DEPARTMENT OF HUMAN SERVICES

DHS-7307-ENG 5-20

COMMUNITY SUPPORTS ADMINISTRATION – HOUSING AND SUPPORT SERVICES

Housing Focused Person-Centered Plan

Person Information

FIRST NAME	MI	LAST NAME	
PREFERRED PRONOUNS	PMI	DATE OF BIRTH	PHONE NUMBER
MAILING ADDRESS			
CITY	STATE	ZIP CODE	
MANAGED CARE PLAN (IF KNOWN)			

Diagnosis:

☐ Developmental Disability ☐ Learning Disability ☐ Mental Illness

☐ Physical Illness, Injury or Impairment ☐ Chemical Dependency

Referral Source:

☐ Professional Statement of need ☐ MNCHOICES ☐ Coordinated Entry

Emergency Contacts (if known)

Name	Relationship	Phone Number

List Person's Guardian, Conservator, Rep-Payee, and/or Power of Attorney

Name	Type of authority	Phone number

About You **(this section is related to the person for whom the plan is being developed)**

What's important to you?

What do you want people to know about you?

Are there any cultural, religious and/or personal identities you want to share about yourself?

Housing Goals

Where are you currently living?

If currently housed, do you like where you are currently living? ◯ Yes ◯ No

What do you like about it?

What don't you like about it?

Which county and/or tribal area would you like to live in?

What is important to you about your housing and community?

Are there any cultural, religious and/or identity specific needs or preferences related to your housing?

What concerns you about your housing now and in the future?

Housing Stabilization Services – Transition/Sustaining

PROVIDER NAME				NPI
STREET ADDRESS	CITY	STATE	ZIP CODE	PHONE NUMBER
AREAS IN NEED OF HOUSING				
SUPPORT INSTRUCTIONS (IDENTIFY WHETHER PERSON IS STARTING WITH TRANSITION OR SUSTAINING SERVICES)				

Non-Housing Related Priorities/Goals:

Support Topic (ex: Employment)	Areas of need	Referral Source

Support Topic (ex: Employment)	Areas of need	Referral Source

Risks and Risk Mitigation:

Identified risk in housing choice	Choice regarding services	Negative outcome that may result	Steps to limit negative outcome

Consultant/Targeted Case Manager Information

Check box that applies: ☐ Housing Consultant ☐ Targeted Case Manager

FIRST NAME	LAST NAME	
PROVIDER AGENCY	PHONE NUMBER	NPI
STREET ADDRESS		
CITY	STATE	ZIP CODE

Housing Focused Person-Centered Plan Signature Sheet

FIRST NAME	LAST NAME	PMI	DATE

TARGETED CASE MANAGER OR HOUSING CONSULTANT	PHONE NUMBER	EXT

This document confirms that I:

- Received required information
- Participated in the development of my plan
- Was given choices about the services I will receive from programs through the Minnesota Department of Human Services.

Materials Shared

I received information about:

Data privacy practices, which explain my right to confidentiality (DHS-489E-ENG [PDF] or agency's form)	◯ Yes ◯ No
Minnesota Health Care Programs Description, DHS-3182-ENG [PDF]	◯ Yes ◯ No
My right to appeal (DHS-1941-ENG [PDF] or agency's form)	◯ Yes ◯ No
Other information, such as _____	◯ Yes ◯ No

Creating My Housing Focused Person-Centered Plan

I was able to invite who I wanted to come to my planning meeting.	◯ Yes ◯ No
I participated in developing my plan for receiving services.	◯ Yes ◯ No
I was offered a choice of services, supports and providers.	◯ Yes ◯ No
I agree with the services, supports and providers indicated in my plan.	◯ Yes ◯ No
I understand if I do not agree with any part of my written support plan, I can call my case manager, Housing Consultant or care coordinator to discuss and make corrections as needed. I also understand I have the right to appeal any decision I disagree with.	◯ Yes ◯ No
I understand my targeted case manager or Housing Consultant will send this signature page to me with my written plan.	◯ Yes ◯ No
My housing focused person centered plan will be shared with the following people/providers for planning and coordination: _____	◯ Yes ◯ No

Comments

My Signature

My signature and responses on this form indicate:

- I received the information mentioned above.
- I know about the choices I have.
- I agree to the delivery of services as developed with my targeted case manager or Housing Consultant.
- The provider(s) listed in this plan can share a written report about my care needs with my targeted case manager or Housing Consultant if I give the provider(s) my permission.

