Person Information

Person's Name
GARY BERGH

Preferred Name
--

Primary Phone
2184376695

Primary Email
--

Date of Birth
01/19/1968

Primary Language
English

Overview

Effective Date Range

Start Date
12/01/2025

End Date
11/30/2026

Program
Developmental Disabilities (DD) Waiver

About Plan

Complex needs
Complex medical and/or complex behavioral needs criteria
Select if the person has complex needs based on the most recent assessment
The person does NOT have complex medical or behavioral needs

Budget Information

Average Monthly Budget
$ 11,474.79

About Me

What do I want my life to look like

Who I am and what is important to me

Gary values maintaining his independence and takes pride in his ability to move and care for himself. Over the past year, he has made significant progress with his mobility, using his walker confidently and enjoying opportunities to walk rather than stay in his wheelchair. He has developed greater strength and confidence in positioning and moving his body with assistance when needed.

Gary enjoys staying engaged with his favorite TV shows and follows Twins baseball and Vikings football closely. Attending another Twins game remains a special goal for him. He has a warm sense of humor and easily gets along with others, making social interactions enjoyable. Family is very important to Gary, and he likes spending time with them and keeping up with their activities.

What I want my life to look like

Gary enjoys a life that includes his favorite TV game shows and staying up-to-date with Twins baseball and Vikings football. He values maintaining his weekly routine, especially attending the ODC in Warren, where he has been going for several years. Continuing these activities helps Gary feel connected, engaged, and supported in his daily life.

My Community Life

Gary enjoys participating in his community and staying socially engaged. He likes going out to eat at different local restaurants and attending social events, such as Halloween and Christmas parties, hosted by other local group homes. These activities help him connect with others and enjoy time outside of his home environment.

My Work Life

Gary is retired from employment at the ODC but continues to stay engaged by participating in their leisure programs. Being involved in these activities allows him to maintain connections, enjoy structured social interaction, and continue pursuing his interests.

My Choice about Work

Not working; not interested in working

My Goals

1 Gary will write a personal letter to a family member or friend at least once per month, with support as needed, to maintain social connections and express himself.

Target Date
Nov 30, 2026

My Action Items

1. Name
   Writing a letter

   Description
   Staff will provide Gary with writing materials, prompts, and guidance as needed each month to help him compose a letter to a family member or friend. Staff will review and assist with mailing the letter if needed, while encouraging Gary to complete as much of the process independently as possible.

2 Gary will participate in at least one community outing each month, such as going to a restaurant, attending a social event, or visiting a local activity, to stay socially engaged and connected to his community.

Target Date
Nov 30, 2026

My Action Items

1. Name
   Outing

   Description
   Staff will plan and accompany Gary on at least one community outing per month, ensuring transportation, accessibility, and safety. Staff will encourage Gary to choose the destination and participate in planning to support his independence and engagement.

My Supports

Services and Supports

Service Type
Services that support me

Start Date
12/01/2025

End Date
11/30/2026

Service Name
Case Management, 15 Minutes

Procedure Code
T1016

Modifiers
UC, --, --, --

Provider Name
KITTSON COUNTY SOCIAL SERVICES

Provider Identification Number (NPI/UMPI)
A000035300

Contact Information
Emily Olson - eolson@co.kittson.mn.us - 218-843-2689

Units
100.00

Rate
$ 23.19

Average Monthly Cost
$ 193.25

Status
--

Area of Need
Communication
Meaningful activities
Self-preservation

Frequency
Other

Other
Flexible

Support Instructions
Case Management is provided by Kittson County Social Services. The case manager works on behalf of the person to identify their unique needs and to minimize the impact of the disability on the person's life while assuring continuity of services and supports for the person. The CM will attend team meetings and monitor goals on a semi-annual basis for appropriateness of goals as they relate to your dreams, goals and aspirations. The CM will also provide input on goal development and monitor for appropriateness of goals. Case management service activities may include: annual reviews of services plans; assisting the person in the identification of potential providers, assisting the person to access services; coordination of services; development of a service plan; evaluation and monitoring of the services identified in the plan: along with informing the person of service options. Case management administrative activities include: intake; screening activity, service authorization; review of eligibility for services; along with responding to requests for conciliation and appeals.

Goals
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Service Type
Services that support me

Start Date
12/01/2025

End Date
11/30/2026

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 - kristal.walen@mcghinc.org - 218-437-6695

Units
365.00

Rate
$ 313.64

Average Monthly Cost
$ 9,539.88

Status
--

Area of Need
Health Interventions

Household management

Learning

Meaningful activities

Memory and cognition

Movement

Personal Cares

Psychosocial health

Self-preservation

Frequency
Other

Other
Daily

Support Instructions

Providers of 245D must pass a back-ground study. Agencies will ensure that their staff are trained in vulnerable adults maltreatment reporting; maltreatment of minors reporting, program abuse and prevention plan, data privacy requirements; recipients rights and staff responsibilities as it relates to ensuring the exercise and protection of those rights; will know the principles of person centered services planning and delivery; safe and correct use of manual restraint in an emergency; responsibilities to prohibited procedures; along with basic first aid and CPR training. Depending on the setting, may be required to provide appropriate and safe techniques in personal hygiene and grooming; appropriate medication administration; an understanding of what constitutes a healthy diet and have the skills necessary to prepare that diet; along the skills necessary to provide appropriate supports of Instrumental activities of daily living (IADL). Provider, when required will development of Person-Centered Planning and Service Delivery, Coordinated Service and Support Plan Addendums, Outcomes, Progress Reviews, Program Abuse Prevention Plans, Individual Abuse Prevention Plans, Self-Management Assessments along with Positive Support Transition Plans. Also, they will provide instruction for skill building, monitor for health and safety, and work on outcomes as determined by team at meetings. The providers will also provide feedback to you and your team about progress on a semi-annual basis and communicate concerns with team.

