Clear Form

DEPARTMENT OF HUMAN SERVICES

DHS-7122-ENG 6-20

# Professional Statement of Need

| APPLICANT NAME | DATE OF BIRTH |
|---|---|
| HOUSING PROVIDER NAME (if available) | MAXIS CASE NUMBER (if available) |

Qualified Professionals (as defined in Section 2) use this form to confirm that a person meets certain criteria for **one or both** of the following:

- Medical Assistance Housing Stabilization Services
- Minnesota Housing Support Program

After completing this form, please return to the person or their authorized representative.

This request does not represent an offer of payment on the part of the state, county, or tribe.

**Do you authorize the Qualified Professional to release your information? *(read and sign below)***

I give permission for the Qualified Professional below to release the requested information to the Minnesota Department of Human Services as well as the county or tribe administering the programs. I know that the information will be used to determine my eligibility for the Minnesota Housing Support Program as well as Medical Assistance Housing Stabilization Services. I know this authorization will end one year from the date I sign it.

State and Federal privacy laws protect my records. I know:

- Why I am being asked to release this information
- I do not have to consent to this authorization, but it may affect my benefits or services if I do not give my consent
- I am giving my written consent for this person/agency to give out this information
- I may stop this authorization with a written notice at any time, but this written notice will not affect information the agency has already requested
- The person or agency who gets my information may pass it on to others.

| APPLICANT SIGNATURE | DATE |
|---|---|

## Section 1: Housing Situation

**What is your current situation? *You may choose more than one option.***

- ☐ I am currently homeless.
- ☐ I am at risk of losing my housing.
- ☐ I am living in, or I have recently transitioned from, an institution (ex. hospital or nursing home) or congregate facility (ex. board and lodge, foster home, assisted living).
- ☐ I am eligible for waiver services (BI, CAC, CADI, DD, EW).
- ☐ I was homeless before entering a correctional, medical, mental health, or substance use disorder treatment center and now I am discharging without a permanent place to live.

## Section 2: Disabling Condition

***A certified disability determination or formal diagnostic assessment is not required (check one).***

| Disabling condition | Allowable qualified professional |
|---|---|
| ◯ Developmental Disability | Mental health professional, licensed school psychologist, a physician, a nurse practitioner, a physician assistant, or certified psychometrist working under the supervision of a licensed psychologist. |
| ◯ Learning Disability | Licensed psychologist or school psychologist with experience determining learning disabilities. |
| ◯ Mental health | Licensed psychiatric registered nurse, licensed psychiatric nurse practitioner, licensed independent clinical social worker (LICSW), licensed professional clinical counselor (LPCC), licensed psychologist (LP), licensed marriage and family therapist (LMFT), or licensed psychiatrist. |
| ◯ Physical illness, injury, or incapacity | Licensed physician, physician's assistant, nurse practitioner, or licensed chiropractor. |
| ◯ Substance Use Disorder | Treatment director, alcohol and drug counselor supervisor, or licensed alcohol and drug counselor (LADC). |

**This condition is current and expected:**

◯ To last at least one year.

◯ To last less than one year, estimated until: _____

| NAME OF QUALIFIED PROFESSIONAL | TITLE / LICENSURE | | |
|---|---|---|---|
| SIGNATURE | DATE | ARE YOU A COUNTY DESIGNEE? ◯ Yes ◯ No | WHICH COUNTY? |

## Section 3: Medical Assistance Housing Stabilization Services

**This Section must be completed by a Qualified Professional.**
**Please identify areas in which the person needs support to find or maintain stable housing.**

- ☐ Communicating needs
- ☐ Mobility
- ☐ Making informed decisions
- ☐ Managing moods or behaviors

| NAME OF QUALIFIED PROFESSIONAL | TITLE / LICENSURE |
|---|---|
| SIGNATURE | DATE |

## Section 4: Minnesota Housing Support Supplemental Services

**This Section must be completed by a Qualified Professional or County Designee.**
**Please indicate which support(s) the person needs to access or maintain housing.**

- ☐ Tenancy supports to assist an individual with finding their own home, landlord negotiation, securing furniture and household supplies, understanding and maintaining tenant responsibilities, conflict negotiation, and budgeting and financial education.
- ☐ Supportive services to assist with basic living and social skills, household management, monitoring of overall well-being, and problem solving.
- ☐ Employment supports to assist with maintaining or increasing employment, increasing earnings, understanding and utilizing appropriate benefits and services, improving physical or mental health, moving toward self-sufficiency, and achieving personal goals.
- ☐ Health supervision services to assist in the preparation and administration of medications other than injectables, the provision of therapeutic diets, taking vital signs, or providing assistance in dressing, grooming, bathing, or with walking devices.

