Clear Form

DEPARTMENT OF HUMAN SERVICES

DHS-7307A-ENG 8-21

COMMUNITY SUPPORTS ADMINISTRATION – HOUSING AND SUPPORT SERVICES

Housing Focused Person-Centered Plan + Home and Community-Based Services (HCBS) Rights Modification

Background information

Targeted case managers and housing consultants use this form when a person needs a modification to their rights based on assessed needs to make sure they are healthy and safe. The person's need for a modification can be identified at an initial assessment, reassessment or by notification from the person's support team, which may include the provider. If the person agrees to the modification plan, the service provider implements the modification plan in this form.

For more information on rights modification, see DHS – Transition plan for home and community-based settings or the Rights Restrictions and Modification video.

For more information on how to complete this form, refer to the HCBS Rights Modification Support Plan Guide for Housing Stabilization Services.

Responsibilities Areas

Targeted case manager or housing consultant

1. The targeted case manager or housing consultant completes Part A and Part B.
2. Once done, the targeted case manager or housing consultant forwards the form to the provider (to complete Part C) through fax, mail, secure email, or delivers it in-person.
3. After receiving the form back from the provider, the targeted case manager or housing consultant reviews the rights modification with the person.
4. When the form is completed and signed by the person, the targeted case manager or housing consultant keeps copy of the signed document in the person's file.

The housing transition or housing sustaining provider

1. The housing transition or housing sustaining provider will get the form from the targeted case manager or housing consultant with Part A and B complete.
2. The housing transition or housing sustaining provider completes Part C and returns the form to the targeted case manager or housing consultant using fax, mail, secure email, or delivers it in-person.
3. Once the targeted case manager or housing consultant reviews the plan with the person and the form is signed and completed by everyone involved, the housing transition or housing sustaining provider must follow the rights modification(s) plan while working with the person.

The person

The person or person's guardian checks whether they agree or disagree with the plan in Part D and then signs the plan.

Part A

Information

Person			
LAST NAME	FIRST NAME	PMI	PREFERRED PRONOUNS
LEGAL NAME (if different from chosen name)	PLAN DATE	EFFECTIVE DATE OF RIGHTS MODIFICATION(S)	
How often will the plan be reviewed? ◯ Annually ◯ Semi-annually ◯ Other			
IF OTHER, DEFINE FREQUENCY			

Housing Stabilization – Transition/sustaining provider	
PROVIDER AGENCY NAME	NPI
PRIMARY CONTACT LAST NAME	FIRST NAME

Targeted case manager or housing consultant	
PROVIDER AGENCY NAME	NPI
LAST NAME	FIRST NAME

Part B. Targeted case manager or housing consultant

The targeted case manager or housing consultant creates the modification plan in this section. The modification must be needed for the person to be safe and healthy. It should be based on the person's assessment (LTCC/MnCHOICES Assessment, Professional Statement of Need, or Coordinated Entry Assessment.)

1. Identify each HCBS right that needs to be modified (check each that apply):

- ☐ Have personal privacy (including the use of the lock on the bedroom door or unit door)
- ☐ Take part in activities that they choose, based on their own schedule supported by the service provider (this right cannot be modified in customized living settings.)
- ☐ Have access to food at any time
- ☐ Choose their own visitors and time of visits.

2. Explain why the person needs the modification(s) for each right(s) and why it is needed. The reason for the change must be based on the person's needs identified in the assessment.

For help completing this section, see HCBS rights modifications examples.

Right	Assessed need	Justification for rights modification
Have personal privacy (including the use of the lock on the bedroom door or unit door)		
Take part in activities that they choose, based on their own schedule supported by the service provider (this right cannot be modified in customized living settings)		
Have access to food at any time		
Choose their own visitors and time of visits.		

Part C. HCBS provider

The housing transition/sustaining provider must complete this section. The person and the targeted case manager or housing consultant will review the modification plan and decide if it meets the person's needs. The provider must:

- Make sure the modification allows the most rights while still protecting the person
- Continue to look for ways to increase the person's rights.

Modification plan information

1. How will the right be modified in the least restrictive manner?
2. What has been tried before?
3. What needs to happen for this person's right's modification to be removed?
4. How often will the rights modification be reviewed? (must be at least annually)

NOTE: The plan must be reviewed at least once a year from the date it was made. It can be reviewed more often, if requested by the person, the person's legal representative (if any), the provider, targeted case manager, or housing consultant.

