)

Did this person gain lawful permanent resident status as an Iraqi or Afghan Special Immigrant or an Amerasian Immigrant?
◯ Yes ◯ No ◯ Person does not have lawful permanent resident status

a. IMMIGRATION DOCUMENT TYPE	b. ALIEN ID NUMBER	c. CARD NUMBER

d. Did this person enter the United States before August 22, 1996? ◯ Yes ◯ No

e. Has this person lived in the United States for five years or more with any of the statuses on Attachment B – List1? ◯ Yes ◯ No

f. DATE OF ENTRY (MM/DD/YYYY)

g. Does this person have an I-864 sponsor? ◯ Yes ◯ No

h. Is this person, or the person's spouse or parent, a veteran or active-duty member of the military? ◯ Yes ◯ No

i. Does this person want help paying for a medical emergency? ◯ Yes ◯ No

j. Is this person getting services from the Center for Victims of Torture? ◯ Yes ◯ No

k. Did this person have a different immigration status before the current status (for example, refugee or asylee)?
◯ Yes – fill in the following ◯ No

What is this person's previous immigration status? (Choose a status from List 1 or List 2 on Attachment B and write it here. If previous status is not listed, write it in.)

ORIGINAL DATE OF ENTRY (MM/DD/YYYY)

3876 November 2026

6. Is everyone applying a U.S. citizen or U.S. national?

◯ Yes ◯ No – fill in the information

Person 1

NAME

What is this person's current immigration status? (Choose a status from Attachment B and write it here. If status is not listed, write in your own.)

a. Immigration document type	b. Alien ID number	c. Card number	d. Date of entry (MM/DD/YYYY)

e. Does this person want help paying for a medical emergency? ◯ Yes ◯ No

f. Is this person getting services from the Center for Victims of Torture? ◯ Yes ◯ No

Answer question g-l if this person is a Lawful Permanent Resident (LPR/Green Card holder), including conditional permanent resident. If not - go to question 7.

g. Has this person been an LPR for five years or more? ◯ Yes ◯ No
Date LPR status granted (MM/DD/YYYY):

h. Did this person gain LPR status as an Iraqi or Afghan Special Immigrant or an Amerasian Immigrant? ◯ Yes ◯ No

i. Did this person have a different status before they were an LPR (for example, refugee or asylee)?
◯ Yes – what status: *(Choose a status from Attachment B or write in your own)*
◯ No

If this person was previously a COFA migrant, a battered noncitizen or paroled for one year or more
Date previous status granted (MM/DD/YYYY):

j. Did this person enter the United States before August 22, 1996? ◯ Yes ◯ No

k. Is this person, or the person's spouse or parent, a veteran or active-duty member of the military? ◯ Yes ◯ No

l. Does this person have an I-864 sponsor? ◯ Yes ◯ No

November

3876 November 2026

MOVED

Update includes:

- Order of questions
- Expanded specific questions

6. Is everyone applying a U.S. citizen or U.S. national?

◯ Yes ◯ No – fill in the information

Person 1

NAME

What is this person's current immigration status? (Choose a status from Attachment B and write it here. If status is not listed, write in your own.)

a. Immigration document type	b. Alien ID number	c. Card number	d. Date of entry (MM/DD/YYYY)

e. Does this person want help paying for a medical emergency? ◯ Yes ◯ No

f. Is this person getting services from the Center for Victims of Torture? ◯ Yes ◯ No

Answer question g-l if this person is a Lawful Permanent Resident (LPR/Green Card holder), including conditional permanent resident. If not - go to question 7.

g. Has this person been an LPR for five years or more? ◯ Yes ◯ No

Date LPR status granted (MM/DD/YYYY):

h. Did this person gain LPR status as an Iraqi or Afghan Special Immigrant or an Amerasian Immigrant? ◯ Yes ◯ No

i. Did this person have a different status before they were an LPR (for example, refugee or asylee)?

◯ Yes – what status: *(Choose a status from Attachment B or write in your own)*

◯ No

If this person was previously a COFA migrant, a battered noncitizen or paroled for one year or more

Date previous status granted (MM/DD/YYYY):

j. Did this person enter the United States before August 22, 1996? ◯ Yes ◯ No

k. Is this person, or the person's spouse or parent, a veteran or active-duty member of the military? ◯ Yes ◯ No

l. Does this person have an I-864 sponsor? ◯ Yes ◯ No

Question 6, person 2

3876 November 2026

Update includes:

- Matched to Question 6 for applicant

Person 2

NAME

What is this person's current immigration status? (Choose a status from Attachment B and write it here. If status is not listed, write in your own.)

a. Immigration document type	b. Alien ID number	c. Card number	d. Date of entry (MM/DD/YYYY)

e. Does this person want help paying for a medical emergency? ◯ Yes ◯ No

f. Is this person getting services from the Center for Victims of Torture? ◯ Yes ◯ No

Answer question g-l if this person is a Lawful Permanent Resident (LPR/Green Card holder), including conditional permanent resident. If not - go to question 7.

g. Has this person been an LPR for five years or more? ◯ Yes ◯ No
Date LPR status granted (MM/DD/YYYY):

h. Did this person gain LPR status as an Iraqi or Afghan Special Immigrant or an Amerasian Immigrant? ◯ Yes ◯ No

i. Did this person have a different status before they were an LPR (for example, refugee or asylee)?
◯ Yes – what status: *(Choose a status from Attachment B or write in your own)*
◯ No

If this person was previously a COFA migrant, a battered noncitizen or paroled for one year or more
Date previous status granted (MM/DD/YYYY):

j. Did this person enter the United States before August 22, 1996? ◯ Yes ◯ No

k. Is this person, or the person's spouse or parent, a veteran or active-duty member of the military? ◯ Yes ◯ No

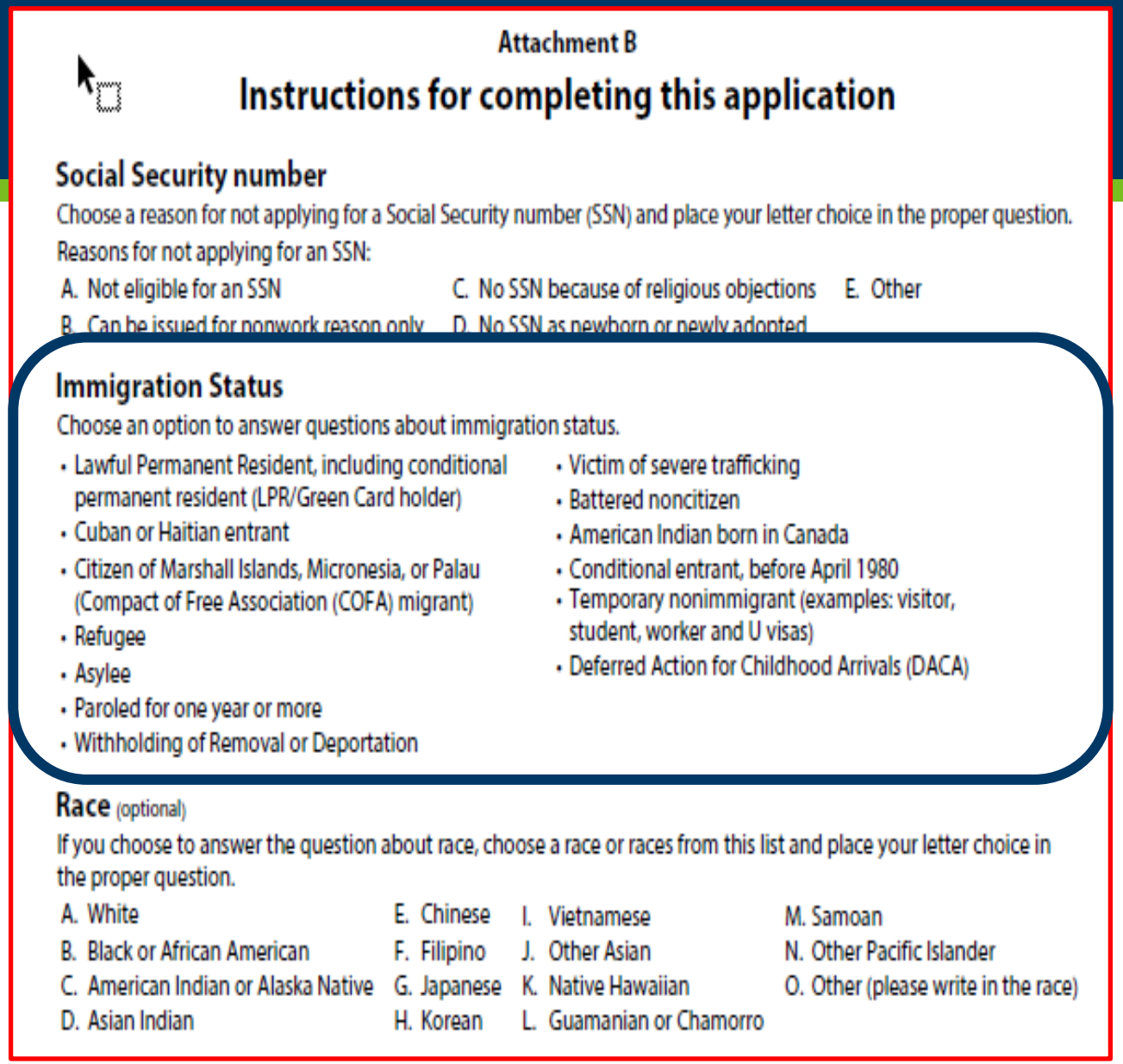
l. Does this person have an I-864 sponsor? ◯ Yes ◯ No

DHS-3876 Updates – Attachment B

3876 November 2026

Update includes:

- One list rather than two containing all statuses



Attachment B

Instructions for completing this application

Social Security number

Choose a reason for not applying for a Social Security number (SSN) and place your letter choice in the proper question.

Reasons for not applying for an SSN:

A. Not eligible for an SSN
B. Can be issued for nonwork reason only
C. No SSN because of religious objections
D. No SSN as newborn or newly adopted
E. Other

Immigration Status

Choose an option to answer questions about immigration status.

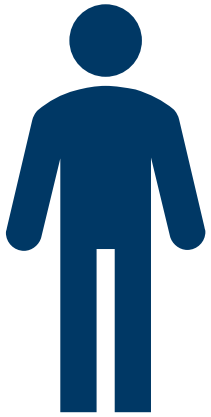
- Lawful Permanent Resident, including conditional permanent resident (LPR/Green Card holder)
- Cuban or Haitian entrant
- Citizen of Marshall Islands, Micronesia, or Palau (Compact of Free Association (COFA) migrant)
- Refugee
- Asylee
- Paroled for one year or more
- Withholding of Removal or Deportation
- Victim of severe trafficking
- Battered noncitizen
- American Indian born in Canada
- Conditional entrant, before April 1980
- Temporary nonimmigrant (examples: visitor, student, worker and U visas)
- Deferred Action for Childhood Arrivals (DACA)

Race (optional)

If you choose to answer the question about race, choose a race or races from this list and place your letter choice in the proper question.

A. White
B. Black or African American
C. American Indian or Alaska Native
D. Asian Indian
E. Chinese
F. Filipino
G. Japanese
H. Korean
I. Vietnamese
J. Other Asian
K. Native Hawaiian
L. Guamanian or Chamorro
M. Samoan
N. Other Pacific Islander
O. Other (please write in the race)

DHS-6696 Immigration data Updates



DHS-6696 Step 2 - person 1 Question 31



DHS-6696 Step 2- persons 2-4 Question 15



DHS-6696 Page 25

Other Immigration Status

DHS-6696 Updates – Step 2, Person 1 Q31

June 2026

STEP 2: PERSON 1 (Continue with yourself)

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 *or conditional permanent resident* (green card holder)*
- ☐ Refugee
- ☐ Asylee
- ☐ Asylum applicant *(see page 25)*
- ☐ 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
- ☐ Citizen of Marshall Islands, Micronesia or Palau (Compact of Free Association (COFA) migrant)
- ☐ Conditional entrant *before 1981*
- ☐ Granted Employment Authorization Document (work permit) excluding DACA
- ☐ Other (*Choose from page 25*)

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

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

*Answer questions d-f if your current status is a lawful permanent resident, conditional permanent 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. Are you, or is your spouse or parent, a veteran or active-duty member of the military? ◯ No ◯ Yes

Answer question g-i only if you are a lawful permanent resident or conditional permanent resident. *If not, go to Question 32.*

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

h. Did you gain lawful permanent resident status as an Iraqi or Afghan Special Immigrant or an Amerasian Immigrant?
◯ No ◯ Yes

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

November 2026

STEP 2: PERSON 1 (Continue with yourself)

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, including conditional permanent resident (LPR/Green Card holder)
- ☐ Cuban or Haitian entrant
- ☐ Citizen of Marshall Islands, Micronesia or Palau (Compact of Free Association (COFA) migrant)
- ☐ Refugee
- ☐ Asylee
- ☐ Asylum applicant (*age 14 or older with a work permit*)
- ☐ Asylum applicant (*under age 14*)
- ☐ Paroled for one year or more
- ☐ Paroled for less than one year
- ☐ Temporary nonimmigrant (visitor, student, worker and U visas)
- ☐ Temporary Protected Status
- ☐ Deferred Action for Childhood Arrivals (DACA)
- ☐ Deferred Action (excluding DACA)
- ☐ Withholding of Removal or Deportation
- ☐ Victim of severe trafficking
- ☐ Battered noncitizen
- ☐ American Indian born in Canada
- ☐ Conditional entrant, *before April 1980*
- ☐ Granted an employment work authorization document (work permit) excluding DACA
- ☐ Other (Choose from page 25):

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

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

Answer questions d-i only if you are a Lawful Permanent Resident (LPR/Green Card holder), including conditional permanent resident. *If not, go to Question 32.*

d. Have you been an LPR for five years or more? ◯ No ◯ Yes

e. Did you gain LPR status as an Iraqi or Afghan Special Immigrant or an Amerasian Immigrant?
◯ No ◯ Yes

f. Did you have a different status before you were an LPR? (example: refugee or asylee)
◯ No ◯ Yes – What status?

