

Support Plan

PMI: 02848534

Person Information

Person's Name	Preferred Name
DEBRA HANGSLEBEN	--
Primary Phone	Primary Email
2187457605	--
Date of Birth	
05/07/1958	
Primary Language	
English	

Overview

Effective Date Range

Start Date	End Date
05/01/2025	04/30/2026

Program
Community Access for Disability Inclusion (CADI) Waiver

About Plan

Case Mix

About Me

Support Plan

PMI: 02848534

What do I want my life to look like

Who I am and what is important to me

Deb is a very personable person who enjoys being out in the community and spending time with people in her apartment building. Deb wants people to know that she is very friendly and willing to have a conversation with anyone if given the opportunity. Deb is very focused on remaining in her apartment and being there as independent as possible. She has lived in the same unit for many years, and after a health scare, she has realized that being in the community is a very important thing to her. Deb enjoys visiting with friends, being outside, going shopping, and spending time in the common area of the apartment building. Deb is a very organized individual and is always willing to work with her team to make sure that her needs are being taken care of. Deb is willing to discuss her care and also inform the team when she feels that she needs something to keep her safe and independent. Her health and overall care are very important to her, and she is always willing to use the services designed for this.

Deb has experienced some health issues over the past year. She has had a heart attack where she was life flighted to Fargo and had stints put in. She was able to recover well after an extended stay in the hospital and a rehab facility. Deb enjoyed her time at the North Star Manor and was really good while there in doing her therapy and making sure she was making the necessary strength gains to get back into her apartment and be as independent as possible. Deb is now back in her apartment and is doing quite well. She said that her health continues to be something she is working at as her stamina and strength aren't like it used to be, but she is able to manage. She continues to use a walker for her stability and balance. Deb does walk slow at times, but she knows that if she takes her time and goes slow that she will get to her destination without any falls. Deb is also dealing with knee and shoulder issues. She is having an MRI on her shoulder in the near future as she said that has been more bothersome than her knee. She is unable to lift it above her head and feels the strength is minimal in it right now. Deb is still due for a knee replacement but needs to wait a period of time after her heart attack. She said that this will be a good thing for her as well.

What I want my life to look like

Deb stated that she likes her life right now and that her current days are exactly what she wants her life to look like. Deb gets up in the morning and has breakfast. After this she

Support Plan

PMI: 02848534

will head down to the common area to see if anyone is having coffee. Then she goes outside to have a cigarette and enjoy the fresh air. After this, she will usually return to her apartment to do a few things and then settle in to watch some TV. Deb takes care of her own cooking and usually has lunch, after lunch she will usually have a quick nap. After her nap, Deb will go out for a cigarette and spend some time in the common area. During the day she will also have providers come in to help her, such as in home and chore services. Deb gets three showers/week which she is grateful for and also helps keep her apartment clean and organized with staff. Deb appreciates that she can have in home take her to/from her appointments, as they usually get some shopping done as well go out to her favorite restaurant, Culvers. She enjoys the butter burgers there, which she usually always orders.

Deb has dramatically cut down her smoking. She said that she used to smoke around a pack/day, but usually only has a couple of cigarettes/day. She is trying to cut back for a potential surgery on her knee and possibly her shoulder. Deb said that she thinks cutting back on the cigarettes will be a good benefit to her. She is using some Nicorette gum to help with the cravings, but overall has been doing most of this "cold turkey." Deb was very proud of her minimal cigarette intake at the meeting.

My Community Life

Deb lives in an apartment building called the Landmark in Warren, MN. She has lived in this building for quite a few years. Deb's apartment is a one bedroom, handicap accessible apartment which suits her physical ability well. The shower is completely walk in where she has a shower chair and rails to use. She also gets assistance from an individual for her showers. Her toilet also has the necessary rails and is a high toilet making it much easier for her to get on and off. Deb has a nice sized living room and kitchen that she enjoys as well. Deb is very involved within the "community" of her apartment building. She spends a lot of time in the common area and outside of the apartment where she socializes and smokes cigarettes. Deb is well known in the apartment and knows most other residents. Staff at the apartment enjoy her company and have been very good with helping Deb when need be. She knows the maintenance man well and he has been able to help her with a few things when they occur. Deb has services to help her get out in the community and these services take her grocery

Support Plan

PMI: 02848534

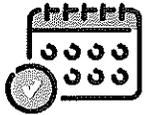
shopping on a regular basis. These services also bring her to/from her appointments. Deb enjoys getting out in the community and doing some things, with her favorite being lunch at Culver's. The community does offer a small variety of volunteer possibilities, but Deb is not interested in these at this time.

