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Tragically, homelessness among older adults is on the rise. According to the Wilder Foundation 2015 Minnesota Homeless Study, older adults (55+) experienced the largest percentage increase in homelessness among all of the age cohorts since their 2009 study. In fact, there were 843 homeless older adults age 55 and older in the state of Minnesota, up from 526 in 2009, indicating a 60% increase. Seventy-one percent (71%) reported having chronic health problems, including high blood pressure, diabetes, and chronic lung problems. In addition, 49% reported having serious mental health problems (Wilder Research, 2015).

Often, these individuals have endured tragedy in various ways, and may have fallen through holes in the safety net and become more ill from severe living conditions, poor nutrition, and little access to good primary health care. Frequently, these older adults appear physically much older than their chronological age, as most have multiple chronic and mental health conditions including anxiety and depression. Many have been diagnosed with disabilities. Catholic Charities continues to witness increasing numbers of older adults in emergency shelters. Currently, about 30% of persons accessing Catholic Charities shelters are age 55 or older, continuing the trend of the last few years. Their needs are complex and require specialized expertise, and need many special considerations when serving them.

Racial disparity is another troubling factor when looking homelessness in the older adult population. According to Wilder Research, although persons of color make up just 7% of Minnesota’s overall older adult population, persons of color make up a startling 52% of the state’s homeless older adult population. Catholic Charities serves a racially and ethnically diverse population. There are some unique challenges that come along with serving such a diverse population, such as language barriers, different cultural beliefs, and lack of trust from those who have experienced institutionally and culturally pervasive racism.

Some tactics that have been helpful in addressing these challenges include utilizing interpreters, attending trainings and seminars on working with other cultures, and involving professionals from specific communities when engaging with them. Another critical step is taking the time to build relationships with those we serve, treating each person as an individual with the understanding that each person has a unique story and life experience, and avoiding judgment.

Catholic Charities’ Homeless Elders Program utilizes a holistic approach when working with clients, taking into account many aspects of the person’s being, including physical health, mental health, chemical health, and the person’s goals. A person-centered approach working alongside the person and focusing on what is important to them is critical to building trust and helping older adults achieve their goals. We connect them with as many ongoing supports as appropriate, including both formal social service supports and informal supports, such as family, friends, and community.

Catholic Charities received a Department of Human Services Live Well at Home Grant in 2016, enabling its Homeless Elders intensive case management program to expand by two case managers and to create a training and best practice training manual for working with homeless older adults. This manual provides information useful in serving this vulnerable population, including information about health insurance benefits, mental health, Social Security, and older adult housing, among other topics.
OVERVIEW
Homeless older adults may be sicker than their younger counterparts. Chronic illnesses in older adults are exacerbated due to the stress of being homeless, focus on survival instead of preventative care, lost or stolen medications, lack of place to store insulin, and other factors. Life expectancy for homeless individuals is lower than the general population, estimated at age 52, versus 80 in the general population. Special considerations need to be taken when working with homeless older adults and potential medical conditions, and the fact that those who are homeless are aging faster needs to be taken into account.

ACTIVITIES OF DAILY LIVING AND INSTRUMENTAL ACTIVITIES OF DAILY LIVING (ADLS AND IADLS)
Many older adults struggle with one or more ADLs or IADLs, which are activities that are necessary to live independently, often learned early in life. ADLs include eating, toileting, grooming, dressing, bathing, walking, and transferring (ex. moving from bed to wheelchair). IADLs consist of more complex tasks, including managing finances, handling transportation, shopping, preparing meals, using the telephone to communicate, managing medications, and completing housework. When older adults start having difficulty with these tasks, it becomes more difficult to live independently and to manage their lives. Older adults may need special considerations in a shelter environment, such as consistent access to restrooms, utilizing elevators, or sleeping on the bottom bunk.

WHAT CAN I DO TO HELP?
Encourage establishing primary care, if not already in place, instead of relying on emergency rooms for health issues. Discuss issues with their physician—often Medical Assistance (MA) can cover some helpful services, such as Personal Care Attendant (PCA), medication management, and assistive devices such as walkers or eyeglasses.

Connect older adults with a health plan if possible, which can provide a Care Coordinator who can assist with coordination of services to a certain point (see “Care Coordination” section).

Help older adults utilize medical rides, available through either MA or their health plan.

Refer for a waiver, which can provide services to assist with many of these tasks if the person meets eligibility (see “Long Term Services and Supports” section).

Connect older adults with other community resources that are designed to help maintain independence. Utilize community resources at the end of this section “Community Resources for Older Adults,” which offer assistance with transportation, grocery shopping, chore services, visits, and other services.

(Continued on next page,)
KEEP IN MIND THE FOLLOWING CONDITIONS THAT OFTEN AFFECT OLDER ADULTS AND IMPACTS THEIR PHYSICAL CARE WHEN HOMELESS:

Incontinence: More common in older adults, incontinence is a common problem in shelter that not only causes difficulty and embarrassment for the person, but also is a community health hazard. Incontinence supplies are covered through Medical Assistance, and someone experiencing this should always talk to their doctor about getting an assessment for underlying causes of incontinence issues and a prescription for the supplies (pads, adult undergarments or diapers) when applicable. Extra supplies should be stored by homeless providers if possible to supply in an emergency.

Urinary Tract Infections (UTIs): Also called a bladder infection, this is more common in older adults due to weakened immune system, weakened pelvic muscles, and sometimes use of incontinence supplies. Older adults sometimes do not experience the physical symptoms (pain during urination, discolored urine), and signs and symptoms show up in a different way. An undiagnosed UTI can be mistaken for memory loss or mental illness and include confusion, agitation, hallucinations, loss of coordination, and dizziness. If some of these issues are noticed, it should always be recommended that the person be screened for a UTI by a physician.
COMMUNITY RESOURCES FOR OLDER ADULTS

Some of these services may be covered by Medical Assistance. Check with individual providers for payment options.

OLDER ADULT RESOURCE SITES

Senior LinkAge Line*: (800) 333-2433
seniorlinkageline.com
This is the MN Board on Aging’s free statewide information and assistance service for older adults. They have expertise in Medicare and other forms of health insurance, services and supports, prescription drug expenses, and can connect you with resources ranging from financial assistance to home care to transportation and many other services for older adults in MN.

Minnesotahelp.info: (800) 333-2433, minnesotahelp.info
A searchable online database of health and human services in Minnesota for older adults, people with disabilities, parents and families, veterans, youth, and people with low-income.

Rebuilding Together – Twin Cities:
(651) 766-4273
rebuildingtogether-twincities.org/resources/chore-senior-services
This site offers links to several resources for older adults, including home maintenance and chore programs, Meals on Wheels, and other forms of assistance for older adults.

MN Seniors Online: (763) 780-8309
mnseniorsonline.com/index
Another comprehensive list of resources for older adults, in MN, with an emphasis on senior housing, businesses serving older adults, and health and home care.

Metro Meals on Wheels: 612 623-3363
meals-on-wheels.com
Care Professionals are able to access on line sign-up for their clients.

Little Brothers: (612) 721-6215
littlebrothersmn.org
Provides visits from a friendly volunteer to reduce isolation and loneliness for isolated older adults, age 65 and older in the Twin Cities. Occasional social events and holiday dinners as well.

Help at Your Door: (651) 642-1892
helpatyourdoor.org
Provides assistance in three areas on a sliding-fee scale basis:
Store to Door will fulfill grocery order and deliver to home for those unable to shop on their own.
Handyman Services will assist with interior or exterior maintenance needs.
Transportation Services provides transportation to run errands, go to medical appointments.

Senior Community Services: (952)746-4046
seniorcommunity.org
Provides some help with housework on a sliding-fee basis, call for details. Website also has other older adult resources and information. Hennepin County.

(Continued on next page,)
Eastside Neighborhood Services:  
(612) 781-6011  
esns.org/Seniors  
Offers several services for older adults including a day center, transportation, older adult-specific employment assistance, and older adult dining options.

ENS Senior Food shelf:  
(612) 788-9521  
1801 Central Ave. NE Minneapolis, MN.  
Eligibility: 55+, low income, living in Hennepin County. Can use in addition to local food shelf.

Living At Home Network:  
(651) 683-2326  
lahnetwork.org  
Provides the following services through volunteers: Friendly visits, help with finances, transportation, legal help, chores and shopping.

Wilder Foundation-Older Adult Services:  
(651) 280-2500  
wilder.org/Programs-Services/Older-Adult-Services/Pages  
Provides several services for older adults including adult day programs, assisted living, health & wellness, memory care, and Meals on Wheels. Some programs (e.g. Meals on Wheels) limited to persons living in certain parts of St. Paul.

Lutheran Social Services:  
(800) 582-5260  
lssmn.org/oa/services  
Provides a range of services for older adults, including Meals on Wheels, caregiver support, older adult companion services, financial and legal resources, and volunteer and job opportunities.

EDUCATIONAL AND ADDITIONAL RESOURCES  
(General information, webinars)  

MN Gerontological Society: mngero.org  
American Society on Aging: asaging.org  
Minnesota Board on Aging: mnaging.org  
National Institute on Aging: nia.nih.gov  
AARP: aarp.org  
Minnesota Association of Area Agencies on Aging: mn4a.org
SUCCESSFUL AGING: MYTH VERSUS REALITY
How does our society view the process of aging and “getting old”? There are many stereotypes and negative images of older adults, often based on the faulty premise that many physical and psychological conditions are a “natural” consequence of getting older. You may be familiar with some of these stereotypes of aging:
- Getting old means being sick
- Older people are unable to change – it’s too late!
- Sexual intimacy is for the young
- Older people have nothing to offer our society
- Others?

Such stereotypes are part of ageism, which is defined as “a deep and profound prejudice against the elderly which is found to some degree in all of us” (Robert N. Butler, Alliance for Aging Research). Ageism affects persons of all ages, including many social service and healthcare professionals; it leads us to make negative assumptions of persons based on age, rather than on functional status, or what is important to and for the person. Such assumptions can become barriers to successful treatment of medical and psychological conditions of older adults, including mental illness, and assumptions about what kind of life the person wants.

OLDER ADULTS AND MENTAL ILLNESS
Currently, one in five older adults (ages 55+) live with some form of mental illness; the most common of these are anxiety disorders, substance abuse disorders and depression. While older adults can have illnesses such as schizophrenia, bipolar disorder, and personality disorders, these usually first develop earlier in life; depression, anxiety, and substance use disorders can develop at any point in a person’s life cycle. Older adults are less likely to seek treatment for mental health issues, often due to the stigma of mental illness; fewer than 40% of older adults with mental health and/or substance use disorders get treatment. However, of those older adults that do seek treatment for mental health concerns, approximately 70-90% experience a significant reduction in symptoms of their mental illness. This section of the manual will focus specifically on anxiety disorders and depression in older adults; substance abuse disorders will be covered in a later section.

(Continued on next page,)
SYMPTOMS OF ANXIETY AND DEPRESSION

It is important to be familiar with and able to recognize symptoms of depression and anxiety, as persons living with these conditions may not be able to or willing to report symptoms themselves. Staff that work directly with older adults may be the first persons to notice emerging signs of depression and anxiety. Symptoms can be both physical and emotional in nature, and include the following:

**Anxiety: Emotional symptoms**
- Excessive worry
- Difficulty controlling worry
- Feelings of dread
- Fear of rejection

**Anxiety: Physical Symptoms**
- Restlessness
- Fatigue easily
- Irritability
- Muscle tension
- Difficulty falling or staying asleep
- Difficulty concentrating or mind going blank
- Nausea and vomiting,
- Impairment in social, occupational, or other functioning

**Depression: Emotional Symptoms**
- Sadness, emptiness, hopelessness
- Loss of interest in activities,
- Anxiety, irritability, anger,
- Difficulty concentrating or making decisions
- Feelings of guilt or worthlessness
- Thoughts of suicide/death
- Withdrawal

**Depression: Physical Symptoms**
- Nausea or digestive problems
- Sleeping too little or too much
- Exhaustion
- Change in appetite or weight
- Physical health complaints
- Headaches
- Unexplained aches and pains

**HOW ARE DEPRESSION AND ANXIETY DIFFERENT IN OLDER ADULTS?**
- In older adults, symptoms of mental illness are often mistaken for symptoms of memory loss. These symptoms include difficulty concentrating, memory issues, and other cognitive and/or functional impairments. They can also include isolation, irritability, and loss of interest in activities.
- Older adults may place an emphasis on the physical symptoms of depression and anxiety, often reporting these to their primary doctor as symptoms of a physical health condition.
- Depression and anxiety can develop with the onset of a severe and/or chronic physical health issue (heart problems, stroke, fracture, vision and/or hearing loss, etc.). In addition, the loss of friends and family that older adults often face, along with the accompanying grief, can trigger depression.
• Older adults often experience increased isolation and lessened social support; there are several factors that affect this (loss of friends and family, lessened mobility, onset of other health problems, etc.). Increased isolation and loss of support may also increase the likelihood that symptoms of depression and anxiety will develop and/or be more difficult to detect.

• Older women are especially vulnerable to depression, as on average they outlive older men, and are often caregivers for friends and family coping with disabling health conditions. As a result, older women may have less social support and more stress, resulting in increased likelihood for depression and/or anxiety to develop.

WHAT CAN I DO TO HELP?

As a service provider for older adults, you have a critically important role in helping persons with mental health issues recognize their symptoms and seek treatment. As mentioned earlier, about 70% to 90% of older adults with mental health issues see significant improvement with treatment. You may be the person that makes a life-changing difference for an older adult struggling with a mental illness!

Treatment options for older adults struggling with mental illness include (but are not limited to) psychotherapy and psychiatric (i.e. medication) services; accessing social support, exercise and proper diet, accessing stable and appropriate housing, and reducing stress. For those with more severe forms of mental illness (i.e. major depression, schizophrenia, bipolar disorder, etc.) a continuum of services are available ranging from Adult Rehabilitative Mental Health Services (ARMHS) and Mental Health – Targeted Case Management (MH-TCM) to Crisis residences and inpatient hospitalizations. See the attachment “Adult Mental Health Services” for more information on these services.

For older adults using medications to manage symptoms of mental illness, it is important to find (if possible) a psychiatrist or other medical professional who specializes in working with older adults. Medication can affect older adults differently due to changes in their bodies associated with aging (loss of muscle mass, changes in liver and kidney function, etc). Some of the treatment resources at the end of this section have trained and experienced providers who may better fit the unique psychological and physiological needs of older adults.
MENTAL HEALTH RESOURCES

Some of these services may be covered by Medical Assistance. Check with individual providers for payment options.

TREATMENT
Volunteers of America – Vona Center for Mental Health
763-225-4052
voamnwi.org/mental-health-services

Associated Clinic of Psychology
612-455-8643
acp-mn.com/geriatric-services

Psych Recovery Inc.
Sarah Anderson, MSW, LICSW: 651-294-3424
psychrecoveryinc.com/seniorServices

Hamm Clinic
651-224-0614
hammclinic.org/senior-services

Jewish Family Service
651-698-0767
jfssp.org/home/services/senior-services

CareProfiler – Geropsychological Services
1-866-551-0996 x3
clinical@careprofiler.com

CRISIS AND COUNTY RESOURCES
(for referral to ARMHS, TCM)

Hennepin County
Front Door: 612-348-4111
COPE Crisis Line (Community Outreach for Psychiatric Emergencies): 612-596-1223
Hennepin County Mental Health Center: 612-596-9438
hennepin.us/residents/health-medical/adult-mental-health-services

Ramsey County
Mental Health Center: 651-266-7890
Crisis: 651-266-7900
Case Management: 651-266-4004
ramseycounty.us/residents/health-medical/clinics-services/mental-health/adult-mental-health

Dakota County
Adult Mental Health: 651-554-6424
24 Hour Crisis Line: 952-891-7171
co.dakota.mn.us/HealthFamily/MentalHealth

Anoka County
Adult Mental Health: 763-324-1420
Crisis: 763-755-3801
anokacounty.us/2398/Behavioral-Health-Services

Statewide Crisis Line for cell phones:
Call: **CRISIS
Crisis Text Line: Text 741741 to communicate with a trained counselor, crisistextline.org

EDUCATION & REFERRAL

National Alliance on Mental Illness (NAMI)
MN Chapter: Kay King: 651-645-2948 x113
namihelps.org/education/older-adults

Minnesota Department of Human Services
mn.gov/dhs/people-we-serve/seniors

Minnesota Board on Aging
651-431-2500, mnaging.org

Senior LinkAge Line
1-800-333-2433, seniorlinkageline.com

Minnesota Help.info
minnesotahelp.info
Adult Mental Health Services

The Department of Human Services (DHS) oversees publicly funded programs offering community-based mental health services for Minnesotans with mental illness. Our staff are dedicated to supporting adults with a mental illness in their personal journey toward recovery.

Strengthening Minnesota's mental health system of care

DHS works to strengthen mental health services and access to these services in all parts of the state.

- DHS works with 16 regional adult mental health initiatives and 11 tribal authorities to develop, implement, monitor and evaluate public mental health services.
- DHS collaborates with providers, managed care organizations, housing and employment agencies, advocates, consumers and family members to develop policies that are recovery-focused and person-centered.
- DHS supports and provides training and technical assistance to direct service providers and counties to ensure that evidence-based and research informed practices are used to promote independent living, community integration and a reduced use of more restrictive services.

Adult Mental Health Continuum of Services

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<th>Outpatient Therapy</th>
<th>MH-TCM</th>
<th>ARMHS</th>
<th>Mobile Crisis</th>
<th>Day Treatment/Partial Hospitalization</th>
<th>IRTS/Residential Crisis</th>
<th>ACT</th>
<th>Hospitals</th>
<th>State Hospital</th>
</tr>
</thead>
</table>

ARMHS — Adult Rehabilitative Mental Health Services  
IRTS — Intensive Residential Treatment Services  
ACT — Assertive Community Treatment  
MH-TCM — Mental Health Targeted Case Management

We help to create a culture that promotes and supports recovery from mental illness.
Community-based services

DHS oversees many publicly funded programs offering community-based mental health services for Minnesotans with mental illness. We are committed to a continuum of treatment and support services that enable adults with a mental illness the freedom of choice in their personal journey toward recovery.

Adult Rehabilitative Mental Health Services
ARMHS brings services directly to people in their own homes or elsewhere in the community, helping individuals acquire, practice and enhance skills that have been lost or diminished.

Assertive Community Treatment
ACT is an intensive, comprehensive, non-residential rehabilitative mental health service directed to individuals with a serious mental illness.

Certified Peer Support
Peer support is provided by current or former mental health service consumers who received special training and certification to help other people become fully engaged in the recovery process.

Day Treatment
Day treatment offers an intensive service with the goal of reducing or relieving the effects of mental illness and providing training to help the person live in the community.

Intensive Residential Treatment Services
IRTS is provided in a residential facility and helps psychiatric stability, personal and emotional adjustment and self-sufficiency, while building skills to live more independently.

Mental Health—Targeted Case Management
MH-TCM assists recipients in gaining access to needed educational, health, legal, medical, social, vocational and other services and supports. The four core components are: assessment, planning, referral/linkage and monitoring/coordination.

Mobile Crisis Services
Mobile crisis teams provide crisis services to individuals within their own homes and at other sites outside the traditional clinical setting.

Outpatient Services
Outpatient Services includes individual, group and family therapy, diagnostic assessments, medication management and psychological testing.

Partial Hospitalization
Partial hospitalization offers time-limited psychotherapy and other therapeutic services.

Permanent Supportive Housing
Supportive housing helps individuals have their own private and secure homes, along with access to the support services they need and want in order to retain their housing.

Residential Crisis Services
Residential Crisis Services offer short-term care at a facility equipped to assess, stabilize, and treat the person’s mental health issues. Stays are typically four to five days but may be as short as one or as long as medically necessary.

Supported Employment
Supported Employment provides people with serious mental illnesses treatment and employment services in order to work in the community.

Text 4 Life
Text 4 Life is a statewide suicide prevention text messaging service.

At DHS, we work to integrate mental health with physical health care, promote successful treatments, and serve people close to their communities, families and other supports.

For accessible formats of this publication or additional equal access to human services, write to DHS.MH@state.mn.us, call 651-431-2225, or use your preferred relay service.
DEMENTIA: MYTH VS. REALITY

MYTH: DEMENTIA IS A NORMAL PART OF AGING.
Fact: 1 in 10 persons ages 65 or older have Alzheimer’s disease or another form of dementia, while 1 in 3 people ages 85 and older have these conditions (ACT on Alzheimer’s MN). This means a majority of older adults do not have dementia.

MYTH: ALL DEMENTIA IS CAUSED BY ALZHEIMER’S DISEASE.
Fact: While 60% - 80% of persons with dementia have Alzheimer’s disease, there are many other disorders that can cause dementia (ACT on Alzheimer’s MN). Other types and causes of dementia are listed below.

WHAT IS DEMENTIA?
Dementia is an umbrella term that describes a group of symptoms and refers to a decline in cognitive and social functioning due to damage or disease of the brain. Dementia is most often not caused by a temporary medical condition; in other words, dementia will usually get worse over time, instead of improving. Dementia causes some types of functional impairment; this can be social, intellectual, emotional, physical, or other areas of functioning. Dementia also causes memory impairment (learning and/or recall), and affects one or more of the following:
• Language disturbance – inability to speak in clear sentences, “word salad”, revert to earlier language, unable to use words, word finding difficulty
• Inability to carry out motor activity unrelated to another motor condition (Apraxia)
• Difficulty recognizing or naming objects, not caused by sensory impairment (Agnosia)
• Difficulty in planning or executing activities

TYPES OF DEMENTIA
Alzheimer’s disease is the most common type of dementia, but there are several other types and causes of dementia:
• Vascular dementia: this can be caused by stroke, heart attack, or other circulatory condition
• Lewy Body dementia: caused by abnormal buildup of proteins (“lewy bodies”)
• Frontal-Temporal dementia: problems with judgement and impulse control, language more affected than memory

TREATABLE CONDITIONS THAT MAY MIMIC DEMENTIA
• Early-onset dementia” here: when someone is diagnosed with dementia before age 65, it is considered “Early-onset dementia
• Parkinson’s Disease; hypothyroidism; Vitamin B-12 deficiency: brain tumor; Huntington’s Disease  (Continued on next page,)
DEPRESSION VERSUS DEMENTIA

As mentioned earlier in this manual, depression and dementia can seem quite similar in their symptoms and effects. Depression can cause signs of decreased functioning, problems with memory, and difficulty concentrating. However, there are several important differences between depression and dementia, as shown in the following table:

<table>
<thead>
<tr>
<th>DEPRESSION</th>
<th>DEMENTIA</th>
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<td>Depression is primarily psychological and psychiatric in nature, and can be caused by an imbalance in the brain and/or loss of coping skills</td>
<td>Dementia has a primarily neurological cause; the structure of the brain itself is changed by diseases that cause dementia.</td>
</tr>
<tr>
<td>Depression can improve with treatment.</td>
<td>Dementia is a pervasive, structural and cognitive decline that does not improve with treatment.</td>
</tr>
<tr>
<td>Change for persons with depression require an awareness of the disease and a willingness to engage in therapy and other forms of treatment.</td>
<td>For persons with dementia, their insight and ability to change is more limited.</td>
</tr>
<tr>
<td>Cognitive changes are usually temporary and can be exaggerated (e.g. saying “I can’t remember anything!” when depressed)</td>
<td>Memory loss and other forms of cognitive impairment are not dependent on feelings of depression and anxiety</td>
</tr>
<tr>
<td>Interventions involve more psychological and psychiatric treatments (i.e. medications, therapy) with a goal of recovery</td>
<td>Interventions are more behavioral, with a goal of optimal wellbeing of person and caregiver</td>
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</table>
DIAGNOSIS OF DEMENTIA
There are several screenings that can indicate the presence of dementia. These simple screenings can be performed by mental health professionals (social workers, psychologists, counselors, etc.) They are used not to diagnose dementia or related diseases, but can indicate the need for further testing. These screenings include the Mini Mental State Exam (MMSE), SLUMS (St. Louis University Mental Status), Mini-Cog, and a clock drawing test. An example of the MMSE is found in the Appendix of this manual. If these tests indicate that dementia may be present, the next step is to refer the person to a neurologist, psychologist, or other specialist for further testing and a more definitive diagnosis.

TREATMENT OF DEMENTIA
Currently, there is no cure for dementia. Medications (e.g. Aricept, Exelon, Razadyne, Nemenda) exist that can slow the progress of memory loss, but cannot reverse the progression of dementia. Behavioral interventions also exist that assist persons with dementia and their caregiver to understand and cope with specific symptoms and behaviors associated with dementia, including, delusions/hallucinations, agitation/restlessness, verbal and physical combativeness, and difficulties in performing activities of daily living (ADLs).