If you were previously a COFA migrant, a battered noncitizen or paroled for one year or more:
Date previous status granted (MM/DD/YYYY): _____

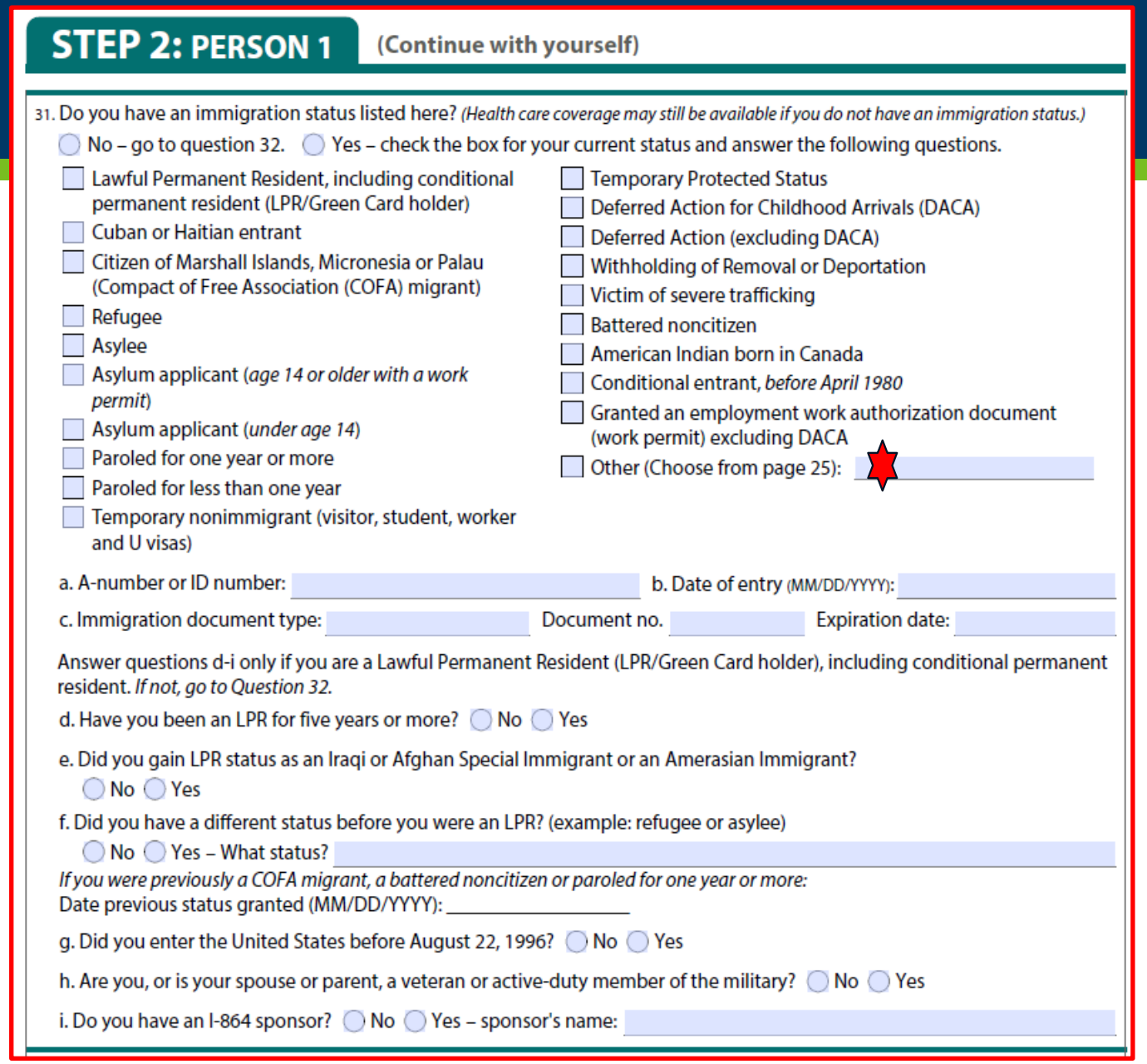
g. Did you enter the United States before August 22, 1996? ◯ No ◯ Yes

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

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

DHS-6696 Application November 2026

- Additional and clearer choices including other choices on page 25 list
- If LPR is yes – more detailed questions for eligibility



STEP 2: PERSON 1 (Continue with yourself)

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, including conditional permanent resident (LPR/Green Card holder)
- ☐ Cuban or Haitian entrant
- ☐ Citizen of Marshall Islands, Micronesia or Palau (Compact of Free Association (COFA) migrant)
- ☐ Refugee
- ☐ Asylee
- ☐ Asylum applicant (*age 14 or older with a work permit*)
- ☐ Asylum applicant (*under age 14*)
- ☐ Paroled for one year or more
- ☐ Paroled for less than one year
- ☐ Temporary nonimmigrant (visitor, student, worker and U visas)
- ☐ Temporary Protected Status
- ☐ Deferred Action for Childhood Arrivals (DACA)
- ☐ Deferred Action (excluding DACA)
- ☐ Withholding of Removal or Deportation
- ☐ Victim of severe trafficking
- ☐ Battered noncitizen
- ☐ American Indian born in Canada
- ☐ Conditional entrant, *before April 1980*
- ☐ Granted an employment work authorization document (work permit) excluding DACA
- ☐ Other (Choose from page 25):

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

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

Answer questions d-i only if you are a Lawful Permanent Resident (LPR/Green Card holder), including conditional permanent resident. *If not, go to Question 32.*

d. Have you been an LPR for five years or more? ○ No ○ Yes

e. Did you gain LPR status as an Iraqi or Afghan Special Immigrant or an Amerasian Immigrant?
○ No ○ Yes

f. Did you have a different status before you were an LPR? (example: refugee or asylee)
○ No ○ Yes – What status?

If you were previously a COFA migrant, a battered noncitizen or paroled for one year or more:
Date previous status granted (MM/DD/YYYY): _____

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

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

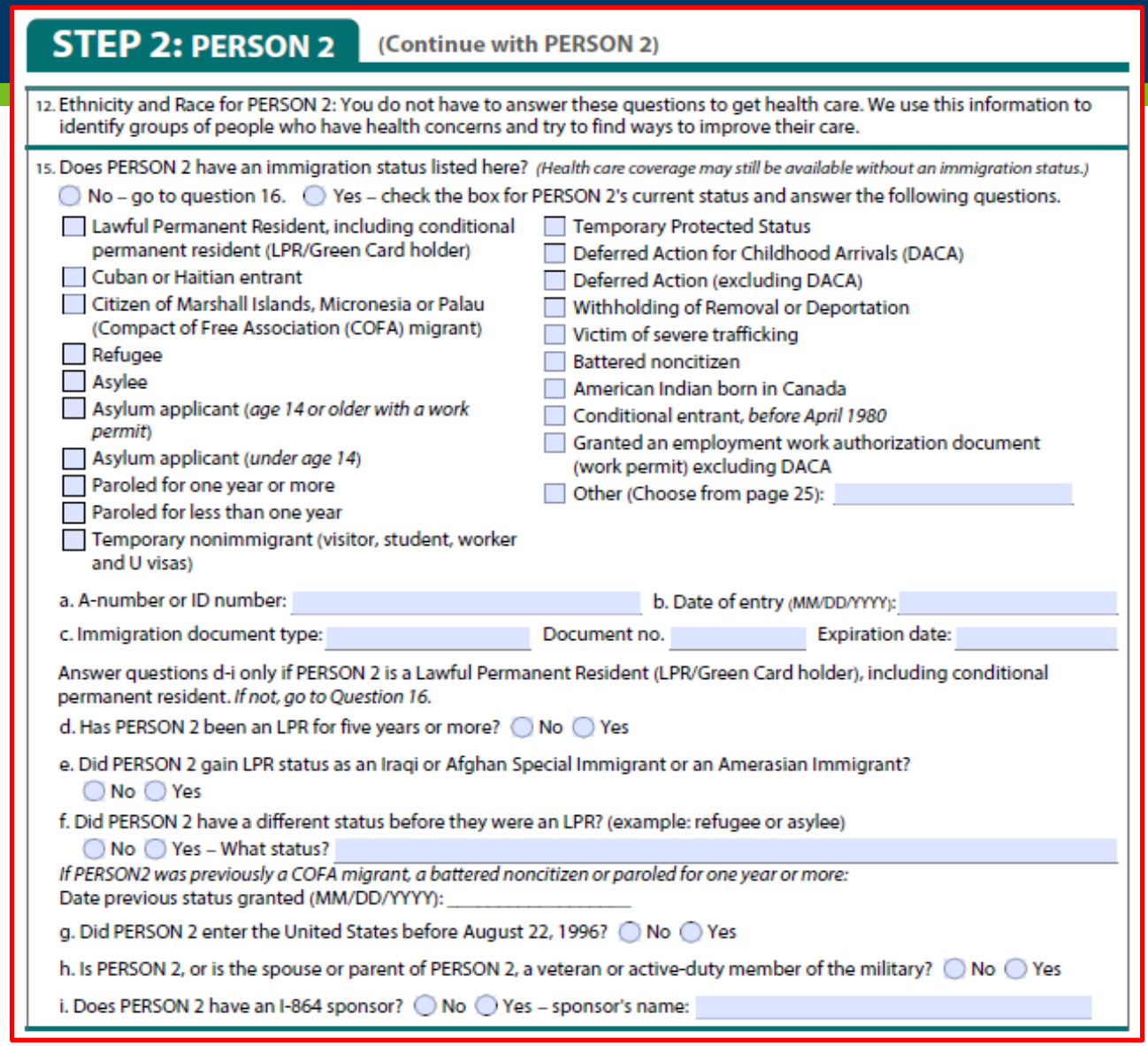
i. Do you have an I-864 sponsor? ○ No ○ Yes – sponsor's name:

Step 2: Person 2

DHS-6696
November 2026

- Matches person 1 section

- Matches person 1 section



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.

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, including conditional permanent resident (LPR/Green Card holder)
- ☐ Cuban or Haitian entrant
- ☐ Citizen of Marshall Islands, Micronesia or Palau (Compact of Free Association (COFA) migrant)
- ☐ Refugee
- ☐ Asylee
- ☐ Asylum applicant (*age 14 or older with a work permit*)
- ☐ Asylum applicant (*under age 14*)
- ☐ Paroled for one year or more
- ☐ Paroled for less than one year
- ☐ Temporary nonimmigrant (visitor, student, worker and U visas)
- ☐ Temporary Protected Status
- ☐ Deferred Action for Childhood Arrivals (DACA)
- ☐ Deferred Action (excluding DACA)
- ☐ Withholding of Removal or Deportation
- ☐ Victim of severe trafficking
- ☐ Battered noncitizen
- ☐ American Indian born in Canada
- ☐ Conditional entrant, *before April 1980*
- ☐ Granted an employment work authorization document (work permit) excluding DACA
- ☐ Other (Choose from page 25): _____

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

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

Answer questions d-i only if PERSON 2 is a Lawful Permanent Resident (LPR/Green Card holder), including conditional permanent resident. *If not, go to Question 16.*

d. Has PERSON 2 been an LPR for five years or more? ○ No ○ Yes

e. Did PERSON 2 gain LPR status as an Iraqi or Afghan Special Immigrant or an Amerasian Immigrant?
○ No ○ Yes

f. Did PERSON 2 have a different status before they were an LPR? (example: refugee or asylee)
○ No ○ Yes – What status? _____

If PERSON2 was previously a COFA migrant, a battered noncitizen or paroled for one year or more:
Date previous status granted (MM/DD/YYYY): _____

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

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

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

Immigration Status Page 25

DHS-6696
November 2026

- List updated



IMMIGRATION STATUS - "OTHER" OPTION

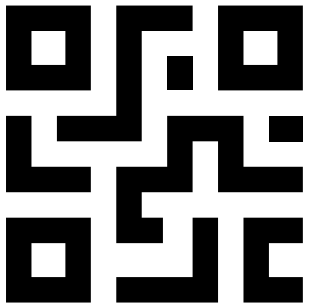
If anyone applying for coverage has an immigration status that is listed here, choose the "Other" box at Question 31 for Person 1 or Question 15 for Persons 2-4. Write the status from this list in the space provided for that question. If anyone applying for coverage does not have a status listed at Question 31 (Person 1) or Question 15 (Persons 2-4) or listed here, answer "No" to Question 31 (Person 1) or Question 15 (Persons 2-4). Health care coverage may still be available if you do not have an immigration status.

- Applicant for:
  - Lawful Permanent Resident
  - Withholding of Removal or Deportation (*age 14 years or older with a work permit*)
  - Withholding of Removal or Deportation (*under age 14*)
- Parolee from Ukraine (entry before 9-30-24)
- Parolee from Afghanistan (entry before 9-30-23)
- Special Immigrant Juvenile petition – pending or approved
- Deferred Enforced Departure
- Convention Against Torture withholding of removal or deportation
- Temporary Resident status
- Family Unity beneficiary
- Administrative order staying removal issued by the Department of Homeland Security

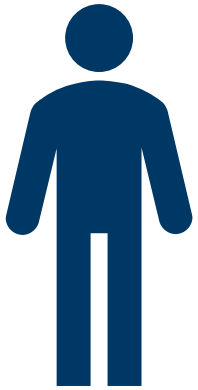
PROJECTED ANNUAL INCOME HELP

Projected annual income is the total income a person expects to have for the entire year, from January through December. A person's projected annual income includes all types of income the person would list on a federal 1040 tax return, plus nontaxable Social Security benefits, tax exempt interest and foreign income. Include all of the income you received from January 1 through this month and from next month through December 31 of this year. If you stopped working at a job, you can find the year-to-date (YTD) income on your last paycheck or review your bank accounts and statements. Include any taxable lump sum incomes you received during the year. Certain expenses are subtracted from the total income for the year. (See Adjustments to Income at Question 41 (Person 1) or Question 25 (Person 2-4) for types of expenses to subtract.)

DHS-6696 Annual Updates



QR Codes



Step 2: Person 1,
questions 35, 37 & 42



Step 2: Person 2,
questions 19, 21 & 26

DHS-6696 Cover page 2

DHS-6696 June 2026

What happens next?

Submit your complete, signed application using the instructions in Step 8 on page 24.

We will review your application and notify you in writing of the results.

Get help with this application

- **Online:** https://mn.gov/dhs/health-care
- **Help from a navigator:** You can get free help from a navigator. Visit https://mn.gov/dhs/navigators or call the DHS Contact Center at **651-478-8348** (833-880-1001 outside the Twin Cities) for help finding a navigator in your area. A navigator can help you with:
  - Filling out your application in person or over the phone.
  - Understanding what programs you might qualify for.
  - Knowing what information or proof you need to apply.
- **General questions about this paper application:** Call the DHS Contact Center at **651-478-8348** (833-880-1001 outside the Twin Cities)

ADA Advisory

For accessible formats of this information or assistance with additional equal access to human services, email us at DHS.info@state.mn.us, call 800-657-3739, or use your preferred relay service.

