DEPARTMENT OF HUMAN SERVICES

DHS-7122-ENG 10-22

Professional Statement of Need

APPLICANT'S NAME	APPLICANT'S LEGAL NAME (IF DIFFERENT)
DATE OF BIRTH	(For Office Use Only) MAXIS CASE NUMBER

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 form does not represent an offer of payment on the part of the state, county, or tribe. Additional information about completing this form may be found in the Professional Statement of Need Guidance for Qualified Professionals (DHS-7122A).

Section 1: Housing Situation

- For MA Housing Stabilization Services: This section is required.
- For Minnesota Housing Support: This section is not required.

What is your current situation? (You may choose more than one option)

- ☐ I am currently homeless.
- ☐ 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 at risk of losing my housing.
- ☐ 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

- For MA Housing Stabilization Services: Must be completed and signed by a Qualified Professional.
- For Minnesota Housing Support: Must be completed and signed by a Qualified Professional or a County/Tribal Designee.
- NOTE: A certified disability determination or formal diagnostic assessment is not required.

Disabling condition	Allowable qualified professional
◯ Developmental Disability	Licensed physician, physician assistant, advanced practice registered nurse (clinical nurse specialist, nurse anesthetist, nurse-midwife, or nurse practitioner), licensed independent clinical social worker, licensed psychologist, certified school psychologist, or certified psychometrist working under the supervision of a licensed psychologist
◯ Learning Disability	Licensed physician, physician assistant, advanced practice registered nurse (clinical nurse specialist, nurse anesthetist, nurse-midwife, or nurse practitioner), licensed independent clinical social worker, licensed psychologist, certified school psychologist, or certified psychometrist working under the supervision of a licensed psychologist
◯ Mental health	Licensed physician, physician assistant, advanced practice registered nurse (clinical nurse specialist, nurse anesthetist, nurse-midwife, or nurse practitioner), tribally certified mental health professional, or mental health professional (a registered nurse certified as a clinical specialist in psychiatric nursing or as a nurse practitioner in psychiatric and mental health nursing, licensed independent clinical social worker, licensed professional clinical counselor, licensed psychologist, licensed marriage and family therapist, or licensed psychiatrist)
◯ Illness, injury, or incapacity	Licensed physician, physician assistant, advanced practice registered nurse (clinical nurse specialist, nurse anesthetist, nurse-midwife, or nurse practitioner), physical therapist, occupational therapist, or licensed chiropractor, according to their scope of practice
◯ Substance Use Disorder	Licensed physician, physician assistant, tribally certified mental health professional, mental health professional (a registered nurse certified as a clinical specialist in psychiatric nursing or as a nurse practitioner in psychiatric and mental health nursing, licensed independent clinical social worker, licensed professional clinical counselor, licensed psychologist, licensed marriage and family therapist, or licensed psychiatrist), a substance use disorder treatment director, an alcohol and drug counselor supervisor, a licensed alcohol and drug counselor, or certified alcohol and drug counselor through the evaluation process established by the International Certification and Reciprocity Consortium Alcohol and Other Drug Abuse, Inc., or the Upper Midwest Indian Council on Addictive Disorder (UMICAD)

This condition is current and expected (check one):

◯ To last at least one year.

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

NAME OF QUALIFIED PROFESSIONAL	TYPE OF QUALIFIED PROFESSIONAL (FROM ABOVE)
QUALIFIED PROFESSIONAL'S EMAIL ADDRESS AND/OR PHONE NUMBER	QUALIFIED PROFESSIONAL'S AGENCY OR ORGANIZATION
ARE YOU A COUNTY/TRIBAL DESIGNEE? ◯ Yes ◯ No	WHICH COUNTY OR TRIBE?

By checking "I agree" and typing my name in the "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)

☐ I agree	SIGNATURE OR TYPED NAME	DATE

Section 3: Medical Assistance Housing Stabilization Services

- For MA Housing Stabilization Services: Must be completed and signed by a Qualified Professional.
- For Minnesota Housing Support: This section is not required.

Please identify areas in which the person needs support to find or maintain stable housing. The selection of one or more assessed need areas is required for eligibility.

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

NAME OF QUALIFIED PROFESSIONAL	TYPE OF QUALIFIED PROFESSIONAL (FROM SECTION 2)
QUALIFIED PROFESSIONAL'S EMAIL ADDRESS AND/OR PHONE NUMBER	QUALIFIED PROFESSIONAL'S AGENCY OR ORGANIZATION

By checking "I agree" and typing my name in the "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)

☐ I agree	SIGNATURE OR TYPED NAME	DATE

Section 4: Minnesota Housing Support Supplemental Services

- For Minnesota Housing Support: Must be completed and signed by a Qualified Professional or County/Tribal Designee.
- For MA Housing Stabilization Services: This section is not required.

Please indicate which support(s) the person needs to access or maintain housing. The selection of two or more supports is required for eligibility.

☐ 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.

NAME OF QUALIFIED PROFESSIONAL	TYPE OF QUALIFIED PROFESSIONAL (FROM SECTION 2)
QUALIFIED PROFESSIONAL'S EMAIL ADDRESS AND/OR PHONE NUMBER	QUALIFIED PROFESSIONAL'S AGENCY OR ORGANIZATION
ARE YOU A COUNTY/TRIBAL DESIGNEE? ◯ Yes ◯ No	COUNTY OR TRIBE

By checking "I agree" and typing my name in the "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)

☐ I agree	SIGNATURE OR TYPED NAME	DATE

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

- **For Minnesota Housing Support applicants who are exiting a residential Behavioral Health Treatment Program: Must be completed and signed by residential Behavioral Health Treatment staff.**
- For MA Housing Stabilization Services: This section is not required.
- NOTE: Sections 1, 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. Residential treatment staff must complete this section whether or not they are a qualified professional.

☐ The person named above lacks a fixed, adequate, nighttime residence upon discharge from this residential Behavioral Health Treatment Program.	DATE OF DISCHARGE:

NAME OF RESIDENTIALTREATMENT STAFF	NAME OF RESIDENTIAL BEHAVIORAL HEALTH TREATMENT PROGRAM
RESIDENTIAL TREATMENT STAFF'S EMAIL ADDRESS AND/OR PHONE NUMBER	

By checking "I agree" and typing my name in the "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)

☐ I agree	SIGNATURE OR TYPED NAME	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။

កំណាត់សំគាល់ ។ 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)