WHAT CAN I DO TO HELP?
The following are strategies and best practices to consider when working with those experiencing memory loss.

- Educate yourself! Learn more about dementia and how it affects the lives of persons living with this disease. Consider taking a “Dementia Friends” training (more information below).
- Continued use of alcohol and/or drugs can make dementia worse, and have negative interactions with prescribed medications. Encourage a person with dementia to limit or end their use of these substances.
- If a person has mild or moderate dementia and can still make decisions for themselves, encourage them to complete an Advance Directive, so they have input on their upcoming medical decisions. See attachments in End of Life Care section, re: Advance Directives for more information.

(Continued on next page)
• Treat the person with dignity and respect. Avoid talking past the person as if they weren’t there.
• Be aware of your feelings. Your tone of voice and facial expression can communicate your attitude. Use a positive tone of voice and friendly facial expressions. While a person with dementia may not remember your name or what you talked about, they may remember the feelings they had while talking with you.
• Offer comfort and reassurance, especially when a person is having difficulty communicating.
• Be patient and supportive. Let the person know you are trying to understand.
• Avoid arguing. This only increases agitation. If the person says something you don’t agree with, let it be.
• Avoid criticizing or correcting. Instead of telling a person they are incorrect, try to find the meaning in what is being said.
• Use statements rather than questions. Avoid quizzing (“Do you remember when?”).
• Give visual clues. Point to the object you want a person to use or begin a task for them.
• Use short, simple phrases, speak slowly and clearly, and repeat information as needed.
• See attachment “Mental Status Evaluation: Memory Screening” for a short, basic screening for memory impairment, which can be administered by a qualified professional, such as a social worker or case manager. This can give an idea if the issue should be discussed with a doctor for further evaluation.
• Refer person to primary care physician for further cognitive testing and care.
**DEMENTIA RESOURCES**

Senior LinkAge Line®:
1-800-333-2433  
seniorlinkageline.com  
Calls are answered 8:00am-4:30pm weekdays

Alzheimer’s Association of Minnesota
1-800-272-3900  
alz.org/mnnd

ACT on Alzheimer’s  
Offers “Dementia Friends” training:  
actonalz.org

MN Gerontological Society  
mngero.org

Minnesota Board on Aging  
651-431-2500  
mnaging.org

Wilder Foundation – Older Adult Services  
651-280-2000  
wilder.org/Programs-Services/Older-Adult-Services/Pages

Minnesota Help.info  
minnesotahelp.info
# Mini-Mental State Examination (MMSE)

Patient's Name: ___________________________ Date: __________

**Instructions:** Ask the questions in the order listed. Score one point for each correct response within each question or activity.

<table>
<thead>
<tr>
<th>Maximum Score</th>
<th>Patient’s Score</th>
<th>Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>5</td>
<td>&quot;What is the year? Season? Date? Day of the week? Month?&quot;</td>
</tr>
<tr>
<td>5</td>
<td></td>
<td>&quot;Where are we now: State? County? Town/city? Hospital? Floor?&quot;</td>
</tr>
<tr>
<td>3</td>
<td></td>
<td>The examiner names three unrelated objects clearly and slowly, then asks the patient to name all three of them. The patient’s response is used for scoring. The examiner repeats them until patient learns all of them, if possible. Number of trials: ________</td>
</tr>
<tr>
<td>5</td>
<td></td>
<td>&quot;I would like you to count backward from 100 by sevens.&quot; (93, 86, 79, 72, 65, ...) Stop after five answers. Alternative: &quot;Spell WORLD backwards.&quot; (D-L-R-O-W)</td>
</tr>
<tr>
<td>3</td>
<td></td>
<td>&quot;Earlier I told you the names of three things. Can you tell me what those were?&quot;</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td>Show the patient two simple objects, such as a wristwatch and a pencil, and ask the patient to name them.</td>
</tr>
<tr>
<td>1</td>
<td></td>
<td>&quot;Repeat the phrase: ‘No ifs, ands, or buts.’&quot;</td>
</tr>
<tr>
<td>3</td>
<td></td>
<td>&quot;Take the paper in your right hand, fold it in half, and put it on the floor.&quot; (The examiner gives the patient a piece of blank paper.)</td>
</tr>
<tr>
<td>1</td>
<td></td>
<td>&quot;Please read this and do what it says.&quot; (Written instruction is &quot;Close your eyes.&quot;)</td>
</tr>
<tr>
<td>1</td>
<td></td>
<td>&quot;Make up and write a sentence about anything.&quot; (This sentence must contain a noun and a verb.)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>&quot;Please copy this picture.&quot; (The examiner gives the patient a blank piece of paper and asks him/her to draw the symbol below. All 10 angles must be present and two must intersect.)</td>
</tr>
</tbody>
</table>

30 TOTAL

(Adapted from Rovner & Folstein, 1987)

Source: www.medicine.uiowa.edu/igecl/ tools/cognitive/MMSE.pdf

Provided by NHCQF, 0106-410
Instructions for administration and scoring of the MMSE

Orientation (10 points):
- Ask for the date. Then specifically ask for parts omitted (e.g., "Can you also tell me what season it is?"). One point for each correct answer.
- Ask in turn, "Can you tell me the name of this hospital (town, county, etc.)?" One point for each correct answer.

Registration (3 points):
- Say the names of three unrelated objects clearly and slowly, allowing approximately one second for each. After you have said all three, ask the patient to repeat them. The number of objects the patient names correctly upon the first repetition determines the score (0-3). If the patient does not repeat all three objects the first time, continue saying the names until the patient is able to repeat all three items, up to six trials. Record the number of trials it takes for the patient to learn the words. If the patient does not eventually learn all three, recall cannot be meaningfully tested.
- After completing this task, tell the patient, "Try to remember the words, as I will ask for them in a little while."

Attention and Calculation (5 points):
- Ask the patient to begin with 100 and count backward by sevens. Stop after five subtractions (93, 86, 79, 72, 65). Score the total number of correct answers.
- If the patient cannot or will not perform the subtraction task, ask the patient to spell the word "world" backwards. The score is the number of letters in correct order (e.g., dlorw=5, dlrow=3).

Recall (3 points):
- Ask the patient if he or she can recall the three words you previously asked him or her to remember. Score the total number of correct answers (0-3).

Language and Praxis (9 points):
- Naming: Show the patient a wrist watch and ask the patient what it is. Repeat with a pencil. Score one point for each correct naming (0-2).
- Repetition: Ask the patient to repeat the sentence after you ("No ifs, ands, or buts."). Allow only one trial. Score 0 or 1.
- 3-Stage Command: Give the patient a piece of blank paper and say, "Take this paper in your right hand, fold it in half, and put it on the floor." Score one point for each part of the command correctly executed.
- Reading: On a blank piece of paper print the sentence, "Close your eyes," in letters large enough for the patient to see clearly. Ask the patient to read the sentence and do what it says. Score one point only if the patient actually closes his or her eyes. This is not a test of memory, so you may prompt the patient to "do what it says" after the patient reads the sentence.
- Writing: Give the patient a blank piece of paper and ask him or her to write a sentence for you. Do not dictate a sentence; it should be written spontaneously. The sentence must contain a subject and a verb and make sense. Correct grammar and punctuation are not necessary.
- Copying: Show the patient the picture of two intersecting pentagons and ask the patient to copy the figure exactly as it is. All ten angles must be present and two must intersect to score one point. Ignore tremor and rotation.

(Folstein, Folstein & McHugh, 1975)
### Interpretation of the MMSE

<table>
<thead>
<tr>
<th>Method</th>
<th>Score</th>
<th>Interpretation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single Cutoff</td>
<td>&lt;24</td>
<td>Abnormal</td>
</tr>
<tr>
<td>Range</td>
<td>&lt;21</td>
<td>Increased odds of dementia</td>
</tr>
<tr>
<td></td>
<td>&gt;25</td>
<td>Decreased odds of dementia</td>
</tr>
<tr>
<td>Education</td>
<td>21</td>
<td>Abnormal for 8&lt;sup&gt;th&lt;/sup&gt; grade education</td>
</tr>
<tr>
<td></td>
<td>&lt;23</td>
<td>Abnormal for high school education</td>
</tr>
<tr>
<td></td>
<td>&lt;24</td>
<td>Abnormal for college education</td>
</tr>
<tr>
<td>Severity</td>
<td>24-30</td>
<td>No cognitive impairment</td>
</tr>
<tr>
<td></td>
<td>18-23</td>
<td>Mild cognitive impairment</td>
</tr>
<tr>
<td></td>
<td>0-17</td>
<td>Severe cognitive impairment</td>
</tr>
</tbody>
</table>

**Sources:**

DEFINING THE ISSUE
Substance Use Disorders (SUD) include abuse of alcohol, illegal and prescription drugs, and other addictive substances, and are one of the fastest growing health problems among adults ages 60 and older in the U.S. According to AARP, at least 17% of older adults misuse alcohol and prescription drugs. However, older adults are among those least likely to seek treatment; less than 40% of older adults with SUD get treatment. Substance use is a special concern for older adults, as age-related health changes, cognitive changes (i.e. memory loss), and the stigma of aging can all be negatively affected by SUD. There are several diagnostic criteria used to indicate the presence and severity of a SUD. The more symptoms shown, the more severe their SUD is. Diagnostic criteria include:

- Physiological and psychological dependence. Signs include the inability to stop using, tolerance (needing more substance to achieve a desired effect), and withdrawal symptoms when a substance is not being used. This can also include taking a substance longer than needed.
- Continued use, even when it causes problems in relationships, causes or worsens a physical or psychological problems, or puts a person in danger
- Functional problems at home or work
- Giving up important social, occupational, and/or recreational activities
- Cravings, or a strong desire or urge to drink alcohol or use another substance
- Spending a great deal of time obtaining, using, or recovering from use of a substance

SIGNS OF A SUBSTANCE USE DISORDER
There are several possible signs that a person might be struggling with a SUD, in addition to the above diagnostic criteria. Note that some of these symptoms are the same as those of depression or other mental illnesses, as well as dementia. If you notice these symptoms in a person you are working with, it is important to consult with your supervisor and/or a medical or behavioral health professional to determine if the person may need help. Signs include:

- Memory issues, especially after use of a substance
- Changes in eating or sleeping habits
- Loss of coordination (walking unsteadily, frequent falls)
- Unexplained bruising (from falls and other physical mishaps related to substance use)
- Irritation, increased depression
- Increased isolation
- Trouble concentrating
- Lack of interest in usual activities
- Problems with hygiene
- Difficulty maintaining contact with friends/family
HOW DO SUBSTANCE USE DISORDERS AFFECT OLDER ADULTS?

As stated above, SUD are of special concern with older adults because of several age-related factors that can be significantly affected by substance use. These factors include:

- **Physiological changes.** Older adults have changes in their bodies which affect their reactions to substance use. Slowing metabolism means that substances are processed more gradually, and stay in the bloodstream for longer periods of time. Senses such as hearing, sight and smell may deteriorate with age, and be more affected by substances than in earlier years. Balance and coordination can also lessen with age and be more difficult to maintain with substance use.

- **Older adults take more medications than younger people.** 50% of adults ages 65+ take at least 5 medications per day, and 12% of adults ages 65+ take over 10 medications per day. These drugs are often prescribed for multiple conditions by multiple physician, and can interact in a harmful way with each other and with substance use. Medications for chronic pain management should be especially well-monitored, as many of these meds are narcotics and have the potential to cause addiction or other harmful effects.

- **Substance use can contribute to or increase memory loss, especially in persons with dementia.**

- **Older adults have an increased risk of suicide, which can be further increased by substance use.**

- **Older adults often experience grief and feelings of loss due to the death of family and friends and changes in relationships.** That can trigger or contribute to the use of substances to cope.

- **Older adults often experience increased isolation and less engagement in the community.** As a result, they may be more at risk to engage in substance use as a means of coping with loneliness or depression stemming from isolation.

- **Substance use can either cause or worsen physical health issues, such as high blood pressure, diabetes, chronic pain, heart problems, and other health conditions often associated with old age.**

TREATMENT OF SUBSTANCE USE DISORDERS

In general, older adults are less likely to report symptoms of SUD, as they may attribute these symptoms to old age or other health problems. Older adults are also less likely to accept a diagnosis of SUD, or accept SUD as a disease; they may feel that substance use is their fault, and may be reluctant to accept help. However, Baby Boomers (born between 1946 and 1964) may be more likely to accept a diagnosis and treatment of SUD, as their generation came of age in an era where illegal drugs were more widely available and had a certain appeal. Older adults can experience more stigma about substance use, especially those that grew up before SUD was treated as a disease. Older adults may also receive less encouragement to seek treatment, even from health professionals; this can be due to ageism and continued stigma surrounding SUD in the medical and behavioral health professions. However, once
they enter treatment, older adults are more motivated to complete treatment, and have higher success rates of staying in long-term recovery than their younger counterparts. Because of this, treatment should be recommended for SUD regardless of age.

**OPIOID USE AND OLDER ADULTS**

In addition to other substance use disorders, opioid use disorders (OUDs) are rapidly increasing in the older adult population in the United States. Per the US Substance Abuse and Mental Health Services Administration (SAMHSA), the population of older adults (ages 65+) who misuse opioids is expected to double from 1.2 percent in 2004 to 2.4 percent in 2020. Much of this misuse is with pain relievers and other prescription medications. More than 80% of all older adults take at least one medication daily, and 50% take 5 medications or more daily. In addition, nearly half of older Americans suffer from a chronic pain disorder; this increases with age (SAMHSA). This has led to increased prescribing of opioids for pain management in older adults: in 2017, nearly 1/3 of all Medicare Part D recipients received an opioid prescription, and 500,000 received high amounts of opioids (SAMHSA, U.S. Department of Health and Human Services).

The use of opioids for pain management can lead to greater independence and greater overall health for older adults, especially when treating debilitating pain that might leave persons immobilized and homebound. However, the increased use of opioids has also led to increased rates of emergency room visits (74%), hospital stays (34%) and drug-related deaths and suicides. Prescription drug-related deaths among adults ages 60+ now surpass those of young people, and opioid-involved suicides have doubled among older adults since 1999. In older adults, opioid-related hospital stays and ER visits increase costs, lead to more patients discharged against medical advice, and involve a higher proportion of patients with chronic health conditions. Opioid abuse is also believed to be a key factor in elder abuse, including physical mistreatment, emotional abuse, financial exploitation, and neglect (SAMSHA).

There are several unique aspects of opioid abuse in older adults, which are similar to those of substance use in general in older adults:

- Older adults often take multiple medications for various conditions; this, combined with age-related changes in drug absorption and metabolism, can mean an increased toxicity when using opioids
- Opioids are more often prescribed to older adults, increasing the risk of abuse
- Grief and loss that are more common for older adults may also increase the risk of opioid abuse.
- Other risk factors associated with substance abuse, including opioid abuse, in older adults are: being female, social isolation, a history of substance use, and a history of mental illness

It is important to keep these risk factors in mind when working with older adults.
WHAT CAN I DO TO HELP?

As with mental health issues, you have a key role in helping older adults you work with recognize symptoms of Substance Use Disorders and seek treatment. Service providers are often faced with bias in working with older adults and substance use, including ageism, stigma surrounding SUD, and willingness to engage in relationships with persons whose substance use may result in challenging and difficult behaviors. However, your experience, compassion, and desire to help may make a life-saving difference to an older adult struggling with substance use.

See following list for educational, treatment, and other resources to assist you.
See attachment “CAGE Substance Abuse Screening Tool” to help start the conversation about substance use and to gage the severity of the issue.
SUBSTANCE ABUSE RESOURCES

Also see resources under “Mental Health” Section
Some of these services may be covered by Medical Assistance. Check with individual providers for payment options.

TREATMENT RESOURCES

Senior Recovery Center
651-773-0473
Provides outpatient alcohol and substance use treatment services to persons ages 50 or older. seniorrecoverycenter.org

Silver Sobriety
651-342-1402
Provides affordable outpatient recovery services for persons ages 50 or older. silversobriety.org

The Retreat
866-928-3434
A residential, non-clinical recovery program based on the 12-step model. (ages 60+)
theretreat.org/programs/older-adult

Mental Health Systems (MHS)
952-835-2002
Provides Dialectical Behavioral Therapy (DBT), Integrated Dual Disorder Treatment (IDDT), and chronic pain management services. mhs-dbt.com

Avivo (Formerly Resource Inc.)
612-752-8000
Mental and chemical health assessment and treatment. https://avivomn.org/services/treatment-and-recovery/

Alcoholics Anonymous (AA), Narcotics Anonymous (NA), and Al-Anon groups in the Twin Cities
aaminneapolis.org
aastpaul.org
naminnesota.org
al-anon-alateen-msp.org

Minnesota Help.info®
minnesotahelp.info

EDUCATIONAL RESOURCES

National Alliance on Mental Illness (NAMI) MN Chapter
namihelps.org

Substance Abuse & Mental Health Services Administration (SAMHSA)
samhsa.gov

MN Center for Mental and Chemical Health (MNCAMH)
mncamh.umn.edu/

MN Department of Human Services (DHS)
mn.gov/dhs/people-we-serve/adults/health-care/substance-abuse/
CAGE Substance Abuse Screening Tool

Directions: Ask your patients these four questions and use the scoring method described below to determine if substance abuse exists and needs to be addressed.

CAGE Questions

1. Have you ever felt you should cut down on your drinking?
2. Have people annoyed you by criticizing your drinking?
3. Have you ever felt bad or guilty about your drinking?
4. Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (eye-opener)?

CAGE Questions Adapted to Include Drug Use (CAGE-AID)

1. Have you ever felt you ought to cut down on your drinking or drug use?
2. Have people annoyed you by criticizing your drinking or drug use?
3. Have you felt bad or guilty about your drinking or drug use?
4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover (eye-opener)?

Scoring: Item responses on the CAGE questions are scored 0 for "no" and 1 for "yes" answers, with a higher score being an indication of alcohol problems. A total score of two or greater is considered clinically significant.

The normal cutoff for the CAGE is two positive answers, however, the Consensus Panel recommends that the primary care clinicians lower the threshold to one positive answer to cast a wider net and identify more patients who may have substance abuse disorders. A number of other screening tools are available.

CAGE is derived from the four questions of the tool: Cut down, Annoyed, Guilty, and Eye-opener

CAGE Source: Ewing 1984
End of life care is an inevitable part of serving older adults. Although most people in the U. S. live until at least the age of 75, those who are homeless or formerly homeless often do not live that long, with life expectancy estimated to be between 42 and 52 years. Everyone deserves dignity and comfort, especially at the end of life. Here are a few recommendations to address end of life planning and care.

**CONNECTION TO LOVED ONES**
Too often, the individuals we work with have become disconnected from loved ones, sometimes by choice, sometimes due to circumstances beyond their control. If the person facing the end of life is open to it, assisting them with reconnecting to those important to them can be invaluable. This can not only be helpful with logistics such as what to do with one’s belongings and how to handle memorial arrangements, but also with dignity and closure for both parties.

**ADVANCE DIRECTIVES** (also called a “Health Care Directive” or “Living Will”):
Advance directives can help a person accomplish two goals: 1) Leave written instructions about your preferences and wishes for care at end of life if they are not able to communicate these wishes, and 2) to appoint another person (called a healthcare agent) to make and communicate these decisions based on your wishes.
- Advance directive forms have two sections that address both of these goals, and you can elect to complete one or the other, or both, and are encouraged to complete both.
- Advance directives do not require an attorney to be completed, but often require a witness to sign the document as well as the person completing the form. They can be revoked or changed at any time, as long as you still have capacity to make decisions.
- If a healthcare agent is named, it is important to discuss your wishes with them and give them a copy of the Advance Directive for their records.
- It is also important to give copies of the document to your healthcare providers and emergency contact. The document can only be utilized if it is available to attending physicians or end of life providers.

See attachments for two versions of Advance Directives and fact sheets that can be used in Minnesota.

**WILLS**
A will is a legal document that outlines how you would like your assets distributed, as well as appointment of guardianship if you have any minor children. Although no attorney is required to create a will, it is recommended to work with an attorney if possible to assist with the process. Many legal aid offices offer this assistance. See attached fact sheet about wills for additional information.

(Continued on next page,)
PALLIATIVE CARE
Palliative Care is an excellent option for someone of any age with a serious illness that is seeking treatment for that illness. It is much like hospice, although different in that hospice is for individuals who are no longer receiving treatment. Palliative care focuses on improving quality of life by helping a patient find relief from symptoms and stress associated with the illness. The care is delivered by a team consisting of doctors, nurses, social workers, chaplains, nutritionists and pharmacists that work together to provide support to not only the patient but also to family and loved ones.

Talk to the providing physician about Palliative Care Services. Medicare and Medicaid provide some coverage for Palliative Care benefits along with some private insurance plans. Check with insurance providers about coverage.

HOSPICE
Hospice is an excellent option for people facing the end of life to utilize, that improves quality of life and comfort in the last months or days of life. It is a healthcare philosophy that provides care and support to people who are facing a life threatening illness, and incorporates physician care, nursing care, counseling and social work services to support an individual. Although many people only receive hospice services in the last few days of life, it can be very helpful in the last several months of someone’s life and helps someone live life to the fullest and be as comfortable as they can toward the end of life.

Hospice services should be offered to someone who:
- is estimated to have 6 months or less to live
- meets specified criteria for certain diseases, determined by medical professional
- wants to focus on relief of suffering and quality of life, rather than cure of the disease

Talk to the providing physician about hospice options. Some providers offer services wherever the person is living (home, skilled nursing facility), and some offer residential (for homeless individuals).

RESOURCE
Minnesota Network of Hospice & Palliative Care: both provider listings and other resources on end of life and comfort care: www.mnhpc.org.

BURIAL AND CREMATION ASSISTANCE
Both Ramsey and Hennepin counties provide financial assistance to help cover the cost of burial and/or cremation if financially eligible. Check with your county for details and application.
Advance Care Planning
Knowing your voice is heard when making decisions about health care is important. Advance Care Planning is the process of preparing for a time when you may not be able to make your own medical decisions. The best time to make these decisions is when you are able to make your own choices.

Health Care Agent
Discussing and sharing your wishes with your loved ones, health care team and health care agent is important. A health care agent makes health care decisions based on your wishes if you are unable to communicate.

Health Care Directive
By writing a Health Care Directive, you can make your voice heard so your wishes are followed. A Health Care Directive is a written plan outlining your values and priorities for your future medical treatment.

Antibiotics
Medicines used to treat infections caused by bacteria.

Artificial hydration and nutrition*
Using IVs or inserting tubes into your mouth, nose or stomach to provide fluids and nutrients if you are not able to eat or drink.

Cardiopulmonary resuscitation (CPR)*
Cardiopulmonary resuscitation is a emergency procedure commonly known as CPR. CPR involves pressing repeatedly on a person’s chest and forcing air through his or her mouth. CPR also may include giving medicine, using special equipment to give electrical shocks to the heart and placing a tube down the throat to help with breathing.

Code status
Refers to terms clinicians use to describe procedures that may be done if a person’s heart and lungs stop working.
- Full code means use CPR.
- DNAR, or Do not attempt resuscitation means do not use CPR. DNAR, however, does include comfort care. DNAR also is known as allow natural death (AND). Some hospitals use DNR, or Do not resuscitate.

Comfort care
Medical care and treatment, including oxygen and medicine, for immediate relief of pain and symptoms. Comfort care does not include ventilator support, artificial hydration and nutrition, or re-hospitalization. Usually, comfort care is provided in a community care setting or home rather than at the hospital.

Dialysis
A process using a machine to clean your blood if your kidneys are not working normally. Healthy kidneys help your body get rid of waste products and extra fluid in your blood.

Hospice
Comfort care that focuses on promoting quality of life when a person is near the end of life. Hospice offers relief from the physical, emotional, and spiritual pain that often comes with a terminal illness.

Intravenous (IV) line
A narrow, flexible plastic tube placed in a vein using a needle. An IV is a way to give fluids, medicine and blood.
Palliative care
Includes comfort care to relieve pain, manage symptoms and provide support for making medical decisions. Palliative care also provides emotional and spiritual support. Can be helpful with any medical treatment, not just for end-of-life or hospice care.

Provider Orders for Life-Sustaining Treatment (POLST)
A POLST is a medical order your health care provider may recommend to document your health care wishes. A POLST provides specific instructions for emergency medical responders and other health care providers. A POLST form is not a replacement for a Health Care Directive and does not name a health care agent.

Ventilator*
Machine that pushes a mixture of air and oxygen in and out of your lungs to breathe for you. The machine connects to a tube that goes through your mouth and down your windpipe at the back of your throat.