ADA1 (3-24)

DHS-6696 November 2026

What happens next?

Submit your complete, signed application using the instructions in Step 8 on page 24.

We will review your application and notify you in writing of the results.

Get help with this application

- Online: www.mn.gov/dhs/health-care
- Free help from a navigator: Visit https://mn.gov/dhs/navigators. Call the DHS Contact Center at **651-478-8348** (833-880-1001 outside the Twin Cities) for help finding a navigator in your area. A navigator can help you with:
  - Filling out your application in person or over the phone.
  - Understanding what programs you might qualify for.
  - Knowing what information or proof you need to apply.
- General questions about this paper application:
  - Call the DHS Contact Center at 651-478-8348 (833-880-1001 outside the Twin Cities).

Apply Online

Get free help from a navigator



ADA Advisory

For accessible formats of this information or assistance with additional equal access to human services, email us at DHS.info@state.mn.us, call 800-657-3739, or use your preferred relay service.

ADA1 (3-24)

DHS-6696 Step 2: Person 1 Questions 35 & 37

June 2026

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** Start with question 34. ☐ **Self-employed** Answer question 38. ☐ **Seasonally employed** Answer question 39. ☐ **Not employed** 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: ◯ Hourly ◯ Weekly ◯ Every two weeks ◯ Twice a month ◯ Monthly ◯ 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: ◯ Hourly ◯ Weekly ◯ Every two weeks ◯ Twice a month ◯ Monthly ◯ Yearly

November 2026

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** Start with question 34. ☐ **Self-employed** Answer question 38. ☐ **Seasonally employed** Answer question 39. ☐ **Not employed** 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: 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. How often are you paid? ◯ Weekly ◯ Every two weeks ◯ Twice a month ◯ Monthly ◯ Yearly

b. How much are you paid? List the dollar amount before taxes are deducted. Subtract amounts deducted from wages by the employer for childcare, health insurance or retirement plans that are not taxable (sometimes called "pre-tax deductions").

Amount: $ per (hour, week, year, etc.)

c. Average hours worked each pay period:

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: 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. How often are you paid? ◯ Weekly ◯ Every two weeks ◯ Twice a month ◯ Monthly ◯ Yearly

b. How much are you paid? List the dollar amount before taxes are deducted. Subtract amounts deducted from wages by the employer for childcare, health insurance or retirement plans that are not taxable (sometimes called "pre-tax deductions").

Amount: $ per (hour, week, year, etc.)

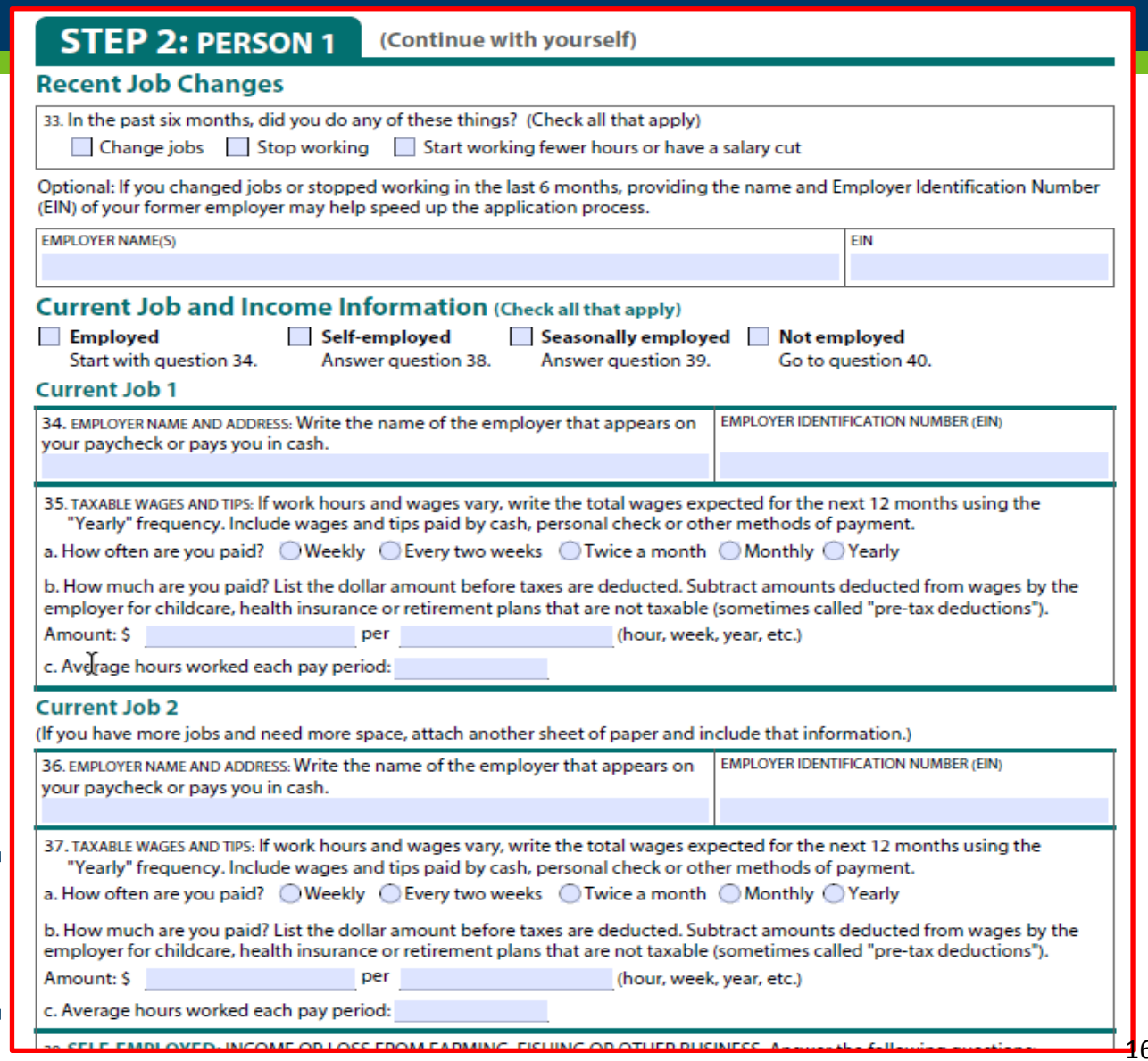
c. Average hours worked each pay period:

DHS-6696 Step 2: Question 35 and 37

November 2026

- Reworded and expanded question for clarity

- Reworded and expanded question for clarity



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** Start with question 34. ☐ **Self-employed** Answer question 38. ☐ **Seasonally employed** Answer question 39. ☐ **Not employed** 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: 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. How often are you paid? ◯ Weekly ◯ Every two weeks ◯ Twice a month ◯ Monthly ◯ Yearly

b. How much are you paid? List the dollar amount before taxes are deducted. Subtract amounts deducted from wages by the employer for childcare, health insurance or retirement plans that are not taxable (sometimes called "pre-tax deductions").

Amount: $ _____ per _____ (hour, week, year, etc.)

c. Average hours worked each pay period: _____

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: 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. How often are you paid? ◯ Weekly ◯ Every two weeks ◯ Twice a month ◯ Monthly ◯ Yearly

b. How much are you paid? List the dollar amount before taxes are deducted. Subtract amounts deducted from wages by the employer for childcare, health insurance or retirement plans that are not taxable (sometimes called "pre-tax deductions").

Amount: $ _____ per _____ (hour, week, year, etc.)

c. Average hours worked each pay period: _____

DHS-6696 Step 2: Question 42

November 2026

- PAI updated to remove 2026 reference



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.

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).

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

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

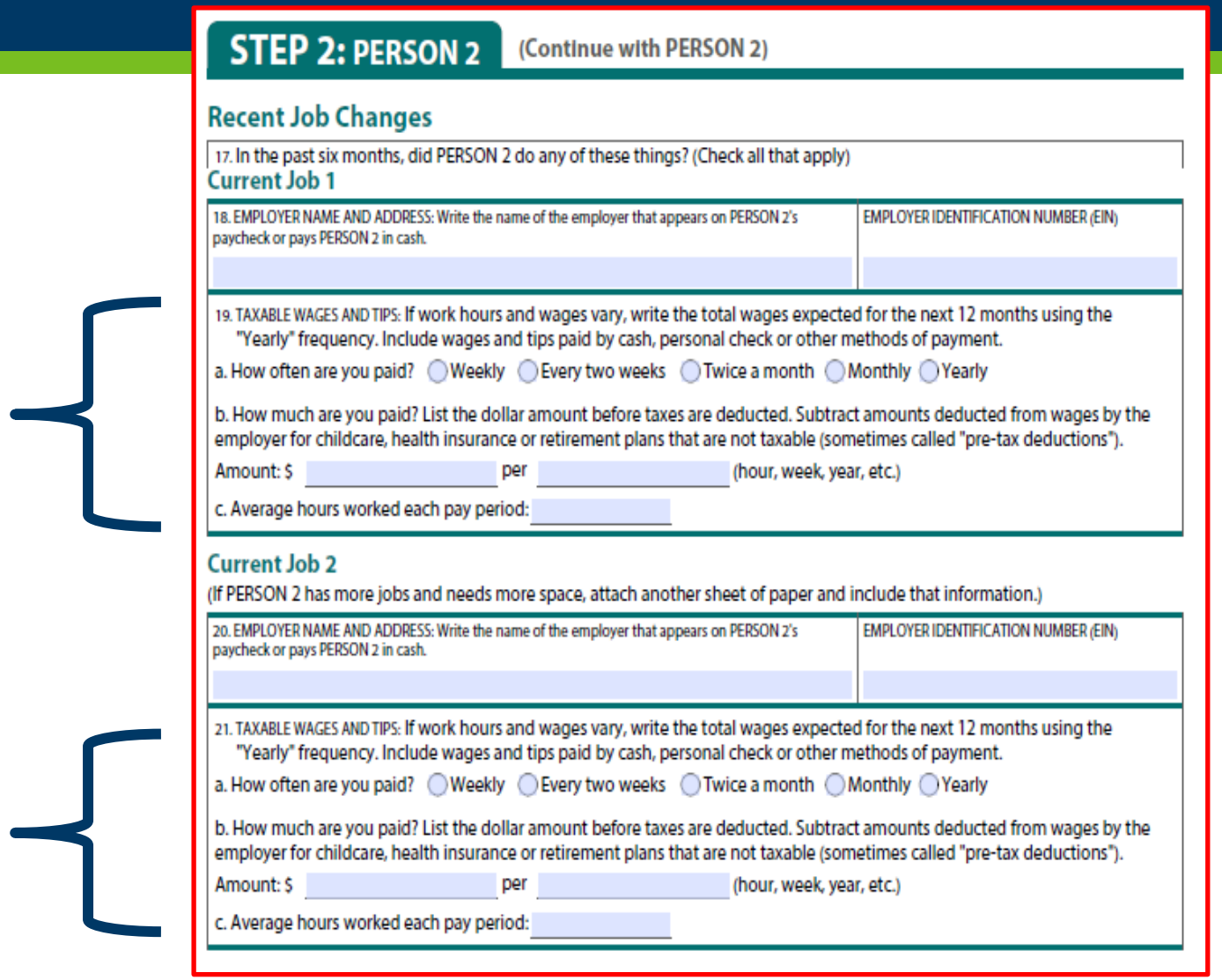
Add up all of the income you received from January 1 until now, and all of the income you expect to receive through December 31.

See page 25 for more information about how to calculate your projected annual income.

Step 2: Person 2 Questions 19 & 21

November 2026

- Same updates to Person 2, 3 and 4 questions 19 & 21



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)

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: 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. How often are you paid? ◯ Weekly ◯ Every two weeks ◯ Twice a month ◯ Monthly ◯ Yearly

b. How much are you paid? List the dollar amount before taxes are deducted. Subtract amounts deducted from wages by the employer for childcare, health insurance or retirement plans that are not taxable (sometimes called "pre-tax deductions").

Amount: $ _____ per _____ (hour, week, year, etc.)

c. Average hours worked each pay period: _____

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: 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. How often are you paid? ◯ Weekly ◯ Every two weeks ◯ Twice a month ◯ Monthly ◯ Yearly

b. How much are you paid? List the dollar amount before taxes are deducted. Subtract amounts deducted from wages by the employer for childcare, health insurance or retirement plans that are not taxable (sometimes called "pre-tax deductions").

