Person Information

Person's Name
SAMANTHA KLEVEN

Preferred Name
--

Primary Phone
2189654588

Primary Email
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Date of Birth
06/16/2005

Primary Language
English

Overview

Effective Date Range

Start Date
02/01/2025

End Date
01/31/2026

Program
Developmental Disabilities (DD) Waiver

About Plan

Budget Information

Average Monthly Budget
$ 9,633.81

About Me

What do I want my life to look like

Who I am and what is important to me

Samantha Kleven is a 19-year-old young adult living in a group home in Argyle, Minnesota. She attends WAO High School where she graduated in 2024, but plans to continue receiving special education services until before her 22nd birthday. Samantha enjoys playing with toys, drawing, coloring and watching movies. She enjoys movies such as Encanto and Barbie and also enjoys dressing up as her favorite characters. Samantha is a caring and inquisitive girl. Samantha wakes up around 6:45 am. She takes medication, brushes her teeth, gets dressed and eats breakfast. She is then picked up by the bus and spends her day at WAO high school receiving special education services. When she returns home she has a snack and plays. She will take a bath, eat supper and take medications. Previously she was going to sleep around 9 pm, however, it has been much earlier recently. Sometimes she is in bed around 6:30pm.

Samantha participated in the development of this plan and she has a choice in goals, services, providers, meeting location, meeting time, meeting participants, meeting agenda, living arrangements, employment options, daily routines, and daily activities.

What I want my life to look like

It is important to Sam to be able to play with her toys and to dress up as her favorite characters. It is important that she have familiar items such as bedding with her. Family is important to Sam and she looks forward to the weekends she spends with her parents.

My Community Life

Samantha enjoys time shopping

My Work Life

Samantha is currently a student at WAO high school and not working at this time.

My Choice about Work

Not working; interested or actively engaged in taking actions toward work goals

Do I need support to achieve work goals?

Yes

The type of support and next steps I need to achieve my work goals:

Samantha will need extensive support and assistance with all aspects of work goal including discovery, job search, and maintaining employment.

My Goals

1 Samantha would like to explore leisure activities in the community.

Target Date
Jan 31, 2026

My Action Items

1. Name
   Community Outings

   Description
   Samantha will participate in regular community outings. Marshall County Group home will assist with this. Samantha's parents and adult sisters will also provide opportunities when possible.

My Supports

People And Community Organizations That Support Me

Person's Name
Jennifer Pageler

Relationship
Special Education Case Manager

Role
Support/Interdisciplinary care team

Organization's Name
--

Support Description
Jennifer Paegler provides special education services at WAO High School.

Frequency
Daily

Area Of Need
☑Communication
☑Learning
☑Meaningful activities
☑Memory and cognition
☑Work/school

Goals
--

Services and Supports

Service Type
Services that support me

Start Date
02/01/2025

End Date
01/31/2026

Service Name
Assistive Technology / Equipment

Procedure Code
T2029

Modifiers
UB, --, --, --

Provider Name
ACTIVSTYLE LLC

Provider Identification Number (NPI/UMPI)
1417954165

Units
48.00

Rate
$ 4.00

Average Monthly Cost
$ 16.00

Status
Change

Area of Need
Health Interventions
Personal Cares

Frequency
Other

Other
4 units per month

Support Instructions
Wipes to aid in incontinence cares.

Goals
--

Service Type
Services that support me

Start Date
02/01/2025

End Date
01/31/2026

Service Name
Community Residential Services, Adult, Daily

Procedure Code
S5140

Modifiers
UC, U9, --, --

Provider Name
Marshall County Group Homes, Inc.

Provider Identification Number (NPI/UMPI)
A307487900

Contact Information
Kristal Walen, 218-437-6695

Units
365.00

Rate
$ 298.56

Average Monthly Cost
$ 9,081.20

Status
--

Area of Need
Communication
Eating and meal preparation
Health Interventions
Household management
Meaningful activities
Personal Cares
Self-preservation
Movement

Frequency
Other

Other
Daily

Support Instructions
Marshall County Group Homes provides daily residential support for Samantha.

Goals

--

Rate Inputs

Residential Address

Street Number
601

Street Name
Cedar ave

City
Argyle

Zip Code
56713

Average Shared Direct Care Staff Hours Per Day

Daytime Hours:
28.86

Overnight Hours:
5.00

Number of Residents
4

Does the person need awake overnight staff?
No

Remote Awake Hours:
0.00

Number of Residents Monitored Remotely
0

Average Individual Direct Care Staff Hours Per Day

Daytime Hours:
0.53

Overnight Hours:
0.00

Licensed Practical Nurse (LPN) Assessment/Treatment
0.01

Registered Nurse (RN) Assessment/Treatment
0.10

Remote Awake Hours:
0.00

Other

Transportation
Adapted vehicle with lift

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
$ 298.56

Final Unit Rate
$ 298.56

Final Rate Details
Framework rate

Total Cost
$ 108,974.40

Service Type
Services that support me

Start Date
02/01/2025

End Date
01/31/2026

Service Name
Family Training, 15 Minute

Procedure Code
S5110

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

Provider Name
MARSHALL COUNTY SOCIAL SERVICES

Provider Identification Number (NPI/UMPI)
A000045100

Contact Information
Wendy Smith, Son Shine Farm Refuge

Units
155.00

Rate
$ 20.00

Average Monthly Cost
$ 258.33

Status
Change

Area of Need
Meaningful activities
Learning
Movement
Psychosocial health
Communication

Frequency
Weekly

Support Instructions
Samantha attends weekly, 75 minute sessions of Equine Assisted Learning during the warmer months.

Goals
--

Service Type
Services that support me

Start Date
02/01/2025

End Date
01/31/2026

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
Cassi Hermanson, 218-745-5124

Units
144.00

Rate
$ 23.19

Average Monthly Cost
$ 278.28

Status
Change

Area of Need
Self-preservation
Psychosocial health

Frequency
Other

Other
3 hours per month

Support Instructions

Case management services to include, monitoring and implementing support plan, assessing for additional needs and linking with services as needed. Samantha or her guardian can request her case manager update her support plan at any time during the year. If there is a complaint or grievance about the services you are receiving, please contact your county case manager or follow the agency's protocol. Minimum face to face contact semi annually with total contact at minimum quarterly. Estimated time three hours per month.

Goals

--

Overall Cost of Services

Total Cost Of Authorized Services

$ 115,605.76

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

Samantha's group home, Marshall County Group Homes, will ensure that she is safe during inclement weather conditions or medical emergencies. In the event of insufficient staffing, MCGH will follow their protocols.

Support Plan Signature Sheet

Effective Date Range

02/01/2025 - 01/31/2026

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
E-Signature

/ /

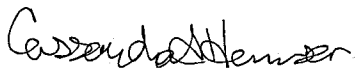
Date Signed
01/29/2025

Date Plan Sent to Me
02/12/2025

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

Case Manager/Care Coordinator

E-Signature

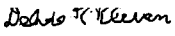


Date Signed

02/12/2025

Other Person's Signature

E-Signature



Name

Debra Kleven

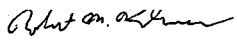
Date Signed

01/29/2025

Relationship

Other Person's Signature

E-Signature



Name

Robert Kleven

Date Signed

01/29/2025

Relationship

Father/Guardian

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

Provider's Name

Marshall County Group Homes, Inc.

Provider's Signature

E-Signature

Date Signature Requested

01/29/2025

Signature Obtained

Yes, Attached

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
1/29/2025	**Cindy Gratzek**