CHAPTER 256D
GENERAL ASSISTANCE

256D.001 MS 2006 [Renumbered 15.001]

256D.01 DECLARATION OF POLICY; CITATION.

Subdivision 1. **Policy.** The objectives of sections 256D.01 to 256D.21 are to provide a sound administrative structure for public assistance programs; to maximize the use of federal money for public assistance purposes; to provide an integrated public assistance program for eligible households in the state without adequate income or resources to maintain a subsistence reasonably compatible with decency and health; and to provide services to help employable and potentially employable persons prepare for and attain self-sufficiency and obtain permanent work.

It is the policy of this state that eligible households unable to provide for themselves and not otherwise provided for by law who meet the eligibility requirements of sections 256D.01 to 256D.21 are entitled to receive grants of general assistance necessary to maintain a subsistence reasonably compatible with decency and health. Providing this assistance is a matter of public concern and a necessity in promoting the public health and welfare.

Subd. 1a. **Standards.** (a) A principal objective in providing general assistance is to provide for single adults, childless couples, or children as defined in section 256D.02, subdivision 6, ineligible for federal programs who are unable to provide for themselves. The minimum standard of assistance determines the total amount of the general assistance grant without separate standards for shelter, utilities, or other needs.

(b) The commissioner shall set the standard of assistance for an assistance unit consisting of an adult recipient who is childless and unmarried or living apart from children and spouse and who does not live with a parent or parents or a legal custodian. When the other standards specified in this subdivision increase, this standard must also be increased by the same percentage.

(c) For an assistance unit consisting of a single adult who lives with a parent or parents, the general assistance standard of assistance is the amount that the aid to families with dependent children standard of assistance, in effect on July 16, 1996, would increase if the recipient were added as an additional minor child to an assistance unit consisting of the recipient's parent and all of that parent's family members, except that the standard may not exceed the standard for a general assistance recipient living alone. Benefits received by a responsible relative of the assistance unit under the supplemental security income program, a workers' compensation program, the Minnesota supplemental aid program, or any other program based on the responsible relative's disability, and any benefits received by a responsible relative of the assistance unit under the Social Security retirement program, may not be counted in the determination of eligibility or benefit level for the assistance unit. Except as provided below, the assistance unit is ineligible for general assistance if the available resources or the countable income of the assistance unit and the parent or parents with whom the assistance unit lives are such that a family consisting of the assistance unit's parent or parents, the parent or parents' other family members and the assistance unit as the only or additional minor child would be financially ineligible for general assistance. For the purposes of calculating the countable income of the assistance unit's parent or parents, the calculation methods, income deductions, exclusions, and disregards used when calculating the countable income for a single adult or childless couple must be used.

(d) For an assistance unit consisting of a childless couple, the standards of assistance are the same as the first and second adult standards of the aid to families with dependent children program in effect on July 16, 1996. If one member of the couple is not included in the general assistance grant, the standard of assistance for the other is the second adult standard of the aid to families with dependent children program as of July 16, 1996.

Subd. 1b. **Rules.** The commissioner shall adopt rules to set standards of assistance and methods of calculating payment to conform with subdivision 1a. When a recipient is a resident of a licensed residential facility, except shelters for the homeless or shelters under section 611A.31, the recipient is not eligible for a full general assistance standard. The state standard of assistance for those recipients who have personal needs not otherwise provided for is the personal needs allowance authorized for medical assistance recipients under section 256B.35.

Subd. 1c. [Repealed, 1989 c 282 art 5 s 133]

Subd. 1d. [Repealed, 1988 c 411 s 9]

Subd. 1e. **Rules regarding emergency assistance.** The commissioner shall adopt rules under the terms of sections 256D.01 to 256D.21 for general assistance, to require use of the emergency program under MFIP as the primary financial resource when available. The commissioner shall adopt rules for eligibility for general assistance of persons with seasonal income and may attribute seasonal income to other periods not in excess of one year from receipt by an applicant or recipient. General assistance payments may not be made for foster care, child welfare services, or other social services. Vendor payments and vouchers may be issued only as authorized in sections 256D.05, subdivision 6, and 256D.09.

Subd. 2. **Citation.** Sections 256D.01 to 256D.21 may be cited as the General Assistance Act.

History: *1973 c 650 art 21 s 1; 1974 c 297 s 1; 1980 c 536 s 1; 1981 c 360 art 2 s 31,54; 1Sp1981 c 4 art 4 s 22; 1983 c 312 art 1 s 27; art 8 s 3; 1984 c 640 s 32; 1984 c 654 art 5 s 26; 1Sp1985 c 9 art 2 s 55,56; 1986 c 444; 1987 c 197 s 5; 1987 c 333 s 18; 1987 c 403 art 3 s 27; 1988 c 689 art 2 s 185; 1989 c 282 art 5 s 42-45; 1990 c 426 art 2 s 1; 1990 c 568 art 4 s 20,21; 1Sp1993 c 1 art 6 s 26; 1995 c 178 art 2 s 17; art 6 s 27; 1995 c 233 art 2 s 56; 1996 c 305 art 2 s 54; 1997 c 85 art 3 s 23-25; 1997 c 107 s 13; 1999 c 159 s 56,57; 2000 c 260 s 97; 2009 c 175 art 3 s 1*

256D.02 DEFINITIONS.

Subdivision 1. **Scope.** For purposes of sections 256D.01 to 256D.21, the terms defined in this section have the meanings given them unless otherwise provided or indicated by the context.

Subd. 2. **Commissioner.** "Commissioner" means the commissioner of human services or a designee.

Subd. 3. **Department.** "Department" means the Department of Human Services.

Subd. 4. **General assistance.** "General assistance" means cash payments to persons unable to provide themselves with a reasonable subsistence compatible with decency and health and who are not otherwise provided for under the laws of this state or the United States.

Subd. 4a. **General assistance medical care.** "General assistance medical care" means payment of all or part of the cost of medical care and services approved by the commissioner pursuant to section 256D.03, subdivision 3, for individuals whose income and resources are insufficient to meet the cost of care.

Subd. 5. [Repealed, 1997 c 85 art 3 s 56]

Subd. 6. **Child.** "Child" means an adult child, a person who qualifies for assistance under section 256D.05, subdivision 1, paragraph (a), clause (10), or until March 31, 1998, the minor child of an individual.

Subd. 7. **Childless couple.** "Childless couple" means two individuals who are married to each other, live in a place of residence maintained by them as their own home, and are either childless or living apart from their children.

Subd. 8. **Income.** "Income" means any form of income, including remuneration for services performed as an employee and net earnings from self-employment, reduced by the amount attributable to employment expenses as defined by the commissioner. The amount attributable to employment expenses shall include amounts paid or withheld for federal and state personal income taxes and federal Social Security taxes.

Income includes any payments received as an annuity, retirement, or disability benefit, including veteran's or workers' compensation; old age, survivors, and disability insurance; railroad retirement benefits; unemployment benefits; and benefits under any federally aided categorical assistance program, supplementary security income, or other assistance program; rents, dividends, interest and royalties; and support and maintenance payments. Such payments may not be considered as available to meet the needs of any person other than the person for whose benefit they are received, unless that person is a family member or a spouse and the income is not excluded under section 256D.01, subdivision 1a. Goods and services provided in lieu of cash payment shall be excluded from the definition of income, except that payments made for room, board, tuition or fees by a parent, on behalf of a child enrolled as a full-time student in a postsecondary institution, and payments made on behalf of an applicant or recipient which the applicant or recipient could legally demand to receive personally in cash, must be included as income. Benefits of an applicant or recipient, such as those administered by the Social Security Administration, that are paid to a representative payee, and are spent on behalf of the applicant or recipient, are considered available income of the applicant or recipient.

Subd. 8a. [Repealed, 1983 c 312 art 8 s 18; 1Sp1985 c 14 art 9 s 78 subd 1]

Subd. 9. [Repealed, 1981 c 360 art 2 s 52]

Subd. 10. [Repealed, 1981 c 360 art 2 s 52]

Subd. 11. **State aid.** "State aid" means state aid to county agencies for general assistance and general assistance medical care expenditures as provided for in section 256D.03, subdivisions 2 and 3.

Subd. 12. **County agency.** "County agency" means the agency designated by the county board of commissioners, human services boards, local social services agencies in the several counties of the state or multicounty local social services agencies or departments where those have been established in accordance with law.

Subd. 12a. **Resident.** (a) For purposes of eligibility for general assistance and general assistance medical care, a person must be a resident of this state.

(b) A "resident" is a person living in the state for at least 30 days with the intention of making the person's home here and not for any temporary purpose. Time spent in a shelter for battered women shall count toward satisfying the 30-day residency requirement. All applicants

for these programs are required to demonstrate the requisite intent and can do so in any of the following ways:

(1) by showing that the applicant maintains a residence at a verified address, other than a place of public accommodation. An applicant may verify a residence address by presenting a valid state driver's license, a state identification card, a voter registration card, a rent receipt, a statement by the landlord, apartment manager, or homeowner verifying that the individual is residing at the address, or other form of verification approved by the commissioner; or

(2) by verifying residence according to Minnesota Rules, part 9500.1219, subpart 3, item C.

(c) For general assistance medical care, a county agency shall waive the 30-day residency requirement in cases of medical emergencies. For general assistance, a county shall waive the 30-day residency requirement where unusual hardship would result from denial of general assistance. For purposes of this subdivision, "unusual hardship" means the applicant is without shelter or is without available resources for food.

The county agency must report to the commissioner within 30 days on any waiver granted under this section. The county shall not deny an application solely because the applicant does not meet at least one of the criteria in this subdivision, but shall continue to process the application and leave the application pending until the residency requirement is met or until eligibility or ineligibility is established.

(d) For purposes of paragraph (c), the following definitions apply (1) "metropolitan statistical area" is as defined by the United States Census Bureau; (2) "shelter" includes any shelter that is located within the metropolitan statistical area containing the county and for which the applicant is eligible, provided the applicant does not have to travel more than 20 miles to reach the shelter and has access to transportation to the shelter. Clause (2) does not apply to counties in the Minneapolis-St. Paul metropolitan statistical area.

(e) Migrant workers as defined in section 256J.08 and, until March 31, 1998, their immediate families are exempt from the residency requirements of this section, provided the migrant worker provides verification that the migrant family worked in this state within the last 12 months and earned at least $1,000 in gross wages during the time the migrant worker worked in this state.

(f) For purposes of eligibility for emergency general assistance, the 30-day residency requirement under this section shall not be waived.

(g) If any provision of this subdivision is enjoined from implementation or found unconstitutional by any court of competent jurisdiction, the remaining provisions shall remain valid and shall be given full effect.

Subd. 13. **Suitable employment.** "Suitable employment" means an appropriate income producing job including, but not limited to, all publicly subsidized jobs procured through the services administered by or coordinated with the commissioner of employment and economic development.

Subd. 14. [Repealed, 1983 c 312 art 8 s 17]

Subd. 15. **Full-time student.** "Full-time student" means a student at a postsecondary institution who attends training for a minimum of 25 hours per week if the training does not involve shop practice and for a minimum of 30 hours per week if the training involves shop practice, or who registers for and attends a minimum of 12 semester hours per semester or 12 quarter hours per quarter.

Subd. 16. **Single adult.** "Single adult" means an individual 18 years or older who is childless and unmarried or living apart from the individual's children and spouse.

Subd. 17. **Professional certification.** "Professional certification" means a statement about a person's illness, injury, or incapacity that is signed by a "qualified professional" as defined in section 256J.08, subdivision 73a.

Subd. 18. **Group health plan.** "Group health plan" means any plan of, or contributed to by, an employer, including a self-insured plan, which provides health care directly or otherwise to the employer's employees, former employees, or the families of the employees or former employees, and includes continuation coverage pursuant to title XXII of the Public Health Service Act, section 4980B of the Internal Revenue Code of 1986, or title VI of the Employee Retirement Income Security Act of 1974.

Subd. 19. **Cost-effective.** "Cost-effective" means that the amount paid by the state for premiums, coinsurance, deductibles, other cost-sharing obligations under a health insurance plan, and other administrative costs is likely to be less than the amount paid for an equivalent set of services by general assistance medical care.

History: *1973 c 650 art 21 s 2; 1975 c 359 s 23; 1976 c 2 s 81; 1977 c 301 s 1,2; 1978 c 772 s 62; 1980 c 536 s 2-7; 1981 c 360 art 2 s 32,33; 1983 c 312 art 8 s 4,5; 1984 c 654 art 5 s 27-29,58; 1Sp1985 c 14 art 9 s 28; 1986 c 444; 1987 c 403 art 3 s 28,29; 1988 c 689 art 2 s 186,187; 1989 c 282 art 5 s 46-48; 1990 c 568 art 4 s 22-24,84; 1990 c 611 s 2; 1991 c 255 s 19; 1992 c 513 art 7 s 125,126; art 8 s 16; 1Sp1993 c 1 art 6 s 27; 1Sp1993 c 6 s 14; 1994 c 483 s 1; 1994 c 631 s 31; 1995 c 178 art 6 s 17; 1995 c 207 art 4 s 3; 1996 c 451 art 2 s 38; 1996 c 465 art 3 s 28; 1997 c 66 s 80; 1997 c 85 art 3 s 26,27; 1997 c 203 art 12 s 3; 1999 c 107 s 66; 2000 c 343 s 4; 2004 c 206 s 52; 2005 c 159 art 5 s 3*

256D.024 PERSONS PROHIBITED FROM RECEIVING BENEFITS.

Subdivision 1. **Person convicted of drug offenses.** (a) If an applicant or recipient has been convicted of a drug offense after July 1, 1997, the assistance unit is ineligible for benefits under this chapter until five years after the applicant has completed terms of the court-ordered sentence, unless the person is participating in a drug treatment program, has successfully completed a drug treatment program, or has been assessed by the county and determined not to be in need of a drug treatment program. Persons subject to the limitations of this subdivision who become eligible for assistance under this chapter shall be subject to random drug testing as a condition of continued eligibility and shall lose eligibility for benefits for five years beginning the month following:

(1) any positive test result for an illegal controlled substance; or

(2) discharge of sentence after conviction for another drug felony.

(b) For the purposes of this subdivision, "drug offense" means a conviction that occurred after July 1, 1997, of sections 152.021 to 152.025, 152.0261, 152.0262, or 152.096. Drug offense also means a conviction in another jurisdiction of the possession, use, or distribution of a controlled substance, or conspiracy to commit any of these offenses, if the offense occurred after July 1, 1997, and the conviction is a felony offense in that jurisdiction, or in the case of New Jersey, a high misdemeanor.

Subd. 2. **Parole violators.** An individual violating a condition of probation or parole or supervised release imposed under federal law or the law of any state is ineligible to receive benefits under this chapter.

Subd. 3. **Fleeing felons.** An individual who is fleeing to avoid prosecution, or custody, or confinement after conviction for a crime that is a felony under the laws of the jurisdiction from which the individual flees, or in the case of New Jersey, is a high misdemeanor, is ineligible to receive benefits under this chapter.

Subd. 4. **Denial of assistance for fraud.** An individual who is convicted in federal or state court of having made a fraudulent statement or representation with respect to the place of residence of the individual in order to receive assistance simultaneously from two or more states is ineligible to receive benefits under this chapter for ten years beginning on the date of the conviction.

History: *1997 c 85 art 3 s 28; 1997 c 203 art 12 s 15; 2005 c 136 art 7 s 21*

256D.03 RESPONSIBILITY TO PROVIDE GENERAL ASSISTANCE.

Subdivision 1. **County administration.** Every county agency shall provide general assistance to persons residing within its jurisdiction who meet the need requirements of sections 256D.01 to 256D.21. General assistance shall be administered by the county agencies according to law and rules promulgated by the commissioner pursuant to sections 14.001 to 14.69.

Subd. 2. **Assistance standards.** State aid shall be paid for all general assistance and grants up to the standards of section 256D.01, subdivision 1a, and according to procedures established by the commissioner, except as provided for under section 256.017.

Subd. 2a. **County agency options.** Any county agency may, from its own resources, make payments of general assistance: (a) at a standard higher than that established by the commissioner without reference to the standards of section 256D.01, subdivision 1; or (b) to persons not meeting the eligibility standards set forth in section 256D.05, subdivision 1, but for whom the aid would further the purposes established in the general assistance program according to rules adopted by the commissioner according to the Administrative Procedure Act. The Minnesota Department of Human Services may maintain client records and issue these payments, providing the cost of benefits is paid by the counties to the Department of Human Services according to section 256.01.

Subd. 3. **General assistance medical care; eligibility.** (a) Beginning April 1, 2010, the general assistance medical care program shall be administered according to section 256D.031, unless otherwise stated, except for outpatient prescription drug coverage, which shall continue to be administered under this section and funded under section 256D.031, subdivision 9, beginning June 1, 2010.

(b) Outpatient prescription drug coverage under general assistance medical care is limited to prescription drugs that:

(1) are covered under the medical assistance program as described in section 256B.0625, subdivisions 13 and 13d; and

(2) are provided by manufacturers that have fully executed general assistance medical care rebate agreements with the commissioner and comply with the agreements. Outpatient prescription drug coverage under general assistance medical care must conform to coverage under the medical assistance program according to section 256B.0625, subdivisions 13 to 13h.

(c) Outpatient prescription drug coverage does not include drugs administered in a clinic or other outpatient setting.

(d) For the period beginning April 1, 2010, to May 31, 2010, general assistance medical care covers the services listed in subdivision 4.

[See Note.]

Subd. 3a. **Claims; assignment of benefits.** Claims must be filed pursuant to section 256D.16. General assistance medical care applicants and recipients must apply or agree to apply third-party health and accident benefits to the costs of medical care. They must cooperate with the state in establishing paternity and obtaining third-party payments. By accepting general assistance, a person assigns to the Department of Human Services all rights to medical support or payments for medical expenses from another person or entity on their own or their dependent's behalf and agrees to cooperate with the state in establishing paternity and obtaining third-party payments. The application shall contain a statement explaining the assignment. Any rights or amounts assigned shall be applied against the cost of medical care paid for under this chapter. An assignment is effective on the date general assistance medical care eligibility takes effect.

[See Note.]

Subd. 3b. **Cooperation.** General assistance applicants and recipients must cooperate with the state and local agency to identify potentially liable third-party payors and assist the state in obtaining third-party payments. Cooperation includes identifying any third party who may be liable for care and services provided under this chapter to the applicant, recipient, or any other family member for whom application is made and providing relevant information to assist the state in pursuing a potentially liable third party.

Subd. 3c. **Drug rebate program.** The commissioner of human services shall continue to administer a drug rebate program for drugs purchased for persons eligible for the general assistance medical care program in accordance with this section and section 256.01, subdivision 2, paragraph (cc).

Subd. 4. [Repealed, 2010 c 200 art 1 s 21]

Subd. 5. [Repealed, 2010 c 382 s 87; 1Sp2010 c 1 art 16 s 47]

Subd. 6. **Division of costs.** The state share of county agency expenditures for general assistance medical care shall be 100 percent. Payments made under this subdivision shall be made according to sections 256B.041, subdivision 5 and 256B.19, subdivision 1. In counties where a pilot or demonstration project is operated for general assistance medical care services, the state may pay 100 percent of the costs of administering the pilot or demonstration project.