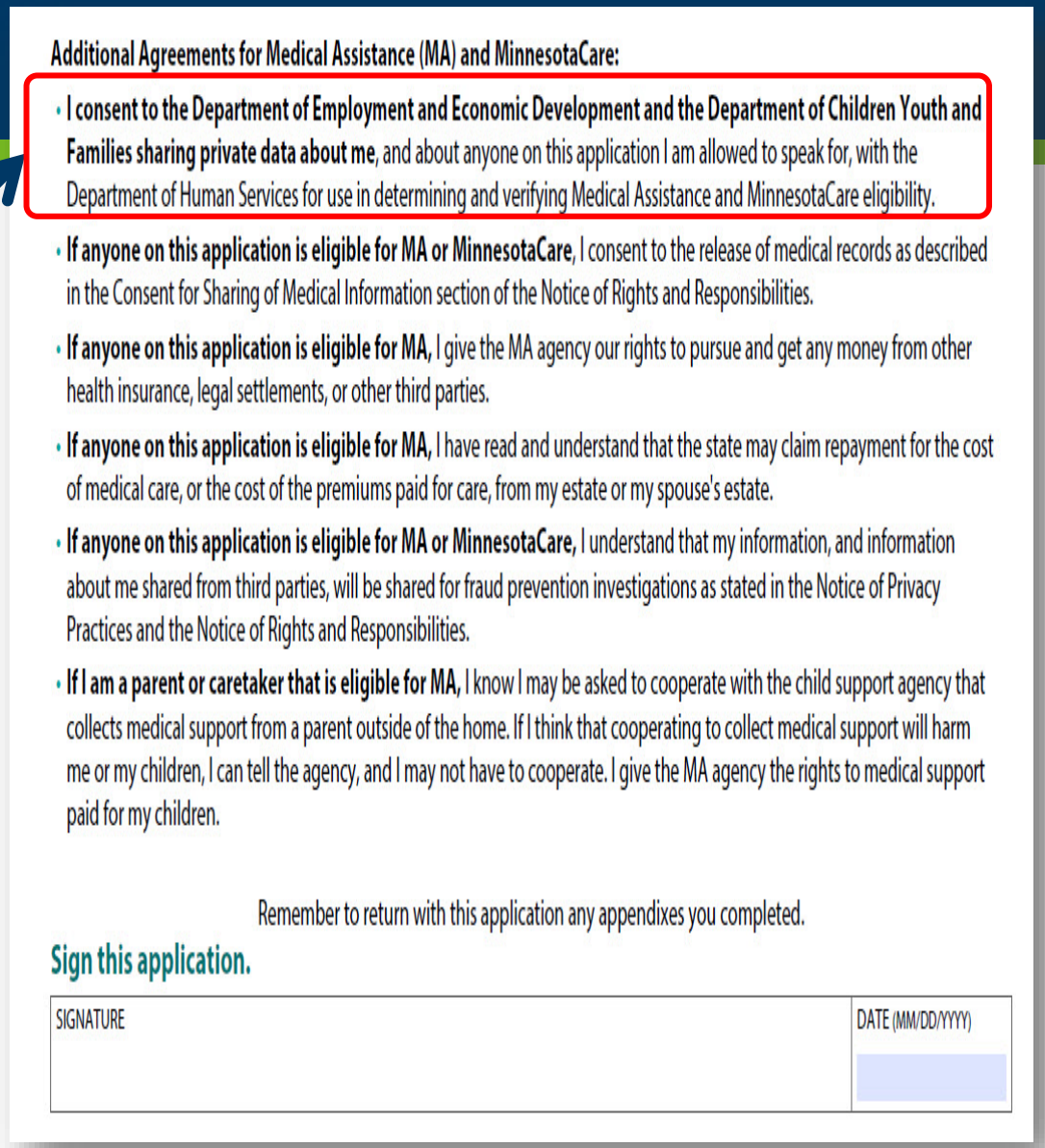
Amount: $ _____ per _____ (hour, week, year, etc.)

c. Average hours worked each pay period: _____

DHS-6696 Updated Consent

November 2026

- Signature page has a new consent
- I consent to the Department of Employment and Economic Development and the Department of Children Youth and Families sharing private data about me, and about anyone on this application I am allowed to speak for, with the Department of Human Services for use in determining and verifying Medical Assistance and Minnesota Care eligibility.



Additional Agreements for Medical Assistance (MA) and MinnesotaCare:

- **I consent to the Department of Employment and Economic Development and the Department of Children Youth and Families sharing private data about me**, and about anyone on this application I am allowed to speak for, with the Department of Human Services for use in determining and verifying Medical Assistance and MinnesotaCare eligibility.
- **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 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)

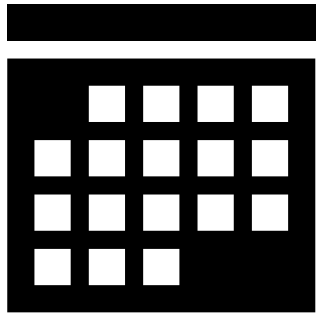
Appendix D (DHS-6696I)
Work or Community Engagement



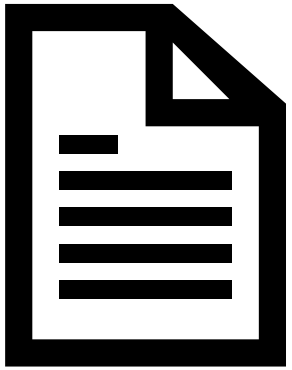
Work or community engagement information

Appendix D

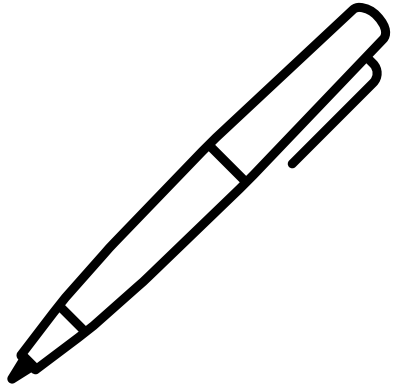
Work or Community Engagement Requirements



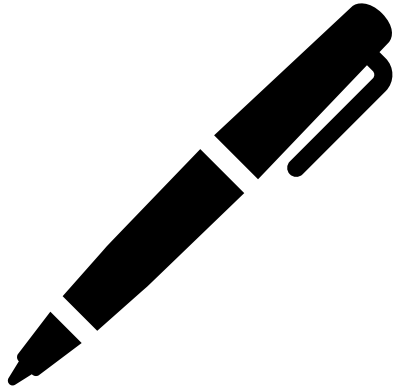
Effective 1/1/2027



New Applications beginning 1/1/2027



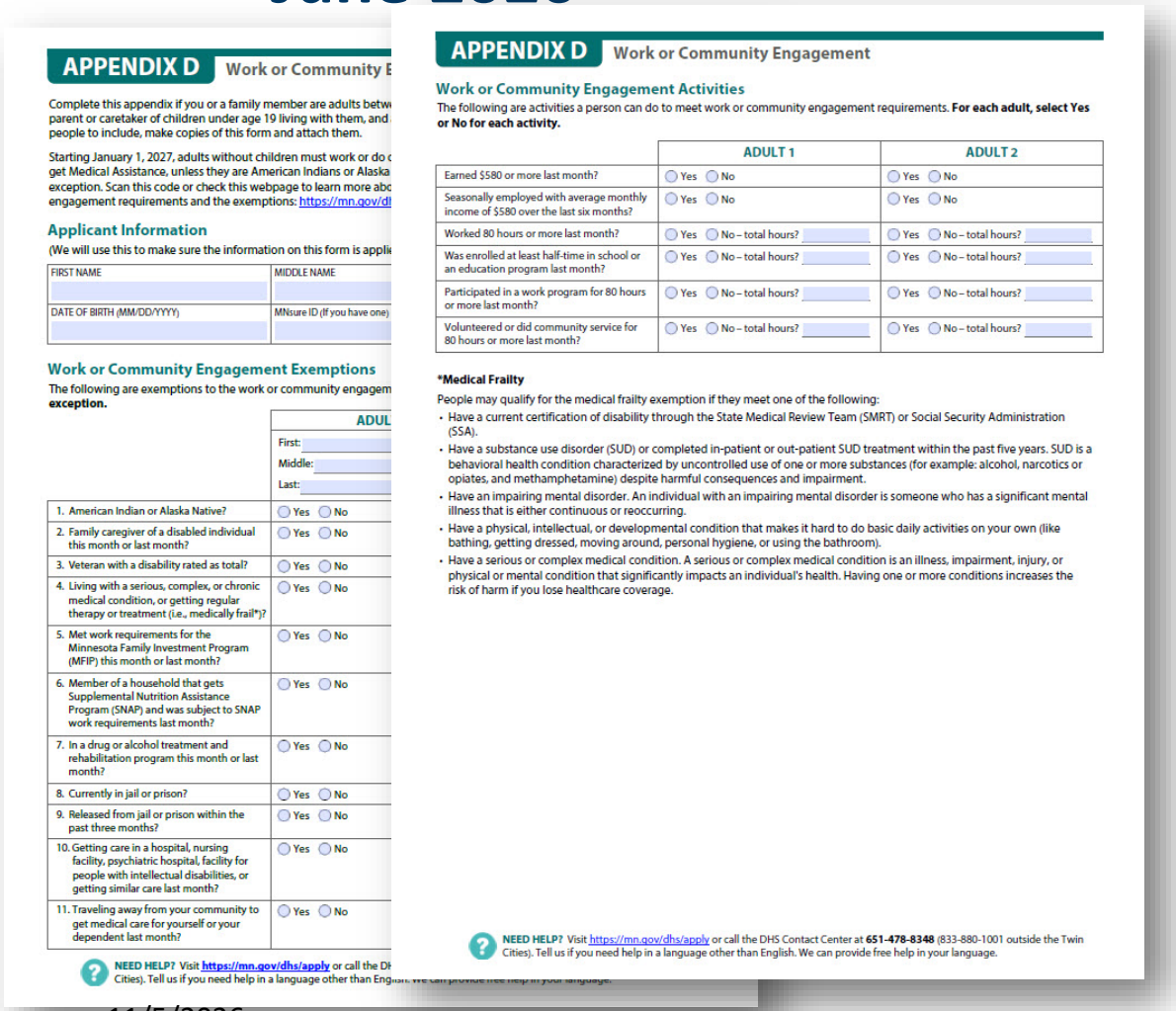
MAXIS Renewals beginning 3/2027



METS Renewals beginning 4/2027

Appendix D Updates

June 2026



APPENDIX D Work or Community E

Complete this appendix if you or a family member are adults betw
parent or caretaker of children under age 19 living with them, and
people to include, make copies of this form and attach them.

Starting January 1, 2027, adults without children must work or do
get Medical Assistance, unless they are American Indians or Alaska
exception. Scan this code or check this webpage to learn more abo
engagement requirements and the exemptions: https://mn.gov/d

Applicant Information

(We will use this to make sure the information on this form is appli

FIRST NAME	MIDDLE NAME
DATE OF BIRTH (MM/DD/YYYY)	MNsure ID (If you have one)

Work or Community Engagement Exemptions

The following are exemptions to the work or community engagem
exception.

	ADUL
	First:
	Middle:
	Last:
1. American Indian or Alaska Native?	◯ Yes ◯ No
2. Family caregiver of a disabled individual this month or last month?	◯ Yes ◯ No
3. Veteran with a disability rated as total?	◯ Yes ◯ No
4. Living with a serious, complex, or chronic medical condition, or getting regular therapy or treatment (i.e., medically frail*)?	◯ Yes ◯ No
5. Met work requirements for the Minnesota Family Investment Program (MFIP) this month or last month?	◯ Yes ◯ No
6. Member of a household that gets Supplemental Nutrition Assistance Program (SNAP) and was subject to SNAP work requirements last month?	◯ Yes ◯ No
7. In a drug or alcohol treatment and rehabilitation program this month or last month?	◯ Yes ◯ No
8. Currently in jail or prison?	◯ Yes ◯ No
9. Released from jail or prison within the past three months?	◯ Yes ◯ No
10. Getting care in a hospital, nursing facility, psychiatric hospital, facility for people with intellectual disabilities, or getting similar care last month?	◯ Yes ◯ No
11. Traveling away from your community to get medical care for yourself or your dependent last month?	◯ Yes ◯ No

NEED HELP? Visit https://mn.gov/dhs/apply or call the DH
Cities). Tell us if you need help in a language other than Eng

APPENDIX D Work or Community Engagement

Work or Community Engagement Activities

The following are activities a person can do to meet work or community engagement requirements. **For each adult, select Yes or No for each activity.**

	ADULT 1	ADULT 2
Earned $580 or more last month?	◯ Yes ◯ No	◯ Yes ◯ No
Seasonally employed with average monthly income of $580 over the last six months?	◯ Yes ◯ No	◯ Yes ◯ No
Worked 80 hours or more last month?	◯ Yes ◯ No – total hours?	◯ Yes ◯ No – total hours?
Was enrolled at least half-time in school or an education program last month?	◯ Yes ◯ No – total hours?	◯ Yes ◯ No – total hours?
Participated in a work program for 80 hours or more last month?	◯ Yes ◯ No – total hours?	◯ Yes ◯ No – total hours?
Volunteered or did community service for 80 hours or more last month?	◯ Yes ◯ No – total hours?	◯ Yes ◯ No – total hours?

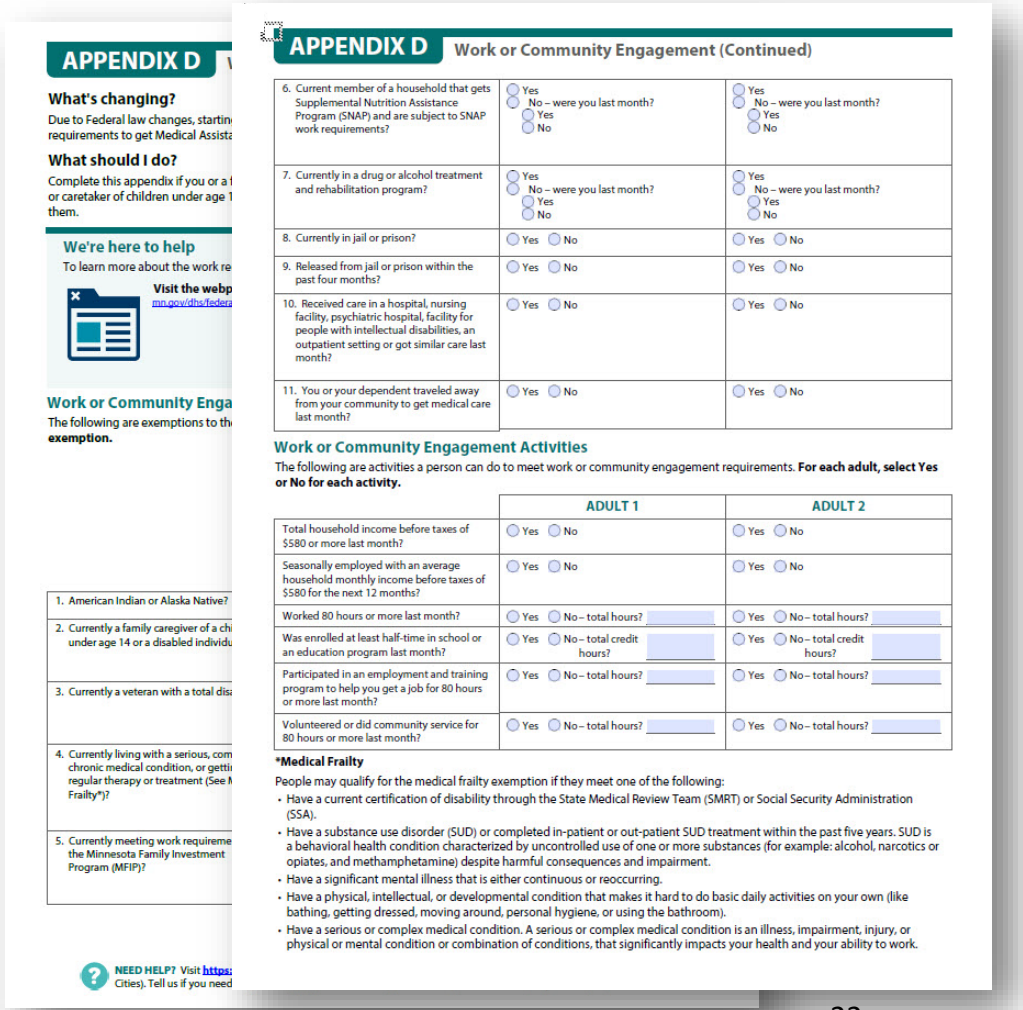
***Medical Frailty**

People may qualify for the medical frailty exemption if they meet one of the following:

- Have a current certification of disability through the State Medical Review Team (SMRT) or Social Security Administration (SSA).
- Have a substance use disorder (SUD) or completed in-patient or out-patient SUD treatment within the past five years. SUD is a behavioral health condition characterized by uncontrolled use of one or more substances (for example: alcohol, narcotics or opiates, and methamphetamine) despite harmful consequences and impairment.
- Have an impairing mental disorder. An individual with an impairing mental disorder is someone who has a significant mental illness that is either continuous or reoccurring.
- Have a physical, intellectual, or developmental condition that makes it hard to do basic daily activities on your own (like bathing, getting dressed, moving around, personal hygiene, or using the bathroom).
- Have a serious or complex medical condition. A serious or complex medical condition is an illness, impairment, injury, or physical or mental condition that significantly impacts an individual's health. Having one or more conditions increases the risk of harm if you lose healthcare coverage.