Goals

--

Rate Inputs

Residential Address

Street Number	Street Name
601	**Cedar Ave**
City	Zip Code
Argyle	**56713**

Average Shared Direct Care Staff Hours Per Day

Daytime Hours:
29.76

Overnight Hours:
5.00

Number of Residents
4

Does the person need awake overnight staff?
Yes

Number of Residents Who Need Awake Overnight Shared Staff
2

Remote Awake Hours:
0.00

Number of Residents Monitored Remotely
0

Average Individual Direct Care Staff Hours Per Day

Daytime Hours:
0.00

Overnight Hours:
0.00

Licensed Practical Nurse (LPN) Assessment/Treatment
0.01

Registered Nurse (RN) Assessment/Treatment
0.09

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
$ 313.64

Final Unit Rate
$ 313.64

Final Rate Details
Framework rate

Total Cost
$ 114,478.60

Service Type
Services that support me

Start Date
12/01/2025

End Date
11/30/2026

Service Name
Day Support Services, 15 Minute

Procedure Code
T2021

Modifiers
UC, --, --, --

Provider Name
OCCUPATIONAL DEVELOPMENT CENTER INC

Provider Identification Number (NPI/UMPI)
A647622800

Contact Information
Jenna Sieracki - JSieracki@odcmn.org - 218-681-4949

Units
4,600.00

Rate
$ 4.00

Average Monthly Cost
$ 1,533.33

Status

--

Area of Need

Communication

Eating and meal preparation

Learning

Meaningful activities

Movement

Self-preservation

Work/school

Frequency

Daily

Support Instructions

Providers of 245D must pass a back-ground study. Agencies will ensure that their staff are trained in vulnerable adults maltreatment reporting; maltreatment of minors reporting, program abuse and prevention plan, data privacy requirements; recipients rights and staff responsibilities as it relates to ensuring the exercise and protection of those rights; will know the principles of person centered services planning and delivery; safe and correct use of manual restraint in an emergency; responsibilities to prohibited procedures; along with basic first aid and CPR training. Depending on the setting, may be required to provide appropriate and safe techniques in personal hygiene and grooming; appropriate medication administration; an understanding of what constitutes a healthy diet and have the skills necessary to prepare that diet; along the skills necessary to provide appropriate supports of Instrumental activities of daily living (IADL). Provider, when required will development of Person-Centered Planning and Service Delivery, Coordinated Service and Support Plan Addendums, Outcomes, Progress Reviews, Program Abuse Prevention Plans, Individual Abuse Prevention Plans, Self-Management Assessments along with Positive Support Transition Plans. Also, they will provide instruction for skill building, monitor for health and safety, and work on outcomes as determined by team at meetings. The providers will also provide feedback to you and your team about progress on a semi-annual basis and communicate concerns with team.

Goals

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Rate Inputs

Direct Care Staffing

Average Staff Ratio
1:4

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
$ 4.00

Final Unit Rate
$ 4.00

Final Rate Details
Framework rate

Total Cost
$ 18,400.00

Service Type
Services that support me

Start Date
12/01/2025

End Date
11/30/2026

Service Name
Transportation, One-Way Trip

Procedure Code
T2003

Modifiers
UC, --, --, --

Provider Name
TRI VALLEY TRANSPORTATION PROGRAMS

Provider Identification Number (NPI/UMPI)
A582467100

Contact Information
Tri-Valley 800-201-3432

Units
500.00

Rate
$ 5.00

Average Monthly Cost
$ 208.33

Status
--

Area of Need
Work/school

Frequency
Daily

Support Instructions
Transportation for the ODC is provided by Tri-Valley who takes on all responsibility for transportation.

Goals
--

Overall Cost of Services

Total Cost Of Authorized Services
$ 137,697.60

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

You are a vulnerable adult and at risk for all types of abuse. Agencies working with you may be required to complete an abuse prevention plan to mitigate any potential harm. Staff working with you need to be properly trained on risk mitigation and proper reporting procedures if abuse occurs or is suspected. If you have a legal representative, they are responsible to help make decisions that reduce the likelihood of health and safety issues occurring. Your guardians are ultimately responsible for ensuring proper health and safety, but providers working with you are also required to follow agency protocol in ensuring your health and safety.

Support Plan Signature Sheet

Effective Date Range

12/01/2025 - 11/30/2026

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 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 have talked with my service planning team about services that support me in my own home. We have determined those services will not meet my needs. I would like to access residential support services.
Not Applicable

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.
218-843-2689

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
11/10/2025

Date Plan Sent to Me
11/10/2025

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

Case Manager/Care Coordinator

E-Signature Emily Olson, LSW

Date Signed

11/05/2025

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

No signature records available.