Clear Form

DEPARTMENT OF HUMAN SERVICES
MnCHOICES

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	SUPPORT PLAN START DATE	SUPPORT PLAN END DATE

CASE MANAGER, CERTIFIED ASSESSOR OR CARE COORDINATOR NAME	TELEPHONE NUMBER	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)	◯ Yes ◯ No
Minnesota Health Care Programs, DHS-3182, (PDF)	◯ Yes ◯ No ◯ Not applicable
My right to appeal (DHS-1941 [PDF] or agency's form)	◯ Yes ◯ No
Other information, such as	◯ Yes ◯ No

Creating my plan

I was given a choice between receiving services in the community or in an institution.	◯ Yes ◯ No ◯ Not applicable
I was able to invite who I wanted to come to my planning meeting.	◯ Yes ◯ No ◯ Not applicable
I participated in developing my plan for receiving services.	◯ Yes ◯ No ◯ 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.	◯ Yes ◯ No ◯ Not applicable
I was offered a choice of services, supports and providers.	◯ Yes ◯ No
I agree with the services, supports and providers indicated in my plan.	◯ Yes ◯ 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.	◯ Yes ◯ No ◯ Not applicable
I understand my case manager, assessor or care coordinator will send this signature page to me with my written plan.	◯ Yes ◯ 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 [CADI], 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.	◯ Yes ◯ No ◯ Not applicable
To use ____ minutes of CFSS/PCA services for alternative services. I will use ____ minutes of CFSS/PCA services.	◯ Yes ◯ No ◯ 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).	◯ Yes ◯ No ◯ Not applicable
I understand that MnCHOICES is an annual assessment for long-term services and supports.	◯ Yes ◯ No ◯ Not applicable
I understand I have the right to request and receive a MnCHOICES assessment at any time.	◯ Yes ◯ No ◯ 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.	◯ Yes ◯ No ◯ Not applicable
I have been given a copy of the MnCHOICES brochure, DHS-7283 (PDF).	◯ Yes ◯ No ◯ Not applicable
My needs have not changed since my last assessment and support plan.	◯ Yes ◯ No ◯ Not applicable
I choose to waive this year's annual MnCHOICES reassessment.	◯ Yes ◯ No ◯ 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	DATE
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	DATE

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

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

ያስተውሉ፡ ካለምንም ክፍያ ይህንን ዶኩመንት የሚተረጉምሎ አስተርጓሚ ከፈለጉ ከላይ ወደተጻፈው የስልክ ቁጥር ይደውሉ።

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. ဖဲနမ့်လိဉ်ဘဉ်တ်မၤစၢၤကလီလၢတ်ကကျိးထံဝဲဒဉ်လ်ာ် တီလ်ာ်မိတခါအံၤန္ဉ်,ကိးဘဉ်လီတဲစိနိ်ဂ််လၢထးအံၤန္ဉ်တက့်.

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

โปธดซาบ. ถ้าหากา ท่านต้องการมการช่วยเหลือในการแปเอกะสารนี้ฟธี, จ่งโทธไปที่หมายเลกข้างเหิงนี้.

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