ROBERT DESCHENE's Support Plan

Created: **July 25, 2024**
For: **ROBERT DESCHENE**

Person Information

Person's Name
ROBERT DESCHENE's Support Plan

Preferred Name
--

Primary Phone
2184378172

Primary Email
--

Date of Birth
02/22/1955

Primary Language
English

Overview

Effective Date Range

Start Date
08/01/2024

End Date
07/31/2025

Program
Developmental Disabilities (DD) Waiver

About Plan

Budget Information

Average Monthly Budget
$ 3,950.79

About Me

What do I want my life to look like

Who I am and what is important to me

ROBERT DESCHENE

Created: **July 25, 2024**
For: **ROBERT DESCHENE**

Robert is a 69-year-old man who lives in his own home in the community of Argyle, MN. Robert lives in this home with his cat, Princess. This home is owned by Robert's sister, Marlene, and Robert pays rent to live there. People are important to Robert. Robert is very social and enjoys visiting with others in the community. He is kind and trusting of those he meets. Robert typically attends many community functions and fundraisers in the evenings/weekends to give him the opportunity to see people. Robert attends church at Our Savior's Lutheran Church in Argyle every Sunday morning. He goes to the community center in Argyle every morning from Monday -- Friday to have coffee and visit with men in the community. Most afternoons and evenings, Robert goes to Legion or The Dell (restaurant/bar) to sit around and visit people. Robert does not like to stay at home for any significant amount of time. He would rather be in the community to see other people. Robert is independent with his personal cares. He lives on his own and does his best to keep his home clean. Robert is kind and respectful to everyone. He likes to make others happy and works hard to complete his goals at work and at home. Robert likes to be reassured that he is doing a good job while at work and at home. Robert is very sociable and likes to visit with others. He does not like to be angry and does not like when someone is upset with him. It is important to Robert to continue working in the community and to live in his home.

What I want my life to look like

Robert wants to stay in his current home and live alone with his cat, Princess. It is important to Robert that his home be maintained for safety reasons. Robert rents his home from his sister, Marlene. Robert is very happy that his bedroom is on the main level of his home and that his bathroom has been remodeled so he has a walk-in shower. He does not want to explore other housing options. Robert does not want to live in a facility.

My Community Life

It is important to Robert that he be able to continue living on his own in the community of Argyle and continue working at the ODC in Warren. Robert currently works at the ODC Monday-Thursday. Robert would like to continue receiving services from in-home family support through Marshall County Group Homes, Inc. He would like them to continue helping him with making menus, grocery shopping, cooking, and providing reminders/assistance with housekeeping tasks. It is important to Robert that he has money available to him when he requests it from his rep payee so he can do the things he wants to do such as attend various community functions, birthday parties, camps, and go out to eat. He wants to be able to continue spending time with friends and family. Robert thinks it is important to keep current on his medical appointments to avoid being hospitalized and he knows it is important to take his medication as it is prescribed. Robert would like others to continue assisting him with scheduling and transporting him to his appointments. Robert enjoys going for walks, biking in the community, going to church, playing games, and going out to eat.

My Work Life

Robert is attending the ODC four days per week (M-Th). Robert has worked at a variety of businesses performing janitorial tasks. Prior to the ODC Production Building closing, Robert also worked there performing assembly jobs. Robert is able to follow direction and ask questions for clarification. Robert will initiate routine tasks. Robert at times needs reminders to perform work to quality standards.

My Choice about Work

Working; not seeking to make changes to current work status or goals

My Goals

1 I will continue to live in my own home, with my cat, Princess.

Target Date
Jul 31, 2025

My Action Items

1. Name
   Home living

   Description
   Robert will take care of his cat on a daily basis. Robert will spend time with his cat each day and will be responsible to brush her, feed her, and clean her litter box daily. Robert will do housekeeping tasks daily to keep his home clean and organized. Robert will review the checklist left by in-home support staff to determine what tasks he needs to complete each week. If something needs repairing or replacing in his home, Robert will contact his sister/landlord, Marlene.