Notwithstanding any provision to the contrary, beginning July 1, 1991, the state shall pay 100 percent of the costs for centralized claims processing by the Department of Administration relative to claims beginning January 1, 1991, and submitted on behalf of general assistance medical care recipients by vendors in the general assistance medical care program.

Beginning July 1, 1991, the state shall reimburse counties up to the limit of state appropriations for general assistance medical care common carrier transportation and related travel expenses provided for medical purposes after December 31, 1990. For purposes of this subdivision, transportation shall have the meaning given it in Code of Federal Regulations, title 42, section 440.170(a), as amended through October 1, 1987, and travel expenses shall have the meaning given in Code of Federal Regulations, title 42, section 440.170(a)(3), as amended through October 1, 1987.

The county shall ensure that only the least costly most appropriate transportation and travel expenses are used. The state may enter into volume purchase contracts, or use a competitive bidding process, whenever feasible, to minimize the costs of transportation services. If the state has entered into a volume purchase contract or used the competitive bidding procedures of chapter 16C to arrange for transportation services, the county may be required to use such arrangements to be eligible for state reimbursement for general assistance medical care common carrier transportation and related travel expenses provided for medical purposes.

In counties where prepaid health plans are under contract to the commissioner to provide services to general assistance medical care recipients, the cost of court ordered treatment that does not include diagnostic evaluation, recommendation, or referral for treatment by the prepaid health plan is the responsibility of the county of financial responsibility.

[See Note.]

Subd. 7. **Duties of the commissioner.** The commissioner shall promulgate rules as necessary to establish:

(a) standards of eligibility, utilization of services, and payment levels;

(b) standards for quality assurance, surveillance, and utilization review procedures that conform to those established for the medical assistance program pursuant to chapter 256B, including general criteria and procedures for the identification and prompt investigation of suspected fraud, theft, abuse, presentment of false or duplicate claims, presentment of claims for services not medically necessary, or false statements or representations of material facts by a vendor or recipient of general assistance medical care, and for the imposition of sanctions against such vendor or recipient of medical care. The rules relating to sanctions shall be consistent with the provisions of section 256B.064, subdivisions 1a and 2; and

(c) administrative and fiscal procedures for payment of the state share of the medical costs incurred by the counties under section 256D.02, subdivision 4a. Rules promulgated pursuant to this clause may include: (1) procedures by which state liability for the costs of medical care incurred pursuant to section 256D.02, subdivision 4a may be deducted from county liability to the state under any other public assistance program authorized by law; (2) procedures for processing claims of counties for reimbursement by the state for expenditures for medical care made by the counties pursuant to section 256D.02, subdivision 4a; and (3) procedures by which the county agencies may contract with the commissioner of human services for state administration of general assistance medical care payments.

[See Note.]

Subd. 8. **Private insurance policies.** (a) Private accident and health care coverage for medical services is primary coverage and must be exhausted before general assistance medical care is paid. When a person who is otherwise eligible for general assistance medical care has private accident or health care coverage, including a prepaid health plan, the private health care benefits available to the person must be used first and to the fullest extent. General assistance medical care payment will not be made when either covered charges are paid in full by a third party or the provider has an agreement to accept payment for less than charges as payment in full. Payment for patients that are simultaneously covered by general assistance medical care and a liable third party other than Medicare will be determined as the lesser of clauses (1) to (3):

(1) the patient liability according to the provider/insurer agreement;

(2) covered charges minus the third-party payment amount; or

(3) the general assistance medical care rate minus the third-party payment amount.

A negative difference will not be implemented.

(b) When a parent or a person with an obligation of support has enrolled in a prepaid health care plan under section 518A.41, subdivision 1, the commissioner of human services shall limit the recipient of general assistance medical care to the benefits payable under that prepaid health care plan to the extent that services available under general assistance medical care are also available under the prepaid health care plan.

(c) Upon furnishing general assistance medical care or general assistance to any person having private accident or health care coverage, or having a cause of action arising out of an occurrence that necessitated the payment of assistance, the state agency shall be subrogated, to the extent of the cost of medical care, subsistence, or other payments furnished, to any rights the person may have under the terms of the coverage or under the cause of action. For purposes of this subdivision, "state agency" includes prepaid health plans under contract with the commissioner according to subdivision 4, paragraph (c), and sections 256B.69 and 256L.12; children's mental health collaboratives under section 245.493; demonstration projects for persons with disabilities under section 256B.77; nursing homes under the alternative payment demonstration project under section 256B.434; and county-based purchasing entities under section 256B.692.

This right of subrogation includes all portions of the cause of action, notwithstanding any settlement allocation or apportionment that purports to dispose of portions of the cause of action not subject to subrogation.

(d) To recover under this section, the attorney general may institute or join a civil action to enforce the subrogation rights the commissioner established under this section.

Any prepaid health plan providing services under subdivision 4, paragraph (c), and sections 256B.69 and 256L.12; children's mental health collaboratives under section 245.493; demonstration projects for persons with disabilities under section 256B.77; nursing homes under the alternative payment demonstration project under section 256B.434; or the county-based purchasing entity providing services under section 256B.692 may retain legal representation to enforce the subrogation rights created under this section or, if no action has been brought, may initiate and prosecute an independent action on their behalf against a person, firm, or corporation that may be liable to the person to whom the care or payment was furnished.

(e) The state agency must be given notice of monetary claims against a person, firm, or corporation that may be liable in damages, or otherwise obligated to pay part or all of the costs related to an injury when the state agency has paid or become liable for the cost of care or payments related to the injury. Notice must be given as follows:

(i) Applicants for general assistance or general assistance medical care shall notify the state or county agency of any possible claims when they submit the application. Recipients of general assistance or general assistance medical care shall notify the state or county agency of any possible claims when those claims arise.

(ii) A person providing medical care services to a recipient of general assistance medical care shall notify the state agency when the person has reason to believe that a third party may be liable for payment of the cost of medical care.

(iii) A person who is party to a claim upon which the state agency may be entitled to subrogation under this section shall notify the state agency of its potential subrogation claim

before filing a claim, commencing an action, or negotiating a settlement. A person who is a party to a claim includes the plaintiff, the defendants, and any other party to the cause of action.

Notice given to the county agency is not sufficient to meet the requirements of paragraphs (b) and (c).

(f) Upon any judgment, award, or settlement of a cause of action, or any part of it, upon which the state agency has a subrogation right, including compensation for liquidated, unliquidated, or other damages, reasonable costs of collection, including attorney fees, must be deducted first. The full amount of general assistance or general assistance medical care paid to or on behalf of the person as a result of the injury must be deducted next and paid to the state agency. The rest must be paid to the public assistance recipient or other plaintiff. The plaintiff, however, must receive at least one-third of the net recovery after attorney fees and collection costs.

[See Note.]

Subd. 9. [Repealed, 2010 c 200 art 1 s 21]

History: *1973 c 650 art 21 s 3; 1975 c 437 art 2 s 8; 1976 c 186 s 1; 1979 c 303 art 2 s 2; 1980 c 349 s 9; 1980 c 536 s 8-10; 1980 c 607 art 2 s 3; 1981 c 360 art 2 s 2 subd 4,34; 1Sp1981 c 2 s 16 subd 2; 1Sp1981 c 4 art 4 s 21; 1982 c 424 s 130; 1982 c 623 s 2; 1983 c 312 art 5 s 29-33; 1984 c 640 s 32; 1984 c 654 art 5 s 30,58; 1Sp1985 c 9 art 2 s 57,58; 1Sp1985 c 14 art 9 s 29; 1986 c 394 s 19; 1987 c 370 art 2 s 15; 1987 c 384 art 2 s 1; 1987 c 403 art 2 s 103-105; art 3 s 30; 1988 c 689 art 2 s 188,268; 1988 c 719 art 8 s 18,19; 1989 c 209 art 1 s 24; 1989 c 282 art 3 s 91,92; art 5 s 49; 1Sp1989 c 1 art 16 s 10,11; 1990 c 422 s 10; 1990 c 568 art 3 s 86-89; art 4 s 25,84; 1991 c 292 art 4 s 68,69; art 5 s 30,31; 1992 c 513 art 7 s 127,128; art 8 s 17; 1993 c 345 art 9 s 15; 1Sp1993 c 1 art 5 s 113,114; art 6 s 28; art 8 s 3; 1995 c 178 art 2 s 28; art 6 s 17; 1995 c 207 art 6 s 104-106; 1996 c 451 art 5 s 33; 1996 c 465 art 3 s 29-31; 1997 c 7 art 5 s 32; 1997 c 85 art 3 s 29; 1997 c 203 art 4 s 57; art 11 s 8-10; art 12 s 4; 1997 c 225 art 1 s 19; art 6 s 6,8; 1998 c 386 art 2 s 81; 1998 c 407 art 4 s 55,56; art 5 s 6; 1999 c 245 art 4 s 86-88; art 10 s 10; 2000 c 340 s 14; 2000 c 488 art 11 s 8; 2001 c 203 s 15; 1Sp2001 c 9 art 2 s 56; art 10 s 66; 2002 c 277 s 32; 2002 c 379 art 1 s 113; 1Sp2003 c 14 art 2 s 41; art 12 s 68,69; 1Sp2003 c 23 s 30; 2004 c 228 art 1 s 43; 2004 c 288 art 6 s 23,24; 2005 c 98 art 2 s 14; 2005 c 164 s 29; 1Sp2005 c 4 art 2 s 15; art 8 s 52,53; 1Sp2005 c 7 s 28; 2006 c 280 s 46; 2006 c 282 art 16 s 11; 2007 c 13 art 1 s 25; 2007 c 147 art 5 s 16,17; art 8 s 28; 2008 c 286 art 1 s 9; 2008 c 326 art 1 s 40; 2009 c 79 art 5 s 53; 2009 c 173 art 1 s 33; art 3 s 17; 2010 c 200 art 1 s 11,18; 2010 c 310 art 16 s 2; 1Sp2010 c 1 art 16 s 30,31*

NOTE: Subdivision 3 was also amended by Laws 2010, chapter 310, article 16, section 2, to read as follows:

"Subd. 3. **General assistance medical care; eligibility.** (a) General assistance medical care may be paid for any person who is not eligible for medical assistance under chapter 256B, including eligibility for medical assistance based on a spenddown of excess income according to section 256B.056, subdivision 5, or MinnesotaCare for applicants and recipients defined in paragraph (c), except as provided in paragraph (d), and:

(1) who is receiving assistance under section 256D.05, except for families with children who are eligible under Minnesota family investment program (MFIP), or who is having a payment made on the person's behalf under sections 256I.01 to 256I.06; or

(2) who is a resident of Minnesota; and

(i) who has gross countable income not in excess of 75 percent of the federal poverty guidelines for the family size, using a six-month budget period and whose equity in assets is not in excess of $1,000 per assistance unit. General assistance medical care is not available for applicants or enrollees who are otherwise eligible for medical assistance but fail to verify their assets. Enrollees who become eligible for medical assistance shall be terminated and transferred to medical assistance. Exempt assets, the reduction of excess assets, and the waiver of excess assets must conform to the medical assistance program in section 256B.056, subdivisions 3 and 3d, with the following exception: the maximum amount of undistributed funds in a trust that could be distributed to or on behalf of the beneficiary by the trustee, assuming the full exercise of the trustee's discretion under the terms of the trust, must be applied toward the asset maximum; or

(ii) who has gross countable income above 75 percent of the federal poverty guidelines but not in excess of 175 percent of the federal poverty guidelines for the family size, using a six-month budget period, whose equity in assets is not in excess of the limits in section 256B.056, subdivision 3c, and who applies during an inpatient hospitalization.

(b) The commissioner shall adjust the income standards under this section each July 1 by the annual update of the federal poverty guidelines following publication by the United States Department of Health and Human Services except that the income standards shall not go below those in effect on July 1, 2009.

(c) Effective for applications and renewals processed on or after September 1, 2006, general assistance medical care may not be paid for applicants or recipients who are adults with dependent children under 21 whose gross family income is equal to or less than 275 percent of the federal poverty guidelines who are not described in paragraph (f).

(d) Effective for applications and renewals processed on or after September 1, 2006, general assistance medical care may be paid for applicants and recipients who meet all eligibility requirements of paragraph (a), clause (2), item (i), for a temporary period beginning the date of application. Immediately following approval of general assistance medical care, enrollees shall be enrolled in MinnesotaCare under section 256L.04, subdivision 7, with covered services as provided in section 256L.03 for the rest of the six-month general assistance medical care eligibility period, until their six-month renewal.

(e) To be eligible for general assistance medical care following enrollment in MinnesotaCare as required by paragraph (d), an individual must complete a new application.

(f) Applicants and recipients eligible under paragraph (a), clause (2), item (i), are exempt from the MinnesotaCare enrollment requirements in this subdivision if they:

(1) have applied for and are awaiting a determination of blindness or disability by the state medical review team or a determination of eligibility for Supplemental Security Income or Social Security Disability Insurance by the Social Security Administration;

(2) fail to meet the requirements of section 256L.09, subdivision 2;

(3) are homeless as defined by United States Code, title 42, section 11301, et seq.;

(4) are classified as end-stage renal disease beneficiaries in the Medicare program;

(5) are enrolled in private health care coverage as defined in section 256B.02, subdivision 9;

(6) are eligible under paragraph (k);

(7) receive treatment funded pursuant to section 254B.02; or

(8) reside in the Minnesota sex offender program defined in chapter 246B.

(g) For applications received on or after October 1, 2003, eligibility may begin no earlier than the date of application. For individuals eligible under paragraph (a), clause (2), item (i), a redetermination of eligibility must occur every 12 months. Individuals are eligible under paragraph (a), clause (2), item (ii), only during inpatient hospitalization but may reapply if there is a subsequent period of inpatient hospitalization.

(h) Beginning September 1, 2006, Minnesota health care program applications and renewals completed by recipients and applicants who are persons described in paragraph (d) and submitted to the county agency shall be determined for MinnesotaCare eligibility by the county agency. If all other eligibility requirements of this subdivision are met, eligibility for general assistance medical care shall be available in any month during which MinnesotaCare enrollment is pending. Upon notification of eligibility for MinnesotaCare, notice of termination for eligibility for general assistance medical care shall be sent to an applicant or recipient. If all other eligibility requirements of this subdivision are met, eligibility for general assistance medical care shall be available until enrollment in MinnesotaCare subject to the provisions of paragraphs (d), (f), and (g).

(i) The date of an initial Minnesota health care program application necessary to begin a determination of eligibility shall be the date the applicant has provided a name, address, and Social Security number, signed and dated, to the county agency or the Department of Human Services. If the applicant is unable to provide a name, address, Social Security number, and signature when health care is delivered due to a medical condition or disability, a health care provider may act on an applicant's behalf to establish the date of an initial Minnesota health care program application by providing the county agency or Department of Human Services with provider identification and a temporary unique identifier for the applicant. The applicant must complete the remainder of the application and provide necessary verification before eligibility can be determined. The applicant must complete the application within the time periods required under the medical assistance program as specified in Minnesota Rules, parts 9505.0015, subpart 5, and 9505.0090, subpart 2. The county agency must assist the applicant in obtaining verification if necessary.

(j) County agencies are authorized to use all automated databases containing information regarding recipients' or applicants' income in order to determine eligibility for general assistance medical care or MinnesotaCare. Such use shall be considered sufficient in order to determine eligibility and premium payments by the county agency.

(k) General assistance medical care is not available for a person in a correctional facility unless the person is detained by law for less than one year in a county correctional or detention facility as a person accused or convicted of a crime, or admitted as an inpatient to a hospital on a criminal hold order, and the person is a recipient of general assistance medical care at the time the person is detained by law or admitted on a criminal hold order and as long as the person continues to meet other eligibility requirements of this subdivision.

(l) General assistance medical care is not available for applicants or recipients who do not cooperate with the county agency to meet the requirements of medical assistance.

(m) In determining the amount of assets of an individual eligible under paragraph (a), clause (2), item (i), there shall be included any asset or interest in an asset, including an asset excluded under paragraph (a), that was given away, sold, or disposed of for less than fair market value within the 60 months preceding application for general assistance medical care or during the period of eligibility. Any transfer described in this paragraph shall be presumed to have been for the purpose of establishing eligibility for general assistance medical care, unless the

individual furnishes convincing evidence to establish that the transaction was exclusively for another purpose. For purposes of this paragraph, the value of the asset or interest shall be the fair market value at the time it was given away, sold, or disposed of, less the amount of compensation received. For any uncompensated transfer, the number of months of ineligibility, including partial months, shall be calculated by dividing the uncompensated transfer amount by the average monthly per person payment made by the medical assistance program to skilled nursing facilities for the previous calendar year. The individual shall remain ineligible until this fixed period has expired. The period of ineligibility may exceed 30 months, and a reapplication for benefits after 30 months from the date of the transfer shall not result in eligibility unless and until the period of ineligibility has expired. The period of ineligibility begins in the month the transfer was reported to the county agency, or if the transfer was not reported, the month in which the county agency discovered the transfer, whichever comes first. For applicants, the period of ineligibility begins on the date of the first approved application.

(n) When determining eligibility for any state benefits under this subdivision, the income and resources of all noncitizens shall be deemed to include their sponsor's income and resources as defined in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, title IV, Public Law 104-193, sections 421 and 422, and subsequently set out in federal rules.

(o) Undocumented noncitizens and nonimmigrants are ineligible for general assistance medical care. For purposes of this subdivision, a nonimmigrant is an individual in one or more of the classes listed in United States Code, title 8, section 1101, subsection (a), paragraph (15), and an undocumented noncitizen is an individual who resides in the United States without the approval or acquiescence of the United States Citizenship and Immigration Services.

(p) Notwithstanding any other provision of law, a noncitizen who is ineligible for medical assistance due to the deeming of a sponsor's income and resources, is ineligible for general assistance medical care.

(q) Effective July 1, 2003, general assistance medical care emergency services end."

NOTE: Subdivisions 3, 3a, 6, 7, and 8 are repealed contingent upon implementation of Minnesota Statutes, section 256B.055, subdivision 15, and 256B.056, subdivisions 3 and 4. Laws 2010, First Special Session chapter 1, article 16, section 47.

256D.031 GENERAL ASSISTANCE MEDICAL CARE.

Subdivision 1. **Eligibility.** (a) Except as provided under subdivision 2, general assistance medical care may be paid for any individual who is not eligible for medical assistance under chapter 256B, including eligibility for medical assistance based on a spenddown of excess income according to section 256B.056, subdivision 5, and who:

(1) is receiving assistance under section 256D.05, except for families with children who are eligible under the Minnesota family investment program (MFIP), or who is having a payment made on the person's behalf under sections 256I.01 to 256I.06; or

(2) is a resident of Minnesota and has gross countable income not in excess of 75 percent of federal poverty guidelines for the family size, using a six-month budget period, and whose equity in assets is not in excess of $1,000 per assistance unit.