For more information about advance care planning or for help creating a Health Care Directive, contact your health care team or Honoring Choices Minnesota.

HonoringChoices.org
612-362-3704

*Additional information available from Honoring Choices Minnesota.
Completing your Honoring Choices Health Care Directive

Completing a directive is a very good thing for all adults to do. The form should be filled out after time spent thinking and talking with loved ones about your values and goals related to your future health care needs. Your directive should be detailed enough to allow people reading it to feel confident they can make decisions that would align with what you would say, if you were able to be a part of the conversation.

If you are in a situation where you cannot communicate, there will still be decisions that need to be made. If you have not talked with those closest to you about what you would want done, they will have to guess, and that is difficult.

We can't do what you want if we don't know what that is.

For that reason it is important that all adults have Advance Care Planning conversations, and ideally write down their goals, values and preferences in a Health Care Directive. This document is your voice – so that in a situation where you are not able to communicate, you can still have a say in the decisions being made.

General notes:

- Write your name and the date on the bottom of every page just in case the pages become separated – that way it is an easy task to put all pages back in order.
- If you have instructions that are longer than the directive allows space for, you may attach additional pages. If you do this, indicate it by initialling one of several boxes throughout the directive (on page 4, 5, or 6).
- This is a "living document" meaning you should review and revise it periodically throughout your lifetime. Life circumstances change, and it's important that your directive stays up-to-date.
This is the page to identify yourself and your Agent(s). Please be sure to write legibly.

It is recommended that you choose one primary Agent, and you may name as many secondary Agents as you like. If you cannot choose between two people and want both as your Agent, one simple distinction might be to select the one that lives closest as your primary Agent and the other as a secondary Agent, and include a written note that you expect both your Agent and secondary Agent to work together to make decisions. Legally, you may name more than one Agent but it is highly recommended that you select one person to be the primary person for discussion and decision-making.

Remember that the first person you think of may or may not be the best person for this role. We recommend you read the Information Sheet on the Role of the Agent, available on the Honoring Choices website. And remember to talk with the person you are asking to be your Agent, to be sure they understand the role and are willing to accept it.

Additional notes on page 1:
1. The box referencing a "professional medical interpreter" is only checked if a language interpreter assists you with this form.
2. This directive is not meant for use for people who have a mental health diagnosis in which invasive treatments are used in treatment. There is a Minnesota Psychiatric Health Care Directive available for people in that situation; a link to this form is available on our website or you can request a copy from your mental health care provider.

This page outlines the legal rights and responsibilities of your Agent, as set by the Minnesota Legislature. You are allowed to change these responsibilities in your directive – you may use the blank space provided to describe your exact wishes.

Possible additional powers or your Agent are listed on the bottom of page 2. Please initial the boxes next to the statements you agree with to help your caregivers understand the scope of your Agent's role. You may leave them blank if you so wish.
Page 3:

Here we ask you to start thinking about healthcare goals and values. Question 1, A Decision for the Present, is focused on your choices if something were to happen to you right now—in your current state of health. Accidents can happen to any of us at any time, and sudden illnesses can strike.

One way some people find helpful to think about it is “if you were in an accident today which caused your heart to stop beating, and/or caused you to stop breathing, what would you want?”

Page 4:

This page takes you further into thinking about healthcare choices. Question 2 offers you the chance to write in any directions or information that is important to you based on your healthcare, history, or other reasons. You do not have to write anything here if nothing comes to mind.

Examples of things some people have written here include preferences about pain medication related to level of awareness, interest in alternative therapies, time limits on treatment trials (please be specific), etc.

Question 3 is similar to question 1 on page 3, in that it asks you to consider life-sustaining treatment choices. The difference is in this question you are asked to imagine a future scenario where you may be elderly and frail, or where you may be diagnosed with a chronic or life-threatening disease.

Please note that efforts to keep you comfortable, which include some types of medication, as well as food and liquid offered by mouth, are offered to all patients. If you do not want these comfort measures, you should describe your preferences here.
Page 5:
This page focuses on what happens after you die. You are asked for your thoughts on organ donation and autopsy. There is blank space left for you to add any additional information you would like to. Some things that people include on this page:

- Preferences on hospice care options
- Preferences regarding burial, cremation, or other options (note there is a space to describe preferences on funerals, memorial services, or other arrangements on page 6)
- Donation of your entire body to science (note this MUST be arranged ahead of time with the recipient organization – your directive alone cannot arrange for this type of whole-body donation)
- Contact information and other details about any pre-arranged plans you have put in place.

Page 6:
Though this page says “Optional” at the top, it is the page that can give the most information to your family, friends, and healthcare team about your personal preferences, values, and choices. We strongly encourage you to answer the questions thoughtfully and thoroughly.

Some examples of things people have included on this page:

- Play list of music they would like played in their room
- Requests that loved ones keep them “looking nice” with combed hair and clean linens
- Requests for visits from pets
- Instructions about wanting or not wanting prayers, spiritual rituals, or other faith-related traditions
- Notes about who to notify (faith leaders, specific friends, extended family members, etc) and who to not notify (it is acceptable to indicate your feelings of what you do not want to happen in your final days)
- Information about memorial services including music, readings, guests, food and beverage, location, and other details
- Personal messages to family/loved ones (for example “please surround my bed and share stories and memories, and laugh together at the joy we have shared.” or “It’s important to me that you all get along, so if you find yourself arguing about my care, take some time to calm down and start again.”)
Page 7:
This page turns your directive into a legal document. You must sign and date it (or authorize another to sign for you if you are unable to sign yourself).

Then, either have your directive notarized or have it signed by two adult witnesses (neither of whom can be your Agent or secondary Agent, and only one of whom can be an employee of your healthcare provider.) You do not need both witnesses and a notary.

Page 8:
This page offers helpful information on what to do after your directive is complete. Keep the original yourself, in a safe but accessible place (not your safe deposit box or on file with your attorney, though you could put copies in both those places). Read the “Five Ds” and remember to revisit your directive over time.

You should give copies to people who will be involved in your future health care:
- Your Agent, as well as your secondary Agent(s)
- Your primary care provider
- Your local hospital (even if you have never been a patient there, they will accept your directive and start a medical file for you so that, if you ever are admitted, it will be on file)

Additionally, some people choose to give copies to:
- Close family members and friends who are not the chosen Agent, but will likely be involved in your care – this avoids surprises later on, and allows them to be aware of your choices in order to support your Agent
- Personal attorney to have on file with copies of your will or other legal documents
- Faith Leader, especially if you have included a request for that leader to be involved in your care and/or to lead a memorial service

Questions? Contact Honoring Choices Minnesota at info@HonoringChoices.org or 612-362-3705
Introduction:

I have completed this Health Care Directive with much thought. This document gives my treatment choices and preferences, and/or appoints a Health Care Agent to speak for me if I cannot communicate or make my own health care decisions. My Health Care Agent, if named, is able to make medical decisions for me, including the decision to refuse treatments that I do not want.

NOTE: This document does not apply to intrusive mental health treatments, defined as electroconvulsive therapy or neuroleptic medications.

Any advance directive document created before this is no longer legal or valid.

My name: ________________________________
My date of birth: __________________________
My address: _______________________________
My telephone numbers: (home) ___________________
(mobile) ___________________

☐ My initials here indicate a professional medical interpreter helped me complete this document.

This is the directive of (name): __________________________

Date Completed: __________________________
Part 1: My Health Care Agent

If I cannot communicate my wishes and health care decisions due to illness or injury, or if my health care team determines that I cannot make my own health care decisions, I choose the following person to communicate my wishes and make my health care decisions. My Health Care Agent must:

- Follow my health care instructions in this document.
- Follow any other health care instructions I have given to him or her.
- Make decisions in my best interest.

**My Primary (main) Health Care Agent is:**

Name: __________________________________________

Relationship: __________________________________

Telephone numbers: (Home)______________________
(Mobile)________________________ (Work)__________

Full address: ______________________________________

_______________________________________________

If I cancel my primary agent’s authority, or if my primary agent is not willing, able, or reasonably available to make health care decisions for me, I choose an alternate Health Care Agent.

**My Alternate Health Care Agent is:**

Name: __________________________________________

Relationship: __________________________________

Telephone numbers: (Home)______________________
(Mobile)________________________ (Work)__________

Full address: ______________________________________

_______________________________________________

**This is the directive of (name):** _______________________

**Date Completed:** ____________________
I understand my Health Care Agent (primary or alternate) cannot be a health care provider or employee of a health care provider giving direct care to me unless I:

- Am related to that person by blood or marriage, registered domestic partnership, or adoption
- Provide a clear reason why I want that person to serve as my agent:

Powers of my Health Care Agent:
My Health Care Agent automatically has all the following powers when I am unable to communicate for myself:

A. Agree to, refuse, or cancel decisions about my health care. This includes tests, medications, surgery, taking out or not putting in tube feedings, and other decisions related to treatments. If treatment has already begun, my agent can continue it or stop it based on my instructions.

B. Interpret any instruction in this document based on his or her understanding of my wishes, values, and beliefs.

C. Review and release my medical records and personal files as needed for my health care, as stated in the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and the Minnesota Health Records Act.

D. Arrange for my health care and treatment in Minnesota or other state or location he or she thinks is appropriate.

E. Decide which health care providers and organizations provide my health care.

F. Make decisions about organ and tissue donation and autopsy according to my instructions in Part 2 of this document.

This is the directive of (name): _________________________________

Date Completed: ______________________________

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Comments or limits on the above:

**Additional powers of my Health Care Agent:**
My initials below indicate I also authorize my Health Care Agent to:

- [ ] Make decisions about the care of my body after death.
- [ ] Continue as my Health Care Agent even if our marriage or domestic partnership is legally ending or has been ended.
- [ ] Make health care decisions for me even if I am able to decide or speak for myself, if I so choose.
- [ ] In the event I am pregnant, decide whether to try to continue my pregnancy to delivery based on my agent's understanding of my values, preferences and/or instructions.

**Part 2: My Health Care Instructions**

My choices and preferences for health care are as follows. I ask my Health Care Agent to communicate these choices, and my health care team to honor them, if I cannot communicate or make my own choices. I have initialed a box below for the option I prefer for each situation.

**NOTE:** You do not need to write instructions about treatments to extend your life, but it is helpful to do so. If you do not have written instructions, your agent will make decisions based on your spoken wishes, or in your best interest if your wishes are unknown.

---

This is the directive of (name): ______________________

Date Completed: ____________________
1. Cardiopulmonary Resuscitation: A Decision for the Present

This decision refers to a treatment choice I am making today based on my current health. Item 3 below (Treatments to Prolong My Life: A Decision for the Future) indicates treatment choices I want if my health changes in the future and I cannot communicate for myself.

CPR is a treatment used to attempt to restore heart rhythm and breathing when they have stopped. CPR may include chest compressions (forceful pushing on the chest to make the blood circulate), medications, electrical shocks, a breathing tube, and hospitalization. I understand that CPR can save a life but does not always work. I also understand that CPR does not work as well for people who have chronic (long-term) diseases or impaired functioning, or both. I understand that recovery from CPR can be painful and difficult.

Therefore:

☐ I want CPR attempted if my heart or breathing stops.

or

☐ I want CPR attempted if my heart or breathing stops based on my current state of health. However, in the future, if my health has changed; for example:

- I have an incurable illness or injury and am dying
- I have no reasonable chance of survival if my heart or breathing stops
- I have little chance of long-term survival if my heart or breathing stops and CPR would cause significant suffering

This is the directive of (name): ________________________________

Date Completed: ______________________

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then my agent or I (if I am able) should discuss CPR with my health care team. My choices in Section 2: Treatment Preferences and Section 3: Treatments to Prolong My Life below should be considered when making this decision.

or

☐ I do not want CPR attempted if my heart or breathing stops. I want to allow a natural death. I understand if I choose this option I should see my health care provider about writing a Do Not Resuscitate (DNR) order.

2. Treatment Choices: My Health Condition

My treatment choices for my specific health condition(s) are written here. With any treatment choice, I understand I will continue to receive pain and comfort medicines, as well as food and liquids by mouth if I am able to swallow.

☐ My initials here indicate additional documents are attached.

This is the directive of (name): ________________________________

Date Completed: ___________________________
3. Treatments to Prolong My Life: A Decision for the Future

If I can no longer make decisions for myself, and my health care team and agent believe I will not recover my ability to know who I am, I want:

NOTE: With either choice, I understand I will continue to receive pain and comfort medicines, as well as food and liquids by mouth if I am able to swallow.

☐ To stop or withhold all treatments that extend my life. This includes but is not limited to tube feedings, IV (intravenous) fluids, respirator/ventilator (breathing machine), cardiopulmonary resuscitation (CPR), and antibiotics.

or

☐ All treatments recommended by my health care team. This includes but is not limited to tube feedings, IV (intravenous) fluids, respirator/ventilator (breathing machine), cardiopulmonary resuscitation (CPR), and antibiotics. I want treatments to continue until my health care team and agent agree such treatments are harmful or no longer helpful.

Comments or directions to my health care team:

__________________________________________________________________________

This is the directive of (name): ________________________________

Date Completed: __________________

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4. Organ donation

☐ I want to donate my eyes, tissues and/or organs, if able. My Health Care Agent, according to Minnesota Law, may start and continue treatments or interventions needed to maintain my organs, tissues and eyes until donation has been completed. My specific wishes (if any) are:

       or

☐ I do not want to donate my eyes, tissues and/or organs.

       or

☐ My Health Care Agent can decide.

5. Autopsy

☐ My Health Care Agent may request an autopsy if the autopsy can help others understand the cause of my death or help with future health care decisions.

       or

☐ I do not want an autopsy unless required by law.

6. Comments or directions to my health care team:
You may use this space to write any additional instructions or messages to your health care team which have not been covered in this directive, or to elaborate on a point for clarification. You may also leave this space blank.

This is the directive of (name): ________________________

Date Completed: ____________________
(Comments or directions to my health care team)

My initials here indicate additional documents are attached.

Part 3: My Hopes and Wishes (Optional)

I want my loved ones to know my following thoughts and feelings:

The things that make life most worth living to me are:

My beliefs about when life would be no longer worth living:

My thoughts about specific medical treatments, if any:

This is the directive of (name): ____________________________

Date Completed: ____________________________
My thoughts and feelings about how and where I would like to die:

If I am nearing my death, I want my loved ones to know that I would appreciate the following for comfort and support (rituals, prayers, music, etc.):

Religious affiliation: I am of the ______________ faith, and am a member of ______________ faith community in (city) ______________. Please notify them of my death and arrange for them to provide my funeral/memorial/burial. I would like my funeral to include, if possible, the following (people, music, rituals, etc.):

Other wishes and instructions:

☐ My initials here indicate additional documents are attached.

This is the directive of (name): ____________________

Date Completed: ____________________

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Part 4: Legal Authority

NOTE: Under Minnesota law, 2 witnesses or a notary public must verify your signature and the date. Your witnesses or notary public cannot be named as your primary or alternate Health Care Agent.

I have made this document willingly. I am thinking clearly. This document states my wishes about my future health care decisions:

Signature: ________________ Date: ____________

If I cannot sign my name, I ask the following person to sign for me:

________________________________________
Printed Name

________________________________________
Signature (of person asked to sign)

Statement of Witnesses:
This document was signed or verified in my presence. I certify that I am at least 18 years of age, and I am not appointed as a primary or alternate Health Care Agent in this document.

If I am a health care provider or an employee of a health care provider giving direct care to the person listed above, I must initial this line: _________. One witness cannot be a provider or an employee of the provider giving direct care on the date this document is signed.

This is the directive of (name): _______________________
Date Completed: ___________________
Witness 1:
Signature: ___________________________  Date: ______________
Print name: ___________________________
Address (optional): _____________________
_____________________________________

Witness 2:
Signature: ___________________________  Date: ______________
Print name: ___________________________
Address (optional): _____________________
_____________________________________

OR

Notary Public:
In the state of Minnesota, County of _________________. In my presence on ________________ (date), __________________________ (name) acknowledged his or her signature on this document or that he or she authorized the person signing this document to sign on his or her behalf. I am not named as a Health Care Agent in this document.

Signature of notary:  
Notary stamp:

My commission expires (date):

This is the directive of (name): __________________________

Date Completed: _____________________
Part 5: Next Steps

Now that I have completed my Health Care Directive, I will also:

- Tell my primary and alternate Health Care Agents and make sure they feel able to do this important job for me in the future.
- Give my primary and alternate Health Care Agents a copy of this completed Health Care Directive.
- Talk to the rest of my family and close friends who might be involved if I have a serious illness or injury, making sure they know who my Health Care Agent is, and what my wishes are.
- Give a copy of this completed Health Care Directive to my doctor and other health care providers, and make sure they understood and will follow my wishes.
- Keep a copy of my Health Care Directive where it can be easily found.
- Take a copy of my Health Care Directive any time I am admitted to a health care facility, and ask that it be placed in my medical record.
- Review my health care wishes every time I have a physical exam or whenever any of the "Five D's" occur:
  
<table>
<thead>
<tr>
<th>Decade</th>
<th>Death</th>
<th>Divorce</th>
<th>Diagnosis</th>
<th>Decline</th>
</tr>
</thead>
<tbody>
<tr>
<td>when I start each new decade of my life.</td>
<td>whenever I experience the death of a loved one.</td>
<td>when I experience a divorce or other major family change.</td>
<td>when I am diagnosed with a serious health condition.</td>
<td>when I experience a significant decline or deterioration of an existing health condition, especially when I am unable to live on my own.</td>
</tr>
</tbody>
</table>

This is the directive of (name): ____________________________

Date Completed: ____________________________
Copies of this document have been given to:

**Primary (main) Health Care Agent** (listed on page 1 of this document)
Name: ________________________________
Telephone: __________________________

**Alternate Health Care Agent** (listed on page 1 of this document)
Name: ________________________________
Telephone: __________________________

**Health Care Provider/Clinic**
Name: ________________________________
Telephone: __________________________
Name: ________________________________
Telephone: __________________________
Name: ________________________________
Telephone: __________________________

If my wishes change, I will fill out a new Health Care Directive. I will give copies of the new document to everyone who has copies of my previous Health Care Directive. I will tell them to destroy the previous version.

______________________________
This is the directive of (name): ______________________

**Date Completed:** ______________________

MY LIVING WILL: A HEALTH CARE DIRECTIVE

1. You do not have to complete all three parts, and you do not have to answer every question. This living will can be a work in progress and changed at any time. If you change your living will, date and initial the changes and have two people witness your changes.

2. If you name a person to act on your behalf (health care agent), be sure to let them know about your Living Will, their appointment to make decisions, and your wishes and values for end of life care. You may want to provide a copy of the Living Will for them.

3. It is a good idea to have your Living Will stored with your medical information or medical record. For the Living Will to be useful in case you are unable to speak for yourself, your emergency contact and health care provider (clinic or hospital) should have a copy at hand. If you have a regular physician or clinic also let him/her know about your wishes.

4. You may also want to leave a copy with your case manager or shelter staff who know you.

5. YOU MUST HAVE YOUR COMPLETED LIVING WILL WITNESSED AND SIGNED BY TWO PEOPLE OR NOTARIZED TO BE A LEGAL DOCUMENT.

6. A wallet sized emergency contact card is included in this packet for you to complete with the name and phone number of a person to contact if you are unable to speak for yourself.

For more information go to - http://www.selph.umn.edu/
My LIVING WILL
A Minnesota Health Care Directive

Identification: The following information will be used to identify you and your family, if you experience a health crisis and are unable to speak for yourself.

Name: ___________________________ Alias (or Street Name): ___________________________

Mailing address: ___________________________

Date of Birth (month/day/year): ___/___/____

Religion or Spirituality: ___________________________

Marital Status: ___________________________

Name and contact information of family members, friends, or agencies I would want notified if I were seriously ill or dying (please include phone numbers if you have them):

__________________________________________________________

I do not want these people notified: __________________________________________

Things that would help emergency and health care staff to identify me: (describe)

Scars: ___________________________

Tattoos/Piercing: ___________________________

Birthmarks: ___________________________

Other: ___________________________

I receive health care at (list doctor, clinic, health plan or hospital):

__________________________________________________________

I (write name here) ___________________________________________ understand that this document allows me to explain what I want for my health care if I cannot speak for myself and to name a person to make health care decisions for me.

Introduction: There are three sections to this living will.

- Part One is for you to explain in a legal document what you would want for your health care in the event that you cannot speak for yourself.
- Part Two is for you to name a person you trust who could make health care decisions for you if you could not speak for yourself.
- Part Three will give you a chance to reflect upon your life and values; this part will help your family, friends, and health care professionals understand you better.

You do not have to complete all three parts, and you do not have to answer every question. This living will can be a work in progress and changed at any time. To make this living will legal, you will need to sign it and have it notarized or witnessed by two people.
Part One: Health Care and After Death Care Instructions

This is what I would want for my medical treatment if I were seriously ill and there was a *good chance I would recover.*

☐ All life sustaining treatments (I want everything done to help me recover – for example CPR, a breathing machine, a feeding tube, all medications, surgery, blood transfusions, etc.)

☐ I would want everything done except the following: □ Feeding Tube □ Other __________

☐ I prefer to have this person decide for me: _______________________________________

☐ I would not want any life sustaining treatments

☐ Other: __________________________

This is what I would want if I were *dying* (for example, if you had advanced cancer and could not make decisions for yourself).

☐ All life sustaining treatments

☐ I would want everything done except the following: □ Feeding Tube □ Other __________

☐ I prefer to have this person decide for me: _______________________________________

☐ I would not want any life sustaining treatments

☐ Other: __________________________

This is what I would want if I were *permanently unconscious* (for example, if you were in an accident that left you in a permanent coma)

☐ All life sustaining treatments

☐ I would want everything done except the following: □ Feeding Tube □ Other __________

☐ I prefer to have this person decide for me: _______________________________________

☐ I would not want any life sustaining treatments

☐ Other: __________________________

This is what I would want if *others had to completely take care of me* (for example, if you had a stroke and you were conscious but couldn’t communicate, bathe yourself, feed yourself, or go to the bathroom on your own).

☐ All life sustaining treatments

☐ I would want everything done except the following: □ Feeding Tube □ Other __________

☐ I prefer to have this person decide for me: _______________________________________

☐ I would not want any life sustaining treatments

☐ Other: __________________________

________________________(Date/Initials) 2
These are my beliefs about when life would no longer be worth living.

This is how I feel about getting pain medication if I were seriously ill or dying.

☐ I want pain medication even if it makes me less alert or could shorten my life if I were dying
☐ I would rather be in pain than risk being less alert.
☐ I don’t know, I would let others decide
Other: ____________________________

This is where I would like to receive health care: ____________________________

This is the doctor that I would like to provide my health care for me (if you have a preference):

This is where I would like to die (at hospital, home, etc.):

These are other wishes or concerns I have about my care at the end of my life:

These are my wishes about organ donation.

☐ I want to donate all my organs (including my eyes and skin)
☐ I want to donate all my organs except: ____________________________
☐ I do not want to donate my organs
☐ Other: ____________________________

These are my wishes about what happens to my body after I die.

☐ I want to be buried. This is where I want to be buried: ____________________________
☐ I want to be cremated. This is where I want my ashes to be stored: ____________________________
☐ These are other wishes I have about what happens to my body after I die: ____________________________

☐ I want a memorial service. These are specific instructions I have for the service (for example who you want to conduct the service, where you want the service, any spiritual or religious traditions or songs you want included in the service).

☐ I do not want a memorial service.

_____________________(Date/Initials)
Part Two: Naming a Person to Make Health Care Decisions
(This person is my appointed health care agent)

This is the person I want to make health care decisions for me:
Name: ____________________________
Relationship to me: ____________________________
Address: ____________________________
Telephone: ____________________________

This is another person I trust to make health care decisions for me:
(If the first person is not available)
Name: ____________________________
Relationship to me: ____________________________
Address: ____________________________
Telephone: ____________________________

I give the person(s) named above the power to (please check all that apply):

☐ Consent to, refuse, or withdraw any health care treatment, service, or procedure.
☐ Stop or not start medical intervention that is keeping or might keep me alive.
☐ Choose my health care providers.
☐ Obtain copies of my medical records and allow others to see them.
☐ Choose where I live when I need health care and how to keep me safe.
☐ Decide whether or not to donate organs, tissues, and eyes, when I die.
☐ Decide what will happen with my body when I die.

These are other things I want the person I name to be able to do, or not do, for me.

These are the reasons I named a health care professional to make decisions for me.
(Fill this question out only if you appointed your health care provider).

