Minnesota Department of **Human Services**

Group Residential Housing - Professional Statement of Need

APPLICANT NAME:	MAXIS CASE NUMBER:	DATE OF BIRTH:
COUNTY:	FINANCIAL WORKER:	FINANCIAL WORKER FAX:
Statement of need is being used for the purpose of: ☐ Establishing GA basis of eligibility ☐ Authorizing GRH supplementary services (Rate 2)		

DHS needs to know that the above applicant:

- Has an illness or condition which limits their ability to work and provide self-support, and
- Needs assistance to access or maintain housing.

The county will use this statement of need to determine if the applicant is eligible to receive Group Residential Housing (GRH) benefits. It may also serve as a basis for a referral to apply for a Social Security disability program. This request does not represent an offer of payment on the part of the state or county agency.

GRH Applicant: Please complete the authorization for release of information.

Authorization for release of information	
I give permission for the Qualified Professional below to release the requested information to the county listed above. The county will use this information to determine my eligibility for Group Residential Housing. 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 • That, generally, I must give my written consent for this person/agency to give out this information, but if I do not consent, the information will not be released unless the law otherwise allows it • 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 be able to pass it on to others • If my information is passed on to others by DHS, it may no longer be protected by this authorization.	
APPLICANT SIGNATURE:	DATE:

GRH provider where applicant intends to reside:

SERVICE PROVIDER/ORGANIZATION NAME:	CONTACT NAME:	
Overcomers International Fellowship	Michael Laidlaw	
PHONE NUMBER:	EMAIL ADDRESS:	VENDOR NUMBER:
(320) 656-1550	dreamcenterpath@aol.com	

When this form is complete, please get it to the financial worker listed above as soon as possible. GRH benefits cannot be approved until this form is received.

Qualified Professional: Please review the definitions of a Qualified Professional prior to making any recommendation to ensure that you meet the "Qualified Professional" requirements for the GRH program. All information that you provide is subject to auditing by DHS.

Indicate type of disabling condition. ***(Check one)***		
X	**Disabling condition**	**Allowable qualified professional**
☐	Developmental Disability	Licensed psychologist, certified school psychologist, or certified psychometrist under the supervision of a licensed psychologist*
☐	Learning Disability	Licensed psychologist or school psychologist with experience determining learning disabilities*
☐	Mental illness	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 physician*
☐	Physical illness, injury, or impairment	Licensed physician, physician's assistant, nurse practitioner, certified nurse midwife or licensed chiropractor*
☐	Chemical dependency	Treatment director, alcohol and drug counselor supervisor, licensed alcohol and drug counselor (LADC), or licensed physician*

*A county human services agency may designate other qualified professionals

Indicate at least two of the following supports that the applicant needs.	
☐	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.

How long do you anticipate the applicant will have an illness or incapacity which limits his/her ability to work and provide self support, and need assistance to access or maintain housing?
☐ Permanent ☐ Other (please specify length of time):

I certify that (client name)_____ has an illness or incapacity which limits his/her ability to work and provide self-support, and needs assistance to access or maintain housing.

NAME OF QUALIFIED PROFESSIONAL:	CLINIC, ORGANIZATION, OR COUNTY NAME:
TITLE / LICENSURE:	ARE YOU A COUNTY DESIGNEE? ☐ YES ☐ NO
SIGNATURE:	DATE:

651-431-3941

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

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

កំណត់សំគាល់ ។ បើអ្នកត្រូវការជំនួយក្នុងការបកប្រែឯកសារនេះដោយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទតាមលេខខាងលើ ។

Pažnja. Ako vam treba besplatna pomoć za tumačenje ovog dokumenta, nazovite gore naveden broj.

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.

ໂປຣດຊາບ. ຖ້າຫາກ ທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປເອກະສານນີ້ຟຣີ, ຈົ່ງໂທຣໄປທີ່ໝາຍເລກຂ້າງເທິງນີ້.

Hubachiisa. Dokumentiin kun bilisa akka siif hiikamu gargaarsa hoo feete, lakkoobsa gubbatti kenname bibili.

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.

LB3-0001 (3-13)

ADA2 (12-12)

This information is available in accessible formats for individuals with disabilities by calling 651-431-3941 or by using your preferred relay service. For other information on disability rights and protections, contact the agency's ADA coordinator.