Exempt assets, the reduction of excess assets, and the waiver of excess assets must conform to the medical assistance program in section 256B.056, subdivisions 3 and 3d, except that the maximum amount of undistributed funds in a trust that could be distributed to or on behalf of the beneficiary

by the trustee, assuming the full exercise of the trustee's discretion under the terms of the trust, must be applied toward the asset maximum.

(b) The commissioner shall adjust the income standards under this section each July 1 by the annual update of the federal poverty guidelines following publication by the United States Department of Health and Human Services.

[See Note.]

Subd. 2. **Ineligible groups.** (a) General assistance medical care may not be paid for an applicant or a recipient who:

(1) is otherwise eligible for medical assistance but fails to verify the applicant's or recipient's assets;

(2) is an adult in a family with children as defined in section 256L.01, subdivision 3a;

(3) is enrolled in private health coverage as defined in section 256B.02, subdivision 9;

(4) is in a correctional facility, including an individual in a county correctional or detention facility as an individual accused or convicted of a crime, or admitted as an inpatient to a hospital on a criminal hold order;

(5) resides in the Minnesota sex offender program defined in chapter 246B;

(6) does not cooperate with the county agency to meet the requirements of medical assistance; or

(7) does not cooperate with a county or state agency or the state medical review team in determining a disability or for determining eligibility for Supplemental Security Income or Social Security Disability Insurance by the Social Security Administration.

(b) Undocumented noncitizens and nonimmigrants are ineligible for general assistance medical care. For purposes of this subdivision, a nonimmigrant is an individual in one or more of the classes listed in United States Code, title 8, section 1101, subsection (a), paragraph (15), and an undocumented noncitizen is an individual who resides in the United States without approval or acquiescence of the United States Citizenship and Immigration Services.

(c) Notwithstanding any other provision of law, a noncitizen who is ineligible for medical assistance due to the deeming of a sponsor's income and resources is ineligible for general assistance medical care.

(d) General assistance medical care recipients who become eligible for medical assistance shall be terminated from general assistance medical care and transferred to medical assistance.

[See Note.]

Subd. 3. **Eligibility and enrollment procedures.** (a) Eligibility for general assistance medical care shall begin no earlier than the date of application. The date of application shall be the date the applicant has provided a name, address, and Social Security number, signed and dated, to the county agency or the Department of Human Services. If the applicant is unable to provide a name, address, Social Security number, and signature when health care is delivered due to a medical condition or disability, a health care provider may act on an applicant's behalf to establish the date of an application by providing the county agency or Department of Human Services with provider identification and a temporary unique identifier for the applicant. The applicant must complete the remainder of the application and provide necessary verification before eligibility can be determined. The applicant must complete the application within the time periods required under the medical assistance program as specified in Minnesota Rules, parts

9505.0015, subpart 5; and 9505.0090, subpart 2. The county agency must assist the applicant in obtaining verification if necessary.

(b) County agencies are authorized to use all automated databases containing information regarding recipients' or applicants' income in order to determine eligibility for general assistance medical care or MinnesotaCare. Such use shall be considered sufficient in order to determine eligibility and premium payments by the county agency.

(c) In determining the amount of assets of an individual eligible under subdivision 1, paragraph (a), clause (2), there shall be included any asset or interest in an asset, including an asset excluded under subdivision 1, paragraph (a), that was given away, sold, or disposed of for less than fair market value within the 60 months preceding application for general assistance medical care or during the period of eligibility. Any transfer described in this paragraph shall be presumed to have been for the purpose of establishing eligibility for general assistance medical care, unless the individual furnishes convincing evidence to establish that the transaction was exclusively for another purpose. For purposes of this paragraph, the value of the asset or interest shall be the fair market value at the time it was given away, sold, or disposed of, less the amount of compensation received. For any uncompensated transfer, the number of months of ineligibility, including partial months, shall be calculated by dividing the uncompensated transfer amount by the average monthly per person payment made by the medical assistance program to skilled nursing facilities for the previous calendar year. The individual shall remain ineligible until this fixed period has expired. The period of ineligibility may exceed 30 months, and a reapplication for benefits after 30 months from the date of the transfer shall not result in eligibility unless and until the period of ineligibility has expired. The period of ineligibility begins in the month the transfer was reported to the county agency, or if the transfer was not reported, the month in which the county agency discovered the transfer, whichever comes first. For applicants, the period of ineligibility begins on the date of the first approved application.

(d) When determining eligibility for any state benefits under this subdivision, the income and resources of all noncitizens shall be deemed to include the noncitizen's sponsor's income and resources as defined in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, title IV, Public Law 104-193, sections 421 and 422, and subsequently set out in federal rules.

(e) Applicants and recipients are eligible for general assistance medical care for a six-month eligibility period, unless a change that affects eligibility is reported. Eligibility may be renewed for additional six-month periods. During each six-month eligibility period, recipients who continue to meet the eligibility requirements of this section are not eligible for MinnesotaCare.

[See Note.]

Subd. 4. **General assistance medical care; services.** (a) Within the limitations described in this section, general assistance medical care covers medically necessary services that include:

(1) inpatient hospital services;

(2) outpatient hospital services;

(3) services provided by Medicare-certified rehabilitation agencies;

(4) prescription drugs;

(5) equipment necessary to administer insulin and diagnostic supplies and equipment for diabetics to monitor blood sugar level;

(6) eyeglasses and eye examinations;

(7) hearing aids;

(8) prosthetic devices, if not covered by veterans benefits;

(9) laboratory and x-ray services;

(10) physicians' services;

(11) medical transportation except special transportation;

(12) chiropractic services as covered under the medical assistance program;

(13) podiatric services;

(14) dental services;

(15) mental health services covered under chapter 256B;

(16) services performed by a certified pediatric nurse practitioner, a certified family nurse practitioner, a certified adult nurse practitioner, a certified obstetric/gynecological nurse practitioner, a certified neonatal nurse practitioner, or a certified geriatric nurse practitioner in independent practice, if (1) the service is otherwise covered under this chapter as a physician service, (2) the service provided on an inpatient basis is not included as part of the cost for inpatient services included in the operating payment rate, and (3) the service is within the scope of practice of the nurse practitioner's license as a registered nurse, as defined in section 148.171;

(17) services of a certified public health nurse or a registered nurse practicing in a public health nursing clinic that is a department of, or that operates under the direct authority of, a unit of government, if the service is within the scope of practice of the public health nurse's license as a registered nurse, as defined in section 148.171;

(18) telemedicine consultations, to the extent they are covered under section 256B.0625, subdivision 3b;

(19) care coordination and patient education services provided by a community health worker according to section 256B.0625, subdivision 49; and

(20) regardless of the number of employees that an enrolled health care provider may have, sign language interpreter services when provided by an enrolled health care provider during the course of providing a direct, person-to-person covered health care service to an enrolled recipient who has a hearing loss and uses interpreting services.

(b) Sex reassignment surgery is not covered under this section.

(c) Outpatient prescription drug coverage is covered in accordance with section 256D.03, subdivision 3.

(d) The following co-payments shall apply for services provided:

(1) $25 for nonemergency visits to a hospital-based emergency room; and

(2) $3 per brand-name drug prescription, and $1 per generic drug prescription, subject to a $7 per month maximum for prescription drug co-payments. No co-payments shall apply to antipsychotic drugs when used for the treatment of mental illness.

(e) Co-payments shall be limited to one per day per provider for nonemergency visits to a hospital-based emergency room. Recipients of general assistance medical care are responsible for all co-payments in this subdivision. Reimbursement for prescription drugs shall be reduced by the amount of the co-payment until the recipient has reached the $7 per month maximum for

prescription drug co-payments. The provider shall collect the co-payment from the recipient. Providers may not deny services to recipients who are unable to pay the co-payment.

(f) Chemical dependency services that are reimbursed under chapter 254B shall not be reimbursed under general assistance medical care.

(g) Inpatient hospital services that are provided in community behavioral health hospitals operated by state-operated services shall not be reimbursed under general assistance medical care.

[See Note.]

Subd. 5. **Payment rates and contract modification; April 1, 2010, to May 31, 2010.** (a) For the period April 1, 2010, to May 31, 2010, general assistance medical care shall be paid on a fee-for-service basis. Fee-for-service payment rates for services other than outpatient prescription drugs shall be set at 37 percent of the payment rate in effect on March 31, 2010.

(b) Outpatient prescription drugs covered under section 256D.03, subdivision 3, provided on or after April 1, 2010, to May 31, 2010, shall be paid on a fee-for-service basis according to section 256B.0625, subdivisions 13 to 13g.

(c) If sections 256B.055, subdivision 15, and 256B.056, subdivisions 3 and 4, are implemented effective July 1, 2010:

(1) general assistance medical care must be paid on a fee-for-service basis for the period June 1 to June 30, 2010;

(2) fee-for-service payment rates for services other than outpatient prescription drugs must be set at 27 percent of the payment rate in effect on March 31, 2010; and

(3) outpatient prescription drugs considered under section 256D.03, subdivision 3, must be paid on a fee-for-service basis according to section 256B.0625, subdivisions 13 to 13g.

[See Note.]

Subd. 6. **Coordinated care delivery systems.** (a) Effective June 1, 2010, the commissioner shall contract with hospitals or groups of hospitals that qualify under paragraph (b) and agree to deliver services according to this subdivision. Contracting hospitals shall develop and implement a coordinated care delivery system to provide health care services to individuals who are eligible for general assistance medical care under this section and who either choose to receive services through the coordinated care delivery system or who are enrolled by the commissioner under paragraph (c). The health care services provided by the system must include: (1) the services described in subdivision 4 with the exception of outpatient prescription drug coverage but shall include drugs administered in a clinic or other outpatient setting; or (2) a set of comprehensive and medically necessary health services that the recipients might reasonably require to be maintained in good health and that has been approved by the commissioner, including at a minimum, but not limited to, emergency care, medical transportation services, inpatient hospital and physician care, outpatient health services, preventive health services, mental health services, and prescription drugs administered in a clinic or other outpatient setting. Outpatient prescription drug coverage is covered on a fee-for-service basis in accordance with section 256D.03, subdivision 3, and funded under subdivision 9. A hospital establishing a coordinated care delivery system under this subdivision must ensure that the requirements of this subdivision are met.

(b) A hospital or group of hospitals may contract with the commissioner to develop and implement a coordinated care delivery system as follows:

(1) effective June 1, 2010, a hospital qualifies under this subdivision if: (i) during calendar year 2008, it received fee-for-service payments for services to general assistance medical care recipients (A) equal to or greater than $1,500,000, or (B) equal to or greater than 1.3 percent of net patient revenue; or (ii) a contract with the hospital is necessary to provide geographic access or to ensure that at least 80 percent of enrollees have access to a coordinated care delivery system; and

(2) effective December 1, 2010, a Minnesota hospital not qualified under clause (1) may contract with the commissioner under this subdivision if it agrees to satisfy the requirements of this subdivision.

Participation by hospitals shall become effective quarterly on June 1, September 1, December 1, or March 1. Hospital participation is effective for a period of 12 months and may be renewed for successive 12-month periods.

(c) Applicants and recipients may enroll in any available coordinated care delivery system statewide. If more than one coordinated care delivery system is available, the applicant or recipient shall be allowed to choose among the systems. The commissioner may assign an applicant or recipient to a coordinated care delivery system if no choice is made by the applicant or recipient. The commissioner shall consider a recipient's zip code, city of residence, county of residence, or distance from a participating coordinated care delivery system when determining default assignment. An applicant or recipient may decline enrollment in a coordinated care delivery system. Upon enrollment into a coordinated care delivery system, the recipient must agree to receive all nonemergency services through the coordinated care delivery system. Enrollment in a coordinated care delivery system is for six months and may be renewed for additional six-month periods, except that initial enrollment is for six months or until the end of a recipient's period of general assistance medical care eligibility, whichever occurs first. A recipient who continues to meet the eligibility requirements of this section is not eligible to enroll in MinnesotaCare during a period of enrollment in a coordinated care delivery system. From June 1, 2010, to February 28, 2011, applicants and recipients not enrolled in a coordinated care delivery system may seek services from a hospital eligible for reimbursement under the temporary uncompensated care pool established under subdivision 8. After February 28, 2011, services are available only through a coordinated care delivery system.

(d) The hospital may contract and coordinate with providers and clinics for the delivery of services and shall contract with essential community providers as defined under section 62Q.19, subdivision 1, paragraph (a), clauses (1) and (2), to the extent practicable. If a provider or clinic contracts with a hospital to provide services through the coordinated care delivery system, the provider may not refuse to provide services to any recipient enrolled in the system, and payment for services shall be negotiated with the hospital and paid by the hospital from the system's allocation under subdivision 7.

(e) A coordinated care delivery system must:

(1) provide the covered services required under paragraph (a) to recipients enrolled in the coordinated care delivery system, and comply with the requirements of subdivision 4, paragraphs (b) to (g);

(2) establish a process to monitor enrollment and ensure the quality of care provided;

(3) in cooperation with counties, coordinate the delivery of health care services with existing homeless prevention, supportive housing, and rent subsidy programs and funding administered by the Minnesota Housing Finance Agency under chapter 462A; and

(4) adopt innovative and cost-effective methods of care delivery and coordination, which may include the use of allied health professionals, telemedicine, patient educators, care coordinators, and community health workers.

(f) The hospital may require a recipient to designate a primary care provider or a primary care clinic. The hospital may limit the delivery of services to a network of providers who have contracted with the hospital to deliver services in accordance with this subdivision, and require a recipient to seek services only within this network. The hospital may also require a referral to a provider before the service is eligible for payment. A coordinated care delivery system is not required to provide payment to a provider who is not employed by or under contract with the system for services provided to a recipient enrolled in the system, except in cases of an emergency. For purposes of this section, emergency services are defined in accordance with Code of Federal Regulations, title 42, section 438.114 (a).

(g) A recipient enrolled in a coordinated care delivery system has the right to appeal to the commissioner according to section 256.045.

(h) The state shall not be liable for the payment of any cost or obligation incurred by the coordinated care delivery system.

(i) The hospital must provide the commissioner with data necessary for assessing enrollment, quality of care, cost, and utilization of services. Each hospital must provide, on a quarterly basis on a form prescribed by the commissioner for each recipient served by the coordinated care delivery system, the services provided, the cost of services provided, and the actual payment amount for the services provided and any other information the commissioner deems necessary to claim federal Medicaid match. The commissioner must provide this data to the legislature on a quarterly basis.

(j) Effective June 1, 2010, the provisions of section 256.9695, subdivision 2, paragraph (b), do not apply to general assistance medical care provided under this section.

(k) Notwithstanding any other provision in this section to the contrary, for participation beginning September 1, 2010, the commissioner shall offer the same contract terms related to an enrollment threshold formula and financial liability protections to a hospital or group of hospitals qualified under this subdivision to develop and implement a coordinated care delivery system as those contained in the coordinated care delivery system contracts effective June 1, 2010.

(l) If sections 256B.055, subdivision 15, and 256B.056, subdivisions 3 and 4, are implemented effective July 1, 2010, this subdivision must not be implemented.

[See Note.]

Subd. 7. **Payments; rate setting for the hospital coordinated care delivery system.** (a) Effective for general assistance medical care services, with the exception of outpatient prescription drug coverage, provided on or after June 1, 2010, through a coordinated care delivery system, the commissioner shall allocate the annual appropriation for the coordinated care delivery system to hospitals participating under subdivision 6 in quarterly payments, beginning on the first scheduled warrant on or after June 1, 2010. The payment shall be allocated among all hospitals qualified to participate on the allocation date as follows:

(1) each hospital or group of hospitals shall be allocated an initial amount based on the hospital's or group of hospitals' pro rata share of calendar year 2008 payments for general assistance medical care services to all participating hospitals;

(2) the initial allocations to Hennepin County Medical Center; Regions Hospital; Saint Mary's Medical Center; and the University of Minnesota Medical Center, Fairview, shall be increased to 110 percent of the value determined in clause (1);

(3) the initial allocation to hospitals not listed in clause (2) shall be reduced a pro rata amount in order to keep the allocations within the limit of available appropriations; and

(4) the amounts determined under clauses (1) to (3) shall be allocated to participating hospitals.

The commissioner may prospectively reallocate payments to participating hospitals on a biannual basis to ensure that final allocations reflect actual coordinated care delivery system enrollment. The 2008 base year shall be updated by one calendar year each June 1, beginning June 1, 2011.

(b) Beginning June 1, 2010, and every quarter beginning in June thereafter, the commissioner shall make one-third of the quarterly payment in June and the remaining two-thirds of the quarterly payment in July to each participating hospital or group of hospitals.

(c) In order to be reimbursed under this section, nonhospital providers of health care services shall contract with one or more hospitals described in paragraph (a) to provide services to general assistance medical care recipients through the coordinated care delivery system established by the hospital. The hospital shall reimburse bills submitted by nonhospital providers participating under this paragraph at a rate negotiated between the hospital and the nonhospital provider.

(d) The commissioner shall apply for federal matching funds under section 256B.199, paragraphs (a) to (d), for expenditures under this subdivision.

(e) Outpatient prescription drug coverage is provided in accordance with section 256D.03, subdivision 3, and paid on a fee-for-service basis under subdivision 9.

[See Note.]

Subd. 8. **Temporary uncompensated care pool.** (a) The commissioner shall establish a temporary uncompensated care pool, effective June 1, 2010. Payments from the pool must be distributed, within the limits of the available appropriation, to hospitals that are not part of a coordinated care delivery system established under subdivision 6.

(b) Hospitals seeking reimbursement from this pool must submit an invoice to the commissioner in a form prescribed by the commissioner for payment for services provided to an applicant or recipient not enrolled in a coordinated care delivery system. A payment amount, as calculated under current law, must be determined, but not paid, for each admission of or service provided to a general assistance medical care recipient on or after June 1, 2010, to February 28, 2011.

(c) The aggregated payment amounts for each hospital must be calculated as a percentage of the total calculated amount for all hospitals.

(d) Distributions from the uncompensated care pool for each hospital must be determined by multiplying the factor in paragraph (c) by the amount of money in the uncompensated care pool that is available for the six-month period.

(e) The commissioner shall apply for federal matching funds under section 256B.199, paragraphs (a) to (d), for expenditures under this subdivision.

(f) Outpatient prescription drugs are not eligible for payment under this subdivision.

[See Note.]

Subd. 9. **Prescription drug pool.** (a) The commissioner shall establish an outpatient prescription drug pool, effective June 1, 2010. Money in the pool must be used to reimburse pharmacies and other pharmacy service providers as defined in Minnesota Rules, part 9505.0340, for the covered outpatient prescription drugs dispensed to recipients. Payment for drugs shall be on a fee-for-service basis according to the rates established in section 256B.0625, subdivision 13e. Outpatient prescription drug coverage is subject to the availability of funds in the pool. If the commissioner forecasts that expenditures under this subdivision will exceed the appropriation for this purpose, the commissioner may bring recommendations to the Legislative Advisory Commission on methods to resolve the shortfall.

(b) Effective June 1, 2010, coordinated care delivery systems established under subdivision 6 shall pay to the commissioner, on a quarterly basis, an assessment equal to 20 percent of payments for the prescribed drugs for recipients of services through that coordinated care delivery system, as calculated by the commissioner based on the most recent available data.