______________________________ (Date/Initials)
Part Three: Maintaining My Dignity

These are the things I am most proud of in my life: (Think about your relationships and goals, what kind of person you are, and what you've accomplished in your life)

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

I would want to be remembered as a person who:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

People who care for me could do the following to respect my dignity at the end of my life:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

These are other values I have that are important to me for my health care at the end of my life:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

These are my goals for my health and health care when I am seriously ill or dying:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

These are my fears about my health and health care when I am seriously ill or dying:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

____________________ (Date/Initials)
These are my concerns about death:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

These are my concerns about a relationship I have:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

These are my concerns about how my health problems might affect others:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Copies of this document will be given to:

1. ___________________________ Phone: ___________________________
2. ___________________________ Phone: ___________________________
3. ___________________________ Phone: ___________________________

Health Care Provider/Clinic:

1. ___________________________ Phone: ___________________________
2. ___________________________ Phone: ___________________________
3. ___________________________ Phone: ___________________________

__________________________ (Date/Initials)
MAKING THE DOCUMENT LEGAL

There are two ways to make this document legal (choose one of them)

1) Sign and Date below. Find two people to witness this document and sign below.
   OR
2) Get this document signed by a notary public, who will watch you sign and date below.

I am thinking clearly, I agree with everything that is written in this document, and I have made this document willingly.

My signature: ____________________________
Date signed: ____________________________
Date of birth: ____________________________
Address: ________________________________

If I cannot sign my name, I can ask someone to sign this document for me.
Signature of the person who I asked to sign this document for me:

__________________________________________________________________________

Printed name of the person who I asked to sign this document for me:

__________________________________________________________________________

CHOOSE EITHER OPTION 1 OR OPTION 2

Option 1: Signatures of Two Witnesses - (Cannot be any person named in Part Two)

1. ____________________________ Date: ____________________________

2. ____________________________ Date: ____________________________

Option 2: Notary Public

In my presence on ____________________________ (date), ____________________________ (name) acknowledged his/her signature on this document or acknowledge that he/she authorized the person signing this document so sign on his/her behalf. I am not named as a health care agent or alternate health care agent in this document.

Signature of Notary ____________________________

Notary Stamp ____________________________

____________________ (Date/Initials) 7
Advance Directive Information
Name/DOB: ____________________________
Emergency Contact: ______________________
Contact Number: _______________________
Living Will Location: ________________________

Advance Directive Information
Name/DOB: ____________________________
Emergency Contact: ______________________
Contact Number: _______________________
Living Will Location: ________________________

Advance Directive Information
Name/DOB: ____________________________
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Contact Number: _______________________
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Living Will Location: ________________________

Advance Directive Information
Name/DOB: ____________________________
Emergency Contact: ______________________
Contact Number: _______________________
Living Will Location: ________________________

Advance Directive Information
Name/DOB: ____________________________
Emergency Contact: ______________________
Contact Number: _______________________
Living Will Location: ________________________
**MEDICAL ASSISTANCE**

Medical Assistance (MA) is Minnesota’s Medicaid program for people with low income. MA covers a wide range of coverage, including, but not limited to: Clinic visits, mental health care, alcohol and drug treatment, hospital stays, limited dental care, as well as assistive equipment such as eyeglasses, hearing aids, canes, and walkers. Home care service including personal care assistant (PCA) services, is part of MA in Minnesota.

For full list of coverage, see attachment “Summary of Coverage, Cost Sharing, and Limits,” or see [edocs.dhs.state.mn.us/lfserver/Public/DHS-3860-ENG](http://edocs.dhs.state.mn.us/lfserver/Public/DHS-3860-ENG).

Members 65+ and some members 19-64 who have MA get health care through health plans. You can choose a health plan from those serving MA members in your county.

Members who do not get health care through a health plan get care on a fee-for-service basis, with providers billing the state directly for services they provide. Health care and home care benefits are the same under managed care or fee-for-service.

**ELIGIBILITY**

To get coverage, you must:
- Be a Minnesota resident
- Be a U.S. citizen or a qualifying noncitizen
- Provide a Social Security number for each person requesting MA, unless an exception is met
- Meet the income limit and asset limit (See attachment “MA Income Limits”)
- Note re: income limits: if someone does not meet the income limit, they may still qualify through using a “spenddown,” which is like a deductible, for more information go to: edocs.dhs.state.mn.us/lfserver/Public/DHS-3017-ENG
- Meet any other program rules.

**APPLY**

There are different ways to apply for MA. Go to your county or tribal office or call 651-431-2670 and ask to have an application mailed to you.

*Online information at: mn.gov/dhs/people-we-serve/adults/health-care/health-care-programs/programs-and-services/adults-apply.*

For assistance completing an application, contact the Senior LinkAge Line at 1-800-333-2433.
MEDICARE
Medicare is the federal health insurance program for people age 65 and older and people with disabilities. It can work together with other insurance plans, including Medical Assistance, and it is best to have both kinds of coverage if eligible.

TYPES OF MEDICARE
Medicare Part A (hospital): Covers inpatient hospital care, skilled nursing facility, hospice, lab tests, surgery, and home health care.
Medicare Part B (medical): Covers doctor and other health care providers’ services, outpatient care, durable medical equipment, prosthetics, orthotics and supplies, home health care, and some preventive services.
Medicare Part C (Medicare Advantage): Private plans that contract with Medicare to provide Medicare Part A, B, and often, Part D prescription drug benefits.
Medicare Part D (drug coverage): See website for specifics on what Rx Part D covers, including formularies.

HOW TO APPLY:
Go to SSA.gov to apply online for Medicare benefits, or go in person to any Social Security Administration office. Some people are automatically enrolled in Medicare upon turning 65, or 24 months after being determined to have a disability.
For assistance with any Medicare issue, contact the Senior LinkAge Line at 1-800-333-2433.

COST ASSISTANCE FOR MEDICARE:
There is often a premium cost for Medicare benefits, but many low income recipients qualify for assistance paying this cost through the state. Check with the county or tribal financial worker to apply for this assistance.

For more information on Medicare, go to medicare.gov., or go to: MinnesotaHelp.info.
OVERVIEW
Most people eligible for Minnesota Health Care Programs (MHCP) are automatically enrolled in a managed care plan. To enroll in a health plan if not already enrolled, or change health plans, contact your county to inquire about the various options available and request an enrollment form. DHS contracts with managed care organizations (MCOs) (including counties or groups of counties known as county-based purchasing or CBP) to provide health care services for MHCP recipients. MHCP recipients must enroll in one of these managed care products (unless excluded from enrollment):

**Managed care organizations** (MCOs) are organizations certified by the Minnesota Department of Health to provide health care benefits to people enrolled in an MHCP in return for payment. MCOs are also referred to as health plans or prepaid health plans (PPHP).

**Minnesota SeniorCare Plus** (MSC+) is a mandatory program for enrollees age 65+ who are required to receive their health care under a health plan. MSC+ includes Elderly Waiver services for enrollees who qualify.

**Minnesota Senior Health Option** (MSHO) is a managed care program that provides integrated Medicare and Medicaid services for Medicaid eligible older adults, age sixty-five (65) and over. Enrollment in the MSHO program, like the MSC+ also includes Elderly Waiver services for enrollees who qualify for this service. Most older adults enroll in MSHO because of the integration of their Medicare benefits, including drug coverage under Medicare Part D. Enrollees have a care coordinator who helps navigate and provide access to health care and other services under MSC+.

**Prepaid Medical Assistance Program** (PMAP) is a prepaid managed care program that serves individuals age 0 to 64, who are eligible for Medical Assistance.

**Special Needs BasicCare** (SNBC) is a voluntary managed care program for people with disabilities ages 18 through 64 who have Medical Assistance (MA). Some SNBC health plans coordinate with other payers, including Medicare Parts A, B and D for enrollees who have that coverage.

People with disabilities who meet the age criteria and have MA fee-for-service (FFS) coverage receive a letter from the Minnesota Department of Human Services (DHS) asking them to enroll in an SNBC health plan. Some people may not get a letter because they are excluded from enrolling in a health plan and will continue to get their coverage through FFS.

- Anyone can choose to not enroll and to stay in fee-for-service coverage. If DHS does not receive the SNBC Choice Form (DHS-6451) by the deadline, the person will automatically be enrolled in SNBC. People can choose to change their health plan (if more than one health plan is available in their county) or disenroll for the next available month. The health plans that are under contract with DHS administer SNBC. It is available in all 87 counties (DHS-5218).
CARE COORDINATORS:
Once someone is enrolled with a health plan, they are usually assigned a Care Coordinator (usually a Nurse or a Social Worker) if eligible. The care coordinator will help answer questions, work with doctors to help get the care needed, and help doctors and other providers share information with each other. They also complete an assessment with the member to assess needs and create a care plan. The Care Coordinator will also be in charge of managing the Elderly Waiver (EW) services if the person is participating in EW. If someone is unsure if they have a Care Coordinator, or does not have the CC’s information, contact their health plan.
PROGRAMS HELPING PEOPLE REMAIN IN THEIR HOMES AND COMMUNITY INCLUDING WAIVERS

Home and community-based waiver programs offer services to assist an individual remain in their homes who are not be able to live independently. These waivers offer a wide range of services and equipment depending on one's needs and budget (determined by an assessment), including, but not limited to, Meals on Wheels, Medication Management, Homemaking services, etc. Home and community-based waiver programs that are available to people who meet the eligibility criteria include:

- **Brain Injury (BI) Waiver:** for people with acquired or traumatic brain injuries who need the level of care provided in a nursing facility or neuro behavioral hospital. The BI waiver provides specialized (cognitive and behavioral supports) services for people with a brain injury. Must be under age 65 to apply to get on BI Waiver.

- **Community Alternative Care (CAC) Waiver:** for chronically ill and medically fragile people who need the level of care provided in a hospital.

- **Community Access for Disability Inclusion (CADI) Waiver:** for people with disabilities who require the level of care provided in a nursing facility. Must be under age 65 to apply for CADI waiver.

- **Developmental Disabilities (DD) Waiver:** for people with developmental disability or related condition who need the level of care provided in an Intermediate Care Facility for Persons with Developmental Disabilities (ICF/DD). Must be under age 65 to apply for DD Waiver.

- **Elderly Waiver (EW):** for people age 65 years and older who require the level of care provided in a nursing facility, and can receive those services in the community.

- **Alternative Care:** (AC) is a program that includes only home and community-based services but not health care coverage. The person must be 65 years or older, have a face-to-face LTCC assessment, meets nursing facility level of care, and meets the financial eligibility criteria. Married couples must have an asset assessment by a county or tribal financial worker, if one has not been previously completed. The assessor completes financial eligibility determination using forms provided by DHS (DHS Forms). The AC program does not include residential services (no foster care or customized living/assisted living).

- **Essential Community Supports:** (ECS) is a program that includes a small basket of services for people age 65 and older with emerging needs for support at home. ECS does not include health care coverage. The person must be 65 years or older, have a face-to-face LTCC assessment, CANNOT meet nursing facility level of care, and meets the financial eligibility criteria. There is no asset assessment for married couples. The assessor completes financial eligibility determination for ECS using forms provided by DHS (DHS Forms). The ECS program does not include residential services (no foster care or customized living/assisted living).

(Continued on next page.)
To get on any waiver, you will contact the local county/tribe to ask for a Long Term Care Consultation (LTCC) assessment, sometimes referred to as a MnCHOICES assessment. If you are on a health plan, talk to your Care Coordinator about the assessment. An assessment visit is required to be completed before any services can be authorized under these programs. The assessment determines program eligibility, while financial workers determine financial eligibility.

*See attachment for list of contacts to request a MnCHOICES or LTCC assessment: “Long-Term Care Consultation contacts.” See attachments for full lists of services available through the various waivers.*

**STATE MEDICAL REVIEW TEAM (SMRT) PROCESS**

In order to qualify for a waiver or certain other disability programs, a person must have a certified disability. Sometimes people who have not yet been approved for Social Security Income or Social Security Disability Insurance (SSI/SSDI) still need waiver services, and can become certified disabled by going through the SMRT process. The State Medical Review Team is a unit of the Department of Human Services (DHS) that determines disability status by working with counties and medical providers review of records, using similar standards as the Social Security Administration. In order to request that the SMRT process began for someone you are working with, contact the person’s county or tribal financial worker to request a referral. They will send out a packet of information and forms to begin the process.
Minnesota Health Care Programs

Summary of Coverage, Cost Sharing and Limits

(Effective Jan. 1, 2018)

This is only a summary. For details about covered services, you can call your worker, health plan or provider. If you are not in a health plan, call the Minnesota Health Care Programs Member Help Desk at 651-431-2670 or 800-657-3739.

Your provider must get approval for some services before you get them. Services must be medically necessary. The following lists do not include all covered services.

Medical Assistance (MA)
MA covers the services listed below. Some people get their MA services through a health plan.

- Alcohol and drug treatment
- Chiropractic care
- Dental care (limited for nonpregnant adults)
- Doctor and clinic visits
- Emergency room (ER) care
- Eyeglasses
- Family planning services
- Hearing aids
- Home care, including personal care assistance (PCA) services
- Hospice care
- Hospital services (inpatient and outpatient)
- Immunizations and vaccines
- Interpreter services
- Lab and X-ray services
- Licensed birth center services
- Medical equipment and supplies
- Medical transportation (emergency and nonemergency)
- Mental health care
- Nursing home care and care in an intermediate care facility for people with developmental disabilities (ICF-DD)
- Outpatient surgery
- Prescriptions and medication management
- Rehabilitative therapy
- Urgent care
- People enrolled in the Refugee MA program
- People in nursing homes or ICF-DDs

If you are not able to pay a copay or deductible, your provider still has to serve you. Providers must take your word that you cannot pay. Providers cannot ask for proof that you cannot pay.

Monthly copays and deductibles are limited to 5 percent of family income for adults with MA who are not otherwise exempt from copays and deductibles.

If you have Medicare: Minnesota Health Care Programs cannot pay for any drugs in the Medicare prescription drug benefit. If you have Medicare, you can get Part D drug coverage. Prescriptions under Part D may have different copays.

Emergency Medical Assistance (EMA)
EMA is fee-for-service coverage. People do not enroll in health plans.

- EMA pays for a medical emergency treated in an emergency room or hospital. Follow-up care from the same provider is covered if the services were paid for as part of treating the emergency.
- EMA may pay for some nursing home and home health care services for some very limited emergency conditions. Your provider must submit a Care Plan Certification Request to get coverage for these services.
- EMA may pay for ongoing treatment of a condition to prevent you from having to go to the hospital. Your provider must submit a Care Plan Certification Request for these services.
- EMA pays for renal dialysis. Your provider must submit a Care Plan Certification Request.
- EMA pays for kidney transplants for eligible patients who are currently receiving dialysis services. Your provider must submit a Care Plan Certification Request for these services.
- EMA pays for treatment of cancer (if not in remission), including surgery, chemotherapy and radiation. Your provider must submit a Care Plan Certification Request.

EMA does not cover nonemergency services. Some examples of services that are not covered are these:
- Alcohol and drug treatment
- Care of chronic conditions (such as diabetes management)
- Day training
- Eyeglasses

MA cost sharing
Cost sharing means the amount you pay toward your medical costs. Cost sharing for adults 21 years old or older is as follows:
- $3.15 monthly deductible
- $3 copay for nonpreventive visits; no copay for mental health visits
- $3.50 copay for nonemergency ER visits
- $3 or $1 copay for prescription drugs, up to $12 per month; no copay for some mental health drugs

These people are exempt from cost sharing:
- American Indians and Native Alaskans who have ever received care from an Indian health care provider
- Pregnant women
- People in hospice care
- People enrolled in the MA Breast and Cervical Cancer program

MA cost sharing for children
Cost sharing for children 21 years old or younger is as follows:
- $3.15 monthly deductible
- $3 copay for nonpreventive visits; no copay for mental health visits
- $3.50 copay for nonemergency ER visits
- $3 or $1 copay for prescription drugs, up to $12 per month; no copay for some mental health drugs

These people are exempt from cost sharing:
- American Indians and Native Alaskans who have ever received care from an Indian health care provider
- Pregnant women
- People in hospice care
- People enrolled in the MA Breast and Cervical Cancer program

MA cost sharing for children and their parents
Cost sharing for children 21 years old or younger and their parents is as follows:
- $3.15 monthly deductible
- $3 copay for nonpreventive visits; no copay for mental health visits
- $3.50 copay for nonemergency ER visits
- $3 or $1 copay for prescription drugs, up to $12 per month; no copay for some mental health drugs

These people are exempt from cost sharing:
- American Indians and Native Alaskans who have ever received care from an Indian health care provider
- Pregnant women
- People in hospice care
- People enrolled in the MA Breast and Cervical Cancer program
- Family planning services
- Organ transplants (Exception: Kidney transplants are covered)
- Most nursing home care or other facility care
- Lab and X-ray services
- Preventive or screening appointments and tests
- Rehabilitative therapy
- Other nonemergency services

If you get MinnesotaCare: You will enroll in a health plan. The plan will mail you information about covered services.

**MinnesotaCare**

**Children under 21 and pregnant women**

There are no copays, deductibles or inpatient limits.

MinnesotaCare covers these things:
- Alcohol and drug treatment
- Chiropractic care
- Dental care
- Doctor and clinic visits
- Emergency room (ER) care
- Eyeglasses
- Family planning services
- Hearing aids
- Home care, including personal care assistance (PCA) services
- Hospice care
- Hospital services (inpatient and outpatient)
- Immunizations and vaccines
- Interpreter services
- Lab and X-ray services
- Licensed birth center services
- Medical equipment and supplies
- Medical transportation (emergency and nonemergency)
- Mental health care
- Nursing home care and care in an intermediate care facility for people with developmental disabilities (ICF-DD)
- Outpatient surgery
- Prescriptions and medication therapy management
- Rehabilitative therapy
- Urgent care

**MinnesotaCare**

Parents, caretakers, and adults without children

Coverage is the same as MinnesotaCare for children under 21 except that copays and deductibles apply and these services are limited:
- Dental care (limited for nonpregnant adults)
- Medical transportation (emergency only)

Also, these services are not covered:
- Intermediate care facility care
- Nursing home care
- Orthodontic services
- Personal care assistance (PCA) services
- Private duty nursing

**MinnesotaCare Cost Sharing and Limits**

Some people 21 years old or older pay cost sharing. Cost sharing means the amount you pay toward your medical costs.
- $3.15 monthly deductible
- $50 copay for ER visits
- $15 copay for nonpreventive visits; no copay for mental health visits
- $150 per inpatient hospital admission
- $25 for outpatient hospital visits
- $50 ambulatory surgery
- $25 copay for eyeglasses
- $6 or $20 copay for prescription drugs up to $60 per month; no copay for some mental health drugs
- $25 per visit for radiology services

American Indians who are members of a federally recognized tribe are exempt from cost sharing.

ER copay does not apply for visits that lead to an inpatient admission.

You must pay your copay directly to your provider. Some providers require that you pay the copay when you arrive for medical service.
### Income and Asset Guidelines

The table below provides income and asset guidelines for various scenarios. The guidelines are effective from 7/1/18 to 6/30/19.

**Note:** Income guidelines are approximations only. Use this chart for general reference only.

<table>
<thead>
<tr>
<th>Income Level</th>
<th>Asset Limit</th>
<th>Family Size</th>
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<tbody>
<tr>
<td>T1 1/16</td>
<td>$18,720</td>
<td>1</td>
</tr>
<tr>
<td>T2 1/16</td>
<td>$19,920</td>
<td>2</td>
</tr>
<tr>
<td>T3 1/16</td>
<td>$21,120</td>
<td>3</td>
</tr>
<tr>
<td>T4 1/16</td>
<td>$22,320</td>
<td>4</td>
</tr>
<tr>
<td>T5 1/16</td>
<td>$23,520</td>
<td>5</td>
</tr>
<tr>
<td>T6 1/16</td>
<td>$24,720</td>
<td>6</td>
</tr>
<tr>
<td>T7 1/16</td>
<td>$25,920</td>
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</tr>
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<td>T8 1/16</td>
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<td>T9 1/16</td>
<td>$28,320</td>
<td>9</td>
</tr>
<tr>
<td>T10 1/16</td>
<td>$29,520</td>
<td>10</td>
</tr>
<tr>
<td>T11 1/16</td>
<td>$30,720</td>
<td>11</td>
</tr>
<tr>
<td>T12 1/16</td>
<td>$31,920</td>
<td>12</td>
</tr>
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</table>

**Effective:** 7/1/18 – 6/30/19
<table>
<thead>
<tr>
<th>No.</th>
<th>Income Limit</th>
<th>No. Asset Limit</th>
<th>No. Asset Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>11,350</td>
<td>1,114</td>
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<td>11,350</td>
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<td>8</td>
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<td>1,114</td>
<td>859</td>
</tr>
</tbody>
</table>

Notes: “FPG” stands for Federal Poverty Guidelines. Income guidelines are approximations only. Use this chart for general reference only.
### Income and asset guidelines for approximations only. Use this chart for general reference only.

A 2% discount is included in each column headed...

<table>
<thead>
<tr>
<th></th>
<th>Adjusted Income (OI)</th>
<th>Non-Adjusted Income (NAI)</th>
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</thead>
<tbody>
<tr>
<td>310% Pfd</td>
<td>300% Pfd</td>
<td>250% Pfd</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Notes:**
- A 2% discount is included in each column headed...
- Please verify this chart. Income thresholds change.
- Use this chart for general guidance only.

**Adjusted Income (OI):**

- OI = NAI - DEDs (including mortgage interest and property taxes)
- DEDs can be subtracted from NAI to get OI

**Non-Adjusted Income (NAI):**

- NAI = Gross income from all sources

**Adjusted Gross Income (AGI):**

- AGI = NAI - DEDs

**Deductions (DEDs):**

- DEDs = Mortgage interest + Property taxes + Other allowable deductions

**Effective Date:**

- Effective 7/1/18 - 6/30/19
<table>
<thead>
<tr>
<th>Family Size</th>
<th>200% FPL</th>
<th>150% FPL</th>
<th>133% FPL</th>
<th>100% FPL</th>
<th>80% FPL</th>
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<tbody>
<tr>
<td>1-Person</td>
<td>$15,900</td>
<td>$12,700</td>
<td>$11,430</td>
<td>$9,600</td>
<td>$7,680</td>
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<tr>
<td>2-Person</td>
<td>$21,700</td>
<td>$17,240</td>
<td>$15,900</td>
<td>$12,960</td>
<td>$10,360</td>
</tr>
<tr>
<td>3-Person</td>
<td>$27,500</td>
<td>$21,740</td>
<td>$20,940</td>
<td>$16,380</td>
<td>$13,040</td>
</tr>
<tr>
<td>4-Person</td>
<td>$33,300</td>
<td>$26,700</td>
<td>$25,980</td>
<td>$20,880</td>
<td>$16,600</td>
</tr>
<tr>
<td>5-Person</td>
<td>$39,100</td>
<td>$31,200</td>
<td>$30,600</td>
<td>$25,560</td>
<td>$21,200</td>
</tr>
</tbody>
</table>

**Notes:** Income and asset guidelines are approximations only. Use this chart for general reference only.

- A $20 discount is included in each amount listed.

- pay a premium and an increased income obligation if required.

- Meet the M-EFF at least half of $20,000 or more.

- Be employed and have Social Security and Medicare (SSA) taxes withheld or paid from earned income.

- First month salaries or wages from $55 (aveerage income level)

- Be covered by the Social Security Administration (SSA) at the same Medical Review Team (SRMT).

- To qualify for M-EFF, your must...

