



HCBS Non-Residential Provider Self-Attestation Survey

State of Hawaii's Department of Human Services
Med-QUEST Division Health Care Services Branch
P.O. Box 700190 Kapolei, Hawaii 96709-0190

Provider Name: _____

Background: On January 16, 2024, the Centers for Medicare and Medicaid Services (CMS) published the Home and Community-Based Services (HCBS) Setting Final Rule 42 CFR §441.301(c)(4) / 42 CFR §441.710(a)(1). The rule requires that Medicaid members (referred to as “client” or “resident”) getting HCBS have access to community resources equal to that of people who do not get HCBS. To ensure compliance to the rule, the Department of Human Services (DHS) Med-QUEST Division (MQD) informed HCBS providers of revised processes related to provider contracting, quality assurance activities, and provider training requirements through memos QI-2222 and QI-2308.

Instruction to providers: All Adult Day Health and Adult Day Care providers must complete this survey in its entirety and upload to Hawaii’s Online Kahu Utility (HOKU) when applying to become a Medicaid HCBS provider.

Before completing the survey, provider **must** read the attached QI-2308 memo and review the training materials on HCBS Setting Final Rule (also known as My Choice My Way in Hawaii) and Person-Centered Thinking and Practices. The training materials are accessible anytime at www.medquest.hawaii.gov in the My Choice My Way page.

When submitting or uploading the survey in the HOKU system, attach redacted and signed (by member/authorized representative) copies of these three documents: LTSS Choice Form, Admission Policy and Agreement or Service Contract, and Health Action Plan or Service Plan.

Providers may send questions related to the HCBS Setting Final Rule/My Choice My Way and request for assistance in completing the survey to mychoicemyway@dhs.hawaii.gov.

Providers may send questions related to the HOKU enrollment process to HCSBInquiries@dhs.hawaii.gov or call the Provider Hotlines at (808) 692-8099 for Oahu and at 1-833-909-3630 for the neighbor islands.

All providers or staff **must** sign below:

☐ I attest that I have read the QI-2308 memo and reviewed the training materials on HCBS Setting Final Rule/My Choice My Way and Person-Centered Practices and Thinking. (Please attach additional page(s) as needed)

_____ Provider’s Name and Signature	_____ Completion Date
_____ Provider’s Name and Signature	_____ Completion Date
_____ Provider’s Name and Signature	_____ Completion Date
_____ Provider’s Name and Signature	_____ Completion Date
_____ Provider’s Name and Signature	_____ Completion Date
_____ Provider’s Name and Signature	_____ Completion Date
_____ Provider’s Name and Signature	_____ Completion Date
_____ Provider’s Name and Signature	_____ Completion Date



HCBS Non-Residential Provider Self-Attestation Survey

State of Hawai'i Department of Human Services
Med-QUEST Division Health Care Services Branch
P.O. Box 700190 Kapolei, Hawaii 96709-0190

Provider Name: _____
Provider's Name and Signature Completion Date



Phone number: _____ Email address: _____

Physical address of business: _____

Date you did this survey: _____

This survey will help us understand the services that you provide to Medicaid members in your day program. We want to hear about your services and how they help our members to be independent, make decisions, and make choices. When responding to the survey questions, keep in mind the HCBS Setting Final Rule/My Choice My Way requirements. Your responses should reflect your general understanding to the final rule and current policies and practices. You may add comments in the spaces provided for additional information.

Things to **THINK** about when you are doing this survey:





1. Think about the **SETTING** your client(s) go to.
2. Tell us what it is like to be at your **DAY PROGRAM**.
3. Tell us about the **CHOICES** your client(s) get to make.
4. Check the box to answer **YES**  or **NO**  to the questions.



HCBS Non-Residential Provider Self-Attestation Survey

State of Hawai'i Department of Human Services
Med-QUEST Division Health Care Services Branch
P.O. Box 700190 Kapolei, Hawaii 96709-0190

