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Home and Community Based Services (HCBS) Provider Quality Self-Assessment

2022

Instructions

This form is required for organizations enrolled to provide HCBS Waiver or Habilitation services in section II. Service Enrollment.

It is strongly recommended that organizations required to submit the annual Provider Quality Self-Assessment, review the full instructions, Frequently Asked Questions (FAQ), troubleshooting tips, and complete the training found here.

The annual self-assessment process requires the completion of two separate documents. The Provider Quality Self-Assessment form is a fillable PDF and must remain in that format upon submission. It includes an electronic signature attesting that the information submitted is true, accurate, complete, and verifiable. The Address Collection Tool is a spreadsheet and should remain in that format upon submission. The attestation also covers information submitted on the Address Collection Tool. Organizations are responsible for ensuring signatory authority. The annual Provider Quality Self-Assessment training and corresponding Frequently Asked Questions (FAQ) addresses some common problems with completing and submitting the self-assessment and Address Collection Tool.
Each organization is required to submit an acceptable self-assessment and corresponding Address Collection Tool by December 31 each year. Incomplete or inaccurate self-assessments, including Address Collection Tools, will not be accepted. Failure to submit a complete and accurate self-assessment by the December 31, will result in a referral to Iowa Medicaid's Program Integrity Unit for appropriate action, which may include sanctions and disenrollment from Iowa Medicaid.

Below is a brief explanation of each section of the Provider Quality Self-Assessment form. For full instructions, troubleshooting tips, and training on the annual Provider Quality Self-Assessment and corresponding Address Collection Tool, please click here.

I. Organizational Details. Identifies the organization submitting the forms.

II. Service Enrollment. Identifies the programs and services your organization is enrolled to provide. If you are uncertain which services you are enrolled for, contact Iowa Medicaid Provider Services via email imeproviderservices@dhs.state.ia.us or contact your HCBS Specialist.

Please note that you are responsible for completing the self-assessment process for all programs your organization is enrolled to provide, regardless of whether these services are currently being provided. If you wish to disenroll from a service, please contact your HCBS Specialist.

III. Self-Assessment Questionnaire. Provides an outline of all basic standards required by law, rule, industry standards, or best practice. You should read each standard, consider your organization's current situation, and select the most appropriate response.

Selecting Yes means your organization meets the standards and would be able to provide verifiable evidence of meeting the standard. You may meet the standard because you are required to by law or rule, organization policy or because your organization does so as best practice or because you are required to by another oversight entity outside of Iowa Medicaid.

Selecting No means your organization does not meet the standard but is required to by law, rule, or organization policy or the standard is otherwise necessary for the services your organization is enrolled to provide. If you select No, you must provide a response in the designated box describing your plan to meet the standard(s). A plan is sometimes also known as a "remediation plan", corrective action plan, or "CAP". It describes what the organization will do correct the problem with specific timelines for achieving compliance.

Selecting NA means the standard is not required by law, rule, or organization policy and is not otherwise necessary for the services your organization is enrolled to provided.

At the end of each topic, there is an opportunity for your organization to highlight how your organization meets or exceeds the requirements.

IV. Guarantee of Accuracy. Identifies your organization's pertinent certifications, accreditations, and licensures. Typically, you would list certifications, accreditations, and licensures that make your organization eligible to enroll for and provide any services identified in II. Service Enrollment. The Guarantee of Accuracy also requires your organization to attest that the information and responses are true, accurate, complete, and verifiable.

V. Direct Support Professional Workforce Data Collection. Provides details about your direct service workforce.

The Address Collection Tool is not published on the Provider Quality Self-Assessment webpage with the other self-assessment documents and resources. A copy of the annual Address Collection Tool is emailed to organizations at the time the annual self-assessment is released each year using the email contacts provided on the previous year's self-assessment. If you did not receive this year's version of the Address Collection Tool, please contact your HCBS Specialist. The Address Collection Tool is a required component of the self-assessment.

Questions should be directed to the HCBS Specialist assigned to the county where the parent organization is located. For a complete list of Quality Improvement Organization (QIO) HCBS Quality Oversight Unit contacts and a list of HCBS Specialists by region, please click here.