My Goals

Support Plan

PMI: 02848534

1 Deb will use her walker while walking, as she can be unsteady in her balance when not using it.



Target Date
Apr 30, 2026

My Action Items

1. Name

Deb

Description

Deb will make sure that she cooperates with support staff that have been arranged to help her with her tasks within her apartment. She will utilize the services necessary to keep her independent in her apartment and will also communicate with staff and case manager to make sure the services she receives are adequate. Deb will work with staff to arrange her appointments and med refills, and she will take her meds as prescribed. She will have a clearly labeled pill box that will be on her kitchen table.

2. Name

Case Manager

Description

Case manager will implement the support plan and make referrals for services as needed and will monitor the services in the plan to ensure that the services offered will meet the assessed needs. Case manager will review plan with individual at least twice a year and will update the plan as needed.

3. Name

Walker Usage

Description

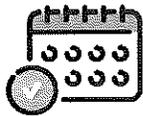
Support Plan

PMI: 02848534

Deb will make sure that she is using her walker when walking. She is to use it during all activity in and out of her apartment. Deb will stop and take breaks if she becomes winded or dizzy.

Deb will maintain her walker and keep case manager informed if her current one is in need of repair or replacement. She likes to replace her walker when they become unsteady in the leg area. Case manager will order a new one for her to maintain integrity with her walker.

2 Deb will continue to work with her support staff to keep her health and maintain her independent lifestyle within her own apartment.



Target Date
Apr 30, 2026

My Action Items

1. Name
Deb

Description

Deb will make sure that she cooperates with support staff that have been arranged to help her with her tasks within her apartment. She will utilize the services necessary to keep her independent in her apartment and will also communicate with staff and case manager to make sure the services she receives are adequate. Deb will work with staff to arrange her appointments and med refills, and she will take her meds as prescribed. She will have a clearly labeled pill box that will be on her kitchen table.

2. Name
Case Manager

Support Plan

PMI: 02848534

Description

Case manager will implement the support plan and make referrals for services as needed and will monitor the services in the plan to ensure that the services offered will meet the assessed needs. Case manager will review plan with individual at least twice a year and will update the plan as needed.

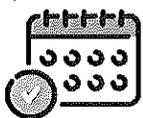
3. Name

Marshall County Group Homes

Description

MCGH staff will provide the necessary in-home services to make sure that Deb is living well, health, and safely in her own apartment. They will provide the necessary staff and guidance to help her with her ADL/IADL activities while also helping with hygiene and med compliance. MCGH staff will also transport her to/from appointments as necessary.

3 Deb wants to continue visiting her mother's grave on an annual basis. Deb will arrange with staff so she can get the necessary transportation for this.



Target Date
May 31, 2025

My Action Items

1. Name

Marshall County Group Homes

Description

MCGH staff will provide the necessary in-home services to make sure that Deb is living well, health, and safely in her own apartment. They will provide the necessary staff and guidance to help her with her ADL/IADL activities while also helping with hygiene and med compliance. MCGH staff will also transport

Support Plan

PMI: 02848534

her to/from appointments as necessary.

Support Plan

PMI: 02848534

My Supports

Support Plan

PMI: 02848534

Services and Supports

Service Type

Services that support me

Start Date

05/01/2025

End Date

04/30/2026

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

Units

2,080.00

Rate

\$ 12.23

Average Monthly Cost

\$ 2,119.87

Status

No change

Frequency

Daily

Support Instructions

**MCGH in-home staff will assist Deb in regards to helping with ADL/IADL activity,
scheduling appointments, grocery shopping, transportation, etc.**

Goals

Support Plan

PMI: 02848534

Deb will continue to work with her support staff to keep her health and maintain her independent lifestyle within her own apartment.