2. Name
   Services

   Description
   Robert will receive independent living skills and training through Marshall County Group Homes in-home support services. They will assist Robert with preventive health care by scheduling and transporting him to medical appointments. In-home staff will notify the team of updates from medical appointments. In-home staff will monitor Robert's medication set up and check for accuracy. In-home support staff will meet with Robert once a week to assist with housekeeping, grocery shopping, and meal preparation. Staff will continue to monitor the condition of Robert's home and will notify the team with any concerns. Staff will assist Robert with meal preparation and grocery shopping each week. They will assist Robert with planning meals and making good food choices for the week.

   Robert will receive home delivered meals 5 days per week through LSS. Robert will have a PERS to use in case of an emergency.

   Sheran will send a check each money to the Marshall County Group Home office for Robert to use when grocery shopping.

2 I want to work in the community and attend the ODC.

Target Date
Jul 31, 2025

My Action Items

1. Name
   Work

   Description
   Robert will be ready at his home to be picked up by Tri-Valley the mornings of Monday - Thursday to get to the ODC on time. Robert will attend the ODC on his scheduled days and will work his community jobs as arranged by ODC staff. ODC staff will provide job coaching when Robert works at the community job sites.

3 I will visit with others in the community each week and I will have my own spending money to purchase items I want.

Target Date
Jul 31, 2025

My Action Items

1. Name
Money

Description
Robert will receive a weekly check of $20 from his rep payee to cash and spend on whatever he chooses. If Robert needs additional funding for something specific coming up such as a camp or birthday party, Robert will contact Sheran and request the additional funding. Sheran will decide if additional funding requested by Robert is warranted and whether or not he has the funding available. Robert will not be dishonest by telling others he doesn't have money or food and ask friends or community members for money. Robert will try to save some of his money to purchase items he wants, such as an ABBA music CD.

My Supports

People And Community Organizations That Support Me

Person's Name
Sheran Neumann

Relationship
Power of Attorney

Role
Support/Interdisciplinary care team

Organization's Name
--

Support Description
Sheran is Robert's cousin. She is also his Rep Payee and his POA. Sheran assists with managing Robert's finances. Sheran's address is 1487 Summit Ave., St. Paul, MN 55105. Her phone contact is 651-230-5618.

Frequency
Daily

Area Of Need

☑Household management

☑Meaningful activities

Goals

--

Person's Name
Marlene Buchner

Relationship
Sibling

Role
Emergency Contact

Organization's Name
--

Support Description
Marlene is Robert's sister and his emergency contact. Marlene owns the home Robert current lives in and is Robert's landlord. Marlene's address is 343 W. Cross Ave., Warren, MN 56762. Her phone contact is 218.201.0931.

Frequency
Daily

Area Of Need

☑Household management

☑Self-preservation

Goals

--

Services and Supports

Service Type

Services that support me

Start Date
08/01/2024

End Date
07/31/2025

Service Name
Case Management, 15 Minutes

Procedure Code
T1016

Modifiers
UC, --, --, --

Provider Name
MARSHALL COUNTY SOCIAL SERVICES

Provider Identification Number (NPI/UMPI)
A000045100

Contact Information
Krissy McMahon, 218-745-5124

Units
240.00

Rate
$ 23.19

Average Monthly Cost
$ 463.80

Status
No change

Area of Need

Health Interventions

Meaningful activities

Self-preservation

Frequency
Other

Other
as needed

Support Instructions

Case manager visits Robert at least twice annually and contacts Robert quarterly. Additional contacts are made with the Robert and the team as needed. Average authorized time of case management is 5 hours per month. Case manager will make referrals as needed, monitor health and safety, implement/monitor/coordinate services and support plan. Case manager can be contacted for any disagreements or conflicts regarding the services or support plan and a team meeting can be held if needed. The case manager can be contacted for any updates or changes to the services or service plan.

Goals

I will continue to live in my own home, with my cat, Princess.

I want to work in the community and attend the ODC.