**Note:** Effective 7/1/17 - 6/30/18
DHS Long-Term Care Consultation Contacts

A

Aitkin
Aitkin County Health & Human Services
204 First St. NW
Aitkin, MN 56431
218-927-7232 or 218-927-7232

Anoka
Anoka County Community Social Services
2100 Third Ave., Suite 340
Government Center
Anoka, MN 55303-2644
763-323-6089 or 763-422-6912

B

Becker
Becker County Human Services
712 Minnesota Ave.
P.O. Box 1637
Detroit Lakes, MN 56501-1637
218-847-5628 x-5339 or 218-847-5628 x-5321

Beltrami
Beltrami County Human Services
616 America Ave. NW, Suite 330
Bemidji, MN 56601
218-333-8043 or 218-333-4195

Benton
Benton County Human Services
P.O. Box 740
Foley, MN 56329
320-968-5187 or 320-968-5098

Big Stone
Big Stone County Family Services
340 NW Second Street

Ortonville, MN 56278
320-839-6385 or 320-839-2555 x-15

Blue Earth
Blue Earth County Human Services
410 S Fifth Street
P.O. Box 3526
Mankato, MN 56002-3526
507-304-4444 or 507-304-4168

Brown
Brown County Family Services
1117 Center St.
P.O. Box 788
New Ulm, MN 56073
507-359-6551 or 507-359-6538

C

Carlton
Carlton County Human Service Center
14 N 11th Street
P.O. Box 650
Cloquet, MN 55720
218-878-2859

Carver
Carver County Community Social Services
602 E Fourth St.
Chaska, MN 55318
952-361-1999 or 952-442-7670

Cass
Cass County Health & Human Services
P.O. Box 519
400 Michigan Avenue
Walker, MN 56484
218-547-1340 x-296 or 218-547-1340 x-223

Chippewa
DHS Long-Term Care Consultation Contacts

Chippewa County Family Services  
719 N Seventh St., Suite 200  
Montevideo, MN 56265  
320-269-6401

Chisago  
Chisago County Health & Human Services  
313 N Main St., Room 240  
Center City, MN 55012  
651-213-5617 or 651-213-5200

Clay  
Clay County Social Service Center  
715 N 11th St., Suite 502  
Moorhead, MN 56560  
218-299-7152 or 218-299-7119

Clearwater  
Clearwater County Dept. of Human Services  
216 Park Ave. NW  
P.O. Box X  
Bagley, MN 56621  
218-694-3535 or 218-694-6164

Cook  
Cook County Social Services  
411 W Second St.  
Grand Marais, MN 55604-2307  
218-387-3000 x-109 or 218-387-3620 x-124

Cottonwood  
Cottonwood County Des Moines Valley Health & Human Services  
P.O. Box 9  
11 Fourth Street  
Windom, MN 56101  
507-831-1259 or 507-847-4000

Crow Wing  
Crow Wing County Social Service Center  
204 Laurel St.

P.O. Box 686  
Brainerd, MN 56401  
218-824-1093 or 218-824-1237

Dakota  
Dakota County Community Services  
1 Mendota Road W, Suite 410  
West Saint Paul, MN 55118-4771  
651-554-6336 or 651-554-6108

Dodge  
Dodge County Human Services  
42 E Main Street  
P.O. Box 129  
Dodge Center, MN 55927  
507-635-6150

Douglas  
Douglas County Social Services  
725 Elm St., Suite 1200  
Alexandria, MN 56308  
320-762-2930 or 320-763-6018

Faribault  
Faribault County Human Services  
412 North Nicollet  
Blue Earth, MN 56013  
507-526-3265 or 507-238-4757

Fillmore  
Fillmore County Social Services  
902 Houston St. NW, Suite 2  
Preston, MN 55965  
507-765-3898

Freeborn
DHS Long-Term Care Consultation Contacts

Freeborn County Department of Human Services
P.O. Box 1246
Albert Lea, MN 56007
507-377-5100 or 507-377-5400

G

Goodhue

Goodhue County Social Service Center
426 West Ave
Red Wing, MN 55066
651-385-3200

Grant

Grant County Social Service Department
621 Pacific Avenue
Morris, MN 56267
320-762-2928 or 320-763-6018

H

Hennepin

Hennepin County Social Services
Gov. Center, 14th floor - MC140
300 S Sixth Street
Minneapolis, MN 55487
612-348-4111

Houston

Houston County Human Services
P.O. Box 310
304 S Marshall St., Suite B
Caledonia, MN 55921
507-725-5810

Hubbard

Hubbard County Social Service Center
301 Court Avenue
Park Rapids, MN 56470
218-732-1451 or 218-732-2306

I

Isanti

Isanti County Family Services
1700 E Rum River Dr. S, Suite A
Cambridge, MN 55008
763-689-8163 or 763-689-1711

Itasca

Itasca County Health & Human Services
1209 SE Second Avenue
Grand Rapids, MN 55744
218-327-2941 or 218-327-6144

J

Jackson

Jackson County Human Services
P.O. Box 67
310 Sherman St.
Jackson, MN 56143
507-847-4000

K

Kanabec

Kanabec County Family Service Department
905 E Forest Ave., Suite 127
Mora, MN 55051
320-679-6394 or 320-679-6330

Kandiyohi

Kandiyohi County Family Service Department
2200 23rd St. NE, Suite 1020
Willmar, MN 56201
320-231-7800 x-2479 or 320-231-7800 x-2482

Kittson
DHS Long-Term Care Consultation Contacts

Kittson County Welfare Department
410 Fifth St. S, #100
Hallock, MN 56728-4140
218-843-2689

Koochiching
Koochiching County Community Services
1000 Fifth St.
International Falls, MN 56649
218-283-7000

L

Lac Qui Parle
Lac Qui Parle County Family Service Center
P.O. Box 7
930 First Ave.
Madison, MN 56256
320-598-7594

Lake
Lake County Human Service Department
616 Third Ave.
Two Harbors, MN 55616
218-834-8416

Lake of the Woods
Lake of the Woods Social Service Department
206 Eighth Ave. SE, Suite 200
Baudette, MN 56623
218-634-2642

Leech Lake Band of Ojibwe
Leech Lake Band of Ojibwe Health Division
115 Sixth St. NW, Suite E
Cass Lake, MN 56633
218-335-4531

Le Sueur
Le Sueur County Department of Human Services
88 S Park Ave.
Le Sueur, MN 56057
507-357-8552 or 507-357-8247

Lincoln
Lincoln County Social Services
607 West Main Street
P.O. Box 44
Marshall, MN 56258
507-657-3781 or 507-532-1226

Lyon
Lyon County Social Services
607 West Main Street
P.O. Box 44
Marshall, MN 56258
507-657-3781 or 507-532-1226

M

Mahnomen
Mahnomen County Human Services
P.O. Box 460
Mahnomen, MN 56557
218-935-2568

Marshall
Marshall County Social Services
208 E Colvin Ave., Suite 14
Warren, MN 56762
218-745-5124

Martin
Martin County Human Services
115 W First Street
Fairmont, MN 56031
507-238-4757

McLeod
DHS Long-Term Care Consultation Contacts

McLeod County Social Service Center
1805 Ford Ave. N, Suite 100
Glencoe, MN 55336
320-864-1239 or 320-864-1395

Meeker

Meeker County Social Services
114 N Holcombe Ave., Suite 180
Litchfield, MN 55355
320-693-5300

Mille Lacs Band of Ojibwe

Mille Lacs Band of Ojibwe
17230 Noopiming Drive
Onamia, MN 56359
320-532-7778

Mille Lacs

Mille Lacs County Community & Veterans Services
525 Second St. SE
Milaca, MN 56353
320-983-8374 or 320-983-8378

Morrison

Morrison County Social Services
200 Broadway Ave. E
Little Falls, MN 56345
320-632-6664 or 320-632-7805

Mower

Mower County Department Human Services
1301 18th Ave. NW, Suite A
Austin, MN 55912
507-437-9728 or 507-437-9775

Murray

Murray County Social Services
607 West Main Street
P.O. Box 44
Marshall, MN 56258
507-657-3781 or 507-532-1226

N

Nicollet

Nicollet County Social Services
501 S Minnesota Ave.
Saint Peter, MN 56072
507-934-7222

Nobles

Nobles County Family Service Agency
P.O. Box 189
318 Ninth St.
Worthington, MN 56187
507-295-5228 or 507-295-5240

Norman

Norman County Social Service Center
15 Second Ave. E
Ada, MN 56510
218-784-5420 or 218-784-5420

O

Olmsted

Olmsted County
2100 Campus Drive SE
Rochester, MN 55904
507-328-6519 or 507-328-6644

Otter Tail

Otter Tail County Human Service Department
530 Fir Avenue W
Fergus Falls, MN 56537
218-998-8150 or 218-998-8148

P

Pennington
# DHS Long-Term Care Consultation Contacts

**Pennington County Dept. of Welfare & Human Services**  
P.O. Box 340  
Thief River Falls, MN 56701  
218-681-2880 x-227

**Red Lake County Social Service Center**  
125 Edward Avenue  
P.O. Box 356  
Red Lake Falls, MN 56750  
218-253-4131 or 218-784-5420

**Pine**  
Pine County Department of Human Services  
130 Oriole St. E, Suite 1  
Sandstone, MN 55072  
320-591-1598 or 320-216-4109

**Redwood**  
Redwood County Human Services  
P.O. Box 510  
302 E Third St.  
Redwood Falls, MN 56283  
507-637-4050 or 507-532-1226

**Pipestone**  
Pipestone County Family Service Agency  
121 W Main Street  
P.O. Box 157  
Pipestone, MN 56164  
888-632-4325 or 507-532-1226

**Renville**  
Renville County Human Services  
105 S Fifth St., Suite 203H  
Olivia, MN 56277  
320-523-2202

**Polk**  
Polk County Social Service Center  
612 North Broadway, Suite 110  
Crookston, MN 56716  
218-281-0630 or 218-470-8418

**Rice**  
Rice County Social Services  
320 Third Street NW, Suite 1  
Faribault, MN 55021  
507-332-5929 or 507-332-5961

**Pope**  
Pope County Family Services  
211 E Minnesota Ave., Suite 100  
Glenwood, MN 56334  
320-763-6018

**Rock**  
Rock County Family Service Agency  
P.O. Box 715  
2 Roundwind Road  
Luverne, MN 56156  
507-283-5070 or 507-532-1226

**Red Lake**  
Ramsey County Human Service Department  
160 E Kellogg Blvd., Suite 8800  
St. Paul, MN 55101  
651-266-3613 FAX 651-266-4432

**Roseau**  
Roseau County Social Service Center  
208 Sixth St. SW  
Roseau, MN 56751  
218-463-2411

**St. Louis**
DHS Long-Term Care Consultation Contacts

St. Louis County North Public Health and Human Services
307 S First Street
P.O. Box 1148
Virginia, MN 55792
218-471-7760 or 218-726-2366

St. Louis County South Public Health and Human Services
320 W Second St., Room 309
Duluth, MN 55802
218-726-2366 or 218-726-2178

Stevens
Stevens County Human Services
621 Pacific Avenue
Morris, MN 56267
320-762-2928 or 320-763-6018

Swift
Swift County Human Services
410 21st St. S
P.O. Box 208
Benson, MN 56215
320-843-3160 or 320-843-6319

T
Todd
Todd County Social Services
119 Third St. South, Suite 2
Long Prairie, MN 56347
320-732-4519 or 320-732-4011

Traverse
Traverse County Social Services Department
621 Pacific Avenue
Morris, MN 56267
320-762-2928 or 320-763-6018

W
Wabasha
Wabasha County Social Service Department
411 Hiawatha Drive E
Wabasha, MN 55981
651-565-5200

Wadena

Sibley
Sibley County Human Services
P.O. Box 166
111 Eighth Street
Gaylord, MN 55334
507-237-4131 or 507-237-4000

Sherburne
Sherburne County Social Services Government Center
13880 Business Center Drive
Elk River, MN 55330
763-765-4095 or 763-765-4340

Stearns
Stearns County Social Services
705 Courthouse Square
P.O. Box 1107
St. Cloud, MN 56302-1107
320-656-6000

Steele
Steele County Human Services
630 Florence Ave.
DHS Long-Term Care Consultation Contacts

Wadena County Social Service Department
124 SE First St.
Wadena, MN 56482
218-631-7605

Waseca

Waseca County Department of Human Services
299 Johnson Ave. SW, Suite 160
Waseca, MN 56093
507-835-0656 or 507-837-5327

Washington

Washington County Community Services Department
14949 62nd St. N
P.O. Box 30
Stillwater, MN 55082-0030
651-430-6484 or 651-430-6576

Watonwan

Watonwan County Human Services
715 Second Ave. S
P.O. Box 31
St. James, MN 56081
507-375-3294

White Earth Band of Ojibwe

White Earth Band of Ojibwe Home Health Agency
P.O. Box 496
White Earth, MN 56591
218-983-3286 x-1277 or 218-983-3286 x-1257

Wilkin

Wilkin County Family Service Agency
300 S Fifth Street
P.O. Box 127
Breckenridge, MN 56520
218-643-7122

Winona

Winona County Department of Human Services
202 W Third St.
Winona, MN 55987
507-457-6500

Wright

Wright County Human Services
1004 Commercial Drive
Buffalo, MN 55313
763-684-8435 or 763-682-7445

Yellow Medicine

Yellow Medicine County Family Service Center
415 9th Ave., Suite 202
Granite Falls, MN 56241
320-564-2211
Elderly Waiver program

What is the Elderly Waiver program?

The Elderly Waiver program funds home and community-based services for people age 65 and older who are eligible for Medical Assistance and require the level of care provided in a nursing home but choose to live in the community. The Minnesota Department of Human Services operates the program under a federal waiver to Minnesota’s Medicaid state plan. Counties, tribal entities and health plan partners administer the program.

What types of services are available?

Covered services include:

- Adult day service
- Case management
- Changes to make homes and equipment accessible
- Chore services
- Companion services
- Consumer-directed community supports
- Home health aides
- Home-delivered meals
- Homemaker services
- Licensed community residential services, including customized living services, family and corporate foster care and residential care
- Nonmedical transportation
- Personal care
- Personal emergency response systems
- Respite care
- Skilled nursing
- Specialized equipment and supplies
- Supports during transitions between different types of housing
- Training and support for family caregivers

Who is eligible?

A person age 65 or older who is assessed through the Long-Term Care Consultation process is eligible for the Elderly Waiver program when the following criteria are met:

- The person is eligible for Medical Assistance and in need of nursing home level of care as determined by the Long-Term Care Consultation process.
- The cost for a person’s Elderly Waiver services cannot be greater than the estimated nursing home cost for that person.
- The person chooses to receive services in the community instead of nursing facility services.
How many people? How many dollars?

In fiscal year 2016, the program served 29,822 people at a total cost of $401,853,154. The average monthly participant population for fiscal year 2016 was 23,303 with an average monthly cost of $1,609 under fee-for-service purchase and $1,340 per participant per month under managed care.

Ninety-two percent of participants receive their services through a managed care organization. Managed care program options include:

- Minnesota Senior Health Options, an integrated Medicaid/Medicare health and long-term care program
- Minnesota Senior Care Plus, a Medicaid health and long-term care option.

What alternatives exist for people who are eligible for the Elderly Waiver?

Alternatives to the Elderly Waiver include Medicaid-certified skilled nursing facilities and certified board-and-care homes. The average cost of these alternative settings is $6,783 per person, per month.

Where can I learn more about the Elderly Waiver?

More information is available on the Minnesota Department of Human Services website, mn.gov/dhs, and in Minnesota Statutes 256B.0915. Information is also available by calling the Senior Linkage Line at 800-333-2433 or going to MinnesotaHelp.info.

How can I enroll?

Contract your county or tribe for a Long-Term Care Consultation. If you are already on Medical Assistance and enrolled in a health plan, you should contact your health plan.

For accessible formats of this publication or assistance with additional equal access to human services, write to dhs.info@state.mn.us, call 651-431-2400, toll-free 800-882-6262, or use your preferred relay service.

mn.gov/dhs
Community Access for Disability Inclusion Waiver supports people with disabilities

Children and adults who have a disability and require nursing facility-level care may be eligible for help. Instead of being cared for in a nursing facility, people can receive services in the community. It might be the person's own home, biological or adoptive parent's home, home of relatives (e.g. sibling, aunt, grandparent, etc.), family foster care home or corporate foster care home, board and lodging facility or a customized living facility. If married, a person may receive services while living at home with his or her spouse. The Community Access for Disability Inclusion (CADI) waiver supports these options.

In state fiscal year 2016, an average of 19,932 Minnesotans were served on the CADI waiver each month at an average monthly cost of $3,069 in state and federal funds. A waiver allows states to obtain federal Medicaid matching funds to provide long-term services and supports to people in community settings instead of institutions.

Who is eligible for the CADI waiver?

Eligibility for the CADI waiver is determined through a screening process. To be eligible, a person must:

- Be on Medical Assistance (MA) or be eligible for MA based on the person's own income or assets.
- Be certified disabled by the Social Security Administration or the State Medical Review Team.
- Be under the age of 65 years old when the person first opens to the waiver.
- Require the level of care provided to people in a nursing facility.
- Have an assessed need for supports and services over and above those available through the MA state plan.
- Choose care and services in the community instead of a nursing facility.

Once eligibility is determined for participation in the CADI waiver, certain questions must be asked about services including:

- Are the services necessary to ensure the person's health and safety?
- Is the service covered by any other funding source, such as MA state plan services, private health care coverage, Medicare, education or Vocational Rehabilitation Service funding?
- Have all options been assessed and does this option meet the desires, needs and preferences of the person?
- Is the cost of the service considered reasonable and customary?
In addition to services covered by Medical Assistance, what other services are available through the CADI Waiver?

- 24-hour emergency assistance
- Adult companion
- Adult day service/Adult day service bath
- Caregiver living expenses
- Case management and case management aide
- Chore
- Consumer-directed community supports, a service option giving the person flexibility and responsibility to direct his or her own services and supports
- Crisis respite
- Customized living
- Environmental accessibility adaptations
- Extended home health aide and nursing
- Extended home health therapies
- Extended personal care assistance
- Extended private duty nursing
- Family training and counseling
- Foster care
- Home delivered meals
- Homemaker
- Housing access coordination
- Independent living skills training
- Individualized home support
- In-home family support
- Night supervision
- Personal support services
- Positive support services
- Prevocational services
- Residential care
- Respite
- Specialist services
- Specialized equipment and supplies
- Supported employment services
- Transitional services
- Transportation

mn.gov/dhs
How can people apply for the CADI Waiver?

Apply for the CADI waiver at your local county public health or social service agency. The DHS Disability Services Division administers the CADI waiver.
Attention. If you need free help interpreting this document, call the above number.

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Nóig só bén trén.

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Developmental Disabilities Waiver supports people with developmental disabilities or related conditions

Children and adults with developmental disabilities or related conditions may be eligible for help. Instead of being cared for in an Intermediate Care Facility for Persons with Developmental Disabilities (ICF/DD), people can receive services in the community. It might be the person’s own home, biological or adoptive parent’s home, home of relatives (e.g., sibling, aunt, grandparent, etc.), family foster care home or a corporate foster care home. If married, a person may receive services while living at home with his or her spouse. The Developmental Disabilities (DD) Waiver supports these options.

In state fiscal year 2016, an average of 16,606 people were served on the DD Waiver each month at an average monthly cost of $6,226 in state and federal funds. A waiver allows states to obtain federal Medicaid matching funds to provide long-term services and supports to people in community settings instead of institutions.

Who is eligible for the DD Waiver?

Eligibility for the DD Waiver is determined through a screening process. To be eligible, a person must:

- Be on Medical Assistance (MA) or be eligible for MA.
- Be determined to have a developmental disability or a related condition.
- Require the level of care provided to people in an ICF/DD.
- Require daily interventions, daily services and a 24-hour plan of care.
- Need a residential habilitation service that must be included in the person’s support plan.
- Have an assessed need for supports and services over and above those available through the MA state plan.
- Choose care and services in the community instead of an ICF/DD.

Once eligibility is determined for participation in the DD Waiver, certain questions must be asked about services including:

- Are the services necessary to ensure the person’s health and safety?
- Will the services address skill development and/or skill maintenance?
- Is the service covered by any other funding source, such as MA state plan services, private health care coverage, Medicare, education or Vocational Rehabilitation Service funding?
- Have all options been assessed and does this option meet the desires, needs and preferences of the person?
- Is the cost of the service considered reasonable and customary?
In addition to services covered by Medical Assistance, what other services are available through the DD Waiver?

- 24-hour emergency assistance
- Adult day service/adult day service bath
- Assistive technology
- Caregiver living expenses
- Case management
- Chore
- Consumer-directed community supports, a service option giving the person flexibility and responsibility to direct his or her own services and supports
- Crisis respite
- Day training and habilitation
- Environmental accessibility adaptations
- Extended personal care assistance
- Family training and counseling
- Home delivered meals
- Homemaker
- Housing access coordination
- Night supervision
- Personal support services
- Positive support services
- Residential habilitation: In-home family support and supported living services
- Respite
- Specialist services
- Supported employment services
- Transitional services
- Transportation

How can people apply for the DD Waiver?

Apply for the DD Waiver at your local county public health or social service agency. The DHS Disability Services Division administers the DD Waiver.

mn.gov/dhs
Brain Injury Waiver supports people with brain injuries

Children and adults who have acquired or traumatic brain injury may be eligible for help. Instead of being cared for in a nursing facility or a neurobehavioral hospital, people can receive services in the community. It might be the person’s own home, biological or adoptive parent’s home, home of relatives (e.g. sibling, aunt, grandparent, etc.), family foster care home or corporate foster care home, board and lodging facility or a customized living facility. If married, a person may receive services while living at home with his or her spouse. The Brain Injury (BI) waiver supports these options.

In state fiscal year 2016, an average of 1301 people were served on the BI waiver each month at an average monthly cost of $6,484 in state and federal funds. A waiver allows states to obtain federal Medicaid matching funds to provide long-term services and supports to people in community settings instead of institutions.

Who is eligible for the BI Waiver?

Eligibility for the BI Waiver is determined through a screening process. To be eligible, a person must:

- Be on Medical Assistance (MA) or be eligible for MA based on the person's own income or assets.
- Be certified disabled by the Social Security Administration or the State Medical Review Team.
- Be under the age of 65 years old when the person first opens to the waiver.
- Require the level of care provided to people in a nursing facility or neurobehavioral hospital.
- Have a documented diagnosis of a traumatic, acquired or degenerative brain injury secondary to an event or disease that is not congenital.
- Have significant behavioral and cognitive impairments related to a brain injury.
- Have the potential to benefit from rehabilitation services as determined by a score of Level IV or above on the Rancho Los Amigos Level of Cognitive Functioning Scale.
- Have an assessed need for supports and services over and above those available through the MA state plan.
- Require a higher level of service than is available through other waivers due to cognitive and behavior impairments.
- Choose care and services in the community instead of a nursing facility or neurobehavioral hospital.

Once eligibility is determined for participation in the BI Waiver, certain questions must be asked about services including:

- Are the services necessary to ensure the person's health and safety?
- Is the service covered by any other funding source, such as MA state plan services, private health care coverage, Medicare, education or Vocational Rehabilitation Service funding?
• Have all options been assessed and does this option meet the desires, needs and preferences of the person?
• Is the cost of the service considered reasonable and customary?

In addition to services covered by Medical Assistance, what other services are available through the BI Waiver?

• 24-hour emergency assistance
• Adult companion
• Adult day service/Adult day service bath
• Caregiver living expenses
• Case management and case management aide
• Chore
• Consumer directed community supports, a service option giving the person flexibility and responsibility to direct his or her own services and supports
  • Crisis respite
  • Customized living
  • Environmental accessibility adaptations
• Extended home health aide and nursing
• Extended home health therapies
• Extended personal care assistance
• Extended private duty nursing
• Family training and counseling
• Foster care
• Home delivered meals
• Homemaker
• Housing access coordination
• Independent living skills therapies
• Independent living skills training
• Individualized home support
• In-home family support
• Night supervision
• Personal support services
• Positive support services
• Prevocational services
• Residential care services
• Respite
• Specialist services
• Specialized equipment and supplies
• Structured day program
• Supported employment services
• Transitional services
• Transportation

How can people apply for the BI Waiver?

Apply for the BI waiver at your local county public health or social service agency. The DHS Disability Services Division administers the BI waiver.
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Внимание: если вам нужна бесплатная помощь в устном переводе данного документа, позвоните по указанному выше телефону.

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Community Alternative Care Waiver supports people who are chronically ill

Children and adults who are chronically ill and require hospital level of care may be eligible for help. Instead of being cared for in a hospital, people can receive services in the community. It might be the person’s own home, biological or adoptive parent’s home, home of relatives (e.g., sibling, aunt, grandparent, etc.), family foster care home or corporate foster care home. If married, a person may receive services while living at home with his or her spouse. The Community Alternative Care (CAC) waiver supports these options.

In state fiscal year 2016, an average of 393 people were served on the CAC waiver each month at an average monthly cost of $6,899 in state and federal funds. A waiver allows states to obtain federal Medicaid matching funds to provide long-term services and supports to people in community settings instead of institutions.

Who is eligible for the CAC waiver?

Eligibility for the CAC waiver is determined through a screening process. To be eligible, a person must:

- Be on Medical Assistance (MA) or be eligible for MA based on the person’s own income or assets.
- Be certified disabled by the Social Security Administration or the State Medical Review Team.
- Be under the age of 65 when the person is approved for waiver services and supports.
- Require the level of care provided to people in a hospital.
- Need skilled assessment and intervention multiple times during a 24-hour period to maintain health and prevent deterioration.
- Have both predictable health needs and the potential for changes in condition that could lead to rapid deterioration or life-threatening episodes.
- Require a 24-hour plan of care that includes a backup plan.
- Be expected to require frequent or continuous care in a hospital without CAC waiver services.
- Have an assessed need for supports and services over and above those available through the MA state plan.
- Choose care and services in the community instead of a hospital.