NEED HELP? Visit https://mn.gov/dhs/apply or call the DHS Contact Center at **651-478-8348** (833-880-1001 outside the Twin Cities). Tell us if you need help in a language other than English. We can provide free help in your language.

November 2026



APPENDIX D

What's changing?

Due to Federal law changes, startin
requirements to get Medical Assist

What should I do?

Complete this appendix if you or a
or caretaker of children under age 1
them.

We're here to help

To learn more about the work re

Visit the webp
mn.gov/dhs/federa

Work or Community Enga

The following are exemptions to th
exemption.

1. American Indian or Alaska Native?
2. Currently a family caregiver of a ch under age 14 or a disabled individu
3. Currently a veteran with a total dis
4. Currently living with a serious, com chronic medical condition, or getti regular therapy or treatment (See M Frailty*)?
5. Currently meeting work requireme the Minnesota Family Investment Program (MFIP)?

NEED HELP? Visit https:
Cities). Tell us if you need

APPENDIX D Work or Community Engagement (Continued)

6. Current member of a household that gets Supplemental Nutrition Assistance Program (SNAP) and are subject to SNAP work requirements?	◯ Yes ◯ No – were you last month? ◯ Yes ◯ No	◯ Yes ◯ No – were you last month? ◯ Yes ◯ No
7. Currently in a drug or alcohol treatment and rehabilitation program?	◯ Yes ◯ No – were you last month? ◯ Yes ◯ No	◯ Yes ◯ No – were you last month? ◯ Yes ◯ No
8. Currently in jail or prison?	◯ Yes ◯ No	◯ Yes ◯ No
9. Released from jail or prison within the past four months?	◯ Yes ◯ No	◯ Yes ◯ No
10. Received care in a hospital, nursing facility, psychiatric hospital, facility for people with intellectual disabilities, an outpatient setting or got similar care last month?	◯ Yes ◯ No	◯ Yes ◯ No
11. You or your dependent traveled away from your community to get medical care last month?	◯ Yes ◯ No	◯ Yes ◯ No

Work or Community Engagement Activities

The following are activities a person can do to meet work or community engagement requirements. **For each adult, select Yes or No for each activity.**

	ADULT 1	ADULT 2
Total household income before taxes of $580 or more last month?	◯ Yes ◯ No	◯ Yes ◯ No
Seasonally employed with an average household monthly income before taxes of $580 for the next 12 months?	◯ Yes ◯ No	◯ Yes ◯ No
Worked 80 hours or more last month?	◯ Yes ◯ No – total hours?	◯ Yes ◯ No – total hours?
Was enrolled at least half-time in school or an education program last month?	◯ Yes ◯ No – total credit hours?	◯ Yes ◯ No – total credit hours?
Participated in an employment and training program to help you get a job for 80 hours or more last month?	◯ Yes ◯ No – total hours?	◯ Yes ◯ No – total hours?
Volunteered or did community service for 80 hours or more last month?	◯ Yes ◯ No – total hours?	◯ Yes ◯ No – total hours?

***Medical Frailty**

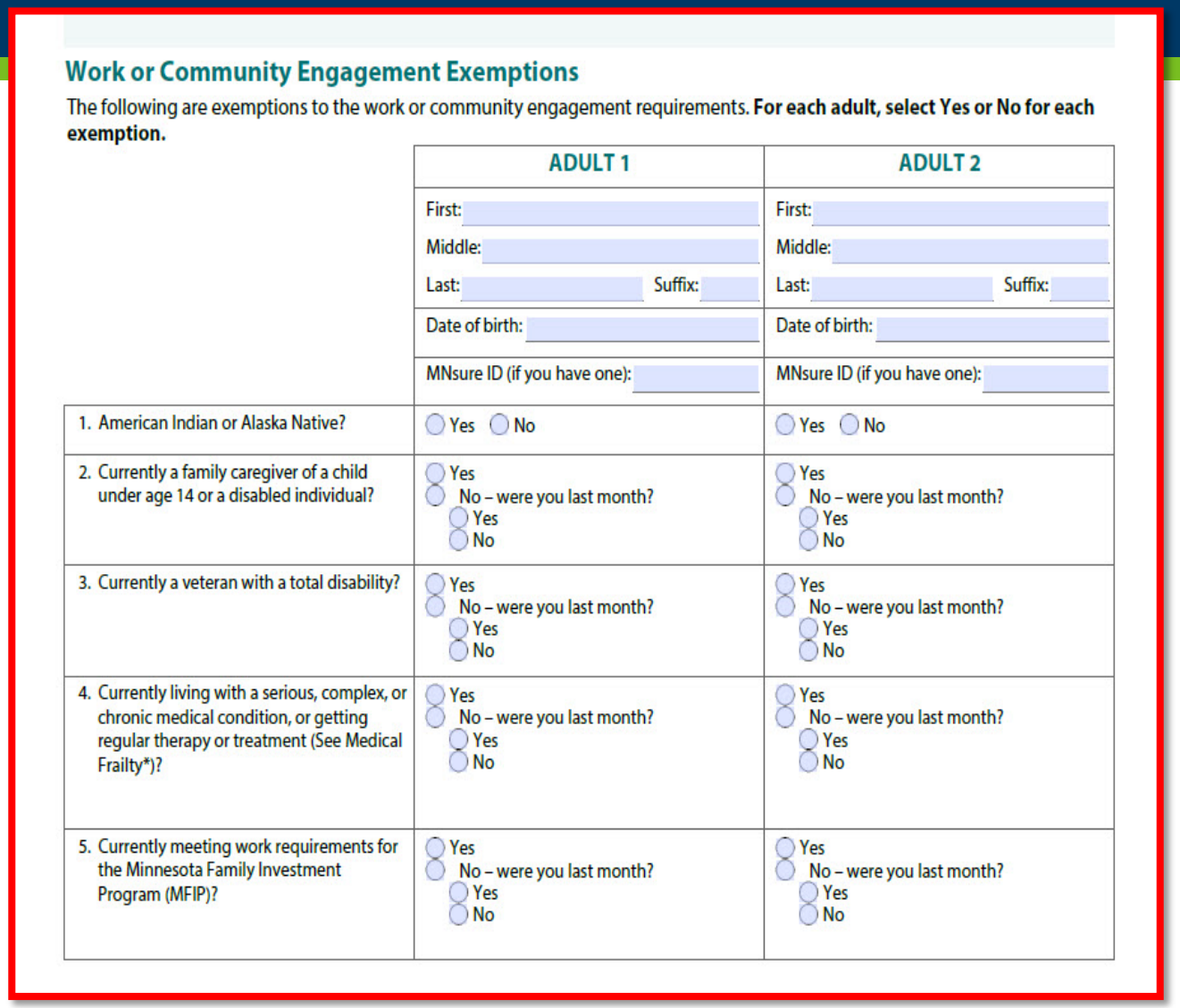
People may qualify for the medical frailty exemption if they meet one of the following:

- Have a current certification of disability through the State Medical Review Team (SMRT) or Social Security Administration (SSA).
- Have a substance use disorder (SUD) or completed in-patient or out-patient SUD treatment within the past five years. SUD is a behavioral health condition characterized by uncontrolled use of one or more substances (for example: alcohol, narcotics or opiates, and methamphetamine) despite harmful consequences and impairment.
- Have a significant mental illness that is either continuous or reoccurring.
- Have a physical, intellectual, or developmental condition that makes it hard to do basic daily activities on your own (like bathing, getting dressed, moving around, personal hygiene, or using the bathroom).
- Have a serious or complex medical condition. A serious or complex medical condition is an illness, impairment, injury, or physical or mental condition or combination of conditions, that significantly impacts your health and your ability to work.

Appendix D (DHS-6696I) Exemptions first page

November 2026

- Question 2 change: Family caregiver for *a child under age 14* or a disabled individual?
- Questions 2 – 7 ask for current answer and an answer *for last month*.



Work or Community Engagement Exemptions

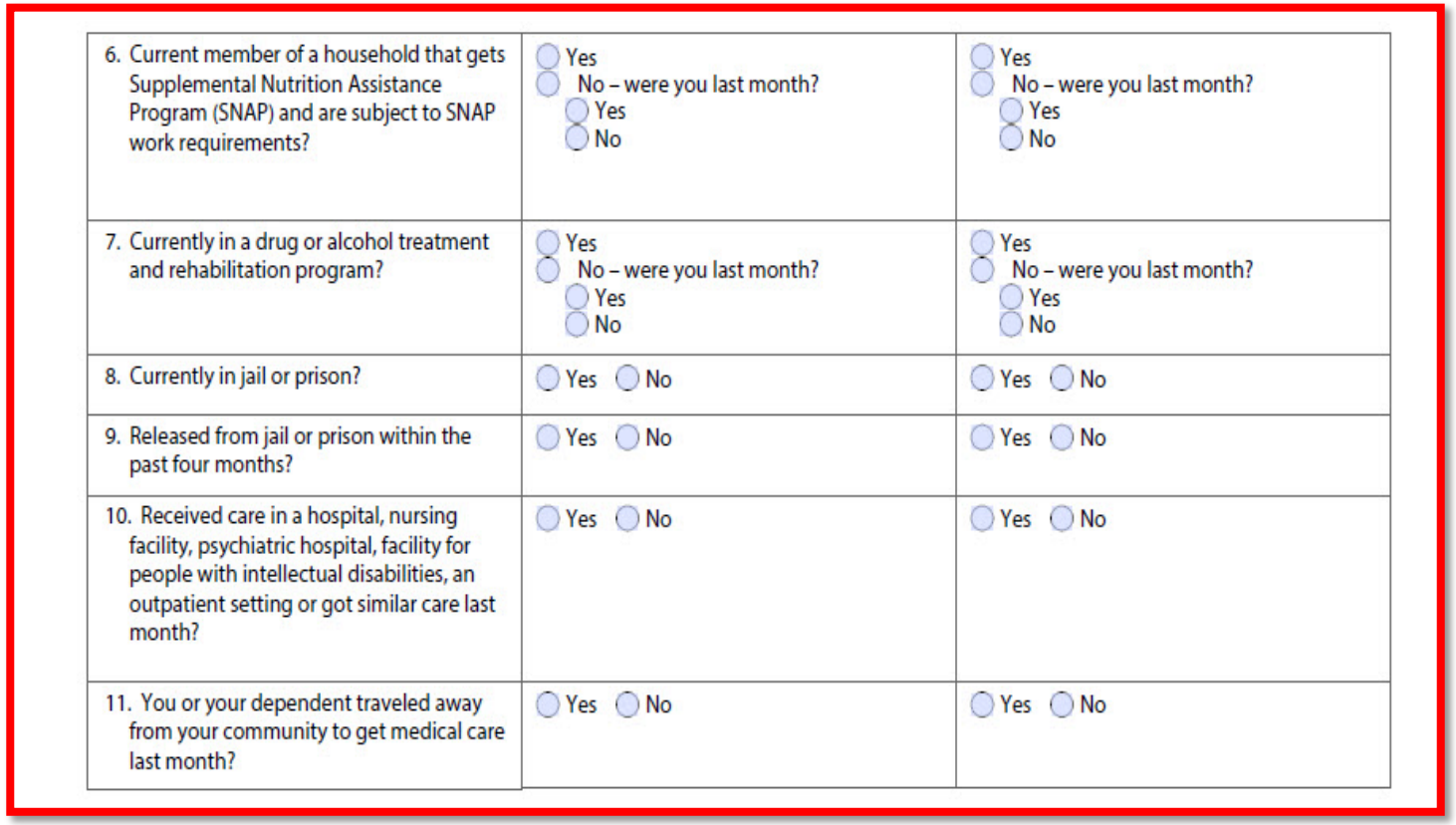
The following are exemptions to the work or community engagement requirements. **For each adult, select Yes or No for each exemption.**

	ADULT 1	ADULT 2
	First: Middle: Last: Suffix: Date of birth: MNsure ID (if you have one):	First: Middle: Last: Suffix: Date of birth: MNsure ID (if you have one):
1. American Indian or Alaska Native?	Yes No	Yes No
2. Currently a family caregiver of a child under age 14 or a disabled individual?	Yes No – were you last month? Yes No	Yes No – were you last month? Yes No
3. Currently a veteran with a total disability?	Yes No – were you last month? Yes No	Yes No – were you last month? Yes No
4. Currently living with a serious, complex, or chronic medical condition, or getting regular therapy or treatment (See Medical Frailty*)?	Yes No – were you last month? Yes No	Yes No – were you last month? Yes No
5. Currently meeting work requirements for the Minnesota Family Investment Program (MFIP)?	Yes No – were you last month? Yes No	Yes No – were you last month? Yes No

Appendix D (DHS-6696I) Exemptions second page

November 2026

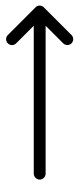
- Questions 2 – 7 ask for current answer and an answer *for last month*.
- Question 9 change: Released from Jail or Prison within the past *four* months.
- Question 10 change: Received care in a hospital, nursing facility, psychiatric hospital, facility for people with intellectual disabilities, an *outpatient setting* or got similar care last month



6. Current member of a household that gets Supplemental Nutrition Assistance Program (SNAP) and are subject to SNAP work requirements?	◯ Yes ◯ No – were you last month? ◯ Yes ◯ No	◯ Yes ◯ No – were you last month? ◯ Yes ◯ No
7. Currently in a drug or alcohol treatment and rehabilitation program?	◯ Yes ◯ No – were you last month? ◯ Yes ◯ No	◯ Yes ◯ No – were you last month? ◯ Yes ◯ No
8. Currently in jail or prison?	◯ Yes ◯ No	◯ Yes ◯ No
9. Released from jail or prison within the past four months?	◯ Yes ◯ No	◯ Yes ◯ No
10. Received care in a hospital, nursing facility, psychiatric hospital, facility for people with intellectual disabilities, an outpatient setting or got similar care last month?	◯ Yes ◯ No	◯ Yes ◯ No
11. You or your dependent traveled away from your community to get medical care last month?	◯ Yes ◯ No	◯ Yes ◯ No

Lookback Period Example for Last 4 months.