Provider Name: _____

		YES 	NO 
CHOICE			
A. Day Program 	<i>Does your client(s) (and/or their authorized representative, Power of Attorney, or legal guardian)</i>		
	1. Have a choice in selecting your day program from among several setting options including non-disability specific settings (Example: LTSS choice form)?	<input type="checkbox"/>	<input type="checkbox"/>
	2. Know about his/her rights?	<input type="checkbox"/>	<input type="checkbox"/>
	3. Have a copy of his/her rights?	<input type="checkbox"/>	<input type="checkbox"/>
	4. If "no" to any question from #1-#3, provide explanation in the comment box.		
Comment:			
	<i>Does your day program</i>		
	5. Post the client's rights where they can see it?	<input type="checkbox"/>	<input type="checkbox"/>
	6. Talk to clients about making choices?	<input type="checkbox"/>	<input type="checkbox"/>
	7. Allow clients to go out in the community if s/he wants to (ex: voting sites, shopping mall, restaurant, stores, banks, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>
	8. If "no" to any question from #5-#7, provide explanation in the comment box.		
Comment:			
B. Program Activities 	<i>Does your client(s) choose</i>		
	9. His/her program activities?	<input type="checkbox"/>	<input type="checkbox"/>
	10. What time to do them?	<input type="checkbox"/>	<input type="checkbox"/>
	11. Whom s/he does the activity with?	<input type="checkbox"/>	<input type="checkbox"/>
	12. If "no" to any question from #9-#11, provide explanation in the comment box.		
Comment:			
	<i>Does your day program</i>		
	13. Have people without a disability?	<input type="checkbox"/>	<input type="checkbox"/>
	14. Support client(s) if s/he is interested in volunteer opportunities?	<input type="checkbox"/>	<input type="checkbox"/>
	15. Support client(s) if s/he is interested in job	<input type="checkbox"/>	<input type="checkbox"/>




HCBS Non-Residential Provider Self-Attestation Survey

State of Hawaii's Department of Human Services
Med-QUEST Division Health Care Services Branch
P.O. Box 700190 Kapolei, Hawaii 96709-0190


Provider Name: _____

	opportunities?		
	16. Have a safe place to put their items?	<input type="checkbox"/>	<input type="checkbox"/>
	17. Have activities that keep him/her involved and active?	<input type="checkbox"/>	<input type="checkbox"/>
	18. Have activities that help him/her relax and slow down?	<input type="checkbox"/>	<input type="checkbox"/>
	19. Have activities s/he can do alone?	<input type="checkbox"/>	<input type="checkbox"/>
	20. Have group activities?	<input type="checkbox"/>	<input type="checkbox"/>
	21. Have activities that encourage him/her to learn new things?	<input type="checkbox"/>	<input type="checkbox"/>
	22. If "no" to any question from #13-#21, provide explanation in the comment box.		


Comment:

C. Meals & Snacks 	<i>Does your client(s) choose</i>		
	23. What s/he wants to eat?	<input type="checkbox"/>	<input type="checkbox"/>
	24. What time s/he wants to eat?	<input type="checkbox"/>	<input type="checkbox"/>
	25. Who s/he eats with?	<input type="checkbox"/>	<input type="checkbox"/>
	26. If "no" to any question from #23-#25, provide explanation in the comment box.		

Comment:

D. Person-Centered Health action plan 	<i>Does your client(s) and/or authorized representative, Power of Attorney, and/or legal guardian</i>		
	27. Attend a Person-Centered Health action planning meeting?	<input type="checkbox"/>	<input type="checkbox"/>
	28. Pick the time, place, and who attends the meeting?	<input type="checkbox"/>	<input type="checkbox"/>
	29. Get to be in charge of their meeting?	<input type="checkbox"/>	<input type="checkbox"/>
	30. Have a person-centered health action plan with his/her interests?	<input type="checkbox"/>	<input type="checkbox"/>
	31. Get to change/update the plan?	<input type="checkbox"/>	<input type="checkbox"/>

Comment:

E. At the program 	<i>Does your day program staff know when to</i>		
	32. Help clients stay calm and relaxed?	<input type="checkbox"/>	<input type="checkbox"/>
	33. Help clients who are stressed and upset?	<input type="checkbox"/>	<input type="checkbox"/>
	34. Ask for client's consent before use of restraints	<input type="checkbox"/>	<input type="checkbox"/>



HCBS Non-Residential Provider Self-Attestation Survey

State of Hawaii's Department of Human Services
Med-QUEST Division Health Care Services Branch
P.O. Box 700190 Kapolei, Hawaii 96709-0190

Provider Name: _____

	and/or restrictive interventions?		
--	-----------------------------------	--	--


Comment:

PRIVACY


	<i>Do you and other staff</i>		
	35. Provide care in private?	<input type="checkbox"/>	<input type="checkbox"/>
	36. Keep the client's and health information private and secured/locked in storage?	<input type="checkbox"/>	<input type="checkbox"/>
	37. Know not to talk about the clients in front of other people?	<input type="checkbox"/>	<input type="checkbox"/>
	38. Have a place for the client to meet with their family and friends in private?	<input type="checkbox"/>	<input type="checkbox"/>
	39. Have a place for the client to talk on the telephone or use the computer (or other devices) in private?	<input type="checkbox"/>	<input type="checkbox"/>

Comment:

DIGNITY & RESPECT


F. Respect 	<i>Do you and other staff</i>		
	40. Say hello and use the client's preferred name?	<input type="checkbox"/>	<input type="checkbox"/>
	41. Talk to the client with respect?	<input type="checkbox"/>	<input type="checkbox"/>
	42. Use words that the client can understand?	<input type="checkbox"/>	<input type="checkbox"/>