Once eligibility is determined for participation in the CAC waiver, certain questions must be asked about services including:

- Are the services necessary to ensure the person’s health and safety?
- Is the service covered by any other funding source, such as MA state plan services, private health care coverage, Medicare, education or vocational rehabilitation service funding?
• Have all options been assessed and does this option meet the desires, needs and preferences of the person?
• Is the cost of the service considered reasonable and customary?

In addition to services covered by Medical Assistance, what other services are available through the CAC waiver?

• 24-hour emergency assistance
• Adult day service in family adult day settings
• Caregiver living expenses
• Case management and case management aide
• Chore
• Consumer-directed community supports, a service option giving the person flexibility and responsibility to direct his or her own services and supports
• Crisis respite
• Environmental accessibility adaptations
• Extended home health aide and nursing
• Extended home health therapies
• Extended personal care assistance
• Extended private duty nursing
• Family training and counseling
• Foster care
• Home-delivered meals
• Homemaker
• Housing access coordination
• Independent living skills training
• Individualized home support
• In-home family support
• Night supervision
• Personal support services
• Positive support services
• Respite for caregiver
• Specialist services
• Specialized equipment and supplies
• Supported employment services
• Transitional services
• Transportation

mn.gov/dhs
How can people apply for the CAC waiver?

Apply for the CAC waiver at your local county public health or social service agency. The DHS Disability Services Division administers the CAC waiver.

This information is available in accessible formats for people with disabilities by calling local 651-431-4300, toll-free 1-866-267-7655, or by using your preferred relay service. For other information on disability rights and protections, contact the agency’s ADA coordinator.
1-866-333-2466

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กรุณาใส่เบอร์打进来的如果你需要免費協助翻譯這份文件，請撥打上面的電話號碼。

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Essential Community Supports (ECS)
Do you or an older adult you know want to stay in your own home or apartment?
Do you need help to do this?
Essential Community Supports could be for you!

What are Essential Community Supports?
- A new state program for older adults who want to stay in their own home or apartment and have modest needs
- A variety of services you can get in your own home or apartment
- A free program for all who meet the basic eligibility requirements

What services are available?
- Chore services
- Homemaking
- Personal Emergency Response System (PERS) pendants and installation
- Support for caregivers
- Help with household management, such as budgeting, and other problem-solving
- Adult day service
- Home-delivered meals
- Case management services, which help you to identify your needs and coordinate services that can help meet them

Who is eligible?
You are eligible to receive services if you:
- Are age 65 or older
- Are not eligible for Medical Assistance
- Do not require the level of care provided in a nursing facility
- Live in your own home or apartment
- Meet financial eligibility criteria for the Alternative Care program
- Need one or more of the Essential Community Support services to live in the community instead of a nursing home or other institution

How does it work?
You get a monthly budget used to pay for the services you need.

You get a case manager to help coordinate your services.

You will need to meet some financial requirements to be eligible for Essential Community Supports.

You can stay on the program as long as you have a need for the services.
Where can I get more information about Essential Community Supports?

Contact your county or tribal social services department or

call the Senior LinkAge Line at 1-800-333-2433 or

go to

mn.gov/dhs or www.MinnesotaHelp.info

Attention: If you need free help interpreting this document, ask your worker or call the number below for your language.

Mلاحظة: إذا أردت مساعدة مجانية لتترجمة هذه الوثيقة، اطلب ذلك من مشرفك أو اتصل على الرقم 0377-358-800-1

Pažnja. Ako vam treba besplatna pomoć za tumačenje ovog dokumenta, pitajte vašeg radnika ili nazovite 1-888-234-3785.

Thov ua twb zoo nyeem. Yog hais tias koj xav tau kev pab txhais lus rau tsab ntauw ntawv no pub dawb, ces nuj koj tus neeg lis dej num los sis hu rau 1-888-486-8377.

โปรดทราบ. ผู้ที่ต้องการการช่วยเหลือในภาษาอื่น ๆ สามารถติดต่อกับเจ้าหน้าที่ของหน่วยงานที่เกี่ยวข้องได้ที่ 1-888-487-8251.

Hubachiisa. Dokumenttiin kun bilisa akka siif hiikamu gargaarsa hoo feete, hojettleota 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.

Dignii. Haddii aad u baahantahay caawimaad lacag-la’aan ah ee tarjumaadda qoraalkan, hawladeenkaaga 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.
There are three different Social Security programs. Below are descriptions of the various programs, including eligibility, how to apply, etc. Additional information can be found at www.ssa.gov. 

National Social Security Administration (SSA) phone number: (800) 772-1213
Minneapolis SSA local card office phone number: (888) 847-0392

**SOCIAL SECURITY**

Also known as “Retirement” benefits, for workers who have reached the full federal retirement age (65-67, depending on when you were born, check website for exact age), and have at least 40 quarters of employment on record (does not count “under the table” work).

Benefit amounts vary, depending on amount paid in during employment. No asset limits. No disability requirement. There is “early retirement” available at age 62, but the benefit amount will be permanently reduced by 10-30%. Benefits can go to a surviving spouse or minor child in the event of death (RSDI).

**How to apply:** Online application available, or applicants can go to their local Social Security office to apply in person (calling for appointment recommended). You can apply for Social Security retirement benefits as early as 3 months before turning 62 or the full retirement age.

**SSDI/RSDI** (Social Security Disability Insurance/ Retirement, Survivors, Disability Insurance)

This type of SS is for workers who became disabled after working at least 40 qualifying quarters of employment, and can no longer work, or perform “substantial gainful activity (SGA)”. The amount of SGA changes, check the SSA website for current amount. Ex. The SGA amount for 2017 was $1170/mo.

Benefit amounts vary, depending on amount paid during employment. There are no asset limits.

**SSI**

This type of Social Security is for anyone over age 18 who cannot perform SGA (see above). No work history is needed. Anyone over age 65 who is very low income can also qualify.

There is a standard SSI amount, which changes occasionally for cost of living increases (check SSA’s website for current amount). The standard SSI amount for 2018 was $750 for an individual, $1125 for a married couple. There are asset limits $2,000 for an individual, $3,000 for a married couple.

*(Continued on next page,)*

Catholic Charities: Working with Older Adults Experiencing Homelessness: Best Practices and Resources
HOW TO APPLY (SSDI/RSDI AND SSI)

Applications can be completed online or in-person. It is highly recommended that either a disability attorney or a SOAR (SSI/SSDI Outreach, Advocacy, and Recovery) advocate is utilized for SSI and SSDI applications because level of disability is often difficult to prove.

There are exceptions to this, such as qualifying for a “compassionate allowance,” which is a list of approx. 100 severe conditions that warrant immediate approval (with medical documentation), such as terminal cancers, ALS, and Huntington Disease.

If the initial applications is denied, and the appeal process is critical and should be encouraged, as applicants often get approved the second time when new evidence is introduced.

**Assistance with application process**: See attachment “Social Security Application Assistance” and “Soar Advocates” for area resources.

**OTHER TERMS:**

**Presumptive Eligibility**: If there is an impairment that is easy to identify (deafness, blindness, amputated limbs, HIV/AIDS w/ medical documentation), SSA can start paying benefits immediately upon application. Payment lasts for 6 months, until the necessary medical documentation is obtained and the application is approved.

**Compassionate Allowances**: A list of impairments/illnesses that are deemed serious enough to approve benefits for individuals very quickly. A list of these impairments can be found on the www.ssa.gov website, and include illnesses such as terminal cancers, and certain brain disorders.

**Blue Book**: SSA listing of impairments that can be found online that outline what conditions and what severity warrant a Social Security approval. The Disability Determination Service (entity that approves or denies SS claims) uses this guide along with the medical evidence collected to determine eligibility. This can be useful information to share with your client’s doctor if they are assisting with providing medical evidence for the case.

**Consultative Examination**: If there is not enough medical evidence, or if the medical records obtained are old, DDS may send the applicant to a doctor of their choosing for a medical examination. If an applicant receives a notice for a consultative examination, it is critical they make it to the appointment.
**Back Pay:** Once approved for SSDI/RSDI or SSI, payment will be made for the time between the date of disability and the date of the application being approved, which is back pay. This may be paid in installments if the amount is very large, and it must be spent if the amount puts someone over the asset limit. If the applicant has been receiving General Assistance benefits, the amount received in GA will be taken out of the back payment, and a statement explaining the amount being recouped will be sent once the SSDI or SSI is approved.

**REPRESENTATIVE PAYEES**
A representative payee (sometimes referred to as a “rep payee” or “payee”) can be very helpful for individuals who have difficulty managing their money. They receive the beneficiary’s Social Security benefits directly and are responsible for paying necessary bills and giving the beneficiary personal needs funds. A payee can be a friend or family member, or a professional representative payee. Professional payees usually charge a fee for their services, but this expense can be offset by an increase in Minnesota Supplemental Aid (MSA) benefits.

In order to qualify for a payee, a person either needs to be determined unable to manage funds via a consultative exam during the application process, or by having a doctor complete a form stating it is necessary. Some common reasons for needing a payee include chemical dependency, severe mental illness, or dementia.

To begin the process of obtaining a payee, contact the preferred payee organization (recommended vs. a friend or family member unless there is a very trustworthy person involved), and they will provide necessary forms to complete to get the process started. Contact your local SSA office for a list of payee organizations in the area.

Once a person has a payee, speak with the county financial worker re: obtaining an increase in MSA benefits, which often offsets the cost of payee services.

*See attachments for list of representative payee organizations in the Twin Cities area.*
Professional Rep Payee Services

**ABC Payee**
(651) 343-2043

**Bill Payment Support Services, Inc.**
PO Box 490413
Blaine, MN 55360
(612) 655-1409

**Owens and Company**
PO Box 1831
Willmar, MN 56201
(320) 214-7000

**Practical Rep Payee Services, Inc.**
PO Box 146
Mayer, MN 55360
(952) 657-2879

**Professional Payee of MN**
PO Box 488
Anoka, MN 55303
(612) 250-5611

**St. Stephen’s Human Services (Formerly Alliance)**
2309 Nicollet Ave.
Minneapolis, MN 55404
(612) 870-0529

*Updated January, 2018*
Social Security Application Assistance

African Community Senior Services
Address: 3040 4th Avenue, Suite 5B, Minneapolis, MN 55408
Phone: 612-735-8776
Website: www.africancommunityseniorservices.com/
Social Security Advocacy Services Provided: Initial Applications, Reconsiderations, SOAR
Fee Arrangement: Will waive all fees for eligible clients
Eligibility: Client must be on one of the following DHS Programs or homeless:

- Diversionary Work Program
- General Assistance
- Group Residential Housing
- Minnesota Family Investment Program
- Refugee Cash Assistance
- Title IV-E Foster Care

Change Healthcare
Address: 1800 Chicago Avenue South, Suite N131, Minneapolis, MN 55404
Phone: 612-872-2080
Website: www.changehealthcare.com
Social Security Advocacy Services Provided: Initial Applications, Reconsiderations, Appeals
Fee Arrangement: Will waive all fees for eligible clients
Eligibility: Client must be on one of the following DHS Programs:

- Diversionary Work Program
- General Assistance
- Group Residential Housing
- Minnesota Family Investment Program
- Refugee Cash Assistance
- Title IV-E Foster Care

Cooper Law, LLC. Address: 825 Nicollet Mall, Suite 950, Minneapolis, MN 55402
Phone: 612-568-4529
Website: www.cooperlawmn.com
Social Security Advocacy Services Provided: Initial Applications, Reconsiderations, Appeals, SOAR
Fee Arrangement: May charge eligible clients a portion of their back-pay
Eligibility: Client must be on one of the following DHS Programs or homeless:
Disability Partners
Address: 2579 Hamline Avenue North, Suite C, St. Paul, MN 55113
Phone: 651-633-4882 or 866-577-9007
Website: www.disabilitypartners.net
Social Security Advocacy Services Provided: Initial Applications, Reconsiderations, Appeals, Continuing Disability Reviews
Fee Arrangement: May charge eligible clients a portion of their back-pay
Eligibility: Client must be on one of the following DHS Programs:
- Diversionary Work Program
- General Assistance
- Group Residential Housing
- Minnesota Family Investment Program
- Refugee Cash Assistance
- Title IV-E Foster Care

Disability Specialists, Inc.
Address: 9558 Ashawa Road, Cook, MN 55723
Phone: 218-666-2676 or 800-642-6393
Website: www.disabilityspecialists.net
Social Security Advocacy Services Provided: Initial Applications, Reconsiderations, Appeals, Continuing Disability Reviews
Fee Arrangement: May charge eligible clients a portion of their back-pay
Eligibility: Client must be on one of the following DHS Programs:
- Diversionary Work Program
- General Assistance
- Group Residential Housing
- Minnesota Family Investment Program
- Refugee Cash Assistance
- Title IV-E Foster Care
MedData, Inc.
Address: 8401 Golden Valley Road, Suite 300, Golden Valley, MN 55427
Phone: 612-332-6773
Website: www.meddata.com/for-patients/disability-services
Social Security Advocacy Services Provided: Initial Applications, Reconsiderations, Appeals
Fee Arrangement: May charge eligible clients a portion of their back-pay
Eligibility: Client must be on one of the following DHS Programs:

- Diversionary Work Program
- General Assistance
- Group Residential Housing
- Minnesota Family Investment Program
- Refugee Cash Assistance
- Title IV-E Foster Care

MedEligible Services
Address: 6160 Summit Drive, Suite 400, Minneapolis, MN 55430
Phone: 763-585-8400
Website: www.arsprofessionals.com/medeligible.html
Social Security Advocacy Services Provided: Initial Applications, Reconsiderations, Appeals
Fee Arrangement: May charge eligible clients a portion of their back-pay
Eligibility: Client must be on one of the following DHS Programs:

- Diversionary Work Program
- General Assistance
- Group Residential Housing
- Minnesota Family Investment Program
- Refugee Cash Assistance
- Title IV-E Foster Care

Metropolitan Community Services (MSC)
Address: 7900 Excelsior Boulevard, Suite 200, Hopkins, MN 55343
Phone: 952-658-8995
Website: www.mcsmn.com
Social Security Advocacy Services Provided: Initial Applications, Reconsiderations, SOAR
Fee Arrangement: Will waive all fees for eligible clients

Eligibility: Client must be on one of the following DHS Programs or homeless:

- Diversionary Work Program
- General Assistance
- Group Residential Housing
- Minnesota Family Investment Program
- Refugee Cash Assistance
- Title IV-E Foster Care

Mid-Minnesota Legal Assistance (Disability Law Center)
Address: 430 1st Avenue North, Suite 300, Minneapolis, MN 55430
Phone: 612-334-5970
Website: www.mylegalaid.org

Social Security Advocacy Services Provided: Appeals

Fee Arrangement: Will waive all fees for eligible clients

Eligibility: Client must be on one of the following DHS Programs:

- Diversionary Work Program
- General Assistance
- Group Residential Housing
- Minnesota Family Investment Program
- Refugee Cash Assistance
- Title IV-E Foster Care

Minnesota Department of Veteran Affairs
Address: Veterans Service Building, 20 West 10th Street, St. Paul, MN 55155
Phone: 651-296-2562
Website: www.mn.gov/mdva/

Social Security Advocacy Services Provided: Initial Applications, Reconsiderations, SOAR

Fee Arrangement: Will waive all fees for eligible clients

Eligibility: Veterans who are homeless or at risk for homelessness

Salvation Army – Twin Cities Social Services
Address: Center City Office, 53 Glenwood Avenue, Minneapolis, MN 55403
Phone: 612-767-0850
Website: www.salvationarmynorth.org

Social Security Advocacy Services Provided: Initial Applications, Reconsiderations, SOAR
Fee Arrangement: Will waive all fees for eligible clients
Eligibility: Client must be on one of the following DHS Programs or homeless:

- Diversionary Work Program
- General Assistance
- Group Residential Housing
- Minnesota Family Investment Program
- Refugee Cash Assistance
- Title IV-E Foster Care

Southern Minnesota Regional Legal Services (SMRLS)
Address: 55 East 5th Street, Suite 400, St. Paul, MN 55101
Phone: 888-575-2954
Website: www.smrls.org
Social Security Advocacy Services Provided: Appeals
Fee Arrangement: Will waive all fees for eligible clients
Eligibility: Client must be on one of the following DHS Programs:

- Diversionary Work Program
- General Assistance
- Group Residential Housing
- Minnesota Family Investment Program
- Refugee Cash Assistance
- Title IV-E Foster Care
There are many benefits and services available to veterans. There are veteran specific housing programs, medical benefits, mental health services, substance abuse programs, and many other services.

All veterans are encouraged to enroll in the VA health care system. If you are assisting a client that reports he/she is a veteran, you can assist them by calling the VA eligibility office to see if they are enrolled in care at the VA in Minneapolis at (612) 467-1991.

If a veteran is not currently enrolled and needs to enroll, they can apply for VA health care online (www.vets.gov/health-care/apply ) or complete an Application for Health Care Benefits after downloading it from the site (Form 10-10EZ). The completed printed form can be mailed to:

Minneapolis VA Healthcare System
Patient Access Center (17A1)
One Veterans Drive
Minneapolis, MN  55417

All applications MUST include the following:
- A copy of both sides of current health insurance card(s)
- A copy of discharge papers: DD214, Report of Separation, or Record of Enlistment
- If the veteran is a Purple Heart recipient, include a copy of the award letter (not the certificate) if “Purple Heart” is not listed on the DD214
- A copy of any service connected disability award letters via a VA Regional Office
- Non-service connected veterans and 0% service connected veterans are required to provide pervious calendar year income

IMPORTANT: Read instructions for “Financial Disclosure” section carefully. Although voluntary, detailed financial information helps determine eligibility and priority, and if not provided, can result in denial of benefits due to current priority structure.

For further information about benefits available through the VA, call (612) 467-2000, or visit their website at minneapolis.va.gov.
ADDITIONAL VETERAN RESOURCES

Minnesota Department of Veteran Affairs
651-296-2562
Veterans Service Building, 20 West 10th Street, St. Paul, MN 55155
mn.gov/mdva

Community Resource and Referral Center (CRRC)
(612) 313-3240
1201 Harmon Place, Minneapolis
minneapolis.va.gov/services/CRRC.asp
- Provides social services to homeless veterans, including connection to housing programs
- Access to waitlist for VASH, the Sec. 8 voucher program for veterans
- Basic services including showers, laundry, computer lab
- Case management

Minnesota Assistance Council for Veterans (MACV)
(612) 726-1327
2700 East Lake St. Suite 3350, Minneapolis
mac-v.org/
- Provides services to homeless veterans in the areas of housing, employment, and civil legal issues
- Several housing programs available, including sober living, transitional housing, and permanent housing

Minnesota Association of County Veterans Service Officers (CVSOs)
macvso.org
- Provides individualized support to veterans and their dependents, providing advice, council, claims assistance, education, and advocacy. Find local directory of contacts on website.
Mid-Minnesota Legal Aid (coverage area: Hennepin Co.): (612) 334-5970 mylegalaid.org
Assists with civil legal issues, with a program focusing on older adults 60+ including the following topics: Housing, public benefits, SSI problems, consume/debtor rights, MA/Medicare, assisted living/ SNF problems, advice and referral for Power of Attorneys, healthcare directives, wills
Services are free.

There are several Legal Aid offices throughout the state, check for local listings at their website: mylegalaid.org/about/locations

SMRLS Senior Law Project: (888) 575-2954 www.smrls.org
Assists with: public benefit issues, housing law, elder abuse, consumer rights, healthcare directives, nursing home issues, utility shut-offs

Estate and Elder Law Services: (612) 676-3600 www.voamnwi.org/estate-and-elder-law
Assists with many estate planning tasks, including: Wills, estate planning, probate, guardianship, advanced directives, powers of attorney, and special needs trusts. Offers private pay as well as a sliding fee scale.

Minnesota Help Info: MinnesotaHelp.info

EXPUNGEMENTS
An expungement is a legal process for sealing a record from the public, or wiping the court record from a person’s record. Expungements of both criminal convictions and unlawful detainers (UD’s), although difficult, are possible and can be very helpful when trying to get approved for housing and gaining employment. Speak with your local court district about self-help centers they may provide, and other resources that can help.

POWERS OF ATTORNEY
A power of attorney (POA) allows a person to give permission to someone else, called an “attorney-in-fact,” to make decisions and take legal action regarding their money and property on their behalf. This is a legal, written document, that must be completed by the person while they are mentally competent. This can be a helpful tool should the person lose capacity and need someone who is competent to make decisions for them. You do not need an attorney to complete the POA process, but it is recommended.

See attachment “Powers of Attorney” for additional information and a sample form.

(Continued on next page,)
GUARDIANSHIPS/CONSERVATORSHIPS
A guardian or conservator may be needed if a person is incapacitated, meaning they are so impaired that they are unable to make or communicate good personal decisions. Guardians make decisions about the personal needs of the person, and conservators make decisions about the financial needs of the person. Guardians and conservators need to be appointed through the courts, and are typically a family member of the person, or a professional guardian or conservator.

Please see attachment “Guardianships and Conservatorships” for additional information.
Powers of Attorney

What is a power of attorney?
A power of attorney is written permission for someone to take care of property or money matters for you, in whatever way you want. In a power of attorney paper, you are called the “principal” (person giving the power). The person who will take care of things for you is called the “attorney-in-fact.” This person does not have to be a lawyer.

If an attorney-in-fact takes legal action in your name, it is the same as if you had done it yourself. With a power of attorney, you can still act for yourself when you want to, but the attorney-in-fact can also act for you. The attorney-in-fact is not your guardian. You cannot be forced to move or forced to do anything you don’t agree to. You do not lose the right to control property or money. You do not lose the right to make decisions about your life like where you live and how you spend your time. You can revoke (take back) the power of attorney at any time.

Usually, you give a power of attorney so someone else can sign papers about property and money matters. The power can be limited to a certain thing, like selling a property, or it can be very broad, such as handling all property and money matters. It depends on what you write on the power of attorney form.

The attorney-in-fact must keep a record of anything they do for you. Legally, they are supposed to do things only in your best interest.

It is important to pick someone you trust deeply. Remember they will have control of things like your bank accounts or property.

You can list more than one attorney-in-fact. If you do, it is important to know that each of them can do things in your name without asking permission from the other. But, you can write on the power of attorney form that you do not want it to be that way. You can also name a “successor attorney”. This is someone who takes over if the first one can’t do it anymore.
How do I make a power of attorney?
A power of attorney must be written, dated, and signed by you in front of a notary public. You can fill out the form at the end of this fact sheet. If you want the power to end at a certain time, list the day, month, and year when it will end.

It is important to understand that the power of attorney is effective as soon as it is signed and notarized. It gives powers to the attorney in fact right away- not only if you become sick or incapacitated.

This is a new power of attorney form that must be used after January 1, 2014. In this new form, the Attorney in Fact has to sign the form too but doesn’t have to sign in front of a notary. The new form has more instructions and warnings about the roles and responsibilities of an Attorney in Fact.

If you did a Power of Attorney form in the past it is still okay. You don’t need to do a new one. If you are making a Power of Attorney form now, use the new form that is attached to this factsheet. Make sure you read the “Important Notice to the Principal” sheet after the form. You need to initial it to show you have read it and keep it as part of the form.

Or you can create a Power of Attorney online at www.LawHelpMN.org/formhelper.

→ Click on “Health Care and Other Powers”
→ Click on “Power of Attorney”

This is a step-by-step interview that lets you print out a completed form when done.

Who can have a power of attorney?
You must be mentally competent and able to make decisions on your own. Mentally competent means that you are “of sound mind.”

If a person is not mentally competent, or incompetent, it is too late to make a power of attorney. In that situation, a guardianship or conservatorship may need to be created.

For more information on these, see our fact sheet, S-7 Guardianships and Conservatorships.
What is a durable power of attorney?
"Durable" means lasting. Normally, if you become mentally incompetent, the power of attorney is not good any more. But you can write that you want to continue the power even if you become incompetent. Then it is called a durable power of attorney. If you say on it "This power of attorney shall not be affected by incapacity of the principal" it would be a durable power of attorney.

If you do become mentally incompetent, a durable power of attorney can only be ended by a court-appointed conservator.

Do I need a lawyer to do a power of attorney?
No. But it is a good idea to use a lawyer. The courts watch over the things that guardians or conservators do, but they do not watch over what an attorney-in-fact does. An attorney-in-fact could take advantage of you. A lawyer can help you put things in your power of attorney papers that limit the actions of the attorney-in-fact or make them have to show what they do with money and property.

How does the power of attorney work?
Both the principal and the attorney-in-fact should have a copy of the document. If you are giving a power to sell land, you need to file a signed original at the county recorder's office. If the power deals with money matters, file a copy with the bank.