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Links and Resources

Iowa Medicaid website
Provider Quality Self-Assessment webpage
Informational Letters
Provider Services and Provider Enrollment
Iowa's HCBS Settings Transition webpage
Competency-Based Training and Technical Assistance for Long-Term Services and Supports
Iowa Administrative Code and Rules (IAC)
Iowa Code (IC)
Code of Federal Regulations (CFR)

I. ORGANIZATION DETAILS

Please identify your parent agency by providing the following information using the text entry fields below.

<table>
<tr><td colspan="6">Employer ID Number (EIN) (9 digits):</td></tr>
<tr><td colspan="6">Associated NPI (list all):</td></tr>
<tr><td colspan="6">Organization Name (as registered to EIN):</td></tr>
<tr><td colspan="3">Mailing Address:</td><td colspan="3">Physical Address:</td></tr>
<tr><td>City:</td><td>State:</td><td>Zip:</td><td>City:</td><td>State:</td><td>Zip:</td></tr>
<tr><td colspan="3">County:</td><td colspan="3">County:</td></tr>
<tr><td colspan="4">Executive Director/Administrator:</td><td colspan="2">Title:</td></tr>
<tr><td colspan="4">Email:</td><td colspan="2">Telephone:</td></tr>
<tr><td colspan="4">Self-Assessment Contact:</td><td colspan="2">Title:</td></tr>
<tr><td colspan="4">Email:</td><td colspan="2">Telephone:</td></tr>
<tr><td colspan="6">Organization Website:</td></tr>
</table>

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If the organization is completing one self-assessment for multiple agencies, identify below any affiliated agencies covered under this self-assessment. Please attach a separate document listing any additional agencies that do not fit in the available space below.

Agency Name	City	County	Associated NPI (list all)

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II. SERVICE ENROLLMENT

Indicate each of the programs and corresponding services your organization is enrolled to provide regardless of whether these services are currently being provided.
**If your organization is not enrolled for any of the services in this section, you are not required to submit the annual Provider Quality Management Self-Assessment.*

	☐ **AIDS/HIV Waiver**	☐ **BI Waiver**
Services	☐ Adult Day Care ☐ Agency Consumer-Directed Attendant Care (CDAC) ☐ Counseling ☐ Respite	☐ Adult Day Care ☐ Behavior Programming ☐ Agency CDAC ☐ Family Counseling and Training ☐ Interim Medical Monitoring and Treatment (IMMT) ☐ Prevocational Services ☐ Respite ☐ Supported Community Living (SCL) ☐ Supported Employment
	☐ **CMH Waiver**	☐ **Elderly Waiver**
Services	☐ Family and Community Support Services ☐ In-home Family Therapy ☐ Respite	☐ Adult Day Care ☐ Agency CDAC ☐ Assisted Living Service ☐ Case Management ☐ Mental Health Outreach ☐ Respite
	☐ **HD Waiver**	☐ **ID Waiver**
Services	☐ Adult Day Care ☐ Agency CDAC ☐ Counseling ☐ IMMT ☐ Respite	☐ Adult Day Care ☐ Agency CDAC ☐ Day Habilitation ☐ IMMT ☐ Prevocational Services ☐ Residential Based Supported Community Living (RBSCL) ☐ Respite ☐ SCL ☐ Supported Employment
	☐ **PD Waiver**	☐ **Habilitation**
Service	☐ Agency CDAC	☐ Day Habilitation ☐ Home-based Habilitation ☐ Prevocational Habilitation ☐ Supported Employment Habilitation

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III. SELF-ASSESSMENT QUESTIONNAIRE

A. ORGANIZATIONAL STANDARDS

To provide quality services to members, organizations need to have sound administrative and organizational practices and a high degree of accountability and integrity. Organizations should have a planned, systematic, organization-wide approach to designing, measuring, evaluating, and improving its level of performance. Use this section to tell us what your organization has in place related to basic standards required by law, rule, industry standards, or best practice.