_____ (PERSON'S NAME) ***has an illness or incapacity which limits their ability to work and provide self-support, and needs assistance to access or maintain housing.***

| NAME OF QUALIFIED PROFESSIONAL | TITLE / LICENSURE | | |
|---|---|---|---|
| SIGNATURE | DATE | ARE YOU A COUNTY DESIGNEE? ◯ Yes ◯ No | WHICH COUNTY? |

## Section 5: Transition from Residential Treatment to Minnesota Housing Support Program

**This Section must be completed by Behavioral Health Treatment Staff.**
Note: Sections 2 and 3 of this form are not required for completion of this section. Residential treatment staff completing this section may be the same as the Qualified Professional listed above.

_____ (PERSON'S NAME) ***lacks a fixed, adequate, nighttime residence upon discharge from***
_____ (NAME OF RESIDENTIAL TREATMENT PROGRAM) ***on*** _____ (EXIT DATE)

| NAME OF TREATMENT STAFF | TITLE / LICENSURE |
|---|---|
| SIGNATURE | DATE |

Attention. If you need free help interpreting this document, ask your worker or call the number below for your language.

ያስተውሉ: ይህንን ዶኩመንት ለመተርጎም እርዳታ የሚፈልጉ ከሆነ: የጉዳዮን ሰራተኛ ይጠይቁ ወይም በሰልክ ቁጥር 1-844-217-3547 ይደውሉ።

ملاحظة: إذا أردت مساعدة مجانية لترجمة هذه الوثيقة، اطلب ذلك من مشرفك أو اتصل على الرقم 1-800-358-0377.

သတိ။ ဤစာရွက်စာတမ်းအားအခမဲ့ဘာသာပြန်ပေးခြင်း အကူအညီလိုအပ်ပါက၊ သင့်လူမှုရေးအလုပ်သမား အားမေးမြန်း ခြင်းသို့ မဟုတ် 1-844-217-3563 ကိုခေါ်ဆိုပါ။

កំណត់សំគាល់ ។ បើអ្នកត្រូវការជំនួយក្នុងការបកប្រែឯកសារនេះដោយឥតគិតថ្លៃ សូមសួរអ្នកកាន់សំណុំរឿង របស់អ្នក ឬហៅទូរស័ព្ទមកលេខ 1-888-468-3787 ។

請注意，如果您需要免費協助傳譯這份文件，請告訴您的工作人員或撥打 1-844-217-3564。

Attention. Si vous avez besoin d'une aide gratuite pour interpréter le présent document, demandez à votre agent chargé du traitement de cas ou appelez le 1-844-217-3548.

Thov ua twb zoo nyeem. Yog hais tias koj xav tau kev pab txhais lus rau tsab ntaub ntawv no pub dawb, ces nug koj tus neeg lis dej num los sis hu rau 1-888-486-8377.

ဟ်သူဉ်ဟ်သးဘဉ်တက့်. ဖဲနမ့်လိဉ်ဘဉ်တ်မၤစၢၤကလီလၢတ်ကကျိးထံဝဲဒဉ်လ်ာ် တီလ်ာ်မီတခါအံၤန္ဉ်,သံကွါဘဉ်ပှၤဂ့ၢ်ဝီအပှၤမၤစၢၤတ်လၢနဂီၢ်မ့တမ့်ကီးဘဉ် 1-844-217-3549 တက့်.

알려드립니다. 이 문서에 대한 이해를 돕기 위해 무료로 제공되는 도움을 받으시려면 담당자에게 문의하시거나 1-844-217-3565으로 연락하십시오.

ໂປຣດຊາບ. ຖ້າຫາກ ທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປເອກະສານນີ້ຟຣີ, ຈົ່ງຖາມພະນັກງານກ່ຽວກັບການຊ່ວຍເຫຼືອ ຂອງທ່ານ ຫຼື ໂທຣໄປທີ່ 1-888-487-8251.

Hubachiisa. Dokumentiin kun bilisa akka siif hiikamu gargaarsa hoo feete, hojjettoota kee gaafadhu ykn afaan ati dubbattuuf bilbilli 1-888-234-3798.

Внимание: если вам нужна бесплатная помощь в устном переводе данного документа, обратитесь к своему социальному работнику или позвоните по телефону 1-888-562-5877.

Digniin. Haddii aad u baahantahay caawimaad lacag-la'aan ah ee tarjumaadda qoraalkan, hawlwadeenkaaga weydiiso ama wac lambarka 1-888-547-8829.

Atención. Si desea recibir asistencia gratuita para interpretar este documento, comuníquese con su trabajador o llame al 1-888-428-3438.

Chú ý. Nếu quý vị cần được giúp đỡ dịch tài liệu này miễn phí, xin gọi nhân viên xã hội của quý vị hoặc gọi số 1-888-554-8759.

LB1 (8-16)

ADA Advisory

For accessible formats of this information, ask your PCA. For assistance with additional equal access to human services, contact your PCA agency's ADA coordinator. ADA3 (2-18)