

# Professional Statement of Need for Housing Stabilization Services, Moving Home Minnesota and Minnesota Housing Support

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 more** of the following:

- Medical Assistance Housing Stabilization Services
- Minnesota Housing Support Program
- Moving Home Minnesota (MHM)
- General Assistance (GA) personal needs allowance (for people receiving Housing Support.)

This form does not represent an offer of payment on the part of the state, county, or tribe.

There are five sections on the Professional Statement of Need. It is important to note that multiple Qualified Professionals can complete and sign different sections, depending on the circumstances and needs of the person.

Qualified Professionals may refer to the [Professional Statement of Need Guidance for Qualified Professionals \(DHS-7122A\)](#) for additional information about:

- How to complete this form.
- What to do with this form when signed and completed.

## Section 1: Housing Situation

- For MA Housing Stabilization Services: This section is required.
- For Moving Home Minnesota 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)
<input type="checkbox"/> I am currently homeless. <input type="checkbox"/> I am at risk of losing my housing. <input type="checkbox"/> 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). <input type="checkbox"/> I am eligible for waiver services (BI, CAC, CADI, DD, EW). <input type="checkbox"/> 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 Moving Home Minnesota 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
<input type="radio"/> 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
<input type="radio"/> 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
<input type="radio"/> 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)
<input type="radio"/> 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
<input type="radio"/> 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? <input type="radio"/> Yes <input type="radio"/> 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)

<input type="checkbox"/> I agree	SIGNATURE OR TYPED NAME	DATE
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### Section 3: Medical Assistance Housing Stabilization Services

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

<input type="checkbox"/> I agree	SIGNATURE OR TYPED NAME	DATE
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## 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 Moving Home Minnesota services: This section is not required.
- 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? <input type="radio"/> Yes <input type="radio"/> 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)

<input type="checkbox"/> I agree	SIGNATURE OR TYPED NAME	DATE
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## 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 Moving Home Minnesota services: This section is not required.
- 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 may complete this section whether or not they are a qualified professional.

<input type="checkbox"/> The person named above lacks a fixed, adequate, nighttime residence upon discharge from this residential Behavioral Health Treatment Program.		DATE OF DISCHARGE
NAME OF RESIDENTIAL TREATMENT 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)

<input type="checkbox"/> I agree	SIGNATURE OR TYPED NAME	DATE
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**NO ENGLISH**



**651-431-3941**

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انتباه. إذا احتجت الى مساعدة مجانية في ترجمة هذه الوثيقة، اتصل بالرقم الموجود في المربع أعلاه. Arabic

মনোযোগ দিন। যদি আপনি বিনামূল্যে এই নথিটির ব্যাখ্যার জন্যে সহায় চান তাহলে উপরোক্ত বাক্সে থাকা নম্বরটিতে কল করুন। Bengali

သတိပြုရန်။ ဤစာတမ်းကို ဘာသာပြန်ဆိုရန်အတွက် အခမဲ့အကူအညီ လိုအပ်ပါက၊ အထက်ဖော်ပြပါ အကွက်ရှိ နံပါတ်ကို ခေါ်ဆိုပါ။ Burmese

ការយកចិត្តទុកដាក់។  
ប្រសិនបើអ្នកត្រូវការជំនួយឥតគិតថ្លៃក្នុងការបកស្រាយឯកសារនេះ សូមហៅទូរសព្ទទៅលេខក្នុងប្រអប់ខាងលើ។ Cambodian

注意!如果您需要免費的口譯支持,請撥打上方方框中的電話號碼。 Cantonese (Traditional Chinese)

wáŋ. héčínhan niyé wačhínŷAn wayúiyeska ki de wówapi sutá, ečíyA kin wóiyawa ed ophíye waŋ. Dakota

Paunawa. Kung kailangan mo ng libreng tulong sa pag-unawa sa kahulugan ng dokumentong ito, tawagan ang numero sa kahon sa itaas. Filipino (Tagalog)

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સાવધાન. જો તમને આ દસ્તાવેજને સમજવા માટે નિ:શુલ્ક મદદની જરૂર હોય, તો ઉપરના બોક્સ પૈકીના નંબર પર કોલ કરો. Gujarati

ध्यान दें। यदि आपको इस दस्तावेज़ की व्याख्या में नि:शुल्क सहायता की आवश्यकता है, तो ऊपर बॉक्स में दिए गए नंबर पर कॉल करें। Hindi