1. PURPOSE AND MISSION *Does your organization…*	
a) Have a mission statement that aligns with the needs, ability, and desires of the members served?	☐ Yes ☐ No ☐ NA
If indicating "No", you must describe a plan to meet the standard(s). Attach additional information as necessary.	
2. FISCAL ACCOUNTABILITY *Does your organization…*	
a) Have a process for establishing a rate for each service?	☐ Yes ☐ No ☐ NA
b) Maintain fiscal and corresponding clinical records for a minimum of five years after the date of the last claim?	☐ Yes ☐ No ☐ NA
If indicating "No", you must describe a plan to meet the standard(s). Attach additional information as necessary.	
3. ORGANIZATIONAL OVERSIGHT *Does your organization…*	
a) Have a committee, board, or advisory board to oversee operations?	☐ Yes ☐ No ☐ NA
b) Ensure committee or board membership includes members, caregivers, and professionals in a related field who can represent the interests of members?	☐ Yes ☐ No ☐ NA
c) Maintain committee or board meeting minutes to demonstrate oversight and active engagement in the organization?	☐ Yes ☐ No ☐ NA

If indicating "No", you must describe a plan to meet the standard(s). Attach additional information as necessary.

4. QUALITY IMPROVEMENT (QI) PROCESSES	
Does your organization…	
a) Have an established systemic, organization-wide quality improvement process? *Does the QI process include:*	☐ Yes ☐ No ☐ NA
b) Discovery: Collecting and reviewing data to identify issues to be monitored for quality improvement with specific sample sizes and acceptable thresholds?	☐ Yes ☐ No ☐ NA
c) Ongoing review of member experiences such as member/stakeholder surveys to determine the need for systemic changes?	☐ Yes ☐ No ☐ NA
d) Ongoing review of records to include service documentation, medication records, incident reports, abuse reports, appeals and grievances, and personnel records?	☐ Yes ☐ No ☐ NA
e) Remediation: The development of a plan to address areas of improvement identified during discovery to include specific timelines for development and completion of action steps?	☐ Yes ☐ No ☐ NA
f) Improvement: Summary of QI activities to include monitoring the impact of remediation plan?	☐ Yes ☐ No ☐ NA

If indicating "No", you must describe a plan to meet the standard(s). Attach additional information as necessary.
Is there anything else you would like to highlight about your organization that would demonstrate how you exceed the basic requirements outlined under organizational standards?

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B. PERSONNEL AND TRAINING

Providers need to have qualified employees commensurate with the needs of the members served and requirements for the employee's position. Employees should be competent to perform duties and interact with members. Use this section to tell us what your organization has in place related to personnel and training standards required by law, rule, industry standards, or best practice.

1. EMPLOYEE SCREENING AND EVALUATION

Does your organization…

a) Complete child and dependent adult abuse background checks prior to hiring an applicant?	☐ Yes ☐ No ☐ NA
b) Complete criminal background checks prior to hiring an applicant?	☐ Yes ☐ No ☐ NA
c) Solicit an evaluation and follow recommendations for hire when a hit is found on a background check?	☐ Yes ☐ No ☐ NA
d) Screen potential employees for exclusion from participation in Federal health care programs prior to hire?	☐ Yes ☐ No ☐ NA
e) Ensure employees are minimally qualified by age, education, certification, experience, and training required or recommended for the services provided and HCBS population served?	☐ Yes ☐ No ☐ NA
f) Complete performance evaluations at least annually to ensure employees are competent to perform duties and interact with members?	☐ Yes ☐ No ☐ NA

If indicating "No", you must describe a plan to meet the standard(s). Attach additional information as necessary.