Service Type

Services that support me

Start Date
08/01/2024

End Date
07/31/2025

Service Name
Home Delivered Meals

Procedure Code
S5170

Modifiers
--, --, --, --

Provider Name
LUTHERAN SOCIAL SERVICE OF MN

Provider Identification Number (NPI/UMPI)
A953725200

Units
261.00

Rate
$ 7.51

Average Monthly Cost
$ 163.34

Status
No change

Area of Need
Eating and meal preparation

Frequency
Weekly

Support Instructions
5 meals per week

Goals
I will continue to live in my own home, with my cat, Princess.

Service Type
Services that support me

Start Date
08/01/2024

End Date
07/31/2025

Service Name
PERS Monthly Service Fee

Procedure Code
S5161

Modifiers
--, --, --, --

Provider Name
MARSHALL COUNTY SOCIAL SERVICES

Provider Identification Number (NPI/UMPI)
A000045100

Units
12.00

Rate
$ 44.95

Average Monthly Cost
$ 44.95

Status
No change

Area of Need

Movement

Self-preservation

Frequency
Monthly

Support Instructions
Monthly PERS (monthly fee of $44.95 for personal emergency system through MobileHelp)

Goals

I will continue to live in my own home, with my cat, Princess.

Service Type

Services that support me

Start Date
08/01/2024

End Date
07/31/2025

Service Name
Individualized Home Supports with Training, 1:1 Ratio, 15 Minute

Procedure Code
H2014

Modifiers
UC, U3, --, --

Provider Name
MARSHALL COUNTY GROUP HOMES INC

Provider Identification Number (NPI/UMPI)
A895217500

Contact Information
Marshall County Group Homes, 218-437-6695

Units
1,352.00

Rate
$ 12.23

Average Monthly Cost
$ 1,377.91

Status
--

Area of Need

Communication

Eating and meal preparation

Health Interventions

Household management

Learning

Meaningful activities

Memory and cognition

Movement

Psychosocial health

Self-preservation

Frequency
Weekly

Support Instructions
Weekly visits, 6.5 hours of service per week (28 hours per month) authorized for home management, transport and attend medical appointments, grocery shopping, meal preparation, run errands as needed, socialization events as needed

Goals

I will continue to live in my own home, with my cat, Princess.

Rate Inputs

Other

Customization
No customization

Rate Notes
--

Non-Framework Rate Information

Unit Rate

Non-framework reason type
--

REQUIRED: Explanation and calculation details for non-framework rate
--

Rate Information

Framework Unit Rate
$ 12.23

Final Unit Rate
$ 12.23

Final Rate Details
Framework rate

Total Cost
$ 16,534.96

Service Type
Services that support me

Start Date
08/01/2024

End Date
07/31/2025

Service Name
Day Support Services, 15 Minute

ROBERT DESCHENE

Created: **July 25, 2024**
For: **ROBERT DESCHENE**

Procedure Code
T2021

Modifiers
UC, --, --, --

Provider Name
OCCUPATIONAL DEVELOPMENT CENTER INC

Provider Identification Number (NPI/UMPI)
A647622800

Contact Information
Warren ODC - MaryBeth Gibson (218-285-7462)

Units
4,130.00

Rate
$ 2.68

Average Monthly Cost
$ 922.37

Status
--

Area of Need
Work/school
Learning
Meaningful activities
Movement

Frequency
Weekly

Support Instructions
Robert attends the ODC 4 days per week.

Goals
I want to work in the community and attend the ODC.

Rate Inputs

Direct Care Staffing

Average Staff Ratio
1:8

Licensed Practical Nurse (LPN) 15 Minute Units
0.00

Registered Nurse (RN) 15 Minute Units
0.00

Other

Customization
No customization

Rates Notes
--

Non-Framework Rate Information

Unit Rate

Non-framework reason type
--

REQUIRED: Explanation and calculation details for non-framework rate
--

Rate Information

Framework Unit Rate
$ 2.68

Final Unit Rate
$ 2.68

Final Rate Details
Framework rate

Total Cost
$ 11,068.40

Service Type

Services that support me

Start Date
08/01/2024

End Date
07/31/2025

Service Name
Employment Support Services, Group Ratio, 15 Minute

Procedure Code
T2019

Modifiers
HQ, --, --, --

Provider Name
OCCUPATIONAL DEVELOPMENT CENTER INC

Provider Identification Number (NPI/UMPI)
A647622800

Contact Information
Warren ODC - MaryBeth Gibson (218-285-7462)

Units
723.00

Rate
$ 6.72

Average Monthly Cost
$ 404.88

Status
No change

Area of Need
Learning
Movement
Work/school

Frequency
Weekly

Support Instructions

Robert attends the ODC 4 days per week and works various community jobs each week.