**NO ENGLISH**



**651-431-3941**

Lus Ceeb Toom. Yog tias koj xav tau kev pab txhais lus dawb ntawm cov ntaub ntawv no, ces hu rau tus nab npawb xov tooj nyob hauv lub npov plaub fab saum toj no. Hmong

ဟ်သုဉ်ဟ်သး. နမ့ၢ်လိဉ်ဘဉ် တၢ်မၤစၢၤကလီၤလၢ ကကိၣ်းထံလံာ်တီလံာ်မိတဖဉ်အယံ, ကိးနီဉ်ဂံၢ်လၢ အအိဉ်ဖဲတၢ်လွံၢ်နၢဉ် လၢတၢ်ဖိခိဉ်အပူၤတက့ၢ်. Karen

이 문서의 내용을 이해하는 데 도움이 필요하시면 위에 있는 전화번호로 연락해 무료 통역 서비스를 받으실 수 있습니다. Korean

تکایه سهرنج بده. نهگهر بۆ وەرگیرانی ئەم بەلگەنامەیە پێویستت بە یارمەتی بێبەرامبەرە، ئەوا پەڕێندێ بەو ژمارەیهوه بکه که له بۆکسهکهی سهر هه دایه Kurdish Sorani

Baldarî. Ger ji bo wergerandina vê belgeyê hewcedariya we bi alîkariya belaş hebe, ji kerema xwe bi hejmara li qutîya jorîn re telefon bikin. Kurdish Kurmanji

Hoŋpín. Tóhán wanǵí thí wíyukčanpi kin yuhá níyunspe héčha čhéya, lé tkíčhun kin k'é nánpa opáwinyan. Lakota

ເອົາໃຈໃສ່. ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອພຣີໃນການຕີຄວາມເອກະສານນີ້, ໃຫ້ໂທຫາເບີທີ່ຢູ່ໃນບ່ອງຂ້າງເທິງ. Lao

注意！如果您需要免费的口译帮助，请拨打上方方框中的电话号码。  
Mandarin (Simplified Chinese)

P̥alɛ ɾɔ piny: Mi gööri luäk lɔrä kɛ luɔc kä mɛmɛ, ɣɔtni nāmbär ɛmɔ tɛɛ nhial guäth ɛmɛ. Nuer

Mah Biz'sin'dan.

Keesh'pin nan'deh'dam'mun chi'wee'chi'goo'yan chi'nis'too'ta'man oo'weh ooshii'be'kan.

Ishi'kidoon ah'kin'das'soon ka'ooshi'bee'kadehk ish'peh'mik ka'shi ka'ka'kak. Ojibwe

**NO ENGLISH**



**651-431-3941**

Hubachiisa:-Yoo barreeffama kana hiikuuf gargaarsa bilisaa barbaaddan, lakkoofsa saanduqa armaan olii keessa jirun bilbilaa Oromo

Atenção. Se você precisar de ajuda gratuita para interpretar este documento, ligue para o número na caixa acima. Portuguese

Внимание! Если Вам нужна бесплатная помощь в переводе этого документа, позвоните по телефону, указанному в рамке выше. Russian

Pažnja. Ukoliko vam je potrebna besplatna pomoć u tumačenju ovog dokumenta, pozovite broj naveden u kvadratu iznad. Serbian

Fiiro gaar ah. Haddii aad u baahan tahay caawimo bilaash si laguugu turjumo dukumiintigan, wac lambarka ku jira sanduuqa sare. Somali

Atención. Si necesita ayuda gratuita para interpretar este documento, llame al número que aparece en el recuadro superior. Spanish

Zingatia. Iwapo unahitaji msaada usio na malipo wa kutafsiri hati hii, piga simu kwa namba iliyo kwenye kisanduku hapo juu. Swahili

ልቢ በሉ፡ ነዚ ሰነድ ንምትርጓም ነፃ ሓገዝ እንተ ደልዮም፣ በቲ ኣብ ላዕሊ ኣብ ውሽጢ ሰደጅ ተቐማሚኩ ዘሎ ቁጽሪ ይደውሉ። Tigrinya

Увага! Якщо Вам потрібна безкоштовна допомога в перекладі цього документа, зателефонуйте за номером, вказаним у рамці вище. Ukrainian

Xin lưu ý: Hãy liên hệ theo số điện thoại trong ô trên nếu bạn cần bất kỳ sự hỗ trợ miễn phí nào để hiểu rõ về tài liệu này. Vietnamese

Àkíyèsí. Tí o bá nílò ìrànlowó pèlú tí tú mò àkòólẹ̀ yìí, pe nọmbà tó wà nínú àpótí tí wà ló kẹ̀. Yoruba

LB (7-24)



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