2. TRAINING

Does your organization train employees on the following required or recommended topics within 30 days of employment for full-time employees and 90 days for part-time employees, unless otherwise indicated?

a) The philosophy of HCBS, including HCBS settings requirements and expectations	☐ Yes ☐ No ☐ NA
b) The organization's mission, policies, and procedures	☐ Yes ☐ No ☐ NA
c) The organization's policy related to identifying and reporting abuse (within 30 days of hire)	☐ Yes ☐ No ☐ NA
d) The designated Child and/or Dependent Adult Abuse and Mandatory Reporting training (within 6 months of hire or proof of completion of the training prior to hire)	☐ Yes ☐ No ☐ NA

e) The designated Child and/or Dependent Adult Abuse and Mandatory Reporting additional training at least every 3 years after the initial training	☐ Yes ☐ No ☐ NA
f) Members' rights including outcomes for rights and dignity as applicable	☐ Yes ☐ No ☐ NA
g) Restrictive interventions (restraints, rights restrictions, and behavioral intervention)	☐ Yes ☐ No ☐ NA
h) Specific behavior support or de-escalation curriculum such as Mandt, Safety-Care, PBIS, CPI, or other	☐ Yes ☐ No ☐ NA
i) Confidentiality and safeguarding member information	☐ Yes ☐ No ☐ NA
j) The organization's policy related to member's medication	☐ Yes ☐ No ☐ NA
k) An approved Medication Manager training for any employees that are administering controlled substances	☐ Yes ☐ No ☐ NA
l) Identifying and reporting incidents	☐ Yes ☐ No ☐ NA
m) Service documentation	☐ Yes ☐ No ☐ NA
n) Individual members' support needs (prior to serving the member and as updates occur)	☐ Yes ☐ No ☐ NA
o) The designated Traumatic Brain Injury Training (modules 1-2) (within 60 days of providing BI Waiver services)	☐ Yes ☐ No ☐ NA
p) CMH Waiver specific topics in addition to B. 2 a-o: *Within 4 months of employment and prior to providing direct service without the presence of experienced staff:*	
1) Serious emotional disturbance and provision of services to children with serious emotional disturbance	☐ Yes ☐ No ☐ NA
2) Appropriate behavioral interventions	☐ Yes ☐ No ☐ NA
3) Professional ethics training	☐ Yes ☐ No ☐ NA
4) 24 hours of training during first year of employment in children's mental health issues	☐ Yes ☐ No ☐ NA

5) 12 hours of training every year thereafter in children's mental health issues	☐ Yes ☐ No ☐ NA
q) RBSCL specific topics in addition to B. 2 a-o:	
1) 24 hours of training during first year of employment in children's ID/DD/MH issues	☐ Yes ☐ No ☐ NA
2) 12 hours of training every year thereafter in children's ID/DD/MH issues	☐ Yes ☐ No ☐ NA
r) Prevocational Services specific topics in addition to B. 2 a-o:	
1) 9.5 hours of training related to employment services (within 6 months of hire or within 6 months of May 4, 2016)	☐ Yes ☐ No ☐ NA
2) 4 hours of training related to employment services every year thereafter	☐ Yes ☐ No ☐ NA
s) Supported Employment specific topics in addition to B. 2 a-o:	
1) 9.5 hours of training related to employment services (within 6 months of hire or within 6 months of May 4, 2016)	☐ Yes ☐ No ☐ NA
2) 4 hours of training related to employment services every year thereafter	☐ Yes ☐ No ☐ NA
3) Certification in job training and coaching for long-term job coaches and small group supported employment direct care staff (within 24 months of hire)	☐ Yes ☐ No ☐ NA
4) Certification as an employment specialist for individual supported employment staff (within 24 months of hire)	☐ Yes ☐ No ☐ NA
t) Day Habilitation services specific topics in addition to I B. 2 a-o for those providing direct services:	
1) 9.5 hours of training related to day habilitation services (within 6 months of hire or within 6 months of February 1, 2021)	☐ Yes ☐ No ☐ NA
2) 4 hours of training related to day habilitation services every year thereafter	☐ Yes ☐ No ☐ NA
u) Home Based Habilitation services specific topics in addition to B. 2 a-o:	
1) 24 hours of training related to mental health and multi-occurring conditions for those providing direct support Home Based Habilitation services (within 12 months of hire)	☐ Yes ☐ No ☐ NA

2) 48 hours of training related to mental health and multi-occurring conditions for those providing direct support to members receiving intensive residential habilitation services (within 12 months of hire)	☐ Yes ☐ No ☐ NA
3) 12 hours of training every year thereafter related to mental health and multi-occurring conditions or other topics related to serving individuals with severe and persistent mental illness for those providing direct support Home Based Habilitation services	☐ Yes ☐ No ☐ NA
v) Other training to ensure your employees are qualified commensurate with the needs of the members served and so that employees are competent to perform duties and interact with members	☐ Yes ☐ No ☐ NA
If indicating "No", you must describe a plan to meet the standard(s). Attach additional information as necessary.	
Is there anything else you would like to highlight about your organization that would demonstrate how you exceed the basic requirements outlined under personnel and training?	

