DEPARTMENT OF HUMAN SERVICES

DHS-7307-ENG 4-24

BEHAVIORAL HEALTH, HOUSING, AND DEAF & HARD OF HEARING SERVICES

Housing Focused Person-Centered Plan

Person Information

FIRST NAME	MI	LAST NAME

LEGAL NAME (if different from chosen name)	PLAN DATE (required)

PREFERRED PRONOUNS	PMI	DATE OF BIRTH	PHONE NUMBER or EMAIL ADDRESS (must list one)

MAILING ADDRESS (list General Delivery if the person is currently residing in a city homeless and does not have an alternate 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

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 Provider – Transition/Sustaining

FIRST NAME (staff person identified at time of submission)		LAST NAME (staff person identified at time of submission)		
PROVIDER AGENCY			NPI	
EMAIL ADDRESS (staff person identified at time of submission)			PHONE NUMBER	
STREET ADDRESS	CITY		STATE	ZIP CODE

CHECK ONE OR MORE ASSESSED NEEDS (MUST REFLECT THE NEED AREAS THAT WERE IDENTIFIED IN THE ASSESSMENT)

☐ Mobility ☐ Communication ☐ Decision making ☐ Managing challenging behaviors

AREAS IN NEED OF HOUSING

How will the areas of assessed need be reflected in the person's housing? Please write at least 3-4 sentences explaining how the person's needs (mobility, communication, decision making, or managing challenging behaviors) affect their ability to find or keep housing.

SUPPORT INSTRUCTIONS

What will the provider do to address the recipient's assessed need(s) related to housing? Please write at least 3-4 sentences explaining how the provider will support the person with their assessed needs and help them find/keep their housing; as well as identify if they are starting with transition or sustaining services.

Moving Expenses

IS THIS PERSON SEEKING MOVING EXPENSES (PERSON MUST BE IN TRANSITION SERVICES)

◯ Yes ◯ No (move to Non-Housing Related Priorities/Goals)

BY SELECTING AN OPTION BELOW, I AM ATTESTING THAT THE PERSON IS LEAVING THIS LIVING SITUATION

◯ Leaving a Medicaid-funded institution
◯ Currently homeless and has stayed in a shelter/county-funded emergency shelter (including hotel voucher program or other county-funded emergency housing sites) at some point over the last 12 months. (By checking this option, I attest the person has self-reported shelter/county-funded emergency shelter stay in the last 12 months.)
◯ Leaving a provider-controlled setting

☐ **BY CHECKING THE BOX, I AM ATTESTING THAT THE PERSON IS MOVING INTO THEIR OWN HOME***

*Home means a setting that a participant owns, rents, or leases that is not operated, owned, or leased by provider of services of supports. **Please verify allowable institutions and provider-controlled settings definitions on the Housing Stabilization Policy page**.

Moving Expense Needs

Please write how the provider will use moving expenses to support the person's move. Please list what the services will be used for (ex. deposits, furniture, application fee, etc.)

Non-Housing Related Priorities/Goals

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

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

Consultant/Targeted or Moving Home MN Case Manager Information

Check box that applies: ☐ Housing Consultant ☐ Targeted Case Manager ☐ Moving Home MN

FIRST NAME (staff person identified at time of submission)	LAST NAME (staff person identified at time of submission)

PROVIDER AGENCY	NPI
EMAIL ADDRESS	PHONE NUMBER

STREET ADDRESS

CITY	STATE	ZIP CODE

ADDITIONAL COMMENTS

APPROVED PROVIDER GEOGRAPHIC AND CULTURAL EXCEPTION ON FILE?

◯ Yes (an exception is approved and on file)

◯ No (an exception does not apply to the provider location)

Housing Focused Person-Centered Plan Signature Sheet

FIRST NAME (recipient)	LAST NAME (recipient)	PMI

TARGETED CASE MANAGER OR HOUSING CONSULTANT	PHONE NUMBER or EMAIL	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-4839E-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.

By checking "I agree" and typing my name in the "Signature" field, I understand that I am electronically signing this form. I attest and certify that the information provided above is true and accurate. I understand that my electronic signature has the same legal effect and can be enforced in the same way as a handwritten signature. (MN Stat. §325L.07)

☐ I agree	SIGNATURE (type name)	DATE

My Support Team

By checking "I agree" and typing my name in the "Signature" field, I understand that I am electronically signing this form. I attest and certify that the information provided above is true and accurate. I understand that my electronic signature has the same legal effect and can be enforced in the same way as a handwritten signature. (MN Stat. §325L.07)

☐ I agree	LEGAL REPRESENTATIVE'S SIGNATURE (if applicable)	DATE
☐ I agree	SIGNATURE OF TARGETED CASE MANAGER WHO HELPED DEVELOP PLAN (if applicable)	DATE

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 written 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.)

By checking "I agree" and typing my name in the "Provider Staff Signature" field, I understand that I am electronically signing this form. I attest and certify that the information provided above is true and accurate. I understand that my electronic signature has the same legal effect and can be enforced in the same way as a handwritten signature. (MN Stat. §325L.07)

☐ I agree	SIGNATURE OF HOUSING CONSULTANT WHO HELPED DEVELOP PLAN (if applicable)	AGENCY	DATE
☐ I agree	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။

កំណត់សំគាល់ ។ បើអ្នកត្រូវការជំនួយក្នុងការបកប្រែឯកសារនេះដោយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទតាមលេខខាងលើ ។

請注意，如果您需要免費協助傳譯這份文件，請撥打上面的電話號碼。

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

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

ဟ်သူဉ်ဟ်သးဘဉ်တက့ၢ်. ဖဲနမ့ၢ်လိဉ်ဘဉ်တၢ်မၤစၢၤကလီလၢတၢ်ကကျိးထံဝဲဒဉ်လံာ်တီလံာ်မီတခါအံၤန့ၣ်, ကိးဘဉ်လီတဲစိနီၣ်ဂံၢ်လၢထးအံၤန့ၣ်တက့ၢ်.

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 (afcelinta) 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.

LB2 (10-20)

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).