When the attorney-in-fact acts for you, they sign their own name and then write:

(\text{their signature}) \quad \text{As attorney-in-fact for} \quad (\text{your name}).

Who should be my attorney-in-fact?
Any competent person over the age of 18 can be your attorney-in-fact. This includes family members. Many people choose a spouse or child. You should be very careful to choose someone you trust.

The attorney-in-fact is responsible for keeping records of all the transactions they do for you. This is called "accounting." You should ask to see these records on a regular basis. Even if you trust someone, getting regular accountings on a quarterly or monthly basis is a good idea. It is also a good idea to have the accountings go to you AND someone else like a family member or friend who can help keep track of things.
Can I stop a power of attorney?
Yes. A competent person can revoke (take back) a power of attorney at any time. You must put in writing that you revoke the power of attorney, and sign and date this in front of a notary. Send copies to the attorney-in-fact and to any person, office or bank the attorney-in-fact dealt with for you. If you do not send out copies of the revocation, the businesses will not know and your attorney-in-fact can still do business in your name.

You should also get the original power of attorney back.

There is a Revocation of Power of Attorney form at the end of this fact sheet.

OR YOU CAN create a Revocation of Power of Attorney online at www.LawHelpMN.org/formhelper.

  → Click on "Health Care and Other Powers"
  → Click on "Power of Attorney Revocation"

This is a step-by-step interview that lets you print out a completed form when done.

Powers of attorney automatically end when the principal dies. If you give a power of attorney to your spouse, it ends if either of you start a divorce, separation, or annulment case.
STATUTORY SHORT FORM POWER OF ATTORNEY
MINNESOTA STATUTES, SECTION 523.23

Before completing and signing this form, the principal must read and initial the IMPORTANT NOTICE TO THE PRINCIPAL that appears after the signature lines in this form. Before acting on behalf of the principal, the attorney(s)-in-fact must sign this form acknowledging having read and understood the IMPORTANT NOTICE TO THE ATTORNEY(S)-IN-FACT that appears after the notice to the principal.

PRINCIPAL (Name and address of person granting the power)

________________________________________

________________________________________

________________________________________

ATTORNEY(S)-IN-FACT
(Names and Addresses)

________________________________________

________________________________________

________________________________________

SUCCESSOR ATTORNEY(S)-IN-FACT
(Optional) To act if any named attorney-in-fact dies, resigns or is otherwise unable to serve.

(Name and Address)
First Successor

________________________________________

________________________________________

Second Successor

________________________________________

NOTICE: If more than one attorney-in-fact is designated to act at the same time, make a check or “x” on the line in front of one of the following statements:

______ Each attorney-in-fact may independently exercise the powers granted.

______ All attorneys-in-fact must jointly exercise the powers granted.

EXPIRATION DATE (Optional)

Use specific month, day and year only
I (the above named Principal), appoint the above named Attorney(s)-in-fact to act as my attorney(s) in fact:

**FIRST:** To act for me in any way I could act with respect to the following matters, as each of them is defined in Minnesota Statutes, section 523.24:

(To grant the attorney-in-fact any of the following powers, make a check or "x" on the line in front of each power being granted. You may, but need not, cross out each power not granted. Failure to make a check or "x" on the line in front of the power will have the effect of deleting the power unless the line in front of the power (N) is checked or x-ed.)

Check or “x”

___ (A) Real property transactions;

   I choose to limit this power to real property in __________________________ County, MN
described as follows: (use legal description. Do not use address.)

___ (B) Tangible personal property transactions;

___ (C) Bond, share, and commodity transactions;

___ (D) Banking transactions;

___ (E) Business operating transactions;

___ (F) Insurance transactions;

___ (G) Beneficiary transactions;

___ (H) Gift transactions;

___ (I) Fiduciary transactions;

___ (J) Claims and litigations;

___ (K) Family maintenance;

___ (L) Benefits from military service;

___ (M) Records, reports, and statements;

___ (N) All of the powers listed in (A) through (M) above and all other matters other than health care decisions under a health care directive that complies with Minnesota Statutes, chapter 145C.

**SECOND:** (you must indicate below whether or not this power of attorney will be effective if you become incapacitated or incompetent. Make a check or "x" on the line in front of the statement that expresses you intent.)

___ This power of attorney shall continue to be effective if I become incapacitated or incompetent.

___ This power of attorney **shall not** be effective if I become incapacitated or incompetent.
THIRD: My attorney(s)-in-fact MAY NOT make gifts to the attorney(s)-in-fact, or anyone the attorney-in-fact is legally obligated to support, UNLESS I have made a check or an “x” on the line in front of the second statement below and I have written in the name(s) of the attorney(s)-in-fact. The second option allows you to limit the gifting power to only the attorney(s)-in-fact you name in the statement. Minnesota Statutes, section 523.24, subdivision 8, clause (2), limits the annual gift(s) made to my attorney(s)-in-fact, or to anyone the attorney(s)-in-fact are legally obligated to support, to an amount, in the aggregate, that does not exceed the federal annual gift tax exclusion amount in the year of the gift.

I do not authorize any of my attorney(s)-in-fact to make gifts to themselves or to anyone the attorney(s) in fact have a legal obligation to support.

I authorize ________________________________ (write in names), as my attorney(s)-in-fact, to make gifts to themselves or to anyone the attorney(s)-in-fact have a legal obligation to support.

FOURTH: (you may indicate below whether or not the attorney-in-fact is required to make an accounting. Make a check or “x” on the line in front of the statement that expresses your intent.)

My attorney-in-fact need not render an accounting unless I request it or the accounting is otherwise required by Minnesota Statutes, section 523.21.

My attorney-in-fact must render ________________________________ (Monthly, Quarterly, Annual) accountings to me, or ________________________________ (Name and Address) during my lifetime, and a final accounting to the personal representative of my estate, if any is appointed, after my death.

IN WITNESS WHEREOF, I have hereunto signed my name this ________ day of ________ 20 ______

(Signature of Principal)

(Acknowledgment of Principal)

STATE OF MINNESOTA )

) ss.

COUNTY OF ________________ )

The foregoing instrument was acknowledged before me this ________ day of __________________

20 ______, by ____________________________  

(Signature of Notary Public or other official)
Acknowledgment of notice to attorney(s)-in-fact and specimen signature of attorney(s)-in-fact.

By signing below, I acknowledge that I have read and understand the IMPORTANT NOTICE TO ATTORNEY(S)-IN-FACT required by Minnesota Statutes, section 523.23, and understand and accept the scope of any limitations to the powers and duties delegated to me by this instrument.

(Notarization not required)

Specimen signature(s) of Attorney(s)-in-Fact:

(Notarization not required)

___________________________________________________________________________

Specimen signature(s) of Attorney(s)-in-Fact:

(Notarization not required)

___________________________________________________________________________

This instrument was drafted by:

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________
IMPORTANT NOTICE TO THE PRINCIPAL

READ THIS NOTICE CAREFULLY. The power of attorney form that you will be signing is a legal document. It is governed by Minnesota Statutes, chapter 523. If there is anything about this form that you do not understand, you should seek legal advice.

PURPOSE: The purpose of the power of attorney is for you, the principal, to give broad and sweeping powers to your attorney(s)-in-fact, who is the person you designate to handle your affairs. Any action taken by your attorney(s)-in-fact pursuant to the powers you designate in this power of attorney form binds you, your heirs and assigns, and the representative of your estate in the same manner as though you took the action yourself.

POWERS GIVEN: You will be granting the attorney(s)-in-fact power to enter into transactions relating to any of your real or personal property, even without your consent or any advance notice to you. The powers granted to the attorney(s)-in-fact are broad and not supervised. THIS POWER OF ATTORNEY DOES NOT GRANT ANY POWERS TO MAKE HEALTH CARE DECISIONS FOR YOU. TO GIVE SOMEONE THOSE POWERS, YOU MUST USE A HEALTH CARE DIRECTIVE THAT COMPLIES WITH MINNESOTA STATUTES, CHAPTER 145(C).

DUTIES OF YOUR ATTORNEY(S)-IN-FACT: Your attorney(s)-in-fact must keep complete records of all transactions entered into on your behalf. You may request that your attorney(s)-in-fact provide you or someone else that you designate a periodic accounting, which is a written statement that gives reasonable notice of all transactions entered into on your behalf. Your attorney(s)-in-fact must also render an accounting if the attorney-in-fact reimburses himself or herself for any expenditure they made on behalf of you.

An attorney-in-fact is personally liable to any person, including you, who is injured by an action taken by an attorney-in-fact in bad faith under the power of attorney or by an attorney-in-fact’s failure to account when the attorney-in-fact has a duty to account under this section. The attorney(s)-in-fact must act with your interests utmost in mind.

TERMINATION: If you choose, your attorney(s)-in-fact may exercise these powers throughout your lifetime, both before and after you become incapacitated. However, a court can take away the powers of your attorney(s)-in-fact because of improper acts. You may also revoke this power of attorney if you wish. This power of attorney is automatically terminated if the power is granted to your spouse and proceedings are commenced for dissolution, legal separation, or annulment of your marriage.

This power of attorney authorizes, but does not require, the attorney(s)-in-fact to act for you. You are not required to sign this power of attorney, but it will not take effect without your signature. You should not sign this power of attorney if you do not understand everything in it, and what your attorney(s)-in-fact will be able to do if you do sign it.

Please place your initials on the following line indicating you have read this IMPORTANT NOTICE TO THE PRINCIPAL:

_________
IMPORTANT NOTICE TO THE ATTORNEY(S)-IN-FACT

You have been nominated by the principal to act as an attorney-in-fact. You are under no duty to exercise the authority granted by the power of attorney. However, when you do exercise any power conferred by the power of attorney, you must:

1) act with the interests of the principal utmost in mind;

2) exercise the power in the same manner as an ordinarily prudent person of discretion and intelligence would exercise in the management of the person’s own affairs;

3) render accountings as directed by the principal or whenever you reimburse yourself for expenditures made on behalf of the principal;

4) act in good faith for the best interest of the principal, using due care, competence, and diligence;

5) cease acting on behalf of the principal if you learn of any event that terminates this power of attorney or terminates your authority under this power of attorney, such as revocation by the principal of the power of attorney, the death of the principal, or the commencement of proceedings for dissolution, separation, or annulment of your marriage to the principal;

6) disclose your identity as an attorney-in-fact whenever you act for the principal by signing in substantially the following manner: Signature by a person as “attorney-in-fact for (name of principal)” or “(name of principal) by (name of the attorney-in-fact) the principal’s attorney-in-fact”;

7) acknowledge you have read and understood this IMPORTANT NOTICE TO THE ATTORNEY(S)-IN-FACT by signing the power of attorney form.

You are personally liable to any person, including the principal, who is injured by an action taken by you in bad faith under the power of attorney or by your failure to account when the duty to account has arisen.

The meaning of the powers granted to you is contained in Minnesota Statutes, chapter 523. If there is anything about this document or your duties that you do not understand, you should seek legal advice.
REVOCATION OF POWER OF ATTORNEY
Minnesota Statutes, § 523.11

TO WHOM IT MAY CONCERN:

I ____________________________ revoke and declare null and void the
POWER OF ATTORNEY I granted to ______________________________
which is dated ___________________ 20 ______

Please be advised that the above-named person no longer has power to act as my attorney-in-fact
in any way.

Date: ________________________ ______________________ (Principal)

STATE OF MINNESOTA
County of ______________________

The foregoing instrument was acknowledged before me this _____ day of ______ 20 ______
by ______________________________

________________________________________
Notary Public
Guardianships and Conservatorships

When is a guardianship or conservatorship needed?
When a person is incapacitated and can't manage their own affairs, a court can name someone to help. Incapacitated means the person is so impaired that they don't have the understanding or ability to make or communicate good and safe personal decisions. They can't meet personal needs for medical care, food, clothing, shelter or safety, or take care of finances, even with help. A court decides if someone is incapacitated.

The court may decide to give a guardian or conservator power to make decisions in some but not all areas of a person's life.

In a guardianship or conservatorship, the person who needs help does not lose important rights, like the right to vote or the right to personal privacy, unless the court has a good reason and makes a specific order.

What is the difference between the two?
- In a guardianship the person who needs help is called the ward. The person helping is called the guardian. A guardian looks after the personal needs of the ward.

- In a conservatorship the person who needs help is called the protected person. The person who helps is the conservator. A conservator looks after the financial affairs of the protected person.

Sometimes, the court will name a guardian and a conservator to help. The court looks for a way to help the ward or protected person with the least amount of limits possible.
Guardianships and conservatorships are very serious and are not set up without good reason. Minnesota law encourages people to try other things before filing for guardianship or conservatorship. That can be things like:

- setting up a health care directive.
  See our fact sheet *Health Care Directives*.

- setting up a power of attorney.
  See our fact sheet *Power of Attorney*.

- naming a representative payee for social security benefits, or

- getting a case manager to help.

A person asking the court for guardianship has to explain what other things they tried and why they didn’t or won’t work.

**What powers does a guardian or a conservator have?**

- A **guardian** has power over the person – They make personal decisions for the ward, like medical care, or where the person will live.

- A **conservator** has power over the estate – They take care of money and property. They handle the income and pay the bills of the protected person.

The guardian or conservator do not have to pay for things for the ward or protected person out of their own money. They use the ward or protected person’s money. But, they must tell the court – usually yearly – what money came in to the protected person or ward, how it was spent and why. They can be held responsible for doing the wrong things with the money.

Guardians and conservators must talk with the ward or protected person and follow their wishes as much as possible. Guardians and conservators must act in the best interest of the ward or protected person.

For example, a guardian can’t agree to medical care that they know is against the ward’s beliefs. They cannot limit the ward’s freedom unless it is needed to protect them from danger.
What rights does a ward or protected person have?
The ward or protected person has legal rights. There may be some limits depending on the orders from the court. But in general, a ward or protected person has the right to:

- Be treated with respect. This includes respecting about medical preferences and religious beliefs.
- Get needed medical treatment in a timely manner.
- Control the things in life that have not been ordered by the court to be someone else’s responsibility.
- Have a guardian or conservator who meets their needs.
- Ask the court if they want to change where they live or keep someone from moving them.
- Decide what should be done with personal belongings like clothes, furniture, vehicles. They also have the right to ask the court to review a guardian or conservator’s plans to deal with their personal belongings.
- Personal privacy.
- Choose who they want to talk to or have visit them (unless there is reason to believe that that the visit may cause harm to safety or health).
- Marry and have children. A ward or protected person has the right to consent or object to sterilization.
- Ask the court to end or change the guardianship or conservatorship.
- Be represented by an attorney in any proceeding, including helping them to ask the court for changes.
- Vote.
How is a guardianship or conservatorship set up?
A person files a case to ask the court to name them or someone else as a guardian or conservator for a person who needs help. The person who needs help must be given notice of the case. They have the right to a lawyer. If they can’t afford a lawyer, the court can order the county to pay for one.

The person filing the case must show “clear and convincing” evidence that a guardianship or conservatorship is needed. This can be hard if the person who needs help doesn’t agree. If the court grants guardianship or conservatorship, then the court order will specify the protections that the ward or protected person needs. The order could give the guardian or conservator full powers but it also may be limited to certain areas of need.

There are forms to ask the court to set up a guardianship or conservatorship for someone who needs help.

Go to www.mncourts.gov.
→ Click on Get Forms
→ Click on Guardianship/Conservatorship

Who can be appointed a guardian or conservator?
The court decides who is appointed as the guardian or conservator. The court might choose:

- a guardian that is currently helping the person in this state or another state
- an agent appointed by the person in a health care directive
- the spouse or another person nominated in a will
- an adult child of the person, or
- the parent of the person.

For the most part, paid caregivers like medical care providers or nursing home residences cannot be appointed as the guardian or conservator.

If it makes sense for two people to be appointed as guardian or conservator, for example two adult children of a senior with advanced dementia, then the court may appoint two co-guardians or co-conservators.
Can a ward or protected person go back to court if they think the guardian or conservator is not acting in their best interest?
Yes. The guardian or conservator is always under the authority of the court, and a ward or protected person can ask the court to order them to do something differently.

A ward or protected person has a right to a lawyer in any guardianship or conservatorship proceeding. If a person knows who their court appointed lawyer is they can contact them for help. A person can also call or write to the probate court, asking for a hearing and asking that a lawyer be appointed to help them.

Can a guardianship or conservatorship be ended?
Yes. The court can end the guardianship or conservatorship if the ward or protected person shows the court that they no longer need help or protection. Usually, a doctor or social worker needs to testify that the ward can handle his or her own affairs. Then court supervision ends and the ward or protected person is free to make their own decisions.

More Resources
For more information, there is a Guardianship and Conservatorship video from the Minnesota Judicial Branch at www.mncourts.gov

→ Click on Help Topics
→ Click on Guardianship and Conservatorship
→ Click on Tools & Resources
→ Scroll down until you see the video

There is also a Minnesota Judicial Branch Guardianship and Conservatorship Manual. It is in the same place as the video above. The manual is the first thing when you click on Tools & Resources. Choose Word Doc or PDF to see it.

Find more fact sheets at www.lawhelpmn.org/LASMfactsheets
Find your local legal aid office at www.lawhelpmn.org/resource/legal-aid-offices

Fact Sheets are legal information NOT legal advice. See a lawyer for advice.
Don't use this fact sheet if it is more than 1 year old. Ask us for updates, a fact sheet list, or alternate formats.
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EXPUNGING AN EVICTION CASE

- **Motion for Eviction Expungement**

  The following information and documents can be helpful in preparing a Motion for Eviction Expungement:

  - **Information**
    - Court file number of eviction case
    - Landlord of the premises that was the subject of the eviction
    - Address of the premises that was the subject of the eviction
    - Dates of tenancy
  - **Documents**
    - Court documents (i.e., summons, complaint, affidavits, answer, order(s), motions, settlement agreement, etc.)
    - Relevant correspondence between tenant and landlord
    - Other supportive documents (i.e., proof of income, housing denial letters, etc.)

  **NOTE:** If there are multiple eviction cases for which tenant wishes to seek expungement, a Notice of Motion and Motion for Eviction Expungement must be prepared, filed, and served for each individual eviction case. (The grounds for each motion may be the same or similar.)

- **Factors Weighing in Favor of Expungement of an Eviction Case**

  - Landlord agreed not to oppose expungement
  - Demonstration of actual harm caused by existence of the eviction record (i.e., tenant has been denied housing due to the presence of an eviction on tenant’s rental history)
  - Tenant is currently employed and able to pay rent
  - There are children in tenant’s household who are also impacted by the eviction on tenant’s rental history
  - An undisputed or proven jurisdictional, procedural, or substantive defect in the eviction case (i.e., improper service, serious habitability problems, landlord waiver of claim by acceptance of rent, filing of action by incorrect plaintiff, mootness of case (tenant moved out before action commenced))
  - Dismissal or judgment on the merits in favor of tenant
  - Lapse of time since eviction action was filed (5-10 years)
  - Lack of other eviction cases in tenant’s rental history
  - Tenant credibility and positive, respectful demeanor at the hearing
• **Factors Hindering Expungement of an Eviction Case**
  - Lack of proven jurisdictional, procedural, or substantive defect in the eviction case (i.e., improper service, serious habitability problems, landlord waiver of claim by acceptance of rent, filing of action by incorrect plaintiff, mootness of case (tenant moved out before action commenced))
  - Extraordinary nature of relief – elimination of public record
  - Tendency to consider substance over procedure (e.g., unpaid rent at the time of the filing of the eviction action)
  - Procedural history (i.e., default judgment against tenant, judgment for failure to meet a deadline imposed by the court, violation of a settlement agreement, etc.)
  - Recency of the eviction case (i.e., within the last 3-5 years)
  - Opposition to expungement by landlord

• **Examples of Good Cases for Eviction Expungement**
  - Tenant won the case – the case was dismissed or tenant won after trial
  - Tenant moved out before the eviction action was served
  - Tenant paid the amount due before or at the time of the initial appearance on the eviction case
  - Tenant settled the case with landlord and landlord permitted tenant to remain in the premises
  - Tenant settled the case with landlord and landlord agreed that the eviction case had been filed because of a misunderstanding or that tenant had defenses

*This document is provided for informational purposes only. Provision of this information does not constitute legal advice or services, nor does provision of this document give rise to an attorney-client relationship.*
Many of our older adult clients are vulnerable to maltreatment. If you suspect abuse or neglect, report to the Minnesota Adult Abuse Reporting Center (MAARC).

**MAARC 24/7: 1-844-880-1574**

**Vulnerable adults include adults over age 18 who:**
- have a physical, mental, or emotional impairment that makes it difficult to care for themselves
- reside in a hospital, nursing home, foster care, housing with services, or other licensed facility
- receive licensed services such as home care, PCA, day services, or other

**Maltreatment includes:**
- physical, emotional, or sexual abuse
- neglect, including failure to provide necessary food, shelter, clothing, healthcare, or supervision by a caregiver, or when a vulnerable adult cannot meet their own needs
- financial exploitation including taking, or using a vulnerable adults money or property

**Signs of maltreatment or abuse:**
- unexplained bruises or injuries
- soiled clothing or unusually messy living quarters
- rapid weight loss
- withdrawal, nervous or fearful behavior
- bills not being paid, unexplained missing funds
- taking a vulnerable adult’s medication, or other property

Anyone can report. Mandated reporters, including social service professionals and volunteers, are required to immediately report suspected vulnerable adult maltreatment to the Minnesota Adult Abuse Reporting Center. All reports are screened and immediately referred to the county when need for emergency adult protective services if identified. Every report is referred to the agency responsible to respond to the allegation. Law enforcement is notified when the allegation may also be a crime. The agency responsible has 5 business days to decide how to respond and inform the reporter of the response. Minnesota law allows agencies to use their own guidelines to decide which allegations require investigation.

*(Continued on next page,)*
Welfare checks: If you are working with an elder and have reason to believe they are unsafe and unable to answer their door or respond to attempts to contact them, a welfare check may be conducted. Sometimes housing managers can and will assist with a welfare check. If they are unable to assist, contact local law enforcement (911) and request a welfare check. Police will respond and attempt to make contact with the person, and under certain circumstances, enter the premises with either keys provided by property management, or forced entry.
ACCESSING SHELTER

If an older adult you are working with is facing homelessness and at the point of needing to stay in shelter, here are some emergency shelter resources:

Ramsey County:
Higher Ground St. Paul (Catholic Charities, shelter for men and women): 651-647-2345
Union Gospel Mission (men only): 651-292-1721

Hennepin County:
Adult Shelter Connect (connects homeless adults to beds at various shelters in Minneapolis): St. Olaf Church, 215 S. 8th St., Minneapolis, go in person to be screened for shelter openings. Hours: Call for current hours of operation. Phone number: 612-248-2350

For victims of domestic violence:
Day One Crisis Hotline (state wide, screening and referral for DV shelters): 866-223-1111

For additional resources:
Minnesota Help.info: minnesotahelp.info

OBTAINING HOUSING

1. GATHER INFORMATION ABOUT CLIENT

Gather as much housing-related information as you can. In order to know where to start, you must have some basic information about the client. An assessment tool should be used, and an example of an assessment used by Catholic Charities’ Homeless Elder staff is included in Attachments. Helpful information to gather:

- Income amount and source
- Past housing history- would previous landlords give a good reference? Are there any Unlawful Detainers (UD’s= court evictions) on record? Is there money owed to a previous landlord? (many landlords require past debt to be paid before renting to someone) Go to: mncourts.gov/PublicAccess to look up MN civil court history, which will include UD’s.
- Criminal history- charges and dates. Go to: mncourts.gov/PublicAccess for MN criminal history, search with name and date of birth if available.
- Credit (ballpark idea if individual has good or bad credit)
- Special needs- is person able to live independently? Are in-home or home healthcare services needed (Ex. help cleaning, cooking, bathing, dressing, medication management, etc.)? Is more structured/supervised housing needed?

(Continued on next page.)
2. EXPLORE TYPES OF HOUSING

There are many types of housing, older adult-specific and otherwise. Here are many of the types, in general order of least-restrictive environment:

**Independent Living:** a building that does not have on-site services, intended for individuals that can live on their own and take care of themselves and their housing. People with in-home services can certainly live in independent housing as well, as long as the services are set up by the individual, their health plan Care Coordinator, or waiver Case Manager (Ex. Personal Care Attendant, Homemaking, Nursing services, etc.)

**Supportive Housing:** Can mean many things, but is often for individuals in recovery from substance abuse or long term homelessness. The building may have a case manager assigned for each resident, programming and activities to help residents get engaged in the community, or may have a social worker on-site to help with issues that may arise. Many of these options are now part of the Coordinated Entry system by county, and require a vulnerability assessment (VI-SPDAT) to determine eligibility.