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C. POLICIES AND PROCEDURES:

Organizations should have a core set of policies and procedures based on the services for which they are enrolled to provide. The policies and procedures are the foundation of an organization's performance and guide them in the provision of services. Policies and procedures should outline the organization's day-to-day operations, ensure compliance with laws and regulations, and give guidance to staff. Organizations must carry out their policies and procedures so that members receive fair, equal, consistent, and positive service experiences. Use this section to tell us what your organization has in place related to standards for service delivery and members' experiences required by law, rule, industry standards, or best practice.

1. ADMISSION AND DISCHARGE	
a) Does your organization have written policies or procedures related to admission and receiving referrals?	☐ Yes ☐ No ☐ NA
b) Do the policies and procedures explain criteria for admission?	☐ Yes ☐ No ☐ NA
c) Does the written policies and procedures explain your processes for referring members to other needed services or providers in the event the member is not accepted for admission or upon discharge from your organization?	☐ Yes ☐ No ☐ NA
d) Does your organization have written policies or procedures related to discharging members?	☐ Yes ☐ No ☐ NA
e) Do the policies and procedures explain potential reasons for discharge and outline steps the member can take if they disagree with the discharge decision?	☐ Yes ☐ No ☐ NA
f) Do you maintain evidence that you followed your written policies and procedures related to admission and discharge?	☐ Yes ☐ No ☐ NA
If indicating "No", you must describe a plan to meet the standard(s). Attach additional information as necessary.	
2. MEMBER CONFIDENTIALITY	
a) Does your organization have written policies or procedures related to maintaining confidential records and safeguarding members' confidentiality?	☐ Yes ☐ No ☐ NA
b) Does your organization use a Release of Information form or other similar document that allows members to authorize what information is shared and with whom?	☐ Yes ☐ No ☐ NA
c) Does the Release of Information form identify a date or event when the authorization ends?	☐ Yes ☐ No ☐ NA

d) Does your organization provide members with written privacy practices outlining how Personal Health Information is shared and with whom?	☐ Yes ☐ No ☐ NA
If indicating "No", you must describe a plan to meet the standard(s). Attach additional information as necessary.	
3. INCIDENTS AND INCIDENT REPORTING	
a) Does your organization have written policies or procedures related to recognizing and reporting major and minor incidents in accordance with IAC?	☐ Yes ☐ No ☐ NA
b) Does your organization maintain evidence that the following notifications are made within prescribed timeframes when an incident occurs?	
1) The supervising staff	☐ Yes ☐ No ☐ NA
2) The member's case manager (major only)	☐ Yes ☐ No ☐ NA
3) The member's legal guardian (major only)	☐ Yes ☐ No ☐ NA
4) The member (major only)	☐ Yes ☐ No ☐ NA
5) Iowa Medicaid and/or other appropriate entities (major only)	☐ Yes ☐ No ☐ NA
c) Does your organization maintain a centralized file of incident reports?	☐ Yes ☐ No ☐ NA
d) Does your organization have a process for noting within the member's record that an incident report was completed?	☐ Yes ☐ No ☐ NA
e) Does your organization have its own form and process for recording minor incidents?	☐ Yes ☐ No ☐ NA
f) Does your organization provide follow-up information or incident reports as requested?	☐ Yes ☐ No ☐ NA
g) Does your organization track incidents in a way that allows you to discover and remediate trends or patterns of incidents?	☐ Yes ☐ No ☐ NA