MY SIGNATURE	DATE

My Support Team

LEGAL REPRESENTATIVE'S SIGNATURE (IF APPLICABLE)	DATE
SIGNATURE OF TARGETED CASE MANAGER WHO HELPED DEVELOP PLAN (IF APPLICABLE)	

Provider(s) Signature

Provider(s) signatures indicate the provider(s) who sign:

- Have reviewed the plan.
- Acknowledge the services and supports in the plan.
- Agree to provide those services and supports as outlined.
- Understand we can submit a written report to the targeted case manager or Housing Consultant about recommendations for the person's care needs for future assessments. (NOTE: The provider should submit the report at least 60 days before the end of the person's current eligibility period so the information can be considered at the person's reassessment.)

SIGNATURE OF HOUSING CONSULTANT WHO HELPED DEVELOP PLAN (IF APPLICABLE)	
AGENCY	DATE
HOUSING TRANSITION/SUSTAINING PROVIDER'S SIGNATURE	
AGENCY	DATE

651-431-4300 or 866-267-7655

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

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

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

သတိ။ ဤစာရွက်စာတမ်းအားအခမဲ့ဘာသာပြန်ပေးခြင်း အကူအညီလိုအပ်ပါက၊ အထက်ပါဖုန်းနံပါတ်ကိုခေါ်ဆိုပါ။

ចំណាត់សំគាល់ ។ បើអ្នកត្រូវការជំនួយក្នុងការបកប្រែឯកសារនេះដោយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទតាមលេខខាងលើ ។

請注意，如果您需要免費協助傳譯這份文件，請撥打上面的電話號碼。

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

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

ဟ်သူဉ်ဟ်သးဘဉ်တက့်. ဖဲနမ့်လိဉ်ဘဉ်တ်မၤစၢၤကလီလၢတ်ကကျိးထံဝဲဒဉ်လံာ် တီလံာ်မီတခါအံၤန္ဉ်,ကိးဘဉ်လီတဲစိနီၢ်ဂ်ၢ်လၢထးအံၤန္ဉ်တက့်.

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

ໂປຣດຊາບ. ຖ້າຫາກ ທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປເອກະສານນີ້ຟຣີ, ຈົ່ງໂທຣໄປທີ່ໝາຍເລກຂ້າງເທິງນີ້.

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

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

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

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

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

LEP (8-16)

For accessible formats of this information or assistance with additional equal access to human services, write to DHS.info@state.mn.us, call 651-431-4300, or use your preferred relay service. ADA1 (2-18)

Appeal Information

If you are dissatisfied with the county agency, tribal nation or managed care organization's action, or feel they have failed to act on you request for home and community-based services, you have the right to appeal within 30 days to your agency, or write directly to:

Minnesota Department of Human Services Appeals Office
P.O. Box 64941
St. Paul, MN 55164-0941

NOTE: If you are enrolled in a managed care organization you also have the option to appeal directly with your managed care organization.

Call
Metro: 651-431-3600 (voice)
Outstate: 800-657-3510 (toll free)
TTY: 800-627-3529
Fax: 651-431-7523

Online filing http://edocs.dhs.state.mn.us/lfserver/Public/DHS-0033-ENG-eform

If you want to have your services continue during an appeal, you must file within 10 days after you receive a notice from your agency about a reduction, denial or termination of your services. If you show good cause for not appealing within the 30-day limit, the state agency can accept your appeal for up to 90 days from the date you receive the notice.

What if I feel I have been discriminated against?

Discrimination is against the law. You have the right to file a complaint if you believe you were discriminated against because of race, color, national origin, religion, creed, sex, sexual orientation, public assistance status, age or disability. To file a complaint, contact:

Minnesota Department of Human Services Equal Opportunity and Access Division
P.O. Box 64997
St. Paul, MN 55164-0997
Call 651-431-3040 (voice) or Minnesota Relay at 711 or 800-627-3529 (toll free)

Minnesota Department of Human Rights
Freeman Building 625 N. Robert Street St. Paul, MN 55155
Call 651-539-1100 (voice), 651-296-1283 (TTY) or
800-65703704 (toll free)

U.S. Department of Health and Human Services' Office for Civil Rights prohibits discrimination in its programs because of race, color, national origin, disability, age, religion or sex. Contact the federal agency directly at:

U.S. Department of Health and Human Services Office for Civil Rights, Region V
233 N. Michigan Ave., Suite 240
Chicago, IL 60601
Call 312-886-2359 (voice), 800-537-7697 (TTY) or 800-368-1019 (toll free).