January	December	November	October
• Current month	• Lookback period		



past 3 months from this date

Medical Frailty definition changes on Appendix D

November 2026

- Update to 3rd and 5th bullets.

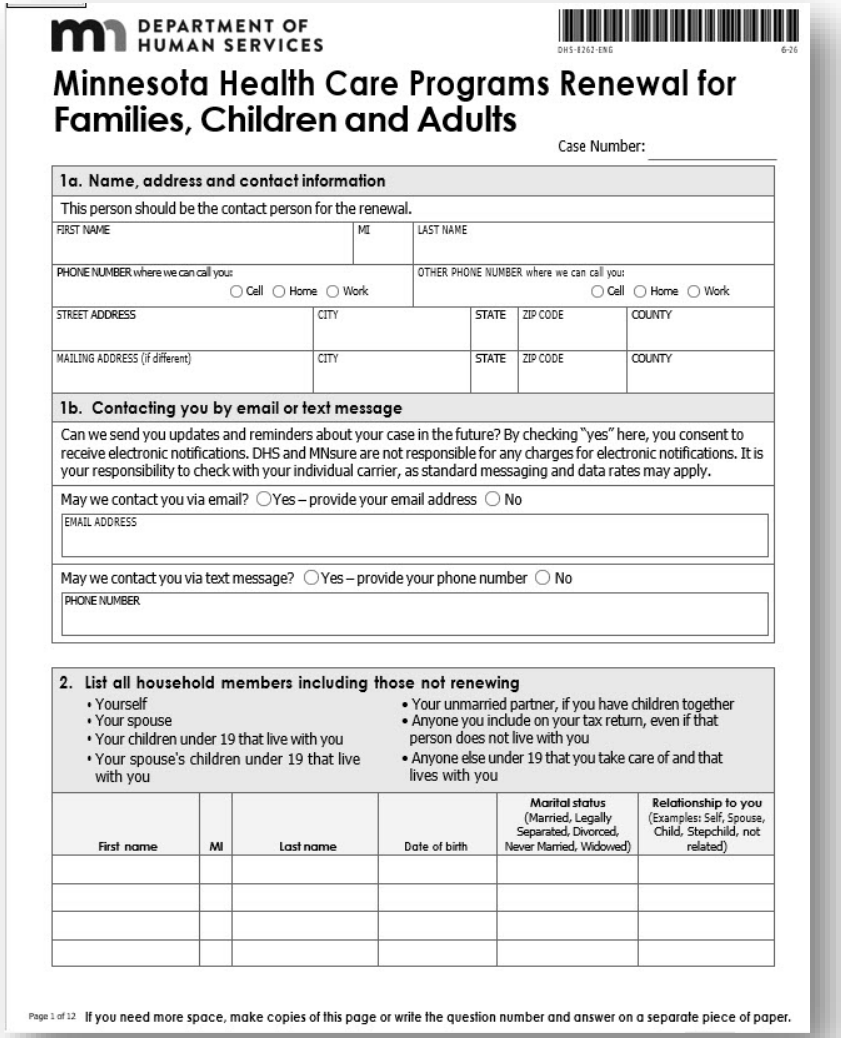
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- Have a substance use disorder (SUD) or completed in-patient or out-patient SUD treatment within the past five years. SUD is a behavioral health condition characterized by uncontrolled use of one or more substances (for example: alcohol, narcotics or opiates, and methamphetamine) despite harmful consequences and impairment.
- Have a significant mental illness that is either continuous or reoccurring.
- Have a physical, intellectual, or developmental condition that makes it hard to do basic daily activities on your own (like bathing, getting dressed, moving around, personal hygiene, or using the bathroom).
- Have a serious or complex medical condition. A serious or complex medical condition is an illness, impairment, injury, or physical or mental condition or combination of conditions, that significantly impacts your health and your ability to work.

DHS-8262 METS Blank Renewal Form Updates

June 2026



DEPARTMENT OF HUMAN SERVICES

DHS-8262-ENG 6-26

Minnesota Health Care Programs Renewal for Families, Children and Adults

Case Number:

1a. Name, address and contact information

This person should be the contact person for the renewal.

FIRST NAME | MI | LAST NAME

PHONE NUMBER where we can call you: ○ Cell ○ Home ○ Work | OTHER PHONE NUMBER where we can call you: ○ Cell ○ Home ○ Work

STREET ADDRESS | CITY | STATE | ZIP CODE | COUNTY

MAILING ADDRESS (if different) | CITY | STATE | ZIP CODE | COUNTY

1b. Contacting you by email or text message

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 your responsibility to check with your individual carrier, as standard messaging and data rates may apply.

May we contact you via email? ○ Yes – provide your email address ○ No

EMAIL ADDRESS

May we contact you via text message? ○ Yes – provide your phone number ○ No

PHONE NUMBER

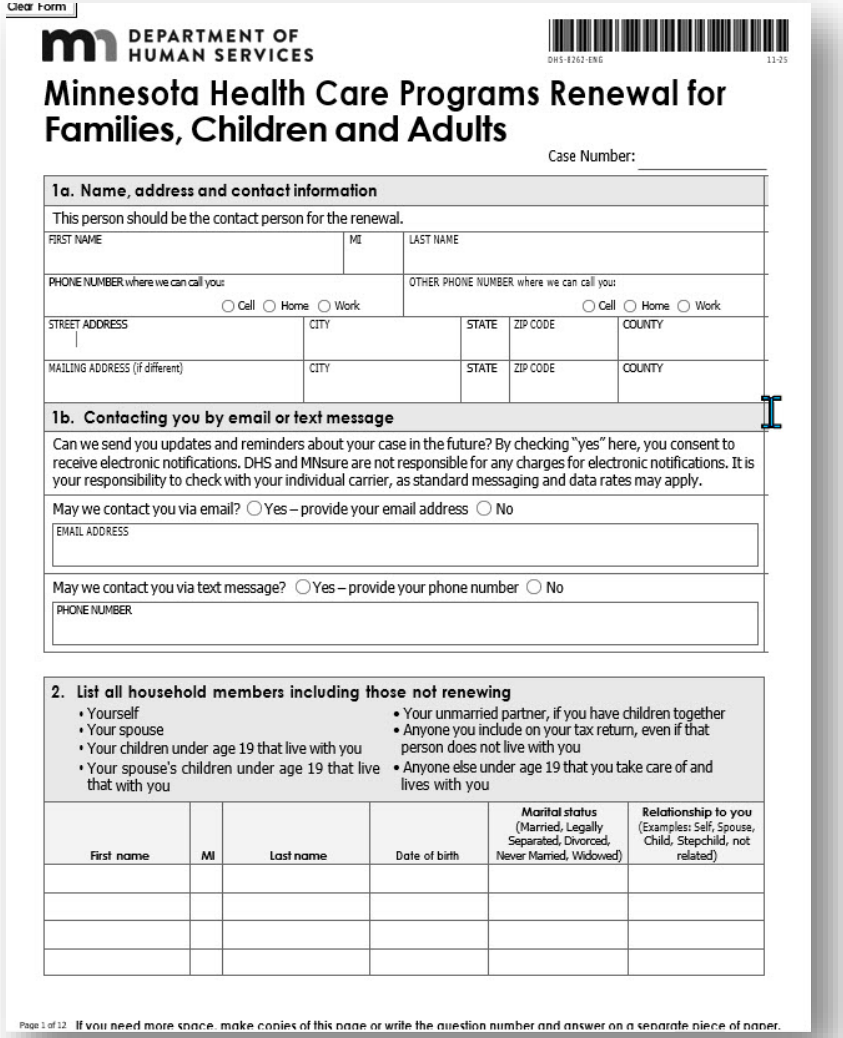
2. List all household members including those not renewing

- 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

First name	MI	Last name	Date of birth	Marital status (Married, Legally Separated, Divorced, Never Married, Widowed)	Relationship to you (Examples: Self, Spouse, Child, Stepchild, not related)

Page 1 of 12 If you need more space, make copies of this page or write the question number and answer on a separate piece of paper.

November 2026



Clear Form

DEPARTMENT OF HUMAN SERVICES

DHS-8262-ENG 11-25

Minnesota Health Care Programs Renewal for Families, Children and Adults

Case Number:

1a. Name, address and contact information

This person should be the contact person for the renewal.

FIRST NAME | MI | LAST NAME

PHONE NUMBER where we can call you: ○ Cell ○ Home ○ Work | OTHER PHONE NUMBER where we can call you: ○ Cell ○ Home ○ Work

STREET ADDRESS | CITY | STATE | ZIP CODE | COUNTY

MAILING ADDRESS (if different) | CITY | STATE | ZIP CODE | COUNTY

1b. Contacting you by email or text message

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 your responsibility to check with your individual carrier, as standard messaging and data rates may apply.

May we contact you via email? ○ Yes – provide your email address ○ No

EMAIL ADDRESS

May we contact you via text message? ○ Yes – provide your phone number ○ No

PHONE NUMBER

2. List all household members including those not renewing

- Yourself
- Your spouse
- Your children under age 19 that live with you
- Your spouse's children under age 19 that live that 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 age 19 that you take care of and lives with you

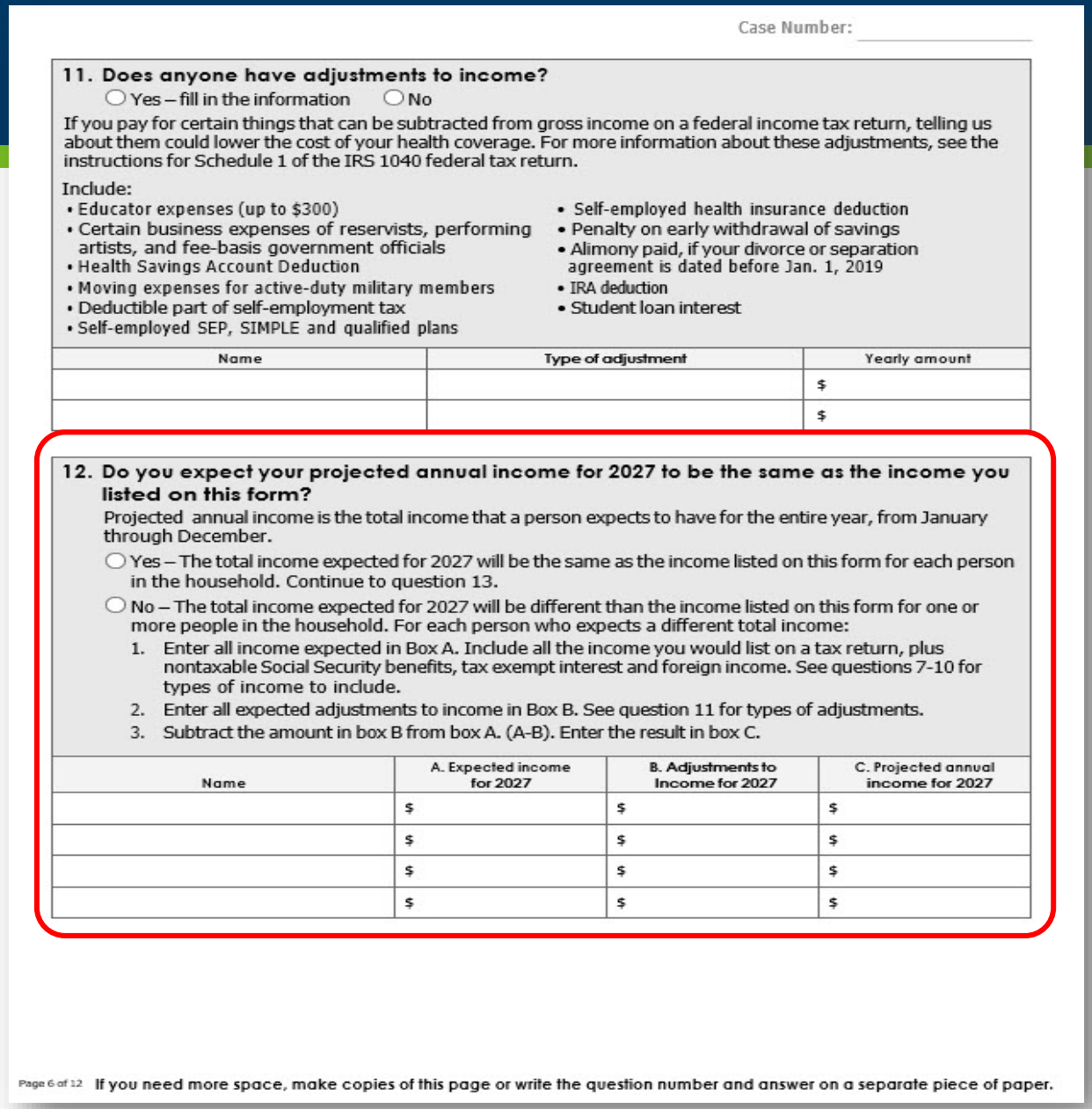
First name	MI	Last name	Date of birth	Marital status (Married, Legally Separated, Divorced, Never Married, Widowed)	Relationship to you (Examples: Self, Spouse, Child, Stepchild, not related)

Page 1 of 12 If you need more space, make copies of this page or write the question number and answer on a separate piece of paper.

Blank Renewal Form page 6

November 2026

- Asks for 2027 PAI attestation.



Case Number: _____

11. Does anyone have adjustments to income?

○ Yes – fill in the information ○ No

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. For more information about these adjustments, see the instructions for Schedule 1 of the IRS 1040 federal tax return.

Include:

- Educator expenses (up to $300)
- Certain business expenses of reservists, performing artists, and fee-basis government officials
- Health Savings Account Deduction
- Moving expenses for active-duty military members
- Deductible part of self-employment tax
- Self-employed SEP, SIMPLE and qualified plans
- Self-employed health insurance deduction
- Penalty on early withdrawal of savings
- Alimony paid, if your divorce or separation agreement is dated before Jan. 1, 2019
- IRA deduction
- Student loan interest

Name	Type of adjustment	Yearly amount
		$
		$

12. Do you expect your projected annual income for 2027 to be the same as the income you listed on this form?

Projected annual income is the total income that a person expects to have for the entire year, from January through December.