If indicating "No", you must describe a plan to meet the standard(s). Attach additional information as necessary.	
4. MEMBERS' MEDICATIONS	
a) Does your organization have written policies and procedures related to handling, storing, administering, and disposing of medications including identification of which staff (if any) have a role in one or more of the processes related to medication?	☐ Yes ☐ No ☐ NA
b) Does your organization have a method for documenting the administration of medications?	☐ Yes ☐ No ☐ NA
c) Does your organization have a process for storing medications in accordance with applicable IAC?	☐ Yes ☐ No ☐ NA
If indicating "No", you must describe a plan to meet the standard(s). Attach additional information as necessary.	
5. APPEALS AND GRIEVANCES	
a) Does your organization have written policies and procedures related to filing and resolving appeals and grievances?	☐ Yes ☐ No ☐ NA
b) Does your organization ensure that members or their legal representatives receive information about the organization's appeals and grievance processes?	☐ Yes ☐ No ☐ NA
If indicating "No", you must describe a plan to meet the standard(s). Attach additional information as necessary.	
6. IDENTIFYING AND REPORTING ABUSE	
a) Does your organization have written policies and procedures related to recognizing and reporting abuse?	☐ Yes ☐ No ☐ NA
b) Do your written policies define abuse for the population(s) served as outlined in applicable Iowa Code?	☐ Yes ☐ No ☐ NA

c) Do your written policies identify a process staff should follow to ensure a member's safety upon receiving an allegation, including when the suspected perpetrator is a staff person?	☐ Yes ☐ No ☐ NA
d) Do your written policies identify contact information for making reports to DHHS and or DIA, if applicable?	☐ Yes ☐ No ☐ NA
e) Do your written policies identify the timeframes required by Iowa Code for reporting suspected abuse?	☐ Yes ☐ No ☐ NA
f) Does your organization maintain evidence that reports were made as required and within prescribed timeframes?	☐ Yes ☐ No ☐ NA
If indicating "No", you must describe a plan to meet the standard(s). Attach additional information as necessary.	
7. PERSON-CENTERED PLANNING	
a) Does your organization have written policies and procedures related to person-centered planning?	☐ Yes ☐ No ☐ NA
b) Does your organization participate in individual members' Interdisciplinary Team (IDT) and the creation of the member's person-centered plan?	☐ Yes ☐ No ☐ NA
c) Does your organization maintain a copy of the person-centered plan that is created through the IDT process?	☐ Yes ☐ No ☐ NA
d) Does your organization create a separate or supplemental plan to the IDT person-centered plan?	☐ Yes ☐ No ☐ NA
e) Is the plan created by the organization consistent or complimentary to the IDT person-centered plan?	☐ Yes ☐ No ☐ NA
f) Does one, both, or a combination of the organization's plan and the IDT person-centered plan include:	
1) Member's goals for applicable services?	☐ Yes ☐ No ☐ NA
2) Interventions and supports needed to help the member meet their goals?	☐ Yes ☐ No ☐ NA
3) Incremental action steps or specific guidance to staff for providing interventions and supports?	☐ Yes ☐ No ☐ NA
4) Due process of any restrictive interventions such as rights restrictions, restraints plans, or behavioral intervention?	☐ Yes ☐ No ☐ NA

