DEPARTMENT OF HUMAN SERVICES
MnCHOICES

DHS-6791D-ENG 8-18

Coordinated Services and Supports Plan Signature Sheet

NAME	ASSESSMENT ID	DATE

CASE MANAGER, CERTIFIED ASSESSOR OR CARE COORDINATOR	TELEPHONE NUMBER	EXT.

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, which explain my right to confidentiality (DHS-4839E [PDF] or agency's form)	Yes	No
Minnesota Health Care Programs, DHS-3182, (PDF)	Yes	No
My right to appeal (DHS-1941 [PDF] or agency's form)	Yes	No
Other information, such as ______	Yes	No

Creating my Coordinated Services and Supports Plan (CSSP)

I was given a choice between receiving services in the community or in an institution.	Yes	No
I was able to invite who I wanted to come to my planning meeting.	Yes	No
I participated in developing my plan for receiving services.	Yes	No
I was given choices of different types of services that could meet my assessed needs as indicated on the Community Support Plan Worksheet I received and through discussion with my case manager.	Yes	No
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
I understand my case manager, assessor or care coordinator will send this signature page to me with my written plan.	Yes	No
My Coordinated Services and Supports Plan will be shared with the following people/providers for planning and coordination:	Yes	No

PCA and Alternative Care/waiver programs

If I am eligible for both personal care assistance (PCA) services **and** an Alternative Care/waiver program (such as the Developmental Disabilities (DD) Waiver, Community Access for Disability Inclusion (CADI) Waiver, etc.), I choose:

To use all of my PCA services in addition to other services/supports as written in my plan.	Yes	No
To use other services/supports as an alternative to ____ minutes of PCA services. I will use ____ minutes of PCA services.	Yes	No

NOTE: If I choose to change this decision, I will call my case manager or care coordinator.

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 case management or developmental disabilities case management with non-Medicaid funded services such as semi-independent living services (SILS).	Yes No
I understand that MnCHOICES is an annual assessment for long-term services and supports.	Yes No
I understand I have the right to request and receive a MnCHOICES assessment at any time.	Yes No
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
I have been given a copy of the MnCHOICES brochure.	Yes No
My needs have not changed since my last assessment and Coordinated Services & Supports Plan (CSSP).	Yes No
I choose to waive this year's annual MnCHOICES reassessment.	Yes No

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 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

My support team

LEGAL REPRESENTATIVE'S SIGNATURE	DATE
SIGNATURE OF CM/CA/CC WHO HELPED DEVELOP PLAN	DATE
OTHER PERSON'S SIGNATURE	DATE
OTHER PERSON'S SIGNATURE	DATE
OTHER PERSON'S SIGNATURE	DATE

Provider(s) signature

Provider(s) signatures indicate the provider(s) who sign:

- Have reviewed the plan.
- Acknowledge the services and supports in the plan.
- Agree to provide those services and supports as outlined.
- Understand we can submit a written report to the case manager or certified assessor about recommendations for the person's care needs for future assessments. (NOTE: The provider should submit the report at least 60 days before the end of the person's current service agreement so the information can be considered at the person's reassessment.)

PROVIDER'S SIGNATURE	
AGENCY	DATE
PROVIDER'S SIGNATURE	
AGENCY	DATE
PROVIDER'S SIGNATURE	
AGENCY	DATE

NOTE: Use another copy if there are more providers who need to sign.

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

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.

ဟ်သူဉ်ဟ်သး. ဖဲနမ့်လိဉ်ဘဉ်တၢ်မၤစၢၤကလီလၢတၢ်ကကျိးထံဝဲဒဉ်လံာ်တီလံာ်မီတခါအံၤန့ၣ်,ကိးဘဉ်လီတဲစိနီၢ်ဂံၢ်လၢထးအံၤန့ၣ်တက့ၢ်.

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

ໂປຣດຊາບ. ຖ້າຫາກ ທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປເອກະສານນີ້ຟຣີ, ຈົ່ງໂທຣໄປທີ່ໝາຍເລກຂ້າງເທີງນີ້.

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 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 (8-16)

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)

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 St.
St. Paul, MN 55155
Call 651-539-1100 (voice), 651-296-1283 (TTY) or 800-657-3704 (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).