[See Note.]

Subd. 10. **Assistance for veterans.** Hospitals participating in the coordinated care delivery system under subdivision 6 shall consult with counties, county veterans service officers, and the Veterans Administration to identify other programs for which general assistance medical care recipients enrolled in their system are qualified.

[See Note.]

History: *2010 c 200 art 1 s 12; 1Sp2010 c 1 art 16 s 32,40-42*

NOTE: Subdivisions 1 to 10, as added by Laws 2010, chapter 200, article 1, section 12, and amended by Laws 2010, First Special Session chapter 1, article 16, sections 32, and 40 to 42, are repealed contingent upon implementation of Minnesota Statutes, sections 256B.055, subdivision 15, and 256B.056, subdivisions 3 and 4. Laws 2010, First Special Session chapter 1, article 16, section 47.

256D.04 DUTIES OF THE COMMISSIONER.

In addition to any other duties imposed by law, the commissioner shall:

(1) Supervise according to section 256.01 the administration of general assistance and general assistance medical care by county agencies as provided in sections 256D.01 to 256D.21;

(2) Promulgate uniform rules consistent with law for carrying out and enforcing the provisions of sections 256D.01 to 256D.21, including section 256D.05, subdivision 3, and section 256.01, subdivision 2, paragraph (16), to the end that general assistance may be administered as uniformly as possible throughout the state; rules shall be furnished immediately to all county agencies and other interested persons; in promulgating rules, the provisions of sections 14.001 to 14.69, shall apply;

(3) Allocate money appropriated for general assistance and general assistance medical care to county agencies as provided in section 256D.03, subdivisions 2 and 3;

(4) Accept and supervise the disbursement of any funds that may be provided by the federal government or from other sources for use in this state for general assistance and general assistance medical care;

(5) Cooperate with other agencies including any agency of the United States or of another state in all matters concerning the powers and duties of the commissioner under sections 256D.01 to 256D.21;

(6) Cooperate to the fullest extent with other public agencies empowered by law to provide vocational training, rehabilitation, or similar services;

(7) Gather and study current information and report at least annually to the governor on the nature and need for general assistance and general assistance medical care, the amounts expended under the supervision of each county agency, and the activities of each county agency and publish such reports for the information of the public;

(8) Specify requirements for general assistance and general assistance medical care reports, including fiscal reports, according to section 256.01, subdivision 2, paragraph (17); and

(9) Ensure that every notice of eligibility for general assistance includes a notice that women who are pregnant may be eligible for medical assistance benefits.

History: *1973 c 650 art 21 s 4; 1977 c 301 s 3; 1980 c 536 s 11; 1981 c 360 art 2 s 35; 1982 c 424 s 130; 1987 c 384 art 2 s 1; 1988 c 719 art 8 s 20; 1989 c 89 s 12; 1990 c 422 s 10; 1990 c 568 art 4 s 84; 1991 c 272 s 1; 1Sp1993 c 1 art 6 s 29; 1995 c 178 art 6 s 17; 1997 c 7 art 2 s 45*

256D.045 SOCIAL SECURITY NUMBER REQUIRED.

To be eligible for general assistance under sections 256D.01 to 256D.21, an individual must provide the individual's Social Security number to the county agency or submit proof that an application has been made. An individual who refuses to provide a Social Security number because of a well-established religious objection as described in Code of Federal Regulations, title 42, section 435.910, may be eligible for general assistance medical care under section 256D.03. The provisions of this section do not apply to the determination of eligibility for emergency general assistance under section 256D.06, subdivision 2. This provision applies to eligible children under the age of 18 effective July 1, 1997.

History: *1995 c 178 art 2 s 29; 1996 c 451 art 2 s 39; 1Sp2005 c 4 art 8 s 54; 2009 c 173 art 3 s 21*

256D.05 ELIGIBILITY FOR GENERAL ASSISTANCE.

Subdivision 1. **Eligibility.** (a) Each assistance unit with income and resources less than the standard of assistance established by the commissioner and with a member who is a resident of the state shall be eligible for and entitled to general assistance if the assistance unit is:

(1) a person who is suffering from a professionally certified permanent or temporary illness, injury, or incapacity which is expected to continue for more than 30 days and which prevents the person from obtaining or retaining employment;

(2) a person whose presence in the home on a substantially continuous basis is required because of the professionally certified illness, injury, incapacity, or the age of another member of the household;

(3) a person who has been placed in, and is residing in, a licensed or certified facility for purposes of physical or mental health or rehabilitation, or in an approved chemical dependency domiciliary facility, if the placement is based on illness or incapacity and is according to a plan developed or approved by the county agency through its director or designated representative;

(4) a person who resides in a shelter facility described in subdivision 3;

(5) a person not described in clause (1) or (3) who is diagnosed by a licensed physician, psychological practitioner, or other qualified professional, as developmentally disabled or mentally ill, and that condition prevents the person from obtaining or retaining employment;

(6) a person who has an application pending for, or is appealing termination of benefits from, the Social Security disability program or the program of supplemental security income for the aged, blind, and disabled, provided the person has a professionally certified permanent or temporary illness, injury, or incapacity which is expected to continue for more than 30 days and which prevents the person from obtaining or retaining employment;

(7) a person who is unable to obtain or retain employment because advanced age significantly affects the person's ability to seek or engage in substantial work;

(8) a person who has been assessed by a vocational specialist and, in consultation with the county agency, has been determined to be unemployable for purposes of this clause; a person is considered employable if there exist positions of employment in the local labor market, regardless of the current availability of openings for those positions, that the person is capable of performing. The person's eligibility under this category must be reassessed at least annually. The county agency must provide notice to the person not later than 30 days before annual eligibility under this item ends, informing the person of the date annual eligibility will end and the need for vocational assessment if the person wishes to continue eligibility under this clause. For purposes of establishing eligibility under this clause, it is the applicant's or recipient's duty to obtain any needed vocational assessment;

(9) a person who is determined by the county agency, according to permanent rules adopted by the commissioner, to be learning disabled, provided that if a rehabilitation plan for the person is developed or approved by the county agency, the person is following the plan;

(10) a child under the age of 18 who is not living with a parent, stepparent, or legal custodian, and only if: the child is legally emancipated or living with an adult with the consent of an agency acting as a legal custodian; the child is at least 16 years of age and the general assistance grant is approved by the director of the county agency or a designated representative as a component of a social services case plan for the child; or the child is living with an adult with the consent of the child's legal custodian and the county agency. For purposes of this clause, "legally emancipated" means a person under the age of 18 years who: (i) has been married; (ii) is on active duty in the uniformed services of the United States; (iii) has been emancipated by a court of competent jurisdiction; or (iv) is otherwise considered emancipated under Minnesota law, and for whom county social services has not determined that a social services case plan is necessary, for reasons other than the child has failed or refuses to cooperate with the county agency in developing the plan;

(11) a person who is eligible for displaced homemaker services, programs, or assistance under section 116L.96, but only if that person is enrolled as a full-time student;

(12) a person who lives more than four hours round-trip traveling time from any potential suitable employment;

(13) a person who is involved with protective or court-ordered services that prevent the applicant or recipient from working at least four hours per day;

(14) a person over age 18 whose primary language is not English and who is attending high school at least half time; or

(15) a person whose alcohol and drug addiction is a material factor that contributes to the person's disability; applicants who assert this clause as a basis for eligibility must be assessed by the county agency to determine if they are amenable to treatment; if the applicant is determined to be not amenable to treatment, but is otherwise eligible for benefits, then general assistance must

be paid in vendor form, for the individual's shelter costs up to the limit of the grant amount, with the residual, if any, paid according to section 256D.09, subdivision 2a; if the applicant is determined to be amenable to treatment, then in order to receive benefits, the applicant must be in a treatment program or on a waiting list and the benefits must be paid in vendor form, for the individual's shelter costs, up to the limit of the grant amount, with the residual, if any, paid according to section 256D.09, subdivision 2a.

(b) As a condition of eligibility under paragraph (a), clauses (1), (3), (5), (8), and (9), the recipient must complete an interim assistance agreement and must apply for other maintenance benefits as specified in section 256D.06, subdivision 5, and must comply with efforts to determine the recipient's eligibility for those other maintenance benefits.

(c) The burden of providing documentation for a county agency to use to verify eligibility for general assistance or for exemption from the food stamp employment and training program is upon the applicant or recipient. The county agency shall use documents already in its possession to verify eligibility, and shall help the applicant or recipient obtain other existing verification necessary to determine eligibility which the applicant or recipient does not have and is unable to obtain.

Subd. 1a. [Repealed, 1983 c 312 art 8 s 17]

Subd. 2. **Use of federal funds.** Effective March 31, 1998, notwithstanding any law to the contrary, if a single adult or childless couple otherwise eligible for general assistance would, but for state statutory restriction or limitation, be eligible for a federally aided assistance program providing benefits equal to or greater than those of general assistance, the single adult or childless couple shall be eligible for that federally aided program and ineligible for general assistance; provided, however, that (a) nothing in this section shall be construed to extend eligibility for federally aided programs to persons not otherwise eligible for general assistance; (b) this section shall not be effective to the extent that federal law or regulation require new eligibility for federal programs to persons not otherwise eligible for general assistance; and (c) nothing in this section shall deny general assistance to a person otherwise eligible who is determined ineligible for a substitute federally aided program.

Subd. 3. [Repealed, 1999 c 216 art 6 s 26]

Subd. 3a. [Repealed, 1999 c 216 art 6 s 26]

Subd. 4. **Consent to review records.** No person shall be eligible for general assistance medical care unless the person has authorized the commissioner of human services in writing to examine all personal medical records developed while receiving general assistance for the purpose of investigating whether or not a vendor has submitted a claim for reimbursement, a cost report or a rate application which the vendor knows to be false in whole or in part, or in order to determine whether or not the medical care provided was medically necessary. The vendor of medical care shall receive notification from the commissioner at least 24 hours before the commissioner gains access to such records. A vendor of medical care shall require presentation of this authorization before the state agency can obtain access to such records unless the vendor already has received written authorization. Notwithstanding any other law to the contrary, a vendor of medical care shall not be subject to any civil or criminal liability for providing access to medical records to the commissioner pursuant to this subdivision.

Subd. 5. **Transfers of property.** The equity value of real and personal property transferred without reasonable compensation within 12 months preceding the date of application for general

assistance must be included in determining the resources of an assistance unit in the same manner as in the Minnesota family investment program under chapter 256J.

Subd. 6. **Assistance for persons without a verified residence.** (a) For applicants or recipients of general assistance or emergency general assistance who do not have a verified residence address, the county agency may provide assistance using one or more of the following methods:

(1) the county agency may provide assistance in the form of vouchers or vendor payments and provide separate vouchers or vendor payments for food, shelter, and other needs;

(2) the county agency may divide the monthly assistance standard into weekly payments, whether in cash or by voucher or vendor payment. Nothing in this clause prevents the county agency from issuing voucher or vendor payments for emergency general assistance in an amount less than the standards of assistance;

(3) the county agency may determine eligibility and provide assistance on a weekly basis. Weekly assistance can be issued in cash or by voucher or vendor payment and can be determined either on the basis of actual need or by prorating the monthly assistance standard; and

(4) for the purposes of clauses (2) and (3), the county agency may divide the monthly assistance standard as follows: $50 per week for each of the first three weeks, and the remainder for the fourth week.

(b) An individual may verify a residence address by providing a driver's license; a state identification card; a statement by the landlord, apartment manager, or homeowner verifying that the individual is residing at the address; or other written documentation approved by the commissioner.

(c) Notwithstanding the provisions of section 256D.06, subdivision 1, if the county agency elects to provide assistance on a weekly payment basis, the agency may not provide assistance for a period during which no need is claimed by the individual unless the individual has good cause for failing to claim need. The individual must be notified, each time weekly assistance is provided, that subsequent weekly assistance will not be issued unless the individual claims need. The advance notice required under section 256D.10 does not apply to weekly assistance that is withheld because the individual failed to claim need without good cause.

(d) The county agency may not issue assistance on a weekly basis to an applicant or recipient who has a professionally certified mental illness or developmental disability, or to an assistance unit that includes minor children, unless requested by the assistance unit.

Subd. 7. **Ineligibility for general assistance.** No single adult or childless couple shall be eligible for general assistance during a period of disqualification because of sanctions.

Subd. 8. **Citizenship.** (a) Effective July 1, 1997, citizenship requirements for applicants and recipients under sections 256D.01 to 256D.03, subdivision 2, and 256D.04 to 256D.21 shall be determined the same as under section 256J.11. The income and assets of sponsors of noncitizens shall be deemed available to general assistance applicants and recipients according to the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Public Law 104-193, title IV, sections 421 and 422, and subsequently set out in federal rules.

(b) As a condition of eligibility, each legal adult noncitizen in the assistance unit who has resided in the country for four years or more and who is under 70 years of age must:

(1) be enrolled in a literacy class, English as a second language class, or a citizen class;

(2) be applying for admission to a literacy class, English as a second language class, and is on a waiting list;

(3) be in the process of applying for a waiver from the United States Citizenship and Immigration Services of the English language or civics requirements of the citizenship test;

(4) have submitted an application for citizenship to the United States Citizenship and Immigration Services and is waiting for a testing date or a subsequent swearing in ceremony; or

(5) have been denied citizenship due to a failure to pass the test after two attempts or because of an inability to understand the rights and responsibilities of becoming a United States citizen, as documented by the United States Citizenship and Immigration Services or the county.

If the county social service agency determines that a legal noncitizen subject to the requirements of this subdivision will require more than one year of English language training, then the requirements of clause (1) or (2) shall be imposed after the legal noncitizen has resided in the country for three years. Individuals who reside in a facility licensed under chapter 144A, 144D, 245A, or 256I are exempt from the requirements of this section.

History: *1973 c 650 art 21 s 5; 1974 c 297 s 2; 1977 c 428 s 7; 1980 c 349 s 10; 1980 c 544 s 1; 1981 c 360 art 2 s 36,54; 1Sp1981 c 4 art 4 s 22,23; 1982 c 633 s 8,9; 1983 c 312 art 1 s 27; 1984 c 654 art 5 s 58; 1Sp1985 c 9 art 2 s 59; 1Sp1985 c 14 art 9 s 75; 1986 c 444; 1987 c 270 s 2; 1987 c 384 art 3 s 5; 1987 c 403 art 2 s 106; art 3 s 31; 1989 c 282 art 5 s 50,51; 1990 c 568 art 4 s 84; 1990 c 611 s 3; 1991 c 255 s 19; 1991 c 292 art 5 s 32-35; 1992 c 513 art 8 s 18; 1Sp1993 c 1 art 6 s 30; 1995 c 178 art 2 s 30; art 6 s 1,17; 1995 c 207 art 5 s 7; 1996 c 465 art 3 s 32; 1997 c 85 art 3 s 30-34; 1997 c 203 art 12 s 5,6; 1998 c 407 art 6 s 14; 1999 c 159 s 58-60; 2004 c 206 s 52; 2005 c 56 s 1; 2007 c 13 art 1 s 25*

256D.051 FOOD STAMP EMPLOYMENT AND TRAINING PROGRAM.

Subdivision 1. **Food stamp employment and training program.** The commissioner shall implement a food stamp employment and training program in order to meet the food stamp employment and training participation requirements of the United States Department of Agriculture. Unless exempt under subdivision 3a, each adult recipient in the unit must participate in the food stamp employment and training program each month that the person is eligible for food stamps. The person's participation in food stamp employment and training services must begin no later than the first day of the calendar month following the determination of eligibility for food stamps. With the county agency's consent, and to the extent of available resources, the person may voluntarily continue to participate in food stamp employment and training services for up to three additional consecutive months immediately following termination of food stamp benefits in order to complete the provisions of the person's employability development plan.

Subd. 1a. **Notices and sanctions.** (a) At the time the county agency notifies the household that it is eligible for food stamps, the county agency must inform all mandatory employment and training services participants as identified in subdivision 1 in the household that they must comply with all food stamp employment and training program requirements each month, including the requirement to attend an initial orientation to the food stamp employment and training program and that food stamp eligibility will end unless the participants comply with the requirements specified in the notice.

(b) A participant who fails without good cause to comply with food stamp employment and training program requirements of this section, including attendance at orientation, will lose food stamp eligibility for the following periods:

(1) for the first occurrence, for one month or until the person complies with the requirements not previously complied with, whichever is longer;

(2) for the second occurrence, for three months or until the person complies with the requirements not previously complied with, whichever is longer; or

(3) for the third and any subsequent occurrence, for six months or until the person complies with the requirements not previously complied with, whichever is longer.

If the participant is not the food stamp head of household, the person shall be considered an ineligible household member for food stamp purposes. If the participant is the food stamp head of household, the entire household is ineligible for food stamps as provided in Code of Federal Regulations, title 7, section 273.7(g). "Good cause" means circumstances beyond the control of the participant, such as illness or injury, illness or injury of another household member requiring the participant's presence, a household emergency, or the inability to obtain child care for children between the ages of six and 12 or to obtain transportation needed in order for the participant to meet the food stamp employment and training program participation requirements.

(c) The county agency shall mail or hand deliver a notice to the participant not later than five days after determining that the participant has failed without good cause to comply with food stamp employment and training program requirements which specifies the requirements that were not complied with, the factual basis for the determination of noncompliance, and the right to reinstate eligibility upon a showing of good cause for failure to meet the requirements. The notice must ask the reason for the noncompliance and identify the participant's appeal rights. The notice must request that the participant inform the county agency if the participant believes that good cause existed for the failure to comply and must state that the county agency intends to terminate eligibility for food stamp benefits due to failure to comply with food stamp employment and training program requirements.

(d) If the county agency determines that the participant did not comply during the month with all food stamp employment and training program requirements that were in effect, and if the county agency determines that good cause was not present, the county must provide a ten-day notice of termination of food stamp benefits. The amount of food stamps that are withheld from the household and determination of the impact of the sanction on other household members is governed by Code of Federal Regulations, title 7, section 273.7.

(e) The participant may appeal the termination of food stamp benefits under the provisions of section 256.045.

Subd. 1b. [Repealed, 1991 c 292 art 5 s 82]

Subd. 2. **County agency duties.** (a) The county agency shall provide to food stamp recipients a food stamp employment and training program. The program must include:

(1) orientation to the food stamp employment and training program;

(2) an individualized employability assessment and an individualized employability development plan that includes assessment of literacy, ability to communicate in the English language, educational and employment history, and that estimates the length of time it will take the participant to obtain employment. The employability assessment and development plan must be completed in consultation with the participant, must assess the participant's assets, barriers, and strengths, and must identify steps necessary to overcome barriers to employment. A copy of the employability development plan must be provided to the registrant;

(3) referral to available accredited remedial or skills training programs designed to address participant's barriers to employment;

(4) referral to available programs that provide subsidized or unsubsidized employment as necessary;

(5) a job search program, including job seeking skills training; and

(6) other activities, to the extent of available resources designed by the county agency to prepare the participant for permanent employment.

In order to allow time for job search, the county agency may not require an individual to participate in the food stamp employment and training program for more than 32 hours a week. The county agency shall require an individual to spend at least eight hours a week in job search or other food stamp employment and training program activities.

