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

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

*A county human services agency may designate other qualified professionals

Indicate at least two of the following supports that the applicant needs.	
☐	Tenancy supports to assist an individual with finding their own home, landlord negotiation, securing furniture and household supplies, understanding and maintaining tenant responsibilities, conflict negotiation, and budgeting and financial education.
☐	Supportive services to assist with basic living and social skills, household management, monitoring of overall well-being, and problem solving.
☐	Employment supports to assist with maintaining or increasing employment, increasing earnings, understanding and utilizing appropriate benefits and services, improving physical or mental health, moving toward self-sufficiency, and achieving personal goals.
☐	Health supervision services to assist in the preparation and administration of medications other than injectables, the provision of therapeutic diets, taking vital signs, or providing assistance in dressing, grooming, bathing, or with walking devices.

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

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

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

This information is available in accessible formats for people with disabilities by calling 651-431-3941 or by using your preferred relay service. For other information on disability rights and protections, contact the agency's ADA coordinator. Minnesota Statutes 13.03, subd. 3 allow people access to private data recorded in their files. Upon request by the applicant or his/her representative, this agency is required by law to provide access to the information contained on this form.