○ Yes – The total income expected for 2027 will be the same as the income listed on this form for each person in the household. Continue to question 13.

○ No – The total income expected for 2027 will be different than the income listed on this form for one or more people in the household. For each person who expects a different total income:

1. Enter all income expected in Box A. Include all the income you would list on a tax return, plus nontaxable Social Security benefits, tax exempt interest and foreign income. See questions 7-10 for types of income to include.
2. Enter all expected adjustments to income in Box B. See question 11 for types of adjustments.
3. Subtract the amount in box B from box A. (A-B). Enter the result in box C.

Name	A. Expected income for 2027	B. Adjustments to Income for 2027	C. Projected annual income for 2027
	$	$	$
	$	$	$
	$	$	$
	$	$	$

Page 6 of 12 If you need more space, make copies of this page or write the question number and answer on a separate piece of paper.

Blank Renewal Form pages 9-10

November 2026

- Question 15 updated with Work or Community Engagement questions

Case Number:

What change will the employer make for the new plan year (if known)?

☐ Employer will not offer health coverage for spouse or dependents

☐ Employer will start offering health coverage to employees' spouse or dependents or change the premium for the lowest-cost plan available for family coverage that meets the minimum value standard. (Premium should reflect discounts for not using tobacco and tobacco cessation programs)

How much would the employee have to pay in premiums for this plan? $ _____

How often? ○ Weekly ○ Every two weeks ○ Twice a month ○ Monthly ○ Quarterly ○ Yearly

Date of change: _____

15. Work or Community Engagement

Complete these questions for all people who meet all the following conditions:

- Between age 19 and 64
- Not a parent or caretaker of a child under age 19 living at home
- Not pregnant
- Not a former foster care youth under age 26 who aged out of foster care at [illegible]8 or older

Work or Community Engagement Exemptions

The following are exemptions to the work or community engagement requirements. For each adult, select Yes or No for each exemption.

American Indian or Alaska Native?	○ Yes	○ No
Currently a family caregiver of a child under age 14 or a disabled individual?	○ Yes	○ No—were you since your last renewal?
Currently a veteran with a total disability?	○ Yes ○ No—were you since your last renewal? ○ Yes ○ No	
Currently living with a serious, complex or chronic medical condition, or getting regular therapy or treatment (See Medical Frailty*)?	○ Yes	○ No—were you since your last renewal? ○ Yes ○ No
Currently meeting work requirements for the Minnesota Family Investment Program (MFIP)?	○ Yes	○ No—were you since your last renewal? ○ Yes ○ No
Current member of a household that gets Supplemental Nutrition Assistance Program (SNAP) and are subject to SNAP work requirements?	○ Yes	○ No—were you since your last renewal? ○ Yes ○ No
Currently in a drug or alcohol treatment and rehabilitation program?	○ Yes	○ No—were you since your last renewal? ○ Yes ○ No
Currently in jail or prison?	○ Yes	○ No—were you since your last renewal? ○ Yes ○ No
Released from jail or prison since your last renewal ?	○ Yes	○ No
Received care in a hospital, nursing facility, psychiatric hospital, facility for people with intellectual disabilities, an outpatient	○ Yes	○ No

Case Number:

setting or got similar care since your last renewal?		
You or your dependent traveled away from your community to get medical care in one or more months since your last renewal?	○ Yes	○ No

Work or Community Engagement Activities

The following are activities a person can do to meet work or community engagement requirements.

Had total household income before taxes of $580 or more in a month since your last renewal?	○ Yes	○ No
Were seasonally employed with an average monthly household income before taxes of $580 since your last renewal?	○ Yes	○ No
Worked 80 hours or more in a month since your last renewal?	○ Yes	○ No—total hours?
Was enrolled at least half-time in school or an education program in a month since your last renewal?	○ Yes	○ No—total credit hours?
Participated in an employment and training program to help you get a job for 80 hours or more, in a month since your last renewal?	○ Yes	○ No—total hours?
Volunteered or did community service for 80 hours or more in a month since your last renewal?	○ Yes	○ No—total hours?

***Medical Frailty**

People may qualify for the medical frailty exemption if they meet one of the following:

- Have a current certification of disability through the State Medical Review Team (SMRT) or Social Security Administration (SSA).
- Have a substance use disorder (SUD) or completed in-patient or out-patient SUD treatment within the past five years. SUD is a behavioral health condition characterized by uncontrolled use of one or more substances (for example: alcohol, narcotics or opiates, and methamphetamine) despite harmful consequences and impairment.
- Have a significant mental illness that is either continuous or reoccurring.
- Have a physical, intellectual, or developmental condition that makes it hard to do basic daily activities on your own (like bathing, getting dressed, moving around, personal hygiene, or using the bathroom).
- Have a serious or complex medical condition. A serious or complex medical condition is an illness, impairment, injury, or physical or mental condition or combination of conditions, that significantly impacts your health and your ability to work.

16. Answer the following questions for all household members

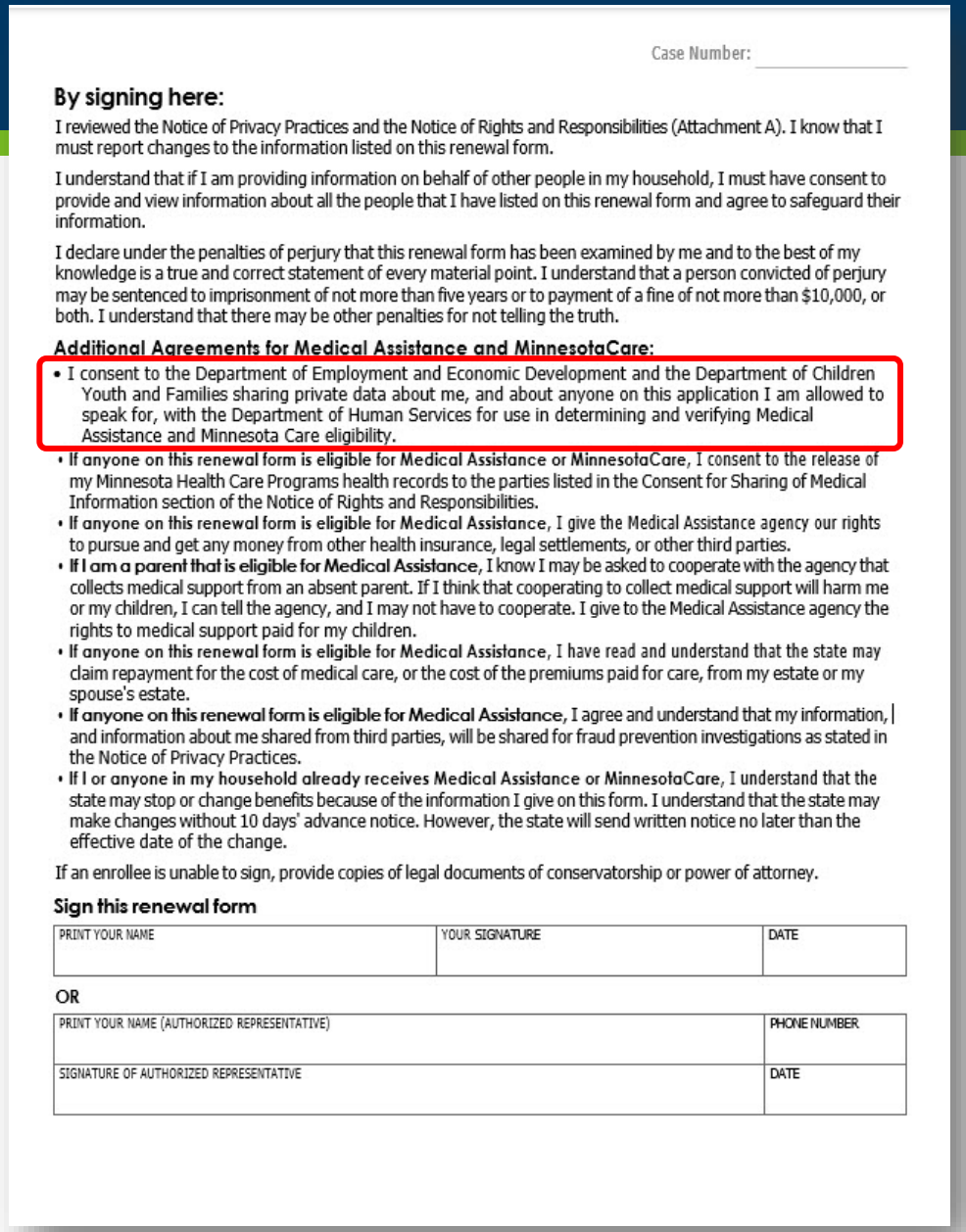
Is anyone in jail or prison?	○ Yes ○ No	If yes, who?	If in jail, is the person awaiting disposition of charges? ○ Yes ○ No
Jail or prison name and address:			Offender ID Number:

Blank Renewal Form page 13

November 2026

- Signature page has a new consent

- I consent to the Department of Employment and Economic Development and the Department of Children Youth and Families sharing private data about me, and about anyone on this application I am allowed to speak for, with the Department of Human Services for use in determining and verifying Medical Assistance and Minnesota Care eligibility.



Case Number:

By signing here:

I 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 renewal form.

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 this renewal form and agree to safeguard their information.

I declare under the penalties of perjury that this renewal form 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 to 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 and MinnesotaCare:

- I consent to the Department of Employment and Economic Development and the Department of Children Youth and Families sharing private data about me, and about anyone on this application I am allowed to speak for, with the Department of Human Services for use in determining and verifying Medical Assistance and Minnesota Care eligibility.
- **If anyone on this renewal form is eligible for Medical Assistance or MinnesotaCare**, I consent to the release of my Minnesota Health Care Programs health records to the parties listed in the Consent for Sharing of Medical Information section of the Notice of Rights and Responsibilities.
- **If anyone on this renewal form is eligible for Medical Assistance**, I give the Medical Assistance agency our rights to pursue and get any money from other health insurance, legal settlements, or other third parties.
- **If I am a parent that is eligible for Medical Assistance**, I know I may be asked to cooperate with the agency that collects medical support from an absent parent. 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 Medical Assistance agency the rights to medical support paid for my children.
- **If anyone on this renewal form is eligible for Medical Assistance**, 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 renewal form is eligible for Medical Assistance**, I agree and 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.
- **If I or anyone in my household already receives Medical Assistance or MinnesotaCare**, I understand that the state may stop or change benefits because of the information I give on this form. I understand that the state may make changes without 10 days' advance notice. However, the state will send written notice no later than the effective date of the change.

If an enrollee is unable to sign, provide copies of legal documents of conservatorship or power of attorney.

Sign this renewal form

PRINT YOUR NAME	YOUR SIGNATURE	DATE

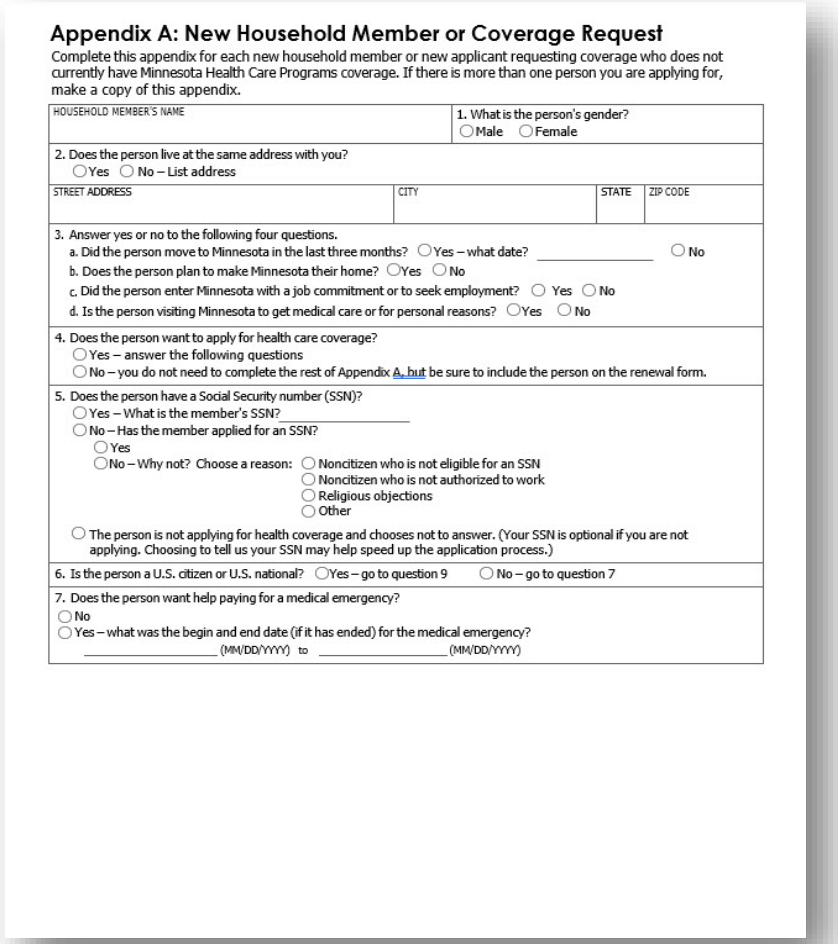
OR

PRINT YOUR NAME (AUTHORIZED REPRESENTATIVE)	PHONE NUMBER
SIGNATURE OF AUTHORIZED REPRESENTATIVE	DATE

Appendix A (DHS-6696D) Updates

Appendix A: New Household Member of Coverage Requested is part of the Blank Renewal Form

June 2026



Appendix A: New Household Member or Coverage Request

Complete this appendix for each new household member or new applicant requesting coverage who does not currently have Minnesota Health Care Programs coverage. If there is more than one person you are applying for, make a copy of this appendix.