Goals

I want to work in the community and attend the ODC.

Rate Inputs

Employment Services

Shared Staff Ratio
Face to Face 1:2

Is the person self-employed?
No

Is the person an owner or partner in a microenterprise?
No

Job #1

Select the occupational grouping for the job position
Building and Grounds Cleaning and Maintenance Occupations (BLS grouping 37-0000)

Person's Job Title:
Janitor

Hourly Wage
13.50

Average Weekly Hours
3.50

Start/Hire Date
4/1/2024 12:00:00 AM

Is the person hired and paid directly by a community employer?
Yes

Does the person earn minimum wage or better (no less than the wages and benefits paid to people who do not have disabilities doing the same type of work)?
Yes

Name of community business where the person works:
City of Warren

Job #2

Select the occupational grouping for the job position
--

Person's Job Title:
--

Hourly Wage
--

Average Weekly Hours
--

Start/Hire Date
--

Is the person hired and paid directly by a community employer?
--

Does the person earn minimum wage or better (no less than the wages and benefits paid to people who do not have disabilities doing the same type of work)?
--

Name of community business where the person works:
--

Job #3

Select the occupational grouping for the job position
--

Person's Job Title:
--

Hourly Wage
--

Average Weekly Hours
--

Start/Hire Date
--

Is the person hired and paid directly by a community employer?
--

Does the person earn minimum wage or better (no less than the wages and benefits paid to people who do not have disabilities doing the same type of work)?
--

Name of community business where the person works:
--

Other

Customization
No customization

Rates Notes
--

Non-Framework Rate Information

Unit Rate

Non-framework reason type
--

REQUIRED: Explanation and calculation details for non-framework rate
--

Rate Information

Framework Unit Rate
$ 6.72

Final Unit Rate
$ 6.72

Final Rate Details
Framework rate

Total Cost
$ 4,858.56

Service Type
Services that support me

Start Date
08/01/2024

End Date
07/31/2025

Service Name
Transportation, One-Way Trip

Procedure Code
T2003

Modifiers
UC, --, --, --

Provider Name
OCCUPATIONAL DEVELOPMENT CENTER INC

Provider Identification Number (NPI/UMPI)
A647622800

Contact Information
Warren ODC - MaryBeth Gibson (218-285-7462)

Units
210.00

Rate
$ 17.00

Average Monthly Cost
$ 297.50

Status
No change

Area of Need
Work/school

Frequency
Weekly

Support Instructions
Robert attends the Warren ODC 4 days per week. The ODC assists with transporting Robert to his community job sites.

Goals
I want to work in the community and attend the ODC.

Service Type
Services that support me

ROBERT DESCHENE

Created: **July 25, 2024**
For: **ROBERT DESCHENE**

Start Date
08/01/2024

End Date
07/31/2025

Service Name
Transportation, One-Way Trip

Procedure Code
T2003

Modifiers
UC, --, --, --

Provider Name
TRI VALLEY TRANSPORTATION PROGRAMS

Provider Identification Number (NPI/UMPI)
A582467100

Units
418.00

Rate
$ 5.00

Average Monthly Cost
$ 174.17

Status
No change

Area of Need

Meaningful activities

Work/school

Frequency
Weekly

Support Instructions
Tri-Valley transports Robert from his home in Argyle to the Warren ODC on Monday - Thursday mornings. to get to work. Tri-Valley also transports Robert from the Warren ODC back to his home in Argyle on those days.

Goals

I want to work in the community and attend the ODC.