Part D. Person/participant: Informed consent

You have to sign this plan. Your signature shows that you reviewed and understand what's in the plan. It also shows whether or not you agree to the plan. Signing this plan does not automatically mean you agree with it. If you want the plan to be used, you must agree this plan works for you. If you agree, check the box saying you approve this plan and then sign. If you don't agree to the plan, check the box saying "I don't want my rights to be modified" and sign the plan.

Your options

The reason for a modification of my rights has been explained to me in a way that I understand. I also understand how my provider will provide the modification to ensure my health, safety and well-being.

◯ **I approve of the modification(s) of my rights identified in this plan.**
I understand that I may withdraw my approval at any time. If I withdraw my approval, I understand that my rights must immediately and fully restored.

◯ **I don't want my rights to be modified.**
I understand that my health, safety and well-being may be at risk. My targeted case manager or housing consultant and my provider will need to decide if my health and welfare will be safe in this setting without the listed modification(s).

Signature section

☐ By checking this box and typing my name in the "Electronic Signature" field, I understand that I am electronically signing this form. I attest and certify that the information provided above is true and accurate. I understand that my electronic signature has the same legal effect and can be enforced in the same way as a handwritten signature. (MN Stat. §325L.07)

PERSON ELECTRONIC SIGNATURE (type name)

☐ By checking this box and typing my name in the "Electronic Signature" field, I understand that I am electronically signing this form. I attest and certify that the information provided above is true and accurate. I understand that my electronic signature has the same legal effect and can be enforced in the same way as a handwritten signature. (MN Stat. §325L.07)

LEGAL REPRESENTATIVE ELECTRONIC SIGNATURE (type name)

651-431-4300 or 866-267-7655

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

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

သတိ။ ဤစာရွက်စာတမ်းအားအခမဲ့ဘာသာပြန်ပေးခြင်း အကူအညီလိုအပ်ပါက၊ အထက်ပါဖုန်းနံပါတ်ကိုခေါ်ဆိုပါ။

កំណត់សំគាល់ ។ 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.ဖဲနမ့်လိဉ်ဘဉ်တ်မၤစၢၤကလီလၢတ်ကကျိးထံဝဲဒဉ်လံာ်တီလံာ်မိတခါအံၤနူဉ်,ကိးဘဉ်လီတဲစိနိုဂ််လၢထးအံၤနူဉ်တက့်.

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, write to DHS.info@state.mn.us, call 651-431-4300, or use your preferred relay service. ADA1 (2-18)

Appeal Information

If you are dissatisfied with the county agency, tribal nation or managed care organization's action, or feel they have failed to act on you request for home and community-based services, you have the right to appeal within 30 days to your agency, or write directly to:

Minnesota Department of Human Services Appeals Office
P.O. Box 64941
St. Paul, MN 55164-0941

NOTE: If you are enrolled in a managed care organization you also have the option to appeal directly with your managed care organization.

Call
Metro: 651-431-3600 (voice)
Outstate: 800-657-3510 (toll free)
TTY: 800-627-3529
Fax: 651-431-7523

Online filing: http://edocs.dhs.state.mn.us/lfserver/Public/DHS-0033-ENG-eform

If you want to have your services continue during an appeal, you must file within 10 days after you receive a notice from your agency about a reduction, denial or termination of your services. If you show good cause for not appealing within the 30-day limit, the state agency can accept your appeal for up to 90 days from the date you receive the notice.

What if I feel I have been discriminated against?

Discrimination is against the law. You have the right to file a complaint if you believe you were discriminated against because of race, color, national origin, religion, creed, sex, sexual orientation, public assistance status, age or disability. To file a complaint, contact:

Minnesota Department of Human Services Equal Opportunity and Access Division
P.O. Box 64997
St. Paul, MN 55164-0997
Call 651-431-3040 (voice) or Minnesota Relay at 711 or 800-627-3529 (toll free)

Minnesota Department of Human Rights
Freeman Building 625 N. Robert Street St. Paul, MN 55155
Call 651-539-1100 (voice), 651-296-1283 (TTY) or
800-65703704 (toll free)

U.S. Department of Health and Human Services' Office for Civil Rights prohibits discrimination in its programs because of race, color, national origin, disability, age, religion or sex. Contact the federal agency directly at:

U.S. Department of Health and Human Services Office for Civil Rights, Region V
233 N. Michigan Ave., Suite 240
Chicago, IL 60601
Call 312-886-2359 (voice), 800-537-7697 (TTY) or 800-368-1019 (toll free).