Comment:

G. Free from being bullied 	<i>Do you and other staff</i>		
	43. Know what to do if s/he has a problem with the staff or service?	<input type="checkbox"/>	<input type="checkbox"/>
	44. Know that his/her complaint is private?	<input type="checkbox"/>	<input type="checkbox"/>
	45. Listen to the client if s/he has concerns?	<input type="checkbox"/>	<input type="checkbox"/>

Comment:

ACCESS



H. Inside the program 	<i>Does your day program</i>		
	46. Allow client(s) to get around safely?	<input type="checkbox"/>	<input type="checkbox"/>
	47. Have ramps, wide doorways, hallways, stair lift or elevator to help clients get around?	<input type="checkbox"/>	<input type="checkbox"/>
	48. Have any gates, Velcro strips, locked doors, or other things that stop clients from going in or out of places?	<input type="checkbox"/>	<input type="checkbox"/>
	49. If yes to #48, have the option to	<input type="checkbox"/>	<input type="checkbox"/>



HCBS Non-Residential Provider Self-Attestation Survey

State of Hawai'i Department of Human Services
Med-QUEST Division Health Care Services Branch
P.O. Box 700190 Kapolei, Hawaii 96709-0190

Provider Name: _____


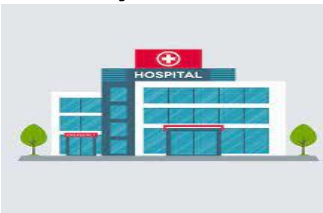
	remove/unlock/open gates, Velcro strips, and/or locked doors if/when s/he wants to with or without support?		
	50. If no to #49, are there any health and safety risk(s) identified and are these documented on the health action plan of at least one Medicaid member that requires safety measures to prevent elopement/wandering?	<input type="checkbox"/>	<input type="checkbox"/>
	51. Have locks or straps on the refrigerator or cabinets that make it hard for clients to get a snack or a drink (exclude medicine cabinets)?	<input type="checkbox"/>	<input type="checkbox"/>
	52. If "yes" to #51, provide explanation in the comment box.		
Comment:			
	<i>Does your client(s)</i>		
	53. Choose who to interact with?	<input type="checkbox"/>	<input type="checkbox"/>
	54. Have visitors at the day program?	<input type="checkbox"/>	<input type="checkbox"/>
	55. Have certain visitor hours?	<input type="checkbox"/>	<input type="checkbox"/>
Comment:			
I. Outside the program 	<i>Does your client(s)</i>		
	56. Have access to ramps, wide doorways, hallways, stair lift and/or elevator to help get inside the program?	<input type="checkbox"/>	<input type="checkbox"/>
	57. Have access to other houses, stores, and businesses with or without support?	<input type="checkbox"/>	<input type="checkbox"/>
	58. Have support to access private and public transportation?	<input type="checkbox"/>	<input type="checkbox"/>
Comment:			
J. Employment 	<i>Does your client(s)</i>		
	59. Have a job?	<input type="checkbox"/>	<input type="checkbox"/>
	60. If no to #59, know who to ask help from or have support to help him/her find a job if s/he wants to work?	<input type="checkbox"/>	<input type="checkbox"/>
	61. If yes to #59, have the option to work with people who do not have a disability if s/he wants to?	<input type="checkbox"/>	<input type="checkbox"/>
62. If yes to #59, choose their work schedule?	<input type="checkbox"/>	<input type="checkbox"/>	
Comment:			



HCBS Non-Residential Provider Self-Attestation Survey

State of Hawai'i Department of Human Services
Med-QUEST Division Health Care Services Branch
P.O. Box 700190 Kapolei, Hawaii 96709-0190

Provider Name: _____

Comment:			
K. Money 	Does your client(s)		
	63. Have a bank account?	<input type="checkbox"/>	<input type="checkbox"/>
	64. If yes to #63, know how/have support to get money when s/he needs it?	<input type="checkbox"/>	<input type="checkbox"/>
	65. If no to #63, want a bank account?	<input type="checkbox"/>	<input type="checkbox"/>
	66. Know who or have support to help him/her open a bank account if s/he wants one?	<input type="checkbox"/>	<input type="checkbox"/>
	67. Pick the person or have authorized representative, Power of Attorney, or legal guardian to help manage his/her money?	<input type="checkbox"/>	<input type="checkbox"/>
Comment:			
PRESUMED QUALITIES OF AN INSTITUTION			
L. Heightened Scrutiny 	Is your setting		
	68. Located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment (Example: nursing home, hospital)?	<input type="checkbox"/>	<input type="checkbox"/>
	69. Located on the grounds of, or immediately adjacent to, a public institution?	<input type="checkbox"/>	<input type="checkbox"/>
	70. Located where there are multiple settings serving people with disabilities co-located and operated/controlled by the same