HOST COUNTY NOTIFICATION
FOR PLACEMENT IN SHERBURNE COUNTY ADULT FOSTER HOME

Client's Name:____
Current Address:____
Date of Birth:____________________________ Sex: ☐Male ☐Female
County of Financial Responsibility:_______________________________________
Is this person open on:
☐MA ☐GA ☐MSA/GRH ☐GAMC ☐IV-E ☐WAIVER (Type:_________)
What county, if any, had the open assistance case? _________________________
Summary of client's problems or limitations **(Please attach a copy of foster home placement agreement and service plan. If DD, include copy of I.S.P.)**

____
____
____
____
____
____
____

Anticipated date of placement:____
Anticipated length of placement:____
Adult Foster Home where placement would occur:___________________________
____
Will your client use any life sustaining medical equipment in this placement?
☐Yes ☐No
If yes, list the equipment:____
What day programming or support arrangements have been made:
____
____
____
Criminal History:____
____
Other behavioral problems/concerns (eg. Medical, sexual, etc.): ______________
____
Client's legal guardian/conservator: _______________________________
Phone Number:____________________________
24 hour emergency contact number for case manager:_______________________
Case Manager's name:____

As the county of responsibility for case management services for a resident in Adult Foster Care you have certain obligations to maintain contact with the resident and foster home. Sherburne County expects you to visit the client and foster care provider within the first 30 days of placement to review the client's individual service plan.

All problems arising in the foster home regarding your client are your responsibility to resolve unless licensing issues are involved. Sherburne County will not provide case management nor in any way offer services to your client. Should concerns be expressed to us regarding problems with your client, we will refer the matter to you.

Sherburne County expects counties using Sherburne County foster homes to abide by the foster care policies we have developed. Upon request, our full policy manual can be provided. Please ensure that the Adult Foster Home will have the name and phone number of how to reach the case manager or designee on a 24 hour basis.

It is expected that all arrangements for Medical Assistance, Group Residential Housing, or General Assistance will be made before the placement occurs.

AGREEMENT

I have read the above out-of-county placement expectations of Sherburne County and agree to abide by them. I acknowledge that _______________ County is and will remain financially responsible for this placement. I agree that _______________ County will pay for placement costs which exceed the amount allowable under the public assistance standard. I also agree that should this placement end due to client behavior or foster home request, my client will return to the county of financial responsibility. I will notify Sherburne County when my client permanently leaves this placement.

____ _________________________

Signature of Case Manager Date

____ _________________________

Signature of Authorized Representative Date
Of County of Financial Responsibility

Attachment A

My Housing Preferences

Client Name				**Date of Birth**
Address				**Gender** ☐ **Male** ☐ **Female**
City	**County**	**State**	**Zip**	**Phone Number**

Use this form to explore service preferences and rank the item. After including the necessary information, rank their importance in the left column.

Ranking	What's important to me?
	Location of my home:
	Private Space:
	My Activities:
	My Schedule:
	Employment:
	Transportation:
	Language/Cultural:
	People who work with me:
	Other: What else is important to me?

Attachment A

I, ___________________________________ (Your Name), have shared my preferences and I understand that I have the right to choose from different providers.

____

My Signature and Date

Case Manager Placement Assessment:

Have you and the person interviewed at the residential service site? ☐ Yes ☐ No

Have you taken the necessary steps to ensure the needs of the person will be met at this site? ☐ Yes ☐ No

The person has been informed of their rights to choose a provider ☐ Yes ☐ No

Is this placement short-term? ☐ Yes ☐ No

If yes, please explain long-term plan to support the person's choices for their housing and services: __________________

____

____

____

____

Case Manager Signature and Date

Attachment B

Pre-Placement Residential Referral

Host County:	**County of Financial Responsibility:**
Host County Contact Information Name: Phone: Fax:	Case Manager Contact Information Name: Phone: Fax: Email:
Proposed Provider (if known):	Provider Address: Provider Phone:
Anticipated Date of Move:	Provider Contact Name:

Recipient Information:

Current Housing: ☐ Own Home ☐ Living with Family ☐ Hospital ☐ ICF/DD/Nursing Facility ☐ Homeless ☐ Corporate Foster Care ☐ Family Foster Care ☐ Board & Lodge ☐ Correctional Facility	Funding Source: ☐ CADI ☐ CAC ☐ TBI ☐DD ☐ EW ☐GRH ☐ Other

Completed *My Housing Preferences* with person on ____________________________
Date

List Top 3 Priorities that relate to residential services

1. ____
2. ____
3. ____

____

Case Manager Signature and Date

Host County Comments: ____
____
____
____
____