If indicating "No", you must describe a plan to meet the standard(s). Attach additional information as necessary.	
8. RESTRICTIVE INTERVENTIONS	
a) Does your organization have written policies and procedures related to the use of restrictive interventions, specifically restraints, rights restrictions, and behavioral intervention? *(*If your organization allows for the use of physical holds, restraints, or other physical intervention techniques, policies and procedures governing their use must include, in addition to standard requirements related to restrictive interventions, the specific types of interventions allowed and specific circumstances when physical intervention may be used, and qualifications and special training required for staff who administer restraints.)*	☐ Yes ☐ No ☐ NA
b) Does your organization have written policies and procedures for the use of a specific behavior intervention program such as Mandt, Safety-Care, PBIS, CPI, or other?	☐ Yes ☐ No ☐ NA
c) Does your organization ensure that members or their legal representatives receive information about the organization's policies of the use of restraints, rights restrictions, and behavioral intervention at admission and any time the policy changes?	☐ Yes ☐ No ☐ NA
d) Does your organization ensure that any planned restrictive interventions are used only for reducing or eliminating specific, maladaptive, targeted behaviors?	☐ Yes ☐ No ☐ NA
e) Does your organization ensure that any planned restrictive interventions are not used as punishment, substitutes for non-aversive programs, or for the convenience of staff?	☐ Yes ☐ No ☐ NA
f) Does the organization ensure that restrictive interventions do not constitute corporal punishment, verbal, or physical abuse?	☐ Yes ☐ No ☐ NA
g) Are planned restrictive interventions time limited and reviewed at least quarterly to determine if the restrictive intervention can be reduced or eliminated?	☐ Yes ☐ No ☐ NA
h) Do restrictive intervention plans demonstrate that due process was applied? *(*Documentation of due process includes an explanation of the need for the restrictive intervention and a summary of less restrictive methods that were attempted, identification of circumstances by which the restriction may be reduced or eliminated, timelines for review, and consent to the restriction.)*	☐ Yes ☐ No ☐ NA
If indicating "No", you must describe a plan to meet the standard(s). Attach additional information as necessary.	

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9. MEMBERS' RIGHTS	
a) Does the organization have written policies and procedures related to member rights?	☐ Yes ☐ No ☐ NA
b) Are members made aware of their rights at admission and anytime the written rights change?	☐ Yes ☐ No ☐ NA
If indicating "No", you must describe a plan to meet the standard(s). Attach additional information as necessary.	
10. DOCUMENTATION OF SERVICES	
a) Does your organization have written policies and procedures related to service documentation?	☐ Yes ☐ No ☐ NA
b) Does service documentation identify the specific service(s) being provided?	☐ Yes ☐ No ☐ NA
c) Does service documentation identify the member receiving the service(s), including the first and last name?	☐ Yes ☐ No ☐ NA
d) Is the complete date and time of the service documented, including the beginning and ending time and beginning and ending date if the service(s) is rendered over more than one day?	☐ Yes ☐ No ☐ NA
e) Is the location where the service(s) was provided documented as applicable?	☐ Yes ☐ No ☐ NA
f) When transportation is provided as part of the service(s), is the name, date, purpose of the trip, and total miles documented?	☐ Yes ☐ No ☐ NA
g) Are incidents, illnesses, unusual or atypical occurrences that occur during service provision documented when applicable?	☐ Yes ☐ No ☐ NA
h) When medication is administered or supplies are dispensed as part of the service(s), is the name, dosage, and route of administration documented?	☐ Yes ☐ No ☐ NA
i) Does service documentation legibly identify the person providing the service(s) including first and last name, any applicable credentials and signature or initials if verifiable to a signature log?	☐ Yes ☐ No ☐ NA
j) Does the service documentation demonstrate that the service is provided as defined and authorized?	☐ Yes ☐ No ☐ NA

k) Does service documentation for each service provide information necessary to substantiate that the service was provided?	☐ Yes ☐ No ☐ NA
If indicating "No", you must describe a plan to meet the standard(s). Attach additional information as necessary.	
11. CONTRACTS FOR SERVICES	
a) Does the organization have written policies and procedures related to service contracts?	☐ Yes ☐ No ☐ NA
b) Does the organization's service contract define the responsibilities of the organization and the member, the rights of the member, the services to be provided to the member by the organization, all room and board and co-pay fees to be charged to the member and the sources of payment?	☐ Yes ☐ No ☐ NA
c) Is the service contracted reviewed at least annually?	☐ Yes ☐ No ☐ NA
If indicating "No", you must describe a plan to meet the standard(s). Attach additional information as necessary.	
Is there anything else you would like to highlight about your organization that would demonstrate how you exceed the basic requirements outlined under policies and procedures?	

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D. HCBS SETTINGS

The Centers for Medicare & Medicaid Services (CMS) issued regulations that define the settings in which it is permissible for states to pay for Medicaid HCBS. The purpose of these regulations is to ensure that individuals receive Medicaid HCBS in settings that are integrated in and support full access to the greater community. This includes opportunities to seek employment and work in competitive and integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree as individuals who do not receive HCBS. Use the questions below to self-assess your organization's compliance with these settings rules. Additionally, you must complete the corresponding Address Collection Tool to list all provider owned and controlled HCBS service locations.