(b) The county agency shall prepare an annual plan for the operation of its food stamp employment and training program. The plan must be submitted to and approved by the commissioner of employment and economic development. The plan must include:

(1) a description of the services to be offered by the county agency;

(2) a plan to coordinate the activities of all public entities providing employment-related services in order to avoid duplication of effort and to provide services more efficiently;

(3) a description of the factors that will be taken into account when determining a client's employability development plan; and

(4) provisions to ensure that the county agency's employment and training service provider provides each recipient with an orientation, employability assessment, and employability development plan as specified in paragraph (a), clauses (1) and (2), within 30 days of the recipient's eligibility for assistance.

Subd. 2a. **Duties of commissioner.** In addition to any other duties imposed by law, the commissioner shall:

(1) based on this section and section 256D.052 and Code of Federal Regulations, title 7, section 273.7, supervise the administration of food stamp employment and training services to county agencies;

(2) disburse money appropriated for food stamp employment and training services to county agencies based upon the county's costs as specified in section 256D.051, subdivision 6c;

(3) accept and supervise the disbursement of any funds that may be provided by the federal government or from other sources for use in this state for food stamp employment and training services;

(4) cooperate with other agencies including any agency of the United States or of another state in all matters concerning the powers and duties of the commissioner under this section and section 256D.052; and

(5) in cooperation with the commissioner of employment and economic development, ensure that each component of an employment and training program carried out under this section is delivered through a statewide workforce development system, unless the component is not available locally through such a system.

Subd. 3. **Participant duties.** In order to receive food stamp assistance, a registrant shall: (1) cooperate with the county agency in all aspects of the food stamp employment and training

program; (2) accept any suitable employment, including employment offered through the Job Training Partnership Act, and other employment and training options; and (3) participate in food stamp employment and training activities assigned by the county agency. The county agency may terminate assistance to a registrant who fails to cooperate in the food stamp employment and training program, as provided in subdivision 1a.

Subd. 3a. **Requirement to register work.** (a) To the extent required under Code of Federal Regulations, title 7, section 273.7(a), each applicant for and recipient of food stamps is required to register for work as a condition of eligibility for food stamp benefits. Applicants and recipients are registered by signing an application or annual reapplication for food stamps, and must be informed that they are registering for work by signing the form.

(b) The commissioner shall determine, within federal requirements, persons required to participate in the food stamp employment and training (FSET) program.

(c) The following food stamp recipients are exempt from mandatory participation in food stamp employment and training services:

(1) recipients of benefits under the Minnesota family investment program, Minnesota supplemental aid program, or the general assistance program;

(2) a child;

(3) a recipient over age 55;

(4) a recipient who has a mental or physical illness, injury, or incapacity which is expected to continue for at least 30 days and which impairs the recipient's ability to obtain or retain employment as evidenced by professional certification or the receipt of temporary or permanent disability benefits issued by a private or government source;

(5) a parent or other household member responsible for the care of either a dependent child in the household who is under age six or a person in the household who is professionally certified as having a physical or mental illness, injury, or incapacity. Only one parent or other household member may claim exemption under this provision;

(6) a recipient receiving unemployment insurance or who has applied for unemployment insurance and has been required to register for work with the Department of Employment and Economic Development as part of the unemployment insurance application process;

(7) a recipient participating each week in a drug addiction or alcohol abuse treatment and rehabilitation program, provided the operators of the treatment and rehabilitation program, in consultation with the county agency, recommend that the recipient not participate in the food stamp employment and training program;

(8) a recipient employed or self-employed for 30 or more hours per week at employment paying at least minimum wage, or who earns wages from employment equal to or exceeding 30 hours multiplied by the federal minimum wage; or

(9) a student enrolled at least half time in any school, training program, or institution of higher education. When determining if a student meets this criteria, the school's, program's or institution's criteria for being enrolled half time shall be used.

Subd. 3b. **Orientation.** The county agency or its employment and training service provider must provide an orientation to food stamp employment and training services to each nonexempt food stamp recipient within 30 days of the date that food stamp eligibility is determined. The orientation must inform the participant of the requirement to participate in services, the date,

time, and address to report to for services, the name and telephone number of the food stamp employment and training service provider, the consequences for failure without good cause to comply, the services and support services available through food stamp employment and training services and other providers of similar services, and must encourage the participant to view the food stamp program as a temporary means of supplementing the family's food needs until the family achieves self-sufficiency through employment. The orientation may be provided through audio-visual methods, but the participant must have the opportunity for face-to-face interaction with county agency staff.

Subd. 3c. [Repealed, 1991 c 292 art 5 s 82]

Subd. 4. [Repealed, 1987 c 403 art 2 s 164]

Subd. 5. [Repealed, 1987 c 403 art 2 s 164]

Subd. 6. [Repealed, 1999 c 245 art 6 s 89]

Subd. 6a. [Repealed, 1Sp1989 c 1 art 16 s 20 subd 3]

Subd. 6b. **Federal reimbursement.** Federal financial participation from the United States Department of Agriculture for food stamp employment and training expenditures that are eligible for reimbursement through the food stamp employment and training program are dedicated funds and are annually appropriated to the commissioner of human services for the operation of the food stamp employment and training program. Federal financial participation for the nonstate portion of food stamp employment and training costs must be paid to the county agency that incurred the costs.

Subd. 6c. **Program funding.** Within the limits of available resources, the commissioner shall reimburse the actual costs of county agencies and their employment and training service providers for the provision of food stamp employment and training services, including participant support services, direct program services, and program administrative activities. The cost of services for each county's food stamp employment and training program shall not exceed the annual allocated amount. No more than 15 percent of program funds may be used for administrative activities. The county agency may expend county funds in excess of the limits of this subdivision without state reimbursement.

Program funds shall be allocated based on the county's average number of food stamp cases as compared to the statewide total number of such cases. The average number of cases shall be based on counts of cases as of March 31, June 30, September 30, and December 31 of the previous calendar year. The commissioner may reallocate unexpended money appropriated under this section to those county agencies that demonstrate a need for additional funds.

Subd. 7. **Registrant status.** A registrant under this section is not an employee for the purposes of workers' compensation, unemployment benefits, retirement, or civil service laws, and shall not perform work ordinarily performed by a regular public employee.

Subd. 8. **Voluntary quit.** A person who is required to participate in food stamp employment and training services is not eligible for food stamps if, without good cause, the person refuses a legitimate offer of, or quits, suitable employment within 60 days before the date of application. A person who is required to participate in food stamp employment and training services and, without good cause, voluntarily quits suitable employment or refuses a legitimate offer of suitable employment while receiving food stamps shall be terminated from the food stamp program as specified in subdivision 1a.

Subd. 9. **Subcontractors.** A county agency may, at its option, subcontract any or all of the duties under this section to a public or private entity approved by the commissioner of employment and economic development.

Subd. 10. [Repealed, 1995 c 178 art 6 s 18]

Subd. 11. [Repealed, 1987 c 403 art 2 s 164]

Subd. 12. [Repealed, 1987 c 403 art 2 s 164]

Subd. 13. [Repealed, 1995 c 178 art 6 s 18]

Subd. 14. [Repealed, 1995 c 178 art 6 s 18]

Subd. 15. [Repealed, 1995 c 178 art 6 s 18]

Subd. 16. [Repealed, 1991 c 292 art 5 s 82]

Subd. 17. [Repealed, 2004 c 288 art 4 s 62]

Subd. 18. **Work experience placements.** (a) To the extent of available resources, each county agency must establish and operate a work experience component in the food stamp employment and training program for recipients who are subject to a federal limit of three months of food stamp eligibility in any 36-month period. The purpose of the work experience component is to enhance the participant's employability, self-sufficiency, and to provide meaningful, productive work activities.

(b) The commissioner shall assist counties in the design and implementation of these components. The commissioner must ensure that job placements under a work experience component comply with section 256J.72. Written or oral concurrence with job duties of persons placed under the community work experience program shall be obtained from the appropriate exclusive bargaining representative.

(c) Worksites developed under this section are limited to projects that serve a useful public service such as health, social service, environmental protection, education, urban and rural development and redevelopment, welfare, recreation, public facilities, public safety, community service, services to aged or disabled citizens, and child care. To the extent possible, the prior training, skills, and experience of a recipient must be used in making appropriate work experience assignments.

(d) Structured, supervised volunteer work with an agency or organization that is monitored by the county service provider may, with the approval of the county agency, be used as a work experience placement.

(e) As a condition of placing a person receiving food stamps in a program under this subdivision, the county agency shall first provide the recipient the opportunity:

(1) for placement in suitable subsidized or unsubsidized employment through participation in job search under section 256D.051; or

(2) for placement in suitable employment through participation in on-the-job training, if such employment is available.

(f) The county agency shall limit the maximum monthly number of hours that any participant may work in a work experience placement to a number equal to the amount of the family's monthly food stamp allotment divided by the greater of the federal minimum wage or the applicable state minimum wage.

After a participant has been assigned to a position for nine months, the participant may not continue in that assignment unless the maximum number of hours a participant works is no greater than the amount of the food stamp benefit divided by the rate of pay for individuals employed in the same or similar occupations by the same employer at the same site.

(g) The participant's employability development plan must include the length of time needed in the work experience program, the need to continue job seeking activities while participating in work experience, and the participant's employment goals.

(h) After each six months of a recipient's participation in a work experience job placement, and at the conclusion of each work experience assignment under this section, the county agency shall reassess and revise, as appropriate, the participant's employability development plan.

(i) A participant has good cause for failure to cooperate with a work experience job placement if, in the judgment of the employment and training service provider, the reason for failure is reasonable and justified. Good cause for purposes of this section is defined in subdivision 1a, paragraph (b).

(j) A recipient who has failed without good cause to participate in or comply with the work experience job placement shall be terminated from participation in work experience job activities. If the recipient is not exempt from mandatory food stamp employment and training program participation under subdivision 3a, the recipient will be assigned to other mandatory program activities. If the recipient is exempt from mandatory participation but is participating as a volunteer, the person shall be terminated from the food stamp employment and training program.

Subd. 19. [Repealed, 1999 c 245 art 6 s 89]

History: *1Sp1985 c 9 art 2 s 60; 1Sp1985 c 14 art 9 s 75; 1986 c 444; 1987 c 403 art 3 s 33-37; 1989 c 282 art 5 s 52-65,133; 1Sp1989 c 1 art 16 s 12,22; 1990 c 568 art 4 s 26-30,84; 1991 c 292 art 5 s 36-42; 1992 c 513 art 8 s 19,20; 1Sp1993 c 1 art 6 s 31,32; 1Sp1993 c 6 s 15; 1994 c 483 s 1; 1995 c 178 art 6 s 2-13,17; 1996 c 465 art 3 s 33,34; 1997 c 66 s 80; 1997 c 85 art 3 s 35-38; 1998 c 407 art 6 s 15; 1999 c 107 s 66; 1999 c 159 s 61; 1999 c 245 art 6 s 1,2; 2000 c 343 s 4; 2004 c 206 s 52; 2004 c 288 art 4 s 27; 2005 c 159 art 5 s 4*

256D.0511 [Repealed, 1997 c 85 art 3 s 56]

256D.0512 FEDERAL WAIVER.

The commissioner shall exercise the authority granted by Public Law 104-193, title VIII, section 824, and request the Secretary of the United States Department of Agriculture to grant waivers of the federal food stamp work requirements of section 824, for every county and reservation in which:

(1) the county or reservation has an unemployment rate over ten percent; or

(2) the county or reservation does not have a sufficient number of jobs to provide employment for individuals.

History: *1997 c 85 art 3 s 39*

256D.0513 BUDGETING LUMP SUMS.

Effective January 1, 1998, nonrecurring lump-sum income received by a recipient of general assistance must be budgeted in the normal retrospective cycle.

History: *1997 c 85 art 3 s 40*

256D.0515 ASSET LIMITATIONS FOR FOOD STAMP HOUSEHOLDS.

All food stamp households must be determined eligible for the benefit discussed under section 256.029. Food stamp households must demonstrate that their gross income is equal to or less than 165 percent of the federal poverty guidelines for the same family size.

History: *2006 c 282 art 22 s 8; 1Sp2010 c 1 art 18 s 1*

NOTE: This section, as added by Laws 2006, chapter 282, article 22, section 8, is effective upon federal approval. Laws 2006, chapter 282, article 22, section 8, the effective date.

256D.0516 EXPIRATION OF FOOD SUPPORT BENEFITS AND REPORTING REQUIREMENTS.

Subdivision 1. **Expiration of food support benefits.** Food support benefits shall not be stored off line or expunged from a recipient's account unless the benefits have not been accessed for 12 months after the month they were issued.

Subd. 2. **Food support reporting requirements.** The commissioner of human services shall implement simplified reporting as permitted under the Food Stamp Act of 1977, as amended, and the food stamp regulations in Code of Federal Regulations, title 7, part 273. Food support recipient households required to report periodically shall not be required to report more often than one time every six months. This provision shall not apply to households receiving food benefits under the Minnesota family investment program waiver.

History: *2007 c 147 art 2 s 21*

256D.052 LITERACY TRAINING FOR RECIPIENTS.

Subdivision 1. [Repealed, 1995 c 178 art 6 s 18]

Subd. 2. [Repealed, 1995 c 178 art 6 s 18]

Subd. 3. **Participant literacy transportation costs.** Within the limits of the state appropriation the county agency must provide transportation to enable food stamp employment and training participants to participate in literacy training under this section. The state shall reimburse county agencies for the costs of providing transportation under this section up to the amount of the state appropriation. Counties must make every effort to ensure that child care is available as needed by recipients who are pursuing literacy training.

Subd. 4. [Repealed, 1995 c 178 art 6 s 18]

Subd. 5. [Repealed, 1989 c 282 art 5 s 133 subd 3; 1Sp1989 c 1 art 16 s 20]

Subd. 6. [Repealed, 1989 c 282 art 5 s 133 subd 3; 1Sp1989 c 1 art 16 s 20]

Subd. 7. [Repealed, 1989 c 282 art 5 s 133 subd 3; 1Sp1989 c 1 art 16 s 20]

History: *1987 c 403 art 3 s 32; 1989 c 246 s 2; 1989 c 282 art 5 s 66-69; 1990 c 568 art 4 s 31,84; 1991 c 292 art 5 s 43,44; 1995 c 178 art 6 s 14*

256D.053 MINNESOTA FOOD ASSISTANCE PROGRAM.

Subdivision 1. **Program established.** The Minnesota food assistance program is established to provide food assistance to legal noncitizens residing in this state who are ineligible to participate in the federal Food Stamp Program solely due to the provisions of section 402 or 403 of Public Law 104-193, as authorized by Title VII of the 1997 Emergency Supplemental

Appropriations Act, Public Law 105-18, and as amended by Public Law 105-185.

Beginning July 1, 2003, the Minnesota food assistance program is limited to those noncitizens described in this subdivision who are 50 years of age or older.

Subd. 2. **Eligibility requirements.** To be eligible for the Minnesota food assistance program, all of the following conditions must be met:

(1) the applicant must meet the initial and ongoing eligibility requirements for the federal Food Stamp Program, except for the applicant's ineligible immigration status;

(2) the applicant must be either a qualified noncitizen as defined in section 256J.08, subdivision 73, or a noncitizen otherwise residing lawfully in the United States;

(3) the applicant must be a resident of the state; and

(4) the applicant must not be receiving assistance under the MFIP or the work first program.

Subd. 3. **Program administration.** (a) The rules for the Minnesota food assistance program shall follow exactly the regulations for the federal Food Stamp Program, except for the provisions pertaining to immigration status under section 402 or 403 of Public Law 104-193.

(b) The county agency shall use the income, budgeting, and benefit allotment regulations of the federal Food Stamp Program to calculate an eligible recipient's monthly Minnesota food assistance program benefit. Until September 30, 1998, eligible recipients under this subdivision shall receive the average per person food stamp issuance in Minnesota in the fiscal year ending June 30, 1997. Beginning October 1, 1998, eligible recipients shall receive the same level of benefits as those provided by the federal Food Stamp Program to similarly situated citizen recipients. The monthly Minnesota food assistance program benefits shall not exceed an amount equal to the amount of federal Food Stamp Program benefits the household would receive if all members of the household were eligible for the federal Food Stamp Program.

(c) Minnesota food assistance program benefits must be disregarded as income in all programs that do not count food stamps as income.

(d) The county agency must redetermine a Minnesota food assistance program recipient's eligibility for the federal Food Stamp Program when the agency receives information that the recipient's legal immigration status has changed in such a way that would make the recipient potentially eligible for the federal Food Stamp Program.

(e) Until October 1, 1998, the commissioner may provide benefits under this section in cash.

Subd. 4. [Repealed, 1999 c 245 art 6 s 89]

History: *1998 c 407 art 6 s 16; 1999 c 245 art 6 s 3; 2000 c 488 art 10 s 5; 1Sp2001 c 9 art 10 s 3,66; 2002 c 379 art 1 s 113*

256D.055 COUNTY DESIGN; WORK FOCUSED PROGRAM.

The commissioner of human services shall issue a request for proposals from counties to submit a plan for developing and implementing a county-designed program. The plan shall be for first-time applicants for the Minnesota family investment program and must emphasize the importance of becoming employed and oriented into the work force in order to become self-sufficient. The plan must target public assistance applicants who are most likely to become self-sufficient quickly with short-term assistance or services such as child care, child support enforcement, or employment and training services.

The plan may include vendor payments, mandatory job search, refocusing existing county or provider efforts, or other program features. The commissioner may approve a county plan which allows a county to use other program funding for the county work focus program in a more flexible manner. Nothing in this section shall allow payments made to the public assistance applicant to be less than the amount the applicant would have received if the program had not been implemented, or reduce or eliminate a category of eligible participants from the program without legislative approval.

If the plan is approved by the commissioner, the county may implement the plan.

History: *1995 c 178 art 2 s 32; 1996 c 465 art 3 s 35; 1997 c 85 art 3 s 41; 1999 c 159 s 62*

256D.057 [Repealed, 3Sp1997 c 1 s 3]

256D.06 AMOUNT OF ASSISTANCE.

Subdivision 1. **Eligibility; amount of assistance.** General assistance shall be granted in an amount that when added to the nonexempt income actually available to the assistance unit, the total amount equals the applicable standard of assistance for general assistance. In determining eligibility for and the amount of assistance for an individual or married couple, the county agency shall disregard the first $50 of earned income per month.