Service Type
Services that support me

Start Date
08/01/2024

End Date
07/31/2025

Service Name
Individualized Home Supports with Training, 1:2 Ratio, 15 Minute

Procedure Code
H2014

Modifiers
UC, UN, U3, --

Provider Name
MARSHALL COUNTY GROUP HOMES INC

Provider Identification Number (NPI/UMPI)
A895217500

Contact Information
Kristal Walen (218-437-6695)

Units
64.00

Rate
$ 6.12

Average Monthly Cost
$ 32.64

Status
No change

Area of Need
Meaningful activities

Frequency
Other

Other
2-4 group outings per year

Support Instructions
Marshall County Group Home (in-home support) will bring Robert on socialization outings with other residents several times per year. Each outing is approximately 5-6 hours.

Goals
I will visit with others in the community each week and I will have my own spending money to purchase items I want.

Rate Inputs

Other

Customization
No customization

Rate Notes
--

Non-Framework Rate Information

Unit Rate

Non-framework reason type
--

REQUIRED: Explanation and calculation details for non-framework rate
--

Rate Information

Framework Unit Rate
$ 6.12

Final Unit Rate
$ 6.12

Final Rate Details
Framework rate

Total Cost
$ 391.68

Service Type

Services that support me

Start Date
08/01/2024

End Date
07/31/2025

Service Name
Transportation, Mileage (Non-Commercial Vehicle)

Procedure Code
S0215

Modifiers
UC, --, --, --

Provider Name
MARSHALL COUNTY SOCIAL SERVICES

Provider Identification Number (NPI/UMPI)
A000045100

Contact Information
Krissy McMahon (218-745-5124)

Units
1,240.00

Rate
$ 0.67

Average Monthly Cost
$ 69.23

Status
No change

Area of Need
Meaningful activities
Household management

Frequency
Other

Other
monthly

Support Instructions

Marshall County Group Homes will provide waiver transportation for Robert to access the community. Generally, to include approximately 90 miles round trip to Grand Forks and back one a month, and two 80 miles round trip per year for group outings. Marshall County Group Homes will send Marshall County Social Services a voucher each month for transportation reimbursement.

Goals

I will continue to live in my own home, with my cat, Princess.

I will visit with others in the community each week and I will have my own spending money to purchase items I want.

Overall Cost of Services

Total Cost Of Authorized Services
$ 47,409.51

Safety and Well-being

My Plan To Address Safety Needs

Need(s) I will address

All areas of need have been addressed

My Backup Plan

Robert requires a 24-hour plan of care. Robert's health and safety needs will be monitored and met by services received through Marshall County Group Homes (in-home supports) and Warren ODC. Robert's POA and family members monitor the cares Robert receives from providers and POA/rep payee oversees his finances. Robert does not need 24-hour supervision and can secure assistance during an emergency. Robert has a land line phone that he can use to contact 911. Robert also has a personal emergency response system he can utilize to secure emergency assistance as needed. Robert is not dependent on daily staffing. However, if staffing were unavailable for an extended period of time in which is health and safety needs were not going to be met, Robert's family would assist with his needs to eliminate potential risks. Robert will receive DD waiver services. Robert participated in the development of this plan and is in agreement to services listed. If he would like an update to be made on his plan, he can contact his case manager to discuss changes. If there is a conflict or disagreement regarding Robert's services, providers, or plan; he can contact his case manager to discuss. Robert can also appeal certain actions by contacting the county agency or Minnesota DHS. (Appeal right information has been provided). Robert would like to have team meetings once a year. He prefers to meet at the ODC in the month of July (during the Marshall County Fair).

Support Plan Signature Sheet

Effective Date Range

08/01/2024 - 07/31/2025

Person

This document confirms I:

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

Materials shared

Data privacy practices, that explain my right to confidentiality (DHS-4839E or agency's form)
Yes

Minnesota Health Care Programs, DHS-3182
Yes

My right to appeal (DHS-1941, or agency's form)
Yes

Other information
--

I was given a choice between receiving services in the community or in an institution.
Yes

I was able to invite who I wanted to come to my planning meeting.
Yes

I participated in developing my plan for receiving services.
Yes

I was given choices of different types of services, housing and employment support that could meet my assessed needs as indicated in my assessment and through discussion with my case manager.
Yes

I was offered a choice of all available services, supports and providers.
Yes

I agree with the services, supports and providers indicated in my plan.
Yes

I understand if I do not agree with any part of my written support plan, I can call my case manager, assessor 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

I understand my case manager, assessor or care coordinator will send this signature page to me with my written plan.
Yes

Comments
--

I can call the following number if I am unable to reach my case manager/care coordinator.
218-745-5124

Signatures

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 case manager, care coordinator and/or certified assessor.