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

\$ 25,438.40

Service Type

Services that support me

Start Date

05/01/2025

End Date

04/30/2026

Service Name

Chore Services, 15 Minute

Support Plan

PMI: 02848534

Procedure Code

S5120

Modifiers

--, --, --, --

Provider Name

MARSHALL COUNTY SOCIAL SERVICES

Provider Identification Number (NPI/UMPI)

A000045100

Units

624.00

Rate

\$ 4.32

Average Monthly Cost

\$ 224.64

Status

No change

Frequency

Weekly

Support Instructions

Chore services will assist Deb with ADL/IADL tasks, especially bathing. She will receive up to 2-3 showers/week with the chore service provider. Chore services will also provide help with random tasks of cleaning and laundry.

Goals

Deb will continue to work with her support staff to keep her health and maintain her independent lifestyle within her own apartment.

Service Type

Services that support me

Start Date

05/01/2025

End Date

04/30/2026

Service Name

Support Plan

PMI: 02848534

Case Management, 15 Minute

Procedure Code

T1016

Modifiers

UC, --, --, --

Provider Name

MARSHALL COUNTY SOCIAL SERVICES

Provider Identification Number (NPI/UMPI)

A000045100

Units

100.00

Rate

\$ 24.47

Average Monthly Cost

\$ 203.92

Status

No change

Frequency

Other

Other

As needed

Support Instructions

Case manager will provide the necessary services and resources to ensure that Deb's needs are met.

Goals

Deb will continue to work with her support staff to keep her health and maintain her independent lifestyle within her own apartment.

Service Type

Services that support me

Support Plan

PMI: 02848534

Start Date

05/01/2025

End Date

04/30/2026

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

\$ 15.00

Average Monthly Cost

\$ 15.00

Status

No change

Frequency

Daily

Support Instructions

PERS pendant will be provided by NVHC

Goals

Deb will use her walker while walking, as she can be unsteady in her balance when not using it.

Deb will continue to work with her support staff to keep her health and maintain her independent lifestyle within her own apartment.

Service Type

Support Plan

PMI: 02848534

Services that support me

Start Date
05/01/2025

End Date
04/30/2026

Service Name
Transportation, Mileage (Non-Commercial Vehicle)

Procedure Code
S0215

Modifiers
UC, --, --, --

Provider Name
MARSHALL COUNTY SOCIAL SERVICES

Provider Identification Number (NPI/UMPI)
A000045100

Units
1,100.00

Rate
\$ 0.67

Average Monthly Cost
\$ 61.42

Status
No change

Frequency
Monthly

Support Instructions
MCGH will provide additional transportation as needed for Deb's outings and appointments

Goals
Deb will continue to work with her support staff to keep her health and maintain her independent lifestyle within her own apartment.

Support Plan

PMI: 02848534

Service Type

Services that support me

Start Date

05/01/2025

End Date

04/30/2026

Service Name

**Case Management Aid (Paraprofessional),
15 Minute**

Procedure Code

T1016

Modifiers

TF, UC, --, --

Provider Name

MARSHALL COUNTY SOCIAL SERVICES

Provider Identification Number (NPI/UMPI)

A000045100

Units

48.00

Rate

\$ 9.39

Average Monthly Cost

\$ 37.56

Status

No change

Frequency

Other

Other

As needed

Support Instructions

Deb has money management through MCSS which requires para professional support

Goals

Support Plan

PMI: 02848534

Deb will continue to work with her support staff to keep her health and maintain her independent lifestyle within her own apartment.

Support Plan

PMI: 02848534

Overall Cost of Services

Total Cost Of Authorized Services
\$ 31,948.80

Safety and Well-being

My Plan To Address Safety Needs

My plan to address needs

--

My Backup Plan

Deb is able to maintain and take care of situations that would be classified as unforeseen events. She understands that when inclement weather is coming that she needs to take shelter and follow all protocols/guidelines that the apartment building has in place for this. Deb is able to use her phone and is able to contact the appropriate people during a situation where she may need help.

Deb has staff available to her during set times/days of the week. She has contact information if she is in need of help. She also has her PERS pendant and she understands that she can push that when necessary to get the appropriate help needed. Deb is able to maintain her life independently and does not need staff physically with her 24 hrs/day.

Deb understands that she is able to participate freely with her plan and services given to her. She is very active in advocating for herself and does an excellent job participating and informing her team of what is working, what is not working, and what she wishes she could try. Deb works very hard with her goal selection, and they mean a lot to her, so she does a really nice job with goal decisions and what she wants to work on. Deb's team always scheduled face to face visits annually and semi-annually. Deb participates in the location, date, and times of meetings. She enjoys meeting at her apartment and always meeting in the morning. She usually provides the team with treats and water or coffee per request.