The following services are subject to the HCBS Settings Rule.

- Adult Day Care
- Agency CDAC
- Assisted Living Service
- Day Habilitation
- Home Based Habilitation
- Prevocational Services
- RBSCL
- SCL
- Supported Employment

☐ If your organization is NOT enrolled for any of the services identified above, check this box proceed to section IV. Guarantee of Accuracy.

**HCBS are required to be provided in such a way that the following standards related to service settings are met. If an individual requires a restriction or limitation in one or more of the areas listed below, due process of that restriction or limitation should be outlined in their person-centered plan. Policies and procedures related to restrictive interventions and person-centered planning should be followed.*

1. SETTINGS-RELATED POLICIES AND PROCEDURES	
a) Are the organization's policies and procedures aligned with HCBS settings requirements?	☐ Yes ☐ No ☐ NA
b) Does the organization ensure staff providing HCBS services, understand and effectively implement the HCBS settings requirements?	☐ Yes ☐ No ☐ NA
c) For settings located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment or in a building on the grounds of, or immediately adjacent to, a public institution; is the organization effectively implementing policies and procedures to ensure the setting overcomes the institutional presumption?	☐ Yes ☐ No ☐ NA
d) For settings that have the effect of isolating individuals receiving HCBS from the broader community of individuals not receiving HCBS, is the organization effectively implementing policies and procedures to ensure the setting overcomes the isolating effect it has on individuals?	☐ Yes ☐ No ☐ NA

If indicating "No", you must describe a plan to meet the standard(s). Attach additional information as necessary.	
2. PHYSICAL LOCATIONS AND CHARACTERISTICS	
All Settings	
a) Are settings integrated into the greater community, allowing members full access to community resources and amenities such as but not limited to: essential and non-essential shopping, recreation, restaurants, religious services, exercise, healthcare, personal grooming services, and opportunities for competitive and integrated employment?	
Adult Day Care	☐ Yes ☐ No ☐ NA
Agency CDAC	☐ Yes ☐ No ☐ NA
Assisted Living Service	☐ Yes ☐ No ☐ NA
Day Habilitation	☐ Yes ☐ No ☐ NA
Home Based Habilitation	☐ Yes ☐ No ☐ NA
Prevocational Services	☐ Yes ☐ No ☐ NA
RBSCL	☐ Yes ☐ No ☐ NA
SCL	☐ Yes ☐ No ☐ NA
Supported Employment	☐ Yes ☐ No ☐ NA
b) Are settings located so that there is not an overconcentration or isolation of HCBS or HCBS members in a certain area?	
Adult Day Care	☐ Yes ☐ No ☐ NA
Agency CDAC	☐ Yes ☐ No ☐ NA
Assisted Living Service	☐ Yes ☐ No ☐ NA
Day Habilitation	☐ Yes ☐ No ☐ NA
Home Based Habilitation	☐ Yes ☐ No ☐ NA
Prevocational Services	☐ Yes ☐ No ☐ NA
RBSCL	☐ Yes ☐ No ☐ NA
SCL	☐ Yes ☐ No ☐ NA
Supported Employment	☐ Yes ☐ No ☐ NA
c) Are all settings located in an area that facilitates members' ability to access community resources without being totally dependent on the service provider to access them or if limitations exist, have adaptions been made to facilitate members' access?	
Adult Day Care	☐ Yes ☐ No ☐ NA
Agency CDAC	☐ Yes ☐ No ☐ NA
Assisted Living Service	☐ Yes ☐ No ☐ NA
Day Habilitation	☐ Yes ☐ No ☐ NA
Home Based Habilitation	☐ Yes ☐ No ☐ NA
Prevocational Services	☐ Yes ☐ No ☐ NA
RBSCL	☐ Yes ☐ No ☐ NA
SCL	☐ Yes ☐ No ☐ NA

alhome healthcare is not enrolled to provide service marked N/A