Subd. 1a. [Repealed, 1983 c 312 art 8 s 17]

Subd. 1b. **Earned income savings account.** In addition to the $50 disregard required under subdivision 1, the county agency shall disregard an additional earned income up to a maximum of $150 per month for: (1) persons residing in facilities licensed under Minnesota Rules, parts 9520.0500 to 9520.0690 and 9530.2500 to 9530.4000, and for whom discharge and work are part of a treatment plan; (2) persons living in supervised apartments with services funded under Minnesota Rules, parts 9535.0100 to 9535.1600, and for whom discharge and work are part of a treatment plan; and (3) persons residing in group residential housing, as that term is defined in section 256I.03, subdivision 3, for whom the county agency has approved a discharge plan which includes work. The additional amount disregarded must be placed in a separate savings account by the eligible individual, to be used upon discharge from the residential facility into the community. For individuals residing in a chemical dependency program licensed under Minnesota Rules, part 9530.4100, subpart 22, item D, withdrawals from the savings account require the signature of the individual and for those individuals with an authorized representative payee, the signature of the payee. A maximum of $1,000, including interest, of the money in the savings account must be excluded from the resource limits established by section 256D.08, subdivision 1, clause (1). Amounts in that account in excess of $1,000 must be applied to the resident's cost of care. If excluded money is removed from the savings account by the eligible individual at any time before the individual is discharged from the facility into the community, the money is income to the individual in the month of receipt and a resource in subsequent months. If an eligible individual moves from a community facility to an inpatient hospital setting, the separate savings account is an excluded asset for up to 18 months. During that time, amounts that accumulate in excess of the $1,000 savings limit must be applied to the patient's cost of care. If the patient continues to be hospitalized at the conclusion of the 18-month period, the entire account must be applied to the patient's cost of care.

Subd. 1c. [Repealed, 1990 c 568 art 4 s 85]

Subd. 2. **Emergency need.** Notwithstanding the provisions of subdivision 1, a grant of

emergency general assistance shall, to the extent funds are available, be made to an eligible single adult, married couple, or family for an emergency need, as defined in rules promulgated by the commissioner, where the recipient requests temporary assistance not exceeding 30 days if an emergency situation appears to exist and the individual or family is ineligible for MFIP or DWP or is not a participant of MFIP or DWP. If an applicant or recipient relates facts to the county agency which may be sufficient to constitute an emergency situation, the county agency shall, to the extent funds are available, advise the person of the procedure for applying for assistance according to this subdivision. An emergency general assistance grant is available to a recipient not more than once in any 12-month period. Funding for an emergency general assistance program is limited to the appropriation. Each fiscal year, the commissioner shall allocate to counties the money appropriated for emergency general assistance grants based on each county agency's average share of state's emergency general expenditures for the immediate past three fiscal years as determined by the commissioner, and may reallocate any unspent amounts to other counties. Any emergency general assistance expenditures by a county above the amount of the commissioner's allocation to the county must be made from county funds.

Subd. 3. [Repealed, 1989 c 282 art 5 s 133; 1Sp1989 c 1 art 16 s 20]

Subd. 4. [Repealed, 1989 c 282 art 5 s 133; 1Sp1989 c 1 art 16 s 20]

Subd. 5. **Eligibility; requirements.** (a) Any applicant, otherwise eligible for general assistance and possibly eligible for maintenance benefits from any other source shall (1) make application for those benefits within 30 days of the general assistance application; and (2) execute an interim assistance agreement on a form as directed by the commissioner.

(b) The commissioner shall review a denial of an application for other maintenance benefits and may require a recipient of general assistance to file an appeal of the denial if appropriate. If found eligible for benefits from other sources, and a payment received from another source relates to the period during which general assistance was also being received, the recipient shall be required to reimburse the county agency for the interim assistance paid. Reimbursement shall not exceed the amount of general assistance paid during the time period to which the other maintenance benefits apply and shall not exceed the state standard applicable to that time period.

(c) The commissioner may contract with the county agencies, qualified agencies, organizations, or persons to provide advocacy and support services to process claims for federal disability benefits for applicants or recipients of services or benefits supervised by the commissioner using money retained under this section.

(d) The commissioner may provide methods by which county agencies shall identify, refer, and assist recipients who may be eligible for benefits under federal programs for the disabled.

(e) The total amount of interim assistance recoveries retained under this section for advocacy, support, and claim processing services shall not exceed 35 percent of the interim assistance recoveries in the prior fiscal year.

Subd. 6. [Repealed, 1989 c 282 art 5 s 133; 1Sp1989 c 1 art 16 s 20]

Subd. 7. **SSI conversions and back claims.** (a) The commissioner of human services shall contract with agencies or organizations capable of ensuring that clients who are presently receiving assistance under sections 256D.01 to 256D.21, and who may be eligible for benefits under the federal Supplemental Security Income program, apply and, when eligible, are converted to the federal income assistance program and made eligible for health care benefits under the medical assistance program. The commissioner shall ensure that money owing to the state under

interim assistance agreements is collected.

(b) The commissioner shall also directly or through contract implement procedures for collecting federal Medicare and medical assistance funds for which clients converted to SSI are retroactively eligible.

(c) The commissioner shall contract with agencies to ensure implementation of this section. County contracts with providers for residential services shall include the requirement that providers screen residents who may be eligible for federal benefits and provide that information to the local agency. The commissioner shall modify the MAXIS computer system to provide information on clients who have been on general assistance for two years or longer. The list of clients shall be provided to local services for screening under this section.

Subd. 8. **Recovery of ATM errors.** For recipients receiving benefits via electronic benefit transfer, if the recipient is overpaid as a result of an automated teller machine (ATM) dispensing funds in error to the recipient, the agency may recover the ATM error by immediately withdrawing funds from the recipient's electronic benefit transfer account, up to the amount of the error.

History: *1973 c 650 art 21 s 6; 1977 c 301 s 4; 1980 c 536 s 12,13; 1980 c 614 s 131; 1981 c 360 art 2 s 37,38; 1983 c 312 art 8 s 7; 1984 c 640 s 32; 1984 c 641 s 25; 1984 c 654 art 5 s 31; 1985 c 252 s 25; 1987 c 403 art 3 s 38-40; 1988 c 689 art 2 s 189-191; 1990 c 568 art 4 s 32,84; 1991 c 292 art 4 s 70; 1992 c 406 s 1; 1992 c 513 art 8 s 21,22; 1994 c 465 art 1 s 30; 1995 c 233 art 2 s 56; 1996 c 465 art 3 s 36; 1997 c 85 art 3 s 43; 1999 c 245 art 6 s 4; 1Sp2001 c 9 art 10 s 66; 1Sp2003 c 14 art 1 s 3; 1Sp2005 c 4 art 3 s 11,12*

256D.065 [Repealed, 1997 c 85 art 3 s 56]

256D.066 [Repealed, 1Sp2001 c 9 art 10 s 67]

256D.07 TIME OF PAYMENT OF ASSISTANCE.

An applicant for general assistance or general assistance medical care authorized by section 256D.03, subdivision 3, shall be deemed eligible if the application and the verification of the statement on that application demonstrate that the applicant is within the eligibility criteria established by sections 256D.01 to 256D.21 and any applicable rules of the commissioner. Any person requesting general assistance or general assistance medical care shall be permitted by the county agency to make an application for assistance as soon as administratively possible and in no event later than the fourth day following the date on which assistance is first requested, and no county agency shall require that a person requesting assistance appear at the offices of the county agency more than once prior to the date on which the person is permitted to make the application. The application shall be in writing in the manner and upon the form prescribed by the commissioner and attested to by the oath of the applicant or in lieu thereof shall contain the following declaration which shall be signed by the applicant: "I declare that this application has been examined by me and to the best of my knowledge and belief is a true and correct statement of every material point." On the date that general assistance is first requested, the county agency shall inquire and determine whether the person requesting assistance is in immediate need of food, shelter, clothing, assistance for necessary transportation, or other emergency assistance pursuant to section 256D.06, subdivision 2. A person in need of emergency assistance shall be granted emergency assistance immediately, and necessary emergency assistance shall continue for up to 30 days following the date of application. A determination of an applicant's eligibility for general assistance shall be made by the county agency as soon as the required verifications are received by the county agency and in no event later than 30 days following the date that the application

is made. Any verifications required of the applicant shall be reasonable, and the commissioner shall by rule establish reasonable verifications. General assistance shall be granted to an eligible applicant without the necessity of first securing action by the board of the county agency. The first month's grant must be computed to cover the time period starting with the date a signed application form is received by the county agency or from the date that the applicant meets all eligibility factors, whichever occurs later.

If upon verification and due investigation it appears that the applicant provided false information and the false information materially affected the applicant's eligibility for general assistance or general assistance medical care provided pursuant to section 256D.03, subdivision 3, or the amount of the applicant's general assistance grant, the county agency may refer the matter to the county attorney. The county attorney may commence a criminal prosecution or a civil action for the recovery of any general assistance wrongfully received, or both.

History: *1973 c 650 art 21 s 7; 1979 c 237 s 1; 1980 c 536 s 14; 1981 c 40 s 1; 1986 c 444; 1988 c 689 art 2 s 192; 1990 c 568 art 4 s 84; 1991 c 292 art 5 s 46*

256D.08 EXCLUSION FROM RESOURCES.

Subdivision 1. **Eligibility; excluded resources.** In determining eligibility of an assistance unit, the following resources shall be excluded:

(1) real or personal property or liquid assets which do not exceed $1,000; and

(2) other property which has been determined, according to limitations contained in rules promulgated by the commissioner, to be essential to the assistance unit as a means of self-support or self-care or which is producing income that is being used for the support of the assistance unit. The commissioner shall further provide by rule the conditions for those situations in which property not excluded under this subdivision may be retained by the assistance unit where there is a reasonable probability that in the foreseeable future the property will be used for the self-support of the assistance unit; and

(3) payments, made according to litigation and subsequent appropriation by the United States Congress, of funds to compensate members of Indian tribes for the taking of tribal land by the federal government.

Subd. 2. **Rulemaking; exclusion of property.** Notwithstanding any other provision of sections 256D.01 to 256D.21, the commissioner shall provide by rule for the exclusion of property from the determination of eligibility for general assistance when it appears likely that the need for general assistance will not exceed 30 days or an undue hardship would be imposed on an assistance unit by the forced disposal of the property.

History: *1973 c 650 art 21 s 8; 1979 c 250 s 2; 1980 c 536 s 15,16; 1987 c 403 art 3 s 41; 1997 c 85 art 3 s 45,46*

256D.09 PAYMENT; ASSESSMENT; OVERPAYMENT.

Subdivision 1. **Presumptive eligibility; payments.** Until the county agency has determined the initial eligibility of the applicant in accordance with section 256D.07, grants for emergency general assistance must be in the form of vouchers or vendor payments unless the county agency determines that a cash grant will best resolve the applicant's need for emergency assistance. Thereafter, grants of general assistance must be paid in cash, by electronic benefit transfer, or by direct deposit into the recipient's account in a financial institution, on the first day of the month, except as allowed in this section.

Subd. 2. **Voucher or vendor payments.** Notwithstanding the provisions of subdivision 1, the commissioner shall provide by rule for situations in which vouchers or vendor payments may be issued by county agencies because of the inability of the recipient to manage a general assistance grant for personal or family benefit.

Subd. 2a. **Vendor payments for drug dependent persons.** If, at the time of application or at any other time, there is a reasonable basis for questioning whether a person applying for or receiving financial assistance is drug dependent, as defined in section 254A.02, subdivision 5, the person shall be referred for a chemical health assessment, and only emergency assistance payments or general assistance vendor payments may be provided until the assessment is complete and the results of the assessment made available to the county agency. A reasonable basis for referring an individual for an assessment exists when:

(1) the person has required detoxification two or more times in the past 12 months;

(2) the person appears intoxicated at the county agency as indicated by two or more of the following:

(i) the odor of alcohol;

(ii) slurred speech;

(iii) disconjugate gaze;

(iv) impaired balance;

(v) difficulty remaining awake;

(vi) consumption of alcohol;

(vii) responding to sights or sounds that are not actually present;

(viii) extreme restlessness, fast speech, or unusual belligerence;

(3) the person has been involuntarily committed for drug dependency at least once in the past 12 months; or

(4) the person has received treatment, including domiciliary care, for drug abuse or dependency at least twice in the past 12 months.

The assessment and determination of drug dependency, if any, must be made by an assessor qualified under Minnesota Rules, part 9530.6615, subpart 2, to perform an assessment of chemical use. The county shall only provide emergency general assistance or vendor payments to an otherwise eligible applicant or recipient who is determined to be drug dependent, except up to 15 percent of the grant amount the person would otherwise receive may be paid in cash. Notwithstanding subdivision 1, the commissioner of human services shall also require county agencies to provide assistance only in the form of vendor payments to all eligible recipients who assert chemical dependency as a basis for eligibility under section 256D.05, subdivision 1, paragraph (a), clauses (1) and (6).

The determination of drug dependency shall be reviewed at least every 12 months. If the county determines a recipient is no longer drug dependent, the county may cease vendor payments and provide the recipient payments in cash.

Subd. 2b. **Disability verification; drug or alcohol dependency.** If at any time there is verification that the client's disability is dependent upon the client's continued drug addiction or alcoholism, general assistance for rent and utilities must be made in the form of vendor payments.

Verification of drug addiction or alcoholism can be received from:

(1) denial of Social Security benefits based on drug addiction or alcoholism;

(2) a statement from the state medical review team that the person's disability is dependent upon continued drug addiction or alcoholism; or

(3) a doctor's statement that the person's disability is dependent upon continued drug addiction or alcoholism.

Subd. 3. [Repealed, 1992 c 513 art 8 s 59]

Subd. 4. [Repealed, 1991 c 292 art 5 s 82]

Subd. 5. **Vendor payments to landlords.** The affected county may require that assistance paid under the emergency general assistance program in the form of a rental unit damage deposit, less any amount retained by the landlord to remedy a tenant's default in payment of rent or other funds due to the landlord pursuant to a rental agreement, or to restore the premises to the condition at the commencement of the tenancy, ordinary wear and tear excepted, be returned to the county when the individual vacates the premises or paid to the recipient's new landlord as a vendor payment. The vendor payment of returned funds shall not be considered a new use of emergency assistance.

Subd. 6. **Recovery of overpayments.** (a) If an amount of general assistance or family general assistance is paid to a recipient in excess of the payment due, it shall be recoverable by the county agency. The agency shall give written notice to the recipient of its intention to recover the overpayment.

(b) When an overpayment occurs, the county agency shall recover the overpayment from a current recipient by reducing the amount of aid payable to the assistance unit of which the recipient is a member, for one or more monthly assistance payments, until the overpayment is repaid. All county agencies in the state shall reduce the assistance payment by three percent of the assistance unit's standard of need in nonfraud cases and ten percent where fraud has occurred, or the amount of the monthly payment, whichever is less, for all overpayments.

(c) In cases when there is both an overpayment and underpayment, the county agency shall offset one against the other in correcting the payment.

(d) Overpayments may also be voluntarily repaid, in part or in full, by the individual, in addition to the aid reductions provided in this subdivision, to include further voluntary reductions in the grant level agreed to in writing by the individual, until the total amount of the overpayment is repaid.

(e) The county agency shall make reasonable efforts to recover overpayments to persons no longer on assistance under standards adopted in rule by the commissioner of human services. The county agency need not attempt to recover overpayments of less than $35 paid to an individual no longer on assistance if the individual does not receive assistance again within three years, unless the individual has been convicted of violating section 256.98.

History: *1973 c 650 art 21 s 9; 1980 c 536 s 17; 1981 c 40 s 2; 1983 c 312 art 8 s 8,9; 1984 c 640 s 32; 1Sp1985 c 9 art 2 s 61,62; 1Sp1985 c 14 art 9 s 30; 1986 c 444; 1988 c 506 s 1; 1990 c 568 art 4 s 33,84; 1995 c 178 art 2 s 33-35; art 6 s 17; 1995 c 233 art 2 s 56; 1996 c 465 art 3 s 37; 1997 c 85 art 3 s 47; art 5 s 23*

256D.091 [Repealed, 1995 c 178 art 6 s 18]

256D.10 ADMINISTRATIVE HEARING PRIOR TO ADVERSE ACTION.

No grant of general assistance except one made pursuant to section 256D.06, subdivision 2; or 256D.08, subdivision 2, shall be reduced, terminated, or suspended unless the recipient receives notice and is afforded an opportunity to be heard prior to any action by the county agency.

Nothing herein shall deprive a recipient of the right to full administrative and judicial review of an order or determination of a county agency as provided for in section 256.045 subsequent to any action taken by a county agency after a prior hearing.

History: *1973 c 650 art 21 s 10; 1980 c 509 s 103; 1980 c 536 s 18; 1986 c 444; 1990 c 568 art 4 s 84; 1991 c 292 art 5 s 47; 1996 c 465 art 3 s 38*

256D.101 [Repealed, 1995 c 178 art 6 s 18]

256D.11 [Repealed, 1981 c 360 art 2 s 52]

256D.111 [Repealed, 1995 c 178 art 6 s 18]

256D.112 [Repealed, 1983 c 312 art 8 s 18; 1Sp1985 c 14 art 9 s 78 subd 1]

256D.113 [Repealed, 1995 c 178 art 6 s 18]

256D.12 [Repealed, 1976 c 131 s 2]

256D.13 MANDAMUS TO COMPEL PAYMENT OF GENERAL ASSISTANCE.

Subdivision 1. **District court.** Notwithstanding the provisions of section 256.045 providing for administrative and judicial review of county agency determinations, a person denied general assistance by the county agency may apply to the district court of the county in which the person's application was filed and the district court shall order the payment of general assistance if the person establishes:

(1) the substantial likelihood of eligibility for and entitlement to general assistance; and

(2) the person or family will suffer irreparable injury if general assistance is not granted without delay.

Subd. 2. **Administrative or judicial review.** The denial by a district court of a writ of mandamus shall not affect the right or scope of administrative or judicial review as set forth in section 256.045.

History: *1973 c 650 art 21 s 13; 1980 c 509 s 104; 1980 c 536 s 27; 1986 c 444; 1990 c 568 art 4 s 84*

256D.14 VIOLATIONS.

Whoever obtains or attempts to obtain, or aids or abets any person to obtain by means of a willfully false statement or representation, or by the intentional withholding or concealment of a material fact, or by impersonation, or other fraudulent device:

(1) assistance to which the person is not entitled; or

(2) assistance greater than that to which the person is reasonably entitled;

shall be considered to have violated section 256.98, and shall be subject to both the criminal and civil penalties provided therein.

History: *1973 c 650 art 21 s 14; 1981 c 360 art 2 s 39; 1986 c 444*

256D.15 RELATIVE'S RESPONSIBILITY.

The financial responsibility of a relative for an applicant for or recipient of general assistance shall not extend beyond the relationship of a spouse or a parent of an adult child who resides with the parent, or the parent of a minor child regardless of where the minor child resides, or a family member who resides with the applicant or recipient.

History: *1973 c 650 art 21 s 15; 1984 c 654 art 5 s 37; 1987 c 403 art 3 s 43; 1995 c 178 art 6 s 17*

256D.16 GENERAL ASSISTANCE TO BE ALLOWED AS CLAIM IN COURT.

On the death of any person who received any general assistance under sections 256D.01 to 256D.21, or on the death of the survivor of a married couple, either or both of whom received general assistance, the total amount paid as general assistance to either or both, without interest, shall be allowed as a claim against the estate of such person or persons by the court having jurisdiction to probate the estate.

History: *1973 c 650 art 21 s 16; 1980 c 536 s 28*

256D.17 DATA PROCESSING PROCEDURES.