The provider(s) listed in this plan can share a written report about my care needs with my case manager and/or certified assessor if I give the provider(s) my permission.

My Signature
Handwritten

Date Signed
07/25/2024

Date Plan Sent to Me
08/02/2024

People – I would like my plan shared with the following people

Case Manager/Care Coordinator
Handwritten

Date Signed
07/25/2024

Providers - I would like my plan shared with the following provider(s)

Provider's Name

MARSHALL COUNTY GROUP HOMES INC

Provider's Signature

Handwritten

Date Signature Requested

08/02/2024

Signature Obtained

Second Attempt To Obtain Signature Date

--

Provider acknowledgements

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 case manager or certified assessor 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 service agreement so the information can be considered at the person's reassessment.)**

Date Signed

Provider Agency

Cindy Gratzek

Provider's Name

OCCUPATIONAL DEVELOPMENT CENTER INC

Provider's Signature

Handwritten

Date Signature Requested

08/02/2024

Signature Obtained

Second Attempt To Obtain Signature Date

--

Provider acknowledgements

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 case manager or certified assessor 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 service agreement so the information can be considered at the person's reassessment.)**

Date Signed

Provider Agency

Mary Gibson

DEPARTMENT OF HUMAN SERVICES
MnCHOICES

Support Plan Signature Sheet

Collect signatures on this form and upload to the person's signature section for the specific plan in the MnCHOICES application.

PERSON'S NAME	SUPPORT PLAN START DATE	SUPPORT PLAN END DATE
Robert Deschene	8/1/24	7/31/25
CASE MANAGER, CERTIFIED ASSESSOR OR CARE COORDINATOR NAME	**TELEPHONE NUMBER**	**EXT.**
Krissy McMahon	218-745-5124	

Person

This document confirms I:

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

Materials shared

I received information about:

Data privacy practices that explain my right to confidentiality (DHS-4839E [PDF] or agency's form)	☒ Yes ○ No
Minnesota Health Care Programs, DHS-3182, (PDF)	☒ Yes ○ No ○ Not applicable
My right to appeal (DHS-1941 [PDF] or agency's form)	☒ Yes ○ No
Other information, such as CADS, MnChoices assessment	☒ Yes ○ No

Creating my plan

I was given a choice between receiving services in the community or in an institution.	☒ Yes ○ No ○ Not applicable
I was able to invite who I wanted to come to my planning meeting.	☒ Yes ○ No ○ Not applicable
I participated in developing my plan for receiving services.	☒ Yes ○ No ○ Not applicable
I was given choices of different types of services, housing and employment support that could meet my assessed needs as indicated in my assessment and through discussion with my case manager.	☒ Yes ○ No ○ Not applicable
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, assessor 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 ○ Not applicable
I understand my case manager, assessor or care coordinator will send this signature page to me with my written plan.	☒ Yes ○ No

CFSS, PCA and Alternative Care/waiver programs

If I am eligible for both Community First Services and Supports and personal care assistance (CFSS/PCA) services and an Alternative Care/ waiver program (such as Developmental Disability [DD] Waiver, Community Access for Disability Inclusion [CADI], Elderly Waiver [EW], etc.) I choose:

To use all of my CFSS/PCA services in addition to other services/supports as written in my plan.	○ Yes ○ No ○ Not applicable
To use ____ minutes of CFSS/PCA services for alternative services. I will use ____ minutes of CFSS/ PCA services.	○ Yes ○ No ○ Not applicable

Rule 185 DD/RC case management recipients

This section only is for Rule 185 developmental disabilities/related conditions (DD/RC) case management recipients who want to waive their annual MnCHOICES reassessment.