**Assisted Living:** This type of housing is a specific type of housing for individuals who are not able to live on their own, either due to physical health, mental health, or dementia (sometimes in a specific “memory care” program). Services on-site include prepared meals, medication management, assistance with cleaning, dressing, bathing, etc, and are tailored to each person's needs. A waiver program often pays for the services for low-income residents in this type of housing (CADI, EW, TBI, DD), and the rent is either subsidized (rare, but some companies do have subsidized Assisted Living buildings) or Housing Support (more common).

**Sober Living:** (Could be either transitional or permanent supportive housing) This type varies somewhat: some buildings are licensed as “sober,” meaning a person's sobriety is verified before move-in, and drug and alcohol tests are required during tenancy. Other sober buildings simply do not allow drugs or alcohol on the premises and tolerate use outside the building as long as residents do not cause disruptions. These buildings often have case managers.

**Skilled Nursing Facility:** Also called a “nursing home,” this type of facility is for someone medically fragile, or who needs transitional or rehabilitative services, requires a physician to determine need and write orders for services needed. The cost of “housing” is incorporated into the NF payment. Coordinate with client's physician if you think this is the best option, as they do need a doctor's order to move in.

**Group Homes and Adult Foster Care:** A supervised housing setting for individuals unable to live in other traditional housing types, often serves people with developmental disabilities or difficult behaviors.
Transitional Housing: This is a time-limited facility, usually a maximum stay of 2 yrs, for people transitioning from homelessness or unstable housing to permanent housing. There are few of these facilities. Some examples include Catholic Charities’ Exodus Residence for people with some health issues, and People Inc’s Safe Haven houses (shorter stay of 30-90 days).

3. REVIEW COST OF HOUSING WITH CLIENT AND WHAT THEY ARE WILLING/ABLE TO PAY

There are different ways that housing is funded, which impacts the amount of rent someone pays:

Market Rate housing: Resident pays full rent. Average rent for 1br. is $800/mo., $600/mo. for a studio. Landlords for the most part are asking someone to make 2.5x-3x the rent in income to be eligible to rent (Ex. for a $750/mo. apt., min. income= $1875/mo.) This is a difficult option for low income individuals.

Tax credit housing (Sec. 42): Slightly reduced rent on regular apts., close to market rate rates. High income individuals cannot rent there.

Section 8 subsidized housing: Rent calculated to be 30% of person’s income, rent adjusted when income changes. There are two types of subsidies:

- Site-based Sec. 8: The subsidy is attached to the unit, tenant cannot take the subsidy with them when they move- this is the kind of subsidy being used when a older adult or other apartment building advertises subsidized rent.
- Sec. 8 vouchers: The tenant has a voucher administered by a local housing authority or housing program, and can be used to subsidize the rent of a market rate apartment in the community.

Section 202 subsidized housing: This is a type of federally subsidized housing that is specifically for older adults. Some of these buildings or rental units also include a preference for older adults who have been displaced, so it is worth asking about for those who are homeless.

Housing Support (formerly Group Residential Housing): A type of housing that gets partially funded through the state, covering room and board. Person pays all income except $99 personal needs amount (Ex. Person on GA of $203/mo. pays $108/mo. rent. Person on SSI of $750/mo. pays $651/mo. rent). There have been some changes for residents who are also employed that enable residents to keep approx. 50% of their earned income when living in Housing Support housing. “Conventional” Housing Support: housing and food are provided in a facility (can be Single Room Occupancy (SRO), shared rooms, or studio or 1br. units.) “Scattered site” Housing Support: where someone lives in a regular apt. in the community and extra funds are provided for food and utilities.

(Continued on next page.)
4. RESEARCH AND CALL HOUSING POSSIBILITIES
See attached next section for ideas of where to look. Schedule appointment for the client if there is a language, hearing, or speech barrier.

5. GO WITH THE CLIENT TO SEE THE BUILDING IF POSSIBLE, AND ASSIST THEM WITH THE APPLICATION TO MAKE SURE IT IS COMPLETE
Walk them through the process. Many older adults get anxious about large amounts of paperwork, which most housing applications require. Some have never had to apply for housing before. Many older adults struggle with eyesight (try to have some “cheater” glasses on hand if possible) or literacy. Technology and the requirement of applying online for some housing options can also be a barrier. Make sure to ask if the person is comfortable using the internet if giving online application information or resources. Provide your contact information to the landlord as back up, in case your client’s phone gets cut off for some reason.

6. FOLLOW UP WITH THE LANDLORD
Contact them if they don’t contact you or client, especially if it’s a large organization like public housing. Checking in on status of the application and offering to assist with follow-up is important.

7. ONCE YOUR CLIENT IS APPROVED FOR HOUSING
Send client (and go with if needed) to the county to apply for Emergency Assistance, which will usually pay for a security deposit and/or first months’ rent, if they have not used it in the last year. Schedule Bridging if your program allows. Try to schedule as soon as you know the move-in date, as appointments often are scheduled several weeks out. Clients in Hennepin Co. can go to Sharing and Caring Hands and receive a new mattress delivered if they show a new lease, call for details.

8. IF YOUR CLIENT IS DENIED HOUSING
Encourage the applicant to appeal the decision, and assist them if possible with the process. Most housing options will want to meet with the applicant face to face and discuss the reason for denial, and are looking for reasons that the person will not have the same issues in the future. Letters of reference can be helpful, and anything else to show positive change. Examples of steps taken to change former issues: going through chemical dependency treatment, having recent positive rental history since past evictions, positive activities currently involved in.
ADDITIONAL INFORMATION ABOUT TYPES OF HOUSING:

INDEPENDENT LIVING
Independent Living is a building that does not have on-site services, intended for individuals that can live on their own and take care of themselves and their housing. People needing in-home services can certainly live in independent housing as well, as long as the services are set up by the individual or their health plan (Ex. PCA, Homemaking, Nursing services, etc.)

Market Rate: (with a few exceptions) require at least 2.5x the rent in income to qualify. Ex. For a basic studio apt. with rent of $550, the person must make a min. of $1,375/mo. Not the rule, but the norm.

Subsidized: Ideal for most low-income individuals. Rent is calculated to be 30% of someone’s income.

WHERE TO LOOK?
Housing Link: housinglink.org: A MN non-profit that keeps an updated database of rentals in MN-search by area, cost, accessibility, housing type. They also maintain a page dedicated to the various housing authorities across the state that offer subsidized housing and which ones are accepting applications.

Craigslist: craigslist.org: Independent classified ads website.

Care Options Network: careoptionsnetwork.org/guidebook/senior_housing Website with various older adult-specific housing listings.

The newspaper, fliers in stores, networking.

SUPPORTIVE HOUSING
Can mean many things, but is often for individuals in recovery from substance abuse or long term homelessness. The building may have a case manager assigned for each resident, programming and activities to help residents get engaged in the community, or may just have a social worker on-site to help with issues that may arise. There are also scattered site programs, such as the Housing First program, that offer vouchers to subsidize the rent, with supportive services coming in, such as a case manager, ARMHS (Adult Rehabilitative Mental Health Services), etc.

- Supportive Housing varies quite a bit. Many are designed for specific groups of people: Long Term Homeless (LTH), people with mental illness or chemical dependency issues (MI/CD), developmental disabilities (DD), Veterans, etc. Make sure to ask admission criteria.

Rent Amount: Many supportive housing options are either Housing Support funded or subsidized, or have market rate rent with a lower minimum income to make it affordable for the average SSI recipient (Ex. Alliance Apts. has both subsidized units and market-rate. Market rate rent is approx. $470, with the min. income being $670, or rent amount +$200)

(Continued on next page.)
WHERE TO LOOK?
Most of these options are now accessed through Coordinated Entry systems in their respective counties. Clients complete a vulnerability assessment called a VI-SPDAT, with an assessor, and then is placed on a priority list for these housing options based on their vulnerability score. For more information about the Coordinated Entry system, visit: www.safehomemn.org. You can also look for other options through United Way 211 or minnesotahelp.info.

Coordinated Entry: Hennepin: Assessors are trained throughout the shelter system, and will identify clients to be assessed. If someone is staying outside or in a vehicle, contact St. Stephens Street Outreach at 612-879-2674. Individuals couch hopping or doubled-up are not eligible at this time.

Coordinated Entry: Ramsey: Primary assessor located at HGSP and Mary Hall, contact at 651-647-2377 to schedule an appt.

Outside the metro area: Ask your county human services agency about contacts for your local coordinated entry system to access housing options.

ASSISTED LIVING
This type of housing is a specific type of housing for individuals who are not able to live on their own, due to physical health, mental health, or memory loss. Services on-site include prepared meals, medication management, assistance with cleaning, dressing, bathing, etc., and are tailored to each person’s needs. A waiver program often pays for the services in this type of housing (CADI, EW, BI, DD), and the rent is either subsidized (rare, but Minneapolis Public Housing Authority and St. Paul Public Housing do have a few subsidized AL buildings) or Housing Support (more common).

Unless your client is very high income, they will need a waiver to pay for services at the Assisted Living. There are different types of waivers: CADI (for adults w/ disabilities), EW (Elderly Waiver for adults 65+), BI (people w/ a Brain Injury), and DD (people w/ developmental disabilities).

To refer someone for a waiver assessment, also called a MnCHOICES or LTCC Assessment:

If someone is on a managed care health plan (Medica, UCare, etc.) : Contact the Care Coordinator to ask about a MnCHOICES or LTCC assessment.
IF NOT ON A MANAGED CARE HEALTH PLAN:
Hennepin County: call the Hennepin County Front Door at 612-348-4111
Ramsey County: call Ramsey County Intake at 651-266-3613
*See attachment: “Long-Term Care Consultation contacts.”

The intake staff will ask about diagnosis, client needs, as well as contact information, and whether or not the person is wanting the assessment. Some AL facilities prefer the client to be approved for the waiver before starting the application/referral process, some will start the process while the waiver is pending, ask about that when you call about vacancies. Various buildings provide different kinds of services, and some have age restrictions, so ask about eligibility criteria as well.

When you find a building that has vacancies or is willing to add your client to wait list, they will most likely schedule a tour with your client and complete a nursing or “wellness assessment” to determine what services the person needs, and if they can meet the client’s needs. They then have to make sure the services they are offering and cost requested to pay for services is approved by the waiver, case manager can then schedule a move-in.

RENT AMOUNT
Rent for AL buildings can work the following ways:
Private Pay (or market rate): person pays full rent on their own, which is usually quite high
Housing Support: In most cases, a person pays all of their income minus $99/mo. (Ex. Person receiving $750/mo. in SSI pays $651), and the rest is covered by the county
Subsidized: person pays 30% of their income for rent.

*Note: Minneapolis Public Housing Authority (MPHA) takes applications for AL buildings two ways, depending on age. For people 62 and older, person can apply at MPHA office for housing (since MPHA is taking full apps. for 62+ only) first, then determine which AL building they can go to (MPHA staff can tell you which buildings have shorter wait times or openings) and apply for that AL program. For people under 62, they must be approved for the AL program first, by scheduling an appt. w/ the building, taking a tour, and having the nursing assessment. After approval for AL program, they can apply for housing portion at the MPHA office.
• St. Paul Public Housing has some buildings that offer limited support services, including service coordination, meals, and housekeeping on a sliding-fee basis, called the Congregate Housing Services Program (CHSP). Contact Program Manager at (651) 292-6035 or visit stpha.org for additional information.
Where to look? www.careoptionsnetwork.org Senior Housing Options Guidebook (for a copy, call the Senior Linkage Line at 1-800-333-2433)
SOBER LIVING
(Could be either transitional or permanent supportive housing) This type varies somewhat: some buildings are licensed as “sober,” meaning a person’s sobriety is verified before move-in, and drug and alcohol tests once a resident are a possibility. Other sober buildings simply do not allow drugs or alcohol on the premises and tolerate use outside the building as long as residents do not cause disruptions. Usually have case managers.
Rent Amount: Varies depending on program. Can be self-pay market rate, subsidized, or Housing Support.
Where to look? minnesotahelp.info, CD treatment facilities often refer as well. Some are accessed through Coordinated Entry systems, but not all.

SKILLED NURSING FACILITY
Also called a “nursing home,” this type of facility is for someone medically fragile, requires a physician to determine need and write orders for SN. Coordinate with their physician if you think this is the best option, as they do need a doctor’s order to move in.
Payment: Nursing care is very expensive, and payment is complex. For a low income person who is on Medicare and Medical Assistance, Medicare will pay for up to the first 120 days, provided the resident is working on therapies to recover from illness/injury. After 120 days, the cost is covered by a combination of MA and private pay, where the resident pays all of their income except $99 personal needs money.

GROUP HOMES AND ADULT FOSTER CARE
A supervised housing setting for individuals unable to live in other traditional housing types, often serves people with developmental disabilities or difficult behaviors. A MnCHOICES or LTCC assessment is needed to begin the process toward moving into a group home.
Rent: Usually Housing Support funded for low-income individuals.
Where to look: mafooopenings.com

TRANSITIONAL HOUSING
This is a time-limited facility, usually a maximum stay of 2 yrs. (some shorter, 60-90 days), for people transitioning from homelessness or unstable housing to permanent housing.
Rent: Usually Housing Support funded.
Where to look: minnesotahelp.info Many transitional housing options are now accessed through Coordinated Entry systems, check with the individual provider for details about how to access and program eligibility.
OTHER HOUSING-RELATED TERMS

Chronic Homeless: Same homeless status as “LTH”, and also has a disabling condition.

Long Term Homeless (LTH): Often an eligibility criteria for some housing options, refers to someone who has been homeless for at least one continuous year, or homeless four or more times in the last three years.

Medical Respite: These are short-term transitional housing options for homeless individuals coming out of hospital settings that are deemed too sick or injured to stay in shelter, but no longer qualifying to stay at the hospital. Stays are coordinated through hospital social workers.

Reasonable Accommodation: An exception to a rule or policy made to accommodate a person’s disability and allow them equal access to use and enjoyment of housing.

Senior Housing: Many housing options, especially those that are subsidized, are designated for older adults. Ask what the age requirement is, as it varies. Most are for individuals age 62 and older, although some accept individuals age 55 and older who have a disability.

Service Animals and Companion Animals: A service animal is an animal specially trained to assist a person with their disability, and the law requires that landlords allow them to live with a resident. Companion animals are animals that provide emotional support to a person with a disability, and are not specially trained. A person may have the right to keep a companion animal, but a reasonable accommodation must be made, including a statement from a doctor explaining the need.

Single Room Occupancy (SRO): Refers to a housing setting where resident has a single bedroom to themselves, with shared community areas, kitchen, and bath facilities.

Studio: A small apartment that includes a kitchenette and private bath, but that does not have a separate bedroom.

Supportive Housing for Chronic Alcoholics (“Wet Houses”): Housing designed for individuals who struggle with alcohol addiction and have been unable to be successful despite treatment attempts. These are funded by GRH, and include supports such as case management and some nursing services.

Tenant Screening Report: A report obtained by a landlord to aid in decision of whether or not to approve a housing applicant. The information is gathered by a third party (ex. Rental History Reports, Rental Research Services), and entails a fee that is often passed along to the applicant in the form of an “application fee”. The report usually includes an applicant’s eviction and rental history, criminal history, and credit information. If a person is denied for a housing unit, they have the right to receive a copy of this report for their review.

Unlawful Detainer (UD): Also called an eviction, the legal process through housing court to remove a tenant from a property, giving owner possession of the property.
ENVIRONMENT / HOUSING:

Are you in danger of losing your current housing?  

☐ Yes  ☐ No

Do you feel safe where you are currently staying?  

☐ Yes  ☐ No

Housing History:

Previous Address:  

Dates: _______ - _______  Landlord Info:  

Reason for leaving:  

Previous Address:  

Dates: _______ - _______  Landlord Info:  

Reason for leaving:  

Previous Address:  

Dates: _______ - _______  Landlord Info:  

Reason for leaving:  

Previous Address:  

Dates: _______ - _______  Landlord Info:  

Reason for leaving:  

Do you have any Unlawful Detainers (UD's) on your record?  

☐ Yes  ☐ No

Details:  

How much rent can you afford to pay?  

Are there any special accommodations needed for housing?  

☐ Yes  ☐ No

Details:  

Do you have any housing applications pending?  

☐ Yes  ☐ No

Have you been denied for housing recently?  

☐ Yes  ☐ No

Are you participating in any other housing program through an agency?  

☐ Yes  ☐ No

Will you need furniture once you secure housing?  

☐ Yes  ☐ No

Have you completed VI-SPDAT housing assessment?  

Yes  No  Score:  

Is there anything else you want to share?  

__________________________________________________________

__________________________________________________________

__________________________________________________________

__________________________________________________________
Are you receiving treatment?  □ Yes  □ No

Type of treatment/ Provider: ________________________________

Would you like assistance finding mental health treatment?  □ Yes  □ No

Do you ever drink alcohol or use illegal drugs?  □ Yes  □ No

Details: ___________________________________________________

Have drugs or alcohol ever been an issue for you?  □ Yes  □ No

Drug(s) of choice: ___________________________  Currently using or sober?  ___________________________

Have you gone to CD treatment in the past?  □ Yes  □ No

Details: ___________________________________________________

Are you interested in going to treatment or in sobriety support?  □ Yes  □ No

SUPPORT SYSTEM/ SPIRITUAL:

Do you have someone you can talk to when you have a problem?  □ Yes  □ No

Who makes up your support system: ____________________________

Are you interested in assistance finding support groups or other social support?  □ Yes  □ No

Do you feel like your spiritual needs are being met?  □ Yes  □ No

Are you interested in spiritual support or counseling?  □ Yes  □ No

CRIMINAL HISTORY:

Do you have any criminal convictions on your record?  □ Yes  □ No

Charges/Dates: ________________________________________________

*attach criminal history print-out

Are you currently on probation or parole?  □ Yes  □ No

Details: ___________________________________________________

Do you have any pending court cases?  □ Yes  □ No

Details: ___________________________________________________

Do you have to register as a sex offender?  □ Yes  □ No
PHYSICAL HEALTH:
How would you rate your overall physical health:

<table>
<thead>
<tr>
<th>01 Poor</th>
<th>02 Fair</th>
<th>03 Good</th>
<th>04 Excellent</th>
</tr>
</thead>
</table>

Diagnosis:

How often do you see a physician?

Have you had any ER, Hospital, or Nursing Home visits in the last 6 months? [ ] Yes [ ] No
If yes, reason:

Physician/Clinic:

Phone: 

Hospital:

Phone: 

Do you have an advance directive? [ ] Yes [ ] No If no, are you interested in completing one? 

Are you able to get the Rx you need? [ ] Yes [ ] No

Are you able to manage your medications and take them as prescribed? [ ] Yes [ ] No

Do you use any of the following assistive devices? Check all that apply

[ ] Cane [ ] Walker [ ] Wheelchair [ ] Hearing Aids [ ] Glasses [ ] Dentures

Need assistance obtaining any of the above? [ ] Yes [ ] No

Do you have any concerns about memory? [ ] Yes [ ] No

Interested in MMSE? [ ] Yes [ ] No Score:

Do you have any concerns about physical, verbal, sexual, or financial abuse? [ ] Yes [ ] No

Explanation:

Have you had any falls in the last 6 months? [ ] Yes [ ] No

MENTAL AND CHEMICAL HEALTH:
How would you rate your overall mental or emotional health:

<table>
<thead>
<tr>
<th>01 Poor</th>
<th>02 Fair</th>
<th>03 Good</th>
<th>04 Excellent</th>
</tr>
</thead>
</table>

Mental Health Diagnosis:

Are you experiencing Anxiety or stress? [ ] Yes [ ] No

Are you experiencing Depression or sadness? [ ] Yes [ ] No

Would you like to take a depression screening? [ ] Yes [ ] No Score:
Documentation:
State ID □ Yes □ No Social Security Card □ Yes □ No
Do you need assistance obtaining these documents? □ Yes □ No

FINANCIAL/HEALTH INSURANCE:
Primary Income Type: ______________ Amount: ______________
Other Source of Income: ______________ Amount: ______________
SNAP? ______________ Total Monthly Income: ______________
Are you pursuing employment, or would you like to? ______________
Are you able to manage your own finances? □ Yes □ No
Do you pay your rent on time? □ Yes □ No
If no, are you working with a rep. payee or power of attorney? ______________
If not, are you interested/willing to get one to assist with your finances? □ Yes □ No
If disabled or elderly and on GA: Do you have a pending SSI/SSDI case? □ Yes □ No
If yes, is someone assisting you? ______________
If no, do you need assistance with applying for SSI/SSDI? □ Yes □ No
How would you rate your credit? ______________

County Case# __________________ Worker Name if applicable: __________________
Medical Assistance PMI: __________________ Medicare #: __________________
Health Plan: __________________ Care Guide?: __________________ Phone: __________________
Do you pay co-pays? □ Yes □ No
Are you open to a waiver (EW/CADI/TBI)? □ Yes □ No
If so, waiver CM: __________________
If so, what services are you receiving? __________________
Do you need assistance with any of the following? Check all that apply:
□ Dressing □ Bathing □ Preparing meals
□ Cleaning □ Scheduling Appts □ Managing Medication
□ Eating □ Transfers □ Budgeting

Revised 4.22.15
Catholic Charities Aging Services
Homeless Elders Program Intake/Assessment

Client Name: __________________________ Assessment Date: _______________________

Reassessment Due: ______________ Reassessment Date: ______________

DEMOGRAPHICS/ CONTACT INFO:

Phone: __________________________ Alternate Phone/Email: ______________________

Address: __________________________ City: __________________________ Zip: ____________

DOB: ____________ SS#: ________-________-________

Emergency Contact: __________________

Phone: __________________________

Relationship to Client: ______________

Marital Status:

<table>
<thead>
<tr>
<th>01 Single</th>
<th>03 Widowed</th>
<th>06 Divorced</th>
</tr>
</thead>
<tbody>
<tr>
<td>02 Married</td>
<td>04 Separated</td>
<td>07 Domestic Partner</td>
</tr>
</tbody>
</table>

Housing Type:

<table>
<thead>
<tr>
<th>01 Shelter</th>
<th>03 Staying with family/friends</th>
<th>05 In Car</th>
</tr>
</thead>
<tbody>
<tr>
<td>02 Transitional</td>
<td>04 Outside</td>
<td>99 Other</td>
</tr>
</tbody>
</table>

Are you planning on living by yourself?  [ ] Yes  [ ] No

Race/Ethnicity: You may choose more than one:

[ ] African  [ ] Multi-Racial
[ ] African American/Black  [ ] Pacific Islander
[ ] Asian  [ ] White/Caucasian
[ ] Native American  [ ] Other (Specify)

Hispanic?  [ ] Yes  [ ] No
Veteran?  [ ] Yes  [ ] No

Citizenship Status? (e.g. immigrant, refugee, undocumented, etc.) ______________________

Preferred Language? ______________________

Are there any cultural/religious practices you would like to share? ______________________

Can you read and write the English language?  [ ] Yes  [ ] No

Do you consider yourself to have a disability?  [ ] Yes  [ ] No

Disability Type:

| 01 Physical/Medical | 02 Mental Health | 03 Cognitive Impairment |

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MPHA Assisted Living Buildings:

**Heritage Commons at Ponds Edge**, 612-377-6655
350 Van White Memorial Blvd. Minneapolis, MN 55405
Provides services to elderly and adults w/ disabilities requiring AL services.

**Signe Manor**, 612-843-0090
2533 1st Ave. S Minneapolis, MN 55404
Provides services to elderly adults. Memory Care program also available.

**Grace Place**, 651-338-7091
630 Cedar Ave. S Minneapolis, MN 55454
Provides AL services to Korean elderly and disabled and newly arrived immigrants, as well as translation services, information and referral, counseling, language classes.

**Lyndale Manor**, 612-529-8497
600 18th Ave. N Minneapolis, MN 55411
Provides AL services to elderly as well as adults w/ disabilities.

**Parker Skyview**, 612-706-0261
1815 Central Ave. NE Minneapolis, MN 55418
Provides AL services to elderly as well as adults w/ disabilities.

**Thomas Feeney Manor**, 612-843-0090
901 4th Ave. N Minneapolis, MN 55405
Provides enhanced assisted living services, as well as a memory care unit.
Thank you for taking the time to review this information, and for your commitment to providing the best possible services to older adults in need in your community. We hope this manual has provided valuable information and general awareness about some of the struggles unique to older adults experiencing homelessness and instability.

We would like to thank the Minnesota Department of Human Services for making this work possible through the Live Well at Home grant.

Please feel free to contact Catholic Charities’ Homeless Elders Program with questions you may have about the material presented in this document.

Catholic Charities Homeless Elders Program
1276 University Ave. W
St. Paul, MN  55104
Intake Line: 651-647-2290