Support Plan

PMI: 02848534

Support Plan Signature Sheet

Effective Date Range

05/01/2025 - 04/30/2026

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

Support Plan

PMI: 02848534

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

Support Plan

PMI: 02848534

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

Signature captured in attachment

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

Case Manager/Care Coordinator

Handwritten

Signature captured in attachment

Date Signed

04/09/2025

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

No signature records available.

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 <i>Debra Hangolsen</i>	SUPPORT PLAN START DATE <i>05-01-25</i>	SUPPORT PLAN END DATE <i>04-30-26</i>
CASE MANAGER, CERTIFIED ASSESSOR OR CARE COORDINATOR NAME <i>Nick Santroski</i>	TELEPHONE NUMBER <i>218-775-5124</i>	EXT.

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)	<input checked="" type="radio"/> Yes <input type="radio"/> No
Minnesota Health Care Programs, DHS-3182, [PDF]	<input checked="" type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not applicable
My right to appeal (DHS-1941 [PDF] or agency's form)	<input checked="" type="radio"/> Yes <input type="radio"/> No
Other information, such as _____	<input type="radio"/> Yes <input type="radio"/> No

Creating my plan

I was given a choice between receiving services in the community or in an institution.	<input checked="" type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not applicable
I was able to invite who I wanted to come to my planning meeting.	<input checked="" type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not applicable
I participated in developing my plan for receiving services.	<input checked="" type="radio"/> Yes <input type="radio"/> No <input type="radio"/> 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.	<input checked="" type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not applicable
I was offered a choice of services, supports and providers.	<input checked="" type="radio"/> Yes <input type="radio"/> No
I agree with the services, supports and providers indicated in my plan.	<input checked="" type="radio"/> Yes <input type="radio"/> 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.	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not applicable
I understand my case manager, assessor or care coordinator will send this signature page to me with my written plan.	<input checked="" type="radio"/> Yes <input type="radio"/> 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 [CADII], 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.	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not applicable
To use _____ minutes of CFSS/PCA services for alternative services. I will use _____ minutes of CFSS/PCA services.	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> 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).	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not applicable
I understand that MnCHOICES is an annual assessment for long-term services and supports.	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not applicable
I understand I have the right to request and receive a MnCHOICES assessment at any time.	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> 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.	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not applicable
I have been given a copy of the MnCHOICES brochure, DHS-7283 (PDF).	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not applicable
My needs have not changed since my last assessment and support plan.	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not applicable
I choose to waive this year's annual MnCHOICES reassessment.	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> 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 <i>Deb Hanzleben</i>	DATE 4-9-25
LEGAL REPRESENTATIVE'S (OR OTHER PERSON'S) SIGNATURE, IF APPLICABLE	DATE

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

My support team

CASE MANAGER/CARE COORDINATOR SIGNATURE <i>[Signature]</i>	DATE 4-9-25
---	----------------

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

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

የስተውሉ: ካለምንም ክፍያ ይህንን ደብዳቤ ለማተራረጥ ለስተርጓሚ አፈላጊ ከላይ ወደተጻፈው የስልክ ቁጥር ይደውሉ።

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

သတိ။ ဤစာရွက်စာတမ်းအားအခမဲ့ဘာသာပြန်ပေးခြင်း အကူအညီလိုအပ်ပါက၊ အထက်ပါဖုန်းနံပါတ်ကိုခေါ်ဆိုပါ။

ကံဝန်ဆောင်မှု ၂။ ပြန်လည်ပေးအပ်မှုအတွက် အထောက်အကူပြုပေးရန်အတွက် အထက်ဖော်ပြပါဖုန်းနံပါတ်ကိုခေါ်ဆိုပါ။

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.

ဟံသာဝတီသံသရာတိုက်၊ ဝန်ဆောင်မှုပေးရန်အတွက် အထောက်အကူပြုပေးရန်အတွက် အထက်ဖော်ပြပါဖုန်းနံပါတ်ကိုခေါ်ဆိုပါ။

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

ໂປຣດຊາບ. ຖ້າຫາກ ທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປເອກະສານນີ້ພຣີ, ຈົ່ງໂທໂປຣໄປທີ່ໜ້າຍເລກຂ້າງເທິງນີ້.

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, 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