The county agency shall, to the extent permitted by federal law or regulation, in addition to any other necessary records and procedures, provide for the inclusion of all general assistance records in any data processing system established for the medical assistance program, in accordance with procedures established by the commissioner.

History: *1973 c 650 art 21 s 17; 1990 c 568 art 4 s 84*

256D.18 [Repealed, 1987 c 363 s 14]

256D.19 ABOLITION OF TOWNSHIP SYSTEM OF POOR RELIEF.

Subdivision 1. **Town system abolished.** The town system for caring for the poor in each of the counties in which it is in effect is hereby abolished. The local social services agency of each county shall administer general assistance under the provisions of Laws 1973, chapter 650, article 21.

Subd. 2. **Local social services agencies duty.** All local social services agencies affected by Laws 1973, chapter 650, article 21 are hereby authorized to take over for the county as of January 1, 1974, the ownership of all case records relating to the administration of poor relief.

History: *1973 c 650 art 21 s 19; 1994 c 631 s 31*

256D.20 TRANSFER OF TOWN EMPLOYEES.

Subdivision 1. **Rules for merit system.** The term "merit system" as used herein shall mean the rules for a merit system of personnel administration for employees of local social services agencies adopted by the commissioner of human services in accordance with the provisions of section 393.07, including the merit system established for Hennepin County pursuant to Laws 1965, chapter 855, as amended, the federal Social Security article as amended, and merit system standards and regulations issued by the federal Social Security Board and the United States Children's Bureau.

Subd. 2. **Designation of employees.** All employees of any municipality or town who are engaged full time in poor relief work therein on January 1, 1974 shall be retained as employees of

the county and placed under the jurisdiction of its local social services agency.

All transferred employees shall be blanketed into the merit system with comparable status, classification, longevity, and seniority, and subject to the administrative requirements of the local social services agency. Employees with permanent status under any civil service provision on January 1, 1974, shall be granted permanent status under the merit system at comparable classifications and in accordance with work assignments made under the authority of the local social services agency as provided by the merit system rules.

The determination of proper job allocation shall be the responsibility of the personnel officer or director as provided under merit system rules applicable to the county involved with the right of appeal of allocation to the Merit System Council or personnel board by any employee affected by this transfer.

All transferred employees shall receive salaries for the classification to which they are allocated in accordance with the schedule in effect for local social services agency employees and at a salary step which they normally would have received had they been employed by the local social services agency for the same period of service they had previously served under the civil service provisions of any municipality or town; provided, however, that no salary shall be reduced as a result of the transfer.

All accumulated sick leave of transferred employees in the amount of 60 days or less shall be transferred to the records of the local social services agency and such accumulated sick leave shall be the legal liability of the local social services agency. All accumulated sick leave in excess of 60 days shall be paid in cash to transferred employees by the municipality or town by which they were employed prior to their transfer, at the time of transfer. In lieu of the cash payment, the municipality or town shall, at the option of the employee concerned, allow a leave of absence with pay, prior to transfer, for all or part of the accumulated sick leave.

Subd. 3. **Merit system transfer.** Employees of municipalities and towns engaged in the work of administering poor relief who are not covered by civil service provisions shall be blanketed into the merit system subject to a qualifying examination. Employees with one year or more service shall be subject to a qualifying examination and those with less than one year's service shall be subject to an open competitive examination.

Subd. 4. **Disbursement of vacation time.** All vacation leave of employees referred to in subdivision 2, accumulated prior to their transfer to county employment shall be paid in cash to them by the municipality or town by which they were employed prior to their transfer, and at the time of their transfer. In lieu of the cash payment, the municipality or town shall, at the option of the employee concerned, allow a leave of absence with pay, prior to such transfer, for all or part of the accumulated vacation time.

History: *1973 c 650 art 21 s 20; 1984 c 654 art 5 s 58; 1994 c 631 s 31*

256D.21 CONTINUATION OF BENEFITS; FORMER MINNEAPOLIS EMPLOYEES.

Subdivision 1. **Continuation of benefits.** Each employee of the city of Minneapolis who is transferred to and employed by the county under the provisions of section 256D.20 and who is a contributing member of a retirement system organized under the provisions of Minnesota Statutes 2008, chapter 422A, is a member of the MERF division of the Public Employees Retirement Association and is entitled to all of the applicable benefits conferred by and subject to all the restrictions of section 353.50.

Subd. 2. **City obligation.** The cost to the public of that portion of the retirement allowances or other benefits accrued while any such employee was in the service of the city of Minneapolis must remain an obligation of the city and a tax must be levied and collected by it to discharge its obligation as provided in section 353.50, subdivision 7.

Subd. 3. **County obligation.** The cost to the public of the retirement allowances or other benefits accruing to employees so transferred to and employed by the county is the obligation of and paid by the county in section 353.50, subdivision 7. The county shall pay to the general employees retirement fund of the Public Employees Retirement Association those amounts. The cost to the public of the retirement coverage under this section must be paid from the county revenue fund by the county auditor, and the county board is authorized to levy and collect such taxes as may be necessary to pay such costs.

History: *1973 c 650 art 21 s 21; 1976 c 239 s 82; 1986 c 444; 2010 c 359 art 12 s 10*

256D.22 [Repealed, 1988 c 719 art 8 s 33]

256D.23 TEMPORARY COUNTY ASSISTANCE PROGRAM.

Subdivision 1. **Program established.** Minnesota residents who meet the income and resource standards of section 256D.01, subdivision 1a, but do not qualify for cash benefits under sections 256D.01 to 256D.21, may qualify for a county payment under this section.

Subd. 2. **Payment amount, duration, and method.** (a) A county may make a payment of up to $203 for a single individual and up to $260 for a married couple under the terms of this subdivision.

(b) Payments to an individual or married couple may only be made once in a calendar year. If the applicant qualifies for a payment as a result of an emergency, as defined by the county, the payment shall be made within ten working days of the date of application. If the applicant does not qualify under the county definition of emergency, the payment shall be made at the beginning of the second month following the month of application, and the applicant must receive the payment in person at the local agency office.

(c) Payments may be made in the form of cash or as vendor payments for rent and utilities. If vendor payments are made, they shall be equal to $203 for a single individual or $260 for a married couple, or the actual amount of rent and utilities, whichever is less.

(d) Each county must develop policies and procedures as necessary to implement this section.

(e) Payments under this section are not an entitlement. No county is required to make a payment in excess of the amount available to the county under subdivision 3.

Subd. 3. **State allocation to counties.** The commissioner shall allocate to each county on an annual basis the amount specifically appropriated for payments under this section. The allocation shall be based on each county's proportionate share of state fiscal year 1994 work readiness expenditures.

History: *1995 c 178 art 6 s 15; 1999 c 159 s 63*

256D.33 CITATION.

Sections 256D.33 to 256D.54 may be cited as the Minnesota Supplemental Aid Act.

History: *1989 c 282 art 5 s 72*

256D.34 POLICY.

The purpose of sections 256D.33 to 256D.54 is to (1) provide a sound administrative structure for public assistance programs; (2) maximize the use of federal funds for public assistance purposes; and (3) provide an integrated public assistance program for all Minnesota residents who are recipients of supplemental security income or who, except for excess income, would be receiving supplemental security income and who are found to have maintenance needs as determined by application of state standards of assistance according to section 256D.44.

History: *1989 c 282 art 5 s 73*

256D.35 DEFINITIONS.

Subdivision 1. **Scope.** The terms defined in this section shall have the meanings given them. The definitions in this section apply to sections 256D.33 to 256D.54.

Subd. 2. [Repealed, 1989 c 282 art 5 s 133]

Subd. 2a. **Aged.** "Aged" means having reached age 65 or reaching the age of 65 during the month of application.

Subd. 3. [Repealed, 1989 c 282 art 5 s 133]

Subd. 3a. **Assistance unit.** "Assistance unit" means the individual applicant or recipient or an eligible applicant married couple or recipient married couple who live together.

Subd. 4. [Repealed, 1989 c 282 art 5 s 133]

Subd. 4a. **Blind.** "Blind" means the condition of a person whose central visual acuity does not exceed 20/200 in the better eye with correcting lenses, or, if visual acuity is greater than 20/200, the condition is accompanied by limitation in the fields of vision such that the widest diameter of the visual field subtends an angle no greater than 20 degrees. A person who receives supplemental security income based on other visual disabilities may also be eligible for the Minnesota supplemental aid program.

Subd. 5. **Commissioner.** "Commissioner" means the commissioner of human services or a designee.

Subd. 6. **Department.** "Department" means the Department of Human Services.

Subd. 7. **County agency.** "County agency" means the local social services agencies in the several counties of the state except that it may also include any multicounty local social services agencies where those have been established in accordance with law.

Subd. 8. [Repealed, 1989 c 282 art 5 s 133]

Subd. 8a. **Disability.** "Disability" means disability as determined under the criteria used by the Title II program of the Social Security Act.

Subd. 8b. **Emergency.** "Emergency" means circumstances that demand immediate action to safeguard against threats to health or safety of an individual.

Subd. 8c. **Financially responsible relative.** "Financially responsible relative" means a spouse or a parent of a minor child.

Subd. 8d. **Good cause.** "Good cause" means a reason for taking an action or failing to take an action that is reasonable and justified when viewed in the context of surrounding circumstances.

Subd. 9. **Homestead.** "Homestead" means a shelter in which the individual or the spouse with whom the individual lives has an ownership interest, and that is the principal residence of the individual, spouse, or the individual's minor or disabled child. The home may be either real or personal property, fixed or mobile, and located on land or water. The home includes all the land that appertains to it and buildings located on that land.

Subd. 10. **Gross income.** "Gross income" means the total amount of earned and unearned money received in a month before any deductions or disregards are applied.

Subd. 11. **In-kind income.** "In-kind income" means income, benefits, or payments that are provided in a form other than money or liquid asset. In-kind income includes goods, produce, services, privileges, or payments on behalf of a person by a third party; except benefits of the recipient, such as those administered by the Social Security Administration, that are paid to a representative payee, and are spent on behalf of the applicant or recipient, are not in-kind income, but are considered available income of the applicant or recipient.

Subd. 11a. **Institution.** "Institution" means a hospital, consistent with Code of Federal Regulations, title 42, section 440.10; regional treatment center inpatient services, consistent with section 245.474; a nursing facility; and an intermediate care facility for persons with developmental disabilities.

Subd. 12. **Lump sum.** "Lump sum" means money received on an irregular or unexpected basis.

Subd. 13. **Maintenance benefit.** "Maintenance benefit" means cash payments, other than Minnesota supplemental aid, provided under law or rule. Maintenance benefit includes workers' compensation, unemployment benefits, railroad retirement, veterans benefits, supplemental security income, Social Security disability insurance, or other benefits identified by the county agency that provide periodic benefits that can be used to meet the basic needs of the assistance unit.

Subd. 14. [Repealed, 1995 c 207 art 5 s 40]

Subd. 15. **Net income.** "Net income" means monthly income remaining after allowable deductions and disregards are subtracted from gross income.

Subd. 16. **Overpayment.** "Overpayment" means an amount of Minnesota supplemental aid paid to a recipient that exceeds the amount to which the recipient is entitled for that month.

Subd. 17. **Potential eligibility.** "Potential eligibility" means a determination by a county agency that an assistance unit or a financially responsible relative appears to meet the eligibility requirements of another maintenance benefit program.

Subd. 18. **Retirement, survivors, and disability insurance.** "Retirement, survivors, and disability insurance" means benefits paid under the federal program for retired, disabled, and surviving spouses of retired or disabled individuals under Title II of the Social Security Act.

Subd. 18a. **Shelter costs.** "Shelter costs" means rent, manufactured home lot rentals; monthly principal, interest, insurance premiums, and property taxes due for mortgages or contract for deed costs; costs for utilities, including heating, cooling, electricity, water, and sewerage; garbage collection fees; and the basic service fee for one telephone.

Subd. 19. [Repealed, 1995 c 207 art 5 s 40]

Subd. 20. **Supplemental security income.** "Supplemental security income" means benefits

paid under the federal program of supplemental security income for the aged, blind, and disabled under Title XVI of the Social Security Act.

History: *1974 c 487 s 1; 1984 c 654 art 5 s 58; 1985 c 248 s 70; 1986 c 444; 1988 c 689 art 2 s 193; 1989 c 282 art 5 s 74-93; 1990 c 426 art 2 s 1; 1992 c 513 art 8 s 24; 1Sp1993 c 1 art 8 s 4; 1994 c 488 s 8; 1994 c 631 s 31; 1999 c 107 s 66; 2000 c 343 s 4; 1Sp2001 c 9 art 3 s 68,69; 2002 c 379 art 1 s 113; 2005 c 56 s 1*

256D.36 STATE PARTICIPATION.

Subdivision 1. **State participation.** The state share of aid paid shall be 100 percent.

Subd. 1a. [Repealed, 1995 c 207 art 5 s 40]

Subd. 2. [Repealed, 1989 c 282 art 5 s 133]

History: *1974 c 487 s 2; 1979 c 303 art 2 s 3; 1980 c 607 art 2 s 4; 1986 c 444; 1988 c 719 art 8 s 21; 1989 c 282 art 5 s 94,95; 1Sp1989 c 1 art 16 s 13; 1990 c 426 art 2 s 1; 1990 c 568 art 4 s 84; 1991 c 292 art 5 s 51; 1995 c 207 art 5 s 8; 1997 c 203 art 11 s 11*

256D.37 [Repealed, 1995 c 207 art 5 s 40]

256D.38 [Repealed, 1989 c 282 art 5 s 133]

256D.385 RESIDENCE.

To be eligible for Minnesota supplemental aid, a person must be a resident of Minnesota and (1) a citizen of the United States, or (2) an alien eligible to receive benefits from the supplemental security income program.

History: *1989 c 282 art 5 s 97; 1995 c 207 art 5 s 9*

256D.39 [Repealed, 1989 c 282 art 5 s 133]

256D.395 APPLICATION PROCEDURES.

Subdivision 1. **Information.** The county agency shall provide information about the program and application procedures to a person who inquires about Minnesota supplemental aid.

Subd. 2. **Filing of application.** The county agency must immediately provide an application form to any person requesting Minnesota supplemental aid. Application for Minnesota supplemental aid must be in writing on a form prescribed by the commissioner. The county agency must determine an applicant's eligibility for Minnesota supplemental aid as soon as the required verifications are received by the county agency and within 30 days after a signed application is received by the county agency for the aged or blind or within 60 days for the disabled. The amount of the first grant of Minnesota supplemental aid awarded to an applicant must be computed to cover the time period starting with the first day of the month in which the county agency received the signed and dated application or the first day of the month in which all eligibility factors were met, whichever is later.

History: *1989 c 282 art 5 s 98*

256D.40 [Repealed, 1976 c 131 s 2]

256D.405 VERIFICATION AND REPORTING REQUIREMENTS.

Subdivision 1. **Verification.** The county agency shall request, and applicants and recipients

shall provide and verify, all information necessary to determine initial and continuing eligibility and assistance payment amounts. If necessary, the county agency shall assist the applicant or recipient in obtaining verifications. If the applicant or recipient refuses or fails without good cause to provide the information or verification, the county agency shall deny or terminate assistance.

Subd. 1a. **Exemption.** Recipients who maintain supplemental security income eligibility are exempt from the reporting requirements of subdivision 1, except that the policies and procedures of transfers of assets are those used by the medical assistance program under section 256B.0595.

Subd. 2. **Redetermination of eligibility.** The eligibility of each recipient must be redetermined at least once every 12 months.

Subd. 3. **Reports.** Recipients must report changes in circumstances that affect eligibility or assistance payment amounts within ten days of the change. Recipients who do not receive SSI because of excess income must complete a monthly report form if they have earned income, if they have income deemed to them from a financially responsible relative with whom the recipient resides, or if they have income deemed to them by a sponsor. If the report form is not received before the end of the month in which it is due, the county agency must terminate assistance. The termination shall be effective on the first day of the month following the month in which the report was due. If a complete report is received within the month the assistance was terminated, the assistance unit is considered to have continued its application for assistance, effective the first day of the month the assistance was terminated.

History: *1989 c 282 art 5 s 99; 1995 c 207 art 5 s 10; 1995 c 248 art 17 s 5*

256D.41 [Repealed, 1989 c 282 art 5 s 133]

256D.415 RESIDENCE; COUNTY OF FINANCIAL RESPONSIBILITY.

The county of financial responsibility is the county specified in section 256G.02, subdivision 4.

History: *1989 c 282 art 5 s 100*

256D.42 [Repealed, 1989 c 282 art 5 s 133]

256D.425 ELIGIBILITY CRITERIA.

Subdivision 1. **Persons entitled to receive aid.** A person who is aged, blind, or 18 years of age or older and disabled and who is receiving supplemental security benefits under Title XVI on the basis of age, blindness, or disability (or would be eligible for such benefits except for excess income) is eligible for a payment under the Minnesota supplemental aid program, if the person's net income is less than the standards in section 256D.44. Persons who are not receiving supplemental security income benefits under Title XVI of the Social Security Act or disability insurance benefits under Title II of the Social Security Act due to exhausting time limited benefits are not eligible to receive benefits under the MSA program. Persons who are not receiving Social Security or other maintenance benefits for failure to meet or comply with the Social Security or other maintenance program requirements are not eligible to receive benefits under the MSA program. Persons who are found ineligible for supplemental security income because of excess income, but whose income is within the limits of the Minnesota supplemental aid program, must have blindness or disability determined by the state medical review team.

Subd. 2. **Resource standards.** The resource standards and restrictions for supplemental aid under this section shall be those used to determine eligibility for disabled individuals in

the supplemental security income program.

Subd. 3. [Repealed, 1995 c 207 art 5 s 40; 1995 c 248 art 17 s 7]

Subd. 4. **Cooperation.** To be eligible for the Minnesota supplemental aid program, applicants and recipients must cooperate with the state and local agency to identify potentially liable third-party payors and assist the state in obtaining third-party payments. Cooperation includes identifying any third party who may be liable for benefits provided under this chapter to the applicant, recipient, or any other family member for whom application is made, and providing relevant information to assist the state in pursuing a potentially liable third party.

History: *1989 c 282 art 5 s 101; 1990 c 568 art 3 s 90; 1995 c 207 art 5 s 11; art 6 s 107; 1Sp2001 c 9 art 10 s 4; 2002 c 379 art 1 s 113*

256D.43 [Repealed, 1989 c 282 art 5 s 133]

256D.435 INCOME.

Subdivision 1. **Income.** For persons receiving supplemental security income benefits, the countable income used to determine eligibility and benefits for Minnesota supplemental aid is the gross amount of the Federal Benefit Rate (FBR) after allowing for the general income disregard in subdivision 5. For persons who have been denied a supplemental security income benefit due to excess income, and have had their blindness or disability determined through the state medical review team, the countable income is the gross amount of earned and unearned income, minus the exclusions and disregards listed in subdivisions 4a, 5, and 6.

Subd. 2. [Repealed, 1995 c 207 art 5 s 40]

Subd. 3. **Application for federally funded benefits.** Persons who live with the applicant or recipient, who have unmet needs and for whom the applicant or recipient has financial responsibility, must apply for and, if eligible, accept the Minnesota family investment program and any other federally funded benefits.