HOUSEHOUSEHOLD MEMBER'S NAME | 1. What is the person's gender? ○ Male ○ Female

2. Does the person live at the same address with you?
○ Yes ○ No – List address

STREET ADDRESS | CITY | STATE | ZIP CODE

3. Answer yes or no to the following four questions.
a. Did the person move to Minnesota in the last three months? ○ Yes – what date? _____ ○ No
b. Does the person plan to make Minnesota their home? ○ Yes ○ No
c. Did the person enter Minnesota with a job commitment or to seek employment? ○ Yes ○ No
d. Is the person visiting Minnesota to get medical care or for personal reasons? ○ Yes ○ No

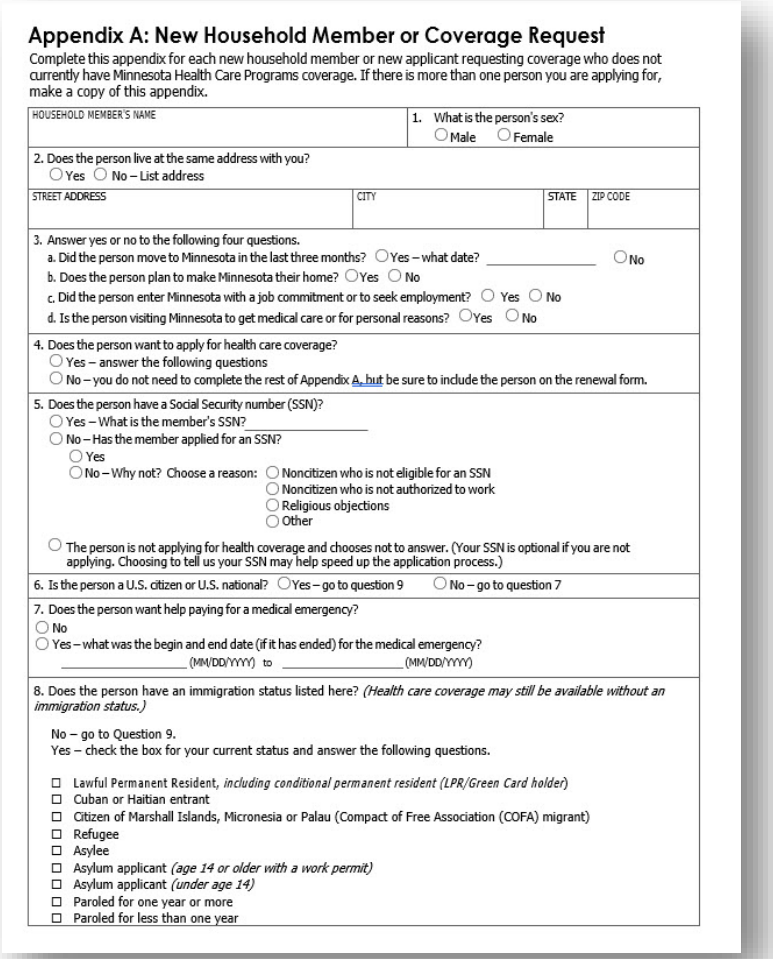
4. Does the person want to apply for health care coverage?
○ Yes – answer the following questions
○ No – you do not need to complete the rest of Appendix A, but be sure to include the person on the renewal form.

5. Does the person have a Social Security number (SSN)?
○ Yes – What is the member's SSN? _____
○ No – Has the member applied for an SSN?
○ Yes
○ No – Why not? Choose a reason: ○ Noncitizen who is not eligible for an SSN ○ Noncitizen who is not authorized to work ○ Religious objections ○ Other
○ The person is not applying for health coverage and chooses 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.)

6. Is the person a U.S. citizen or U.S. national? ○ Yes – go to question 9 ○ No – go to question 7

7. Does the person 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)

November 2026



Appendix A: New Household Member or Coverage Request

Complete this appendix for each new household member or new applicant requesting coverage who does not currently have Minnesota Health Care Programs coverage. If there is more than one person you are applying for, make a copy of this appendix.

HOUSEHOLD MEMBER'S NAME | 1. What is the person's sex? ○ Male ○ Female

2. Does the person live at the same address with you?
○ Yes ○ No – List address

STREET ADDRESS | CITY | STATE | ZIP CODE

3. Answer yes or no to the following four questions.
a. Did the person move to Minnesota in the last three months? ○ Yes – what date? _____ ○ No
b. Does the person plan to make Minnesota their home? ○ Yes ○ No
c. Did the person enter Minnesota with a job commitment or to seek employment? ○ Yes ○ No
d. Is the person visiting Minnesota to get medical care or for personal reasons? ○ Yes ○ No

4. Does the person want to apply for health care coverage?
○ Yes – answer the following questions
○ No – you do not need to complete the rest of Appendix A, but be sure to include the person on the renewal form.

5. Does the person have a Social Security number (SSN)?
○ Yes – What is the member's SSN? _____
○ No – Has the member applied for an SSN?
○ Yes
○ No – Why not? Choose a reason: ○ Noncitizen who is not eligible for an SSN ○ Noncitizen who is not authorized to work ○ Religious objections ○ Other
○ The person is not applying for health coverage and chooses 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.)

6. Is the person a U.S. citizen or U.S. national? ○ Yes – go to question 9 ○ No – go to question 7

7. Does the person 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)

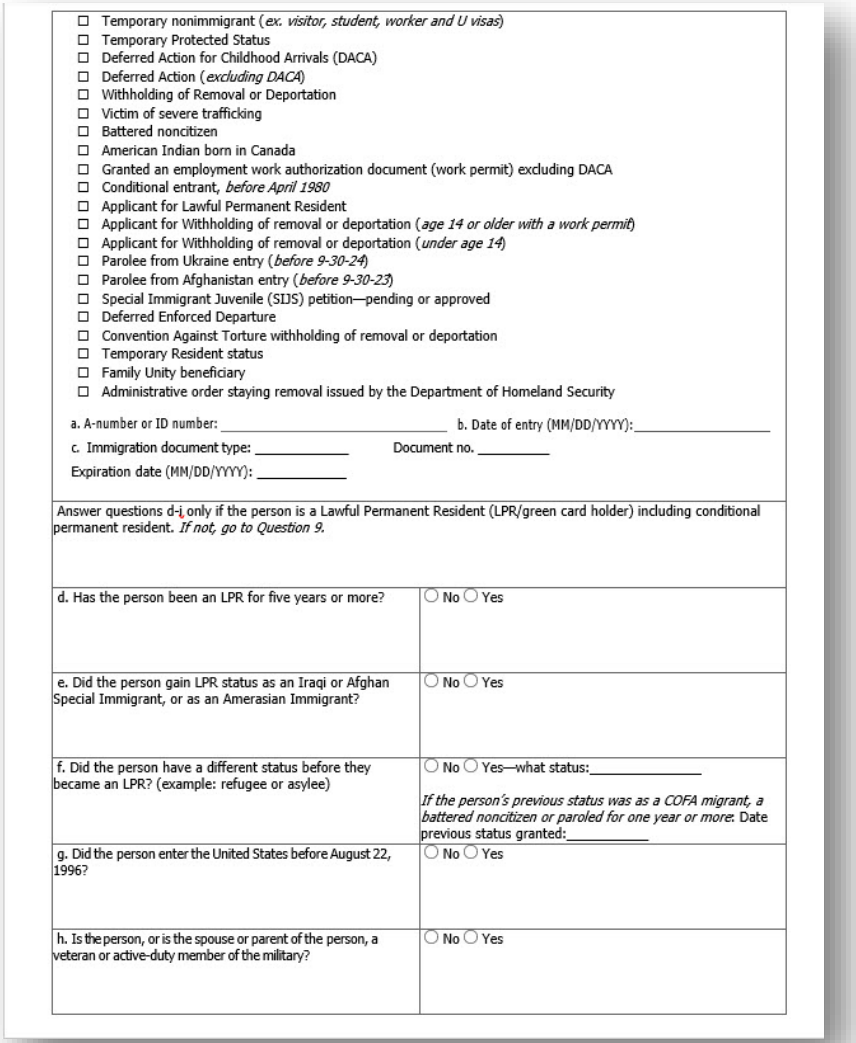
8. Does the person have an immigration status listed here? *(Health care coverage may still be available without an immigration status.)*

No – go to Question 9.
Yes – check the box for your current status and answer the following questions.

☐ Lawful Permanent Resident, *including conditional permanent resident (LPR/Green Card holder)*
☐ Cuban or Haitian entrant
☐ Citizen of Marshall Islands, Micronesia or Palau (Compact of Free Association (COFA) migrant)
☐ Refugee
☐ Asylee
☐ Asylum applicant *(age 14 or older with a work permit)*
☐ Asylum applicant *(under age 14)*
☐ Paroled for one year or more
☐ Paroled for less than one year

Appendix A pages 2-3

November 2026



- ☐ Temporary nonimmigrant (*ex. visitor, student, worker and U visas*)
- ☐ Temporary Protected Status
- ☐ Deferred Action for Childhood Arrivals (DACA)
- ☐ Deferred Action (*excluding DACA*)
- ☐ Withholding of Removal or Deportation
- ☐ Victim of severe trafficking
- ☐ Battered noncitizen
- ☐ American Indian born in Canada
- ☐ Granted an employment work authorization document (work permit) excluding DACA
- ☐ Conditional entrant, *before April 1980*
- ☐ Applicant for Lawful Permanent Resident
- ☐ Applicant for Withholding of removal or deportation (*age 14 or older with a work permit*)
- ☐ Applicant for Withholding of removal or deportation (*under age 14*)
- ☐ Parolee from Ukraine entry (*before 9-30-24*)
- ☐ Parolee from Afghanistan entry (*before 9-30-23*)
- ☐ Special Immigrant Juvenile (SIJS) petition—pending or approved
- ☐ Deferred Enforced Departure
- ☐ Convention Against Torture withholding of removal or deportation
- ☐ Temporary Resident status
- ☐ Family Unity beneficiary
- ☐ Administrative order staying removal issued by the Department of Homeland Security

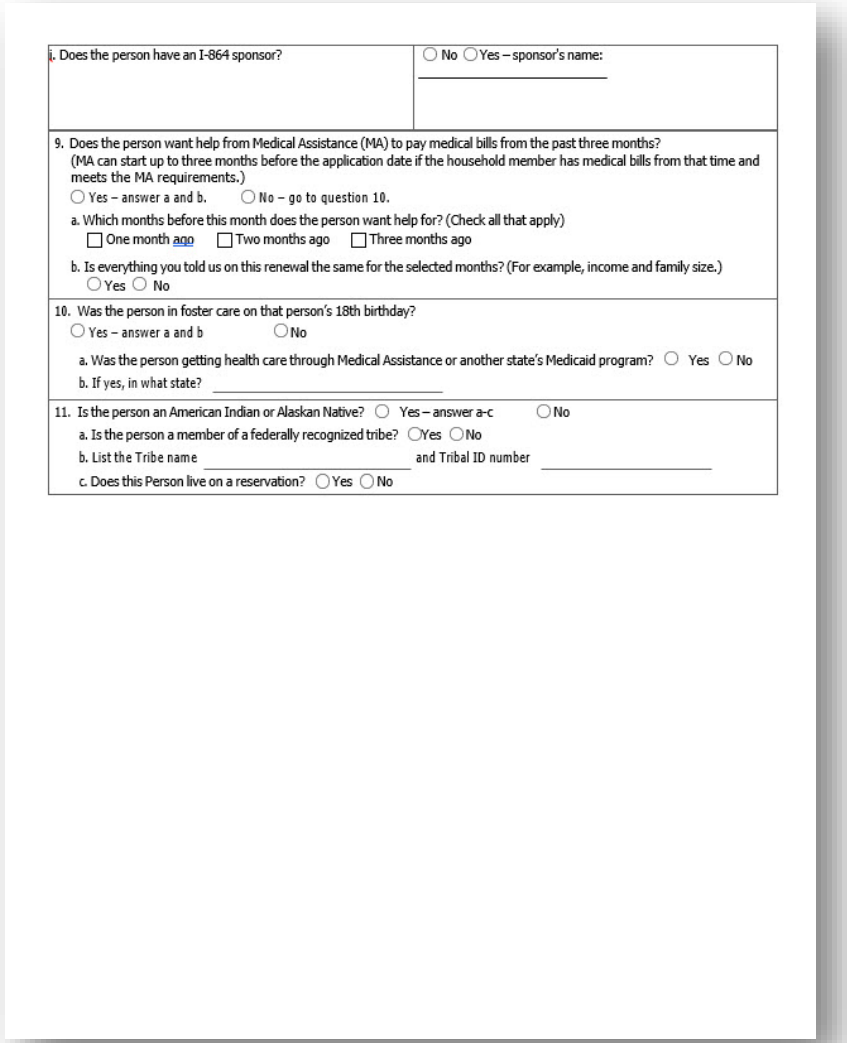
a. A-number or ID number: _____ b. Date of entry (MM/DD/YYYY): _____

c. Immigration document type: _____ Document no. _____

Expiration date (MM/DD/YYYY): _____

Answer questions d-i only if the person is a Lawful Permanent Resident (LPR/green card holder) including conditional permanent resident. *If not, go to Question 9.*

d. Has the person been an LPR for five years or more?	○ No ○ Yes
e. Did the person gain LPR status as an Iraqi or Afghan Special Immigrant, or as an Amerasian Immigrant?	○ No ○ Yes
f. Did the person have a different status before they became an LPR? (example: refugee or asylee)	○ No ○ Yes—what status: _____ *If the person's previous status was as a COFA migrant, a battered noncitizen or paroled for one year or more*: Date previous status granted: _____
g. Did the person enter the United States before August 22, 1996?	○ No ○ Yes
h. Is the person, or is the spouse or parent of the person, a veteran or active-duty member of the military?	○ No ○ Yes



i. Does the person have an I-864 sponsor?	○ No ○ Yes – sponsor's name: _____

9. Does the person want help from Medical Assistance (MA) to pay medical bills from the past three months? (MA can start up to three months before the application date if the household member has medical bills from that time and meets the MA requirements.)
   ○ Yes – answer a and b. ○ No – go to question 10.
   a. Which months before this month does the person want help for? (Check all that apply)
      ☐ One month ago ☐ Two months ago ☐ Three months ago
   b. Is everything you told us on this renewal the same for the selected months? (For example, income and family size.)
      ○ Yes ○ No

10. Was the person in foster care on that person's 18th birthday?
    ○ Yes – answer a and b ○ No
    a. Was the person getting health care through Medical Assistance or another state's Medicaid program? ○ Yes ○ No
    b. If yes, in what state? _____

11. Is the person an American Indian or Alaskan Native? ○ Yes – answer a-c ○ No
    a. Is the person a member of a federally recognized tribe? ○ Yes ○ No
    b. List the Tribe name _____ and Tribal ID number _____
    c. Does this Person live on a reservation? ○ Yes ○ No

Thank You!

Amy Harlin, HCEO

dhs.hc.Trainersonline-questions@state.mn.us