I only receive developmental disabilities (DD) case management or DD case management with non-Medicaid funded services such as semi-independent living services (SILS).	◯ Yes ◯ No ◯ Not applicable
I understand that MnCHOICES is an annual assessment for long-term services and supports.	◯ Yes ◯ No ◯ Not applicable
I understand I have the right to request and receive a MnCHOICES assessment at any time.	◯ Yes ◯ No ◯ Not applicable
My case manager has explained to me how MnCHOICES could help me evaluate my needs and learn about possible support options available to me.	◯ Yes ◯ No ◯ Not applicable
I have been given a copy of the MnCHOICES brochure, DHS-7283 (PDF).	◯ Yes ◯ No ◯ Not applicable
My needs have not changed since my last assessment and support plan.	◯ Yes ◯ No ◯ Not applicable
I choose to waive this year's annual MnCHOICES reassessment.	◯ Yes ◯ No ◯ Not applicable

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 case manager, care coordinator and/or certified assessor.
- The provider(s) listed in this plan can share a written report about my care needs with my case manager and/or certified assessor if I give the provider(s) my permission.

MY SIGNATURE	DATE
ROBERT V OESCHGER	7 25 24
LEGAL REPRESENTATIVE'S (OR OTHER PERSON'S) SIGNATURE, IF APPLICABLE	DATE

I would like my plan shared with the following people and providers:

Marshall County Group Homes
Warren ODC
Sheran Neumann
Marlene Buchner

My support team

CASE MANAGER/CARE COORDINATOR SIGNATURE	DATE
Kristy McMahon	7/25/24

651-431-4300 or 866-267-7655 (toll free)

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. ဖဲနမ့်လိဉ်ဘဉ်တ်မၤစၢၤကလီလၢတ်ကကျိးထံဝဲဒဉ်လ်ာ် တီလ်ာ်စီတခါအံၤနှဉ်,ကိးဘဉ်လီတဲစီနီါ်လၢထးအံၤနှဉ်တက့်.

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)

ADA Advisory

For accessible formats of this information or assistance with additional equal access to human services, email DHS.info@state.mn.us, call 651-431-4300 or 866-267-7655 (toll free) or use your preferred relay service. (ADA1[2-18])

Civil Rights Notice

Discrimination is against the law. The Minnesota Department of Human Services (DHS) does not discriminate on the basis of any of the following:

- race
- color
- national origin
- creed
- religion
- sexual orientation
- public assistance status
- marital status
- age
- disability
- sex
- political beliefs

Civil Rights Complaints

You have the right to file a discrimination complaint if you believe you were treated in a discriminatory way by a social services agency.

Contact **DHS** directly only if you have a discrimination complaint:

Civil Rights Coordinator
Minnesota Department of Human Services
Equal Opportunity and Access Division
P.O. Box 64997
St. Paul, MN 55164-0997
651-431-3040 (voice) or use your preferred relay service

Minnesota Department of Human Rights (MDHR)

In Minnesota, you have the right to file a complaint with the MDHR if you believe you have been discriminated against because of any of the following:

- race
- color
- national origin
- religion
- creed
- sex
- sexual orientation
- marital status
- public assistance status
- disability

Contact the **MDHR** directly to file a complaint:

Minnesota Department of Human Rights
540 Fairview Avenue North, Suite 201
St. Paul, MN 55104
651-539-1100 (voice)
800-657-3704 (toll free)
711 or 800-627-3529 (MN Relay)
651-296-9042 (fax)
Info.MDHR@state.mn.us

U.S. Department of Health and Human Services' Office for Civil Rights (OCR)

You have the right to file a complaint with the OCR, a federal agency, if you believe you have been discriminated against because of any of the following:

- race
- color
- national origin
- age
- disability
- sex
- religion

Contact the **OCR** directly to file a complaint:

Office for Civil Rights
U.S. Department of Health and Human Services
Midwest Region
233 N. Michigan Avenue, Suite 240
Chicago, IL 60601
Customer Response Center: Toll-Free: 800-368-1019
TDD Toll-Free: 800-537-7697
ocrmail@hhs.gov