Subd. 4. **Allocation and deeming of income.** The county agency shall apply the supplemental security income rules regarding financial responsibility when determining the amount of income to allocate or deem.

Subd. 4a. **Exclusions.** The income exclusions used to determine eligibility for Minnesota supplemental aid are those used to determine benefits for supplemental security income.

Subd. 5. **General income disregard.** The county agency shall disregard the first $20 of the assistance unit's unearned or earned income.

Subd. 6. **Earned income disregards.** The earned income disregards used to determine eligibility for Minnesota supplemental aid are those used to determine benefits for supplemental security income.

Subd. 7. [Repealed, 1995 c 207 art 5 s 40]

Subd. 8. [Repealed, 1995 c 207 art 5 s 40]

Subd. 9. [Repealed, 1995 c 207 art 5 s 40]

Subd. 10. [Repealed, 1995 c 207 art 5 s 40]

History: *1989 c 282 art 5 s 102; 1990 c 568 art 4 s 84; 1995 c 207 art 5 s 12-17; 1997 c 85 art 3 s 48; 1999 c 159 s 64*

256D.44 STANDARDS OF ASSISTANCE.

Subdivision 1. **Use of standards; increases.** The state standards of assistance for basic needs, plus special need items establish the total amount of need for an applicant for or recipient of Minnesota supplemental aid, used to determine the assistance unit's eligibility for Minnesota supplemental aid. The state standards of assistance for basic needs must increase by an amount equal to the dollar value, rounded up to the nearest dollar, of any cost of living increases in the supplemental security income program.

Subd. 2. **Standard of assistance for certain persons.** The state standard of assistance for a person who: (1) is eligible for a medical assistance home and community-based services waiver; (2) has been determined by the local agency to meet the plan requirements for placement in a group residential housing facility under section 256I.04, subdivision 1a; or (3) is eligible for a shelter needy payment under subdivision 5, paragraph (f), is the standard established in subdivision 3, paragraph (a) or (b).

Subd. 3. **Standard of assistance for basic needs.** Except as provided in subdivision 4, the monthly state standard of assistance for basic needs is as follows:

(a) If an applicant or recipient does not reside with another person or persons, the state standard of assistance is $519.

(b) If an applicant married couple or recipient married couple who live together, does not reside with others, the state standard of assistance is $778.

(c) If an applicant or recipient resides with another person or persons, the state standard of assistance is $395.

(d) If an applicant married couple or recipient married couple who live together, resides with others, the state standard of assistance is $519.

(e) Married couples, living together who do not reside with others and were receiving MSA prior to January 1, 1994, and whose eligibility has not been terminated a full calendar month, the state standard of assistance is $793.

(f) Married couples living together who reside with others and were receiving MSA prior to January 1, 1994, and whose eligibility has not been terminated a full calendar month, the state standard of assistance is $782.

(g) For an individual who (1) receives Supplemental Security Income under federal living arrangement D or (2) is a resident of a licensed residential facility and has unmet personal needs, the state standard of assistance is the personal needs allowance for medical assistance recipients under section 256B.35.

Subd. 4. **Temporary absence due to illness.** For the purposes of this subdivision, "home" means a residence owned or rented by a recipient or the recipient's spouse. Home does not include a group residential housing facility. Assistance payments for recipients who are temporarily absent from their home due to hospitalization for illness must continue at the same level of payment during their absence if the following criteria are met:

(1) a physician certifies that the absence is not expected to continue for more than three months;

(2) a physician certifies that the recipient will be able to return to independent living; and

(3) the recipient has expenses associated with maintaining a residence in the community.

Subd. 5. **Special needs.** In addition to the state standards of assistance established in subdivisions 1 to 4, payments are allowed for the following special needs of recipients of Minnesota supplemental aid who are not residents of a nursing home, a regional treatment center, or a group residential housing facility.

(a) The county agency shall pay a monthly allowance for medically prescribed diets if the cost of those additional dietary needs cannot be met through some other maintenance benefit. The need for special diets or dietary items must be prescribed by a licensed physician. Costs for special diets shall be determined as percentages of the allotment for a one-person household under the thrifty food plan as defined by the United States Department of Agriculture. The types of diets and the percentages of the thrifty food plan that are covered are as follows:

(1) high protein diet, at least 80 grams daily, 25 percent of thrifty food plan;

(2) controlled protein diet, 40 to 60 grams and requires special products, 100 percent of thrifty food plan;

(3) controlled protein diet, less than 40 grams and requires special products, 125 percent of thrifty food plan;

(4) low cholesterol diet, 25 percent of thrifty food plan;

(5) high residue diet, 20 percent of thrifty food plan;

(6) pregnancy and lactation diet, 35 percent of thrifty food plan;

(7) gluten-free diet, 25 percent of thrifty food plan;

(8) lactose-free diet, 25 percent of thrifty food plan;

(9) antidumping diet, 15 percent of thrifty food plan;

(10) hypoglycemic diet, 15 percent of thrifty food plan; or

(11) ketogenic diet, 25 percent of thrifty food plan.

(b) Payment for nonrecurring special needs must be allowed for necessary home repairs or necessary repairs or replacement of household furniture and appliances using the payment standard of the AFDC program in effect on July 16, 1996, for these expenses, as long as other funding sources are not available.

(c) A fee for guardian or conservator service is allowed at a reasonable rate negotiated by the county or approved by the court. This rate shall not exceed five percent of the assistance unit's gross monthly income up to a maximum of $100 per month. If the guardian or conservator is a member of the county agency staff, no fee is allowed.

(d) The county agency shall continue to pay a monthly allowance of $68 for restaurant meals for a person who was receiving a restaurant meal allowance on June 1, 1990, and who eats two or more meals in a restaurant daily. The allowance must continue until the person has not received Minnesota supplemental aid for one full calendar month or until the person's living arrangement changes and the person no longer meets the criteria for the restaurant meal allowance, whichever occurs first.

(e) A fee of ten percent of the recipient's gross income or $25, whichever is less, is allowed for representative payee services provided by an agency that meets the requirements under SSI regulations to charge a fee for representative payee services. This special need is available to all recipients of Minnesota supplemental aid regardless of their living arrangement.

(f)(1) Notwithstanding the language in this subdivision, an amount equal to the maximum allotment authorized by the federal Food Stamp Program for a single individual which is in effect on the first day of July of each year will be added to the standards of assistance established in subdivisions 1 to 4 for adults under the age of 65 who qualify as shelter needy and are: (i) relocating from an institution, or an adult mental health residential treatment program under section 256B.0622; (ii) eligible for the self-directed supports option as defined under section 256B.0657, subdivision 2; or (iii) home and community-based waiver recipients living in their own home or rented or leased apartment which is not owned, operated, or controlled by a provider of service not related by blood or marriage, unless allowed under paragraph (g).

(2) Notwithstanding subdivision 3, paragraph (c), an individual eligible for the shelter needy benefit under this paragraph is considered a household of one. An eligible individual who receives this benefit prior to age 65 may continue to receive the benefit after the age of 65.

(3) "Shelter needy" means that the assistance unit incurs monthly shelter costs that exceed 40 percent of the assistance unit's gross income before the application of this special needs standard. "Gross income" for the purposes of this section is the applicant's or recipient's income as defined in section 256D.35, subdivision 10, or the standard specified in subdivision 3, paragraph (a) or (b), whichever is greater. A recipient of a federal or state housing subsidy, that limits shelter costs to a percentage of gross income, shall not be considered shelter needy for purposes of this paragraph.

(g) Notwithstanding this subdivision, to access housing and services as provided in paragraph (f), the recipient may choose housing that may be owned, operated, or controlled by the recipient's service provider. In a multifamily building of four or more units, the maximum number of apartments that may be used by recipients of this program shall be 50 percent of the units in a building. This paragraph expires on June 30, 2012.

Subd. 6. **County agency standards of assistance.** The county agency may establish standards of assistance for basic needs, special needs, and clothing and personal needs that exceed the corresponding state standards of assistance. State aid is not available for costs above state standards.

Subd. 7. [Repealed, 1995 c 207 art 5 s 40]

History: *1989 c 282 art 5 s 103; 1990 c 568 art 4 s 84; 1991 c 292 art 7 s 21; 1Sp1993 c 1 art 8 s 5,6; 1994 c 465 art 1 s 31; 1995 c 207 art 5 s 18-23; 1995 c 263 s 4; 1997 c 85 art 3 s 49; 1999 c 159 s 65; 1Sp2001 c 9 art 3 s 70; 2002 c 379 art 1 s 113; 1Sp2003 c 14 art 1 s 4; 1Sp2005 c 4 art 2 s 16; 2008 c 363 art 15 s 15,16; 2009 c 79 art 8 s 73; 2009 c 142 art 2 s 41; 2009 c 173 art 1 s 45; 2009 c 175 art 3 s 2; 2010 c 301 art 1 s 3; 2010 c 352 art 1 s 21*

256D.45 PAYMENT PERIOD.

Subdivision 1. **Budgeting.** The payment period and budgeting cycle for Minnesota supplemental aid are those of the supplemental security income program.

Subd. 2. **Gross income test.** The county agency shall apply a gross income test prospectively for each month of program eligibility. An assistance unit is ineligible when nonexcluded income, before applying any disregards or deductions, exceeds 300 percent of the supplemental security income standard for an individual.

Subd. 3. **Amount of assistance.** The amount of assistance is the difference between the recipient's net income and the applicable standards of assistance in section 256D.44, subdivisions

2 to 4, for persons living independently.

History: *1989 c 282 art 5 s 104; 1990 c 568 art 4 s 84; 1995 c 207 art 5 s 24*

256D.46 EMERGENCY MINNESOTA SUPPLEMENTAL AID.

Subdivision 1. **Eligibility.** A county agency must grant emergency Minnesota supplemental aid, to the extent funds are available, if the recipient is without adequate resources to resolve an emergency that, if unresolved, will threaten the health or safety of the recipient. For the purposes of this section, the term "recipient" includes persons for whom a group residential housing benefit is being paid under sections 256I.01 to 256I.06.

Subd. 2. **Income and resource test.** All income and resources available to the recipient must be considered in determining the recipient's ability to meet the emergency need. Property that can be liquidated in time to resolve the emergency and income, excluding an amount equal to the Minnesota supplemental aid standard of assistance, that is normally disregarded or excluded under the Minnesota supplemental aid program must be considered available to meet the emergency need.

Subd. 3. **Payment amount.** The amount of assistance granted under emergency Minnesota supplemental aid is limited to the amount necessary to resolve the emergency. An emergency Minnesota supplemental aid grant is available to a recipient no more than once in any 12-month period. Funding for emergency Minnesota supplemental aid is limited to the appropriation. Each fiscal year, the commissioner shall allocate to counties the money appropriated for emergency Minnesota supplemental aid grants based on each county agency's average share of state's emergency Minnesota supplemental aid expenditures for the immediate past three fiscal years as determined by the commissioner, and may reallocate any unspent amounts to other counties. Any emergency Minnesota supplemental aid expenditures by a county above the amount of the commissioner's allocation to the county must be made from county funds.

History: *1989 c 282 art 5 s 105; 1995 c 207 art 5 s 25,26; 1998 c 407 art 6 s 17; 1Sp2003 c 14 art 1 s 5,6*

256D.47 PAYMENT METHODS.

Minnesota supplemental aid payments must be issued to the recipient, a protective payee, or a conservator or guardian of the recipient's estate in the form of county warrants immediately redeemable in cash, electronic benefits transfer, or by direct deposit into the recipient's account in a financial institution. Minnesota supplemental aid payments must be issued regularly on the first day of the month. The supplemental aid warrants must be mailed only to the address at which the recipient resides, unless another address has been approved in advance by the county agency. Vendor payments must not be issued by the county agency except for nonrecurring emergency need payments; at the request of the recipient; for special needs, other than special diets; or when the agency determines the need for protective payments exist.

History: *1989 c 282 art 5 s 106; 1990 c 568 art 4 s 84*

256D.48 PROTECTIVE PAYMENTS.

Subdivision 1. **Need for protective payee.** The county agency shall determine whether a recipient needs a protective payee when a physical or mental condition renders the recipient unable to manage funds and when payments to the recipient would be contrary to the recipient's welfare. Protective payments must be issued when there is evidence of: (1) repeated inability to

plan the use of income to meet necessary expenditures; (2) repeated observation that the recipient is not properly fed or clothed; (3) repeated failure to meet obligations for rent, utilities, food, and other essentials; (4) evictions or a repeated incurrence of debts; or (5) lost or stolen checks. The determination of representative payment by the Social Security Administration for the recipient is sufficient reason for protective payment of Minnesota supplemental aid payments.

Subd. 2. **Establishing protective payment.** When the county agency determines that a recipient needs a protective payee, the county agency shall appoint a payee according to the procedures in paragraphs (a) and (b).

(a) The county agency shall consider the recipient's preference of protective payee. The protective payee must have an interest in or concern for the welfare of the recipient. The protective payee must be capable of and willing to provide the required assistance. A vendor of goods or services, including the recipient's landlord, shall not serve as protective payee.

(b) The county agency shall reconsider the need for a protective payee at least annually. The criteria used to determine a person's continuing need for a protective payee are the criteria used in the supplemental security income program to determine if a person is incapable of managing or directing the management of the person's money. If the need for protective payment is likely to continue beyond two years, the county agency shall seek judicial appointment of a guardian or other legal representative.

Subd. 3. **Protective payee for payments made by the Social Security Administration.** If the assistance unit receives benefits from the Social Security Administration, the county agency shall also petition the Social Security Administration to establish a representative payee for those benefits.

History: *1989 c 282 art 5 s 107; 1995 c 207 art 5 s 27; 1Sp2003 c 14 art 1 s 7*

256D.49 PAYMENT CORRECTION.

Subdivision 1. **When.** When the county agency finds that the recipient has received less than or more than the correct payment of Minnesota supplemental aid benefits, the county agency shall issue a corrective payment or initiate recovery under subdivision 3, as appropriate.

Subd. 2. **Underpayment of monthly grants.** When the county agency determines that an underpayment of the recipient's monthly payment has occurred, it shall, during that same month, issue a corrective payment. Corrective payments must be excluded when determining the applicant's or recipient's income and resources for the month of payment.

Subd. 3. **Overpayment of monthly grants and recovery of ATM errors.** When the county agency determines that an overpayment of the recipient's monthly payment of Minnesota supplemental aid has occurred, it shall issue a notice of overpayment to the recipient. If the person is no longer receiving Minnesota supplemental aid, the county agency may request voluntary repayment or pursue civil recovery. If the person is receiving Minnesota supplemental aid, the county agency shall recover the overpayment by withholding an amount equal to three percent of the standard of assistance for the recipient or the total amount of the monthly grant, whichever is less. For recipients receiving benefits via electronic benefit transfer, if the overpayment is a result of an automated teller machine (ATM) dispensing funds in error to the recipient, the agency may recover the ATM error by immediately withdrawing funds from the recipient's electronic benefit transfer account, up to the amount of the error. Residents of nursing homes, regional treatment centers, and facilities with negotiated rates shall not have overpayments recovered

from their personal needs allowance.

History: *1989 c 282 art 5 s 108; 1996 c 465 art 3 s 39*

256D.50 NOTICE.

Subdivision 1. **Ten-day notice.** The county agency shall give recipients ten days' advance notice when the agency intends to terminate, suspend, or reduce a grant. The ten-day notice must be in writing on a form prescribed by the commissioner. The notice must be mailed or given to the recipient not later than ten days before the effective date of the action. The notice must clearly state the action the county agency intends to take, the reasons for the action, the right to appeal the action, and the conditions under which assistance can be continued while an appeal is pending.

Subd. 2. **Five-day notice.** Five days' advance notice is sufficient when the county agency has verified and documented that the case facts require termination, suspension, or reduction of the grant for probable fraud by a recipient. If the last day of the five-day period falls on a weekend or holiday, the effective date of the action is the next working day.

Subd. 3. **Adequate notice.** Notice must be given no later than the effective date of the action when: (1) the county agency has factual information confirming the death of a person included in the grant; (2) the county agency receives a clear written statement, signed by a recipient, that the recipient no longer wishes assistance; (3) the county agency receives a clear statement, signed by a recipient, reporting information that the recipient acknowledges will require termination of or a reduction in the grant; (4) a recipient has been placed in a skilled nursing home, intermediate care, or a long-term hospitalization facility; (5) a recipient has been admitted to or committed to an institution; or (6) a recipient's whereabouts are unknown and the county agency mail to the recipient has been returned by the post office showing no forwarding address.

History: *1989 c 282 art 5 s 109*

256D.51 APPEALS.

Subdivision 1. **Right to appeal.** Applicants and recipients may appeal under section 256.045 if they are aggrieved by an action or by inaction of the county agency.

Subd. 2. **Continuation of payment pending appeal decision.** When assistance is reduced, suspended, or terminated, the client has the right to choose to have the grant continued while an appeal is pending if the appellant files the appeal within ten days after the date the notice is mailed or before the effective date of the proposed action, whichever is later.

History: *1989 c 282 art 5 s 110*

256D.52 FRAUD.

A person who obtains or tries to obtain, or aids or abets any person in obtaining assistance to which the person is not entitled by a willfully false statement or representation, or by the intentional withholding or concealment of a material fact, or by impersonation, or other fraudulent device, violates section 256.98 and is subject to both the criminal and civil penalties in that section.

History: *1989 c 282 art 5 s 111*

256D.53 DUTIES OF THE COMMISSIONER.

In addition to other duties imposed by law, the commissioner shall:

(1) supervise the administration of Minnesota supplemental aid by county agencies as provided in sections 256D.33 to 256D.54;

(2) adopt permanent rules consistent with law for carrying out and enforcing the provisions of sections 256D.33 to 256D.54, so that Minnesota supplemental aid may be administered as uniformly as possible throughout the state;

(3) immediately upon adoption, give rules to all county agencies and other interested persons;

(4) establish necessary administrative and fiscal procedures; and

(5) allocate money appropriated for Minnesota supplemental aid to county agencies.

History: *1989 c 282 art 5 s 112*

256D.54 APPLICATION FOR OTHER BENEFITS.

Subdivision 1. **Potential eligibility.** An applicant or recipient who is otherwise eligible for supplemental aid and who is potentially eligible for maintenance benefits from any other source shall (1) apply for those benefits within 30 days of the county's determination of potential eligibility for those benefits; and (2) execute an interim assistance authorization agreement on a form as directed by the commissioner.

Subd. 2. **Recovery of supplemental aid under an interim assistance agreement.** If a recipient is eligible for benefits from other sources, and receives a payment from another source for a period during which supplemental aid was also issued, the recipient shall reimburse the county agency for the interim assistance paid. Reimbursement shall not exceed the amount of supplemental aid paid during the time period to which the other maintenance benefits apply. Reimbursement shall not exceed the state standard that applies to that time period. Reimbursement may be sought directly from the other source of maintenance income but remains the primary obligation of the recipient when an interim assistance agreement has been executed.

Subd. 3. [Repealed, 1Sp2005 c 4 art 3 s 20]

History: *1989 c 282 art 5 s 113; 1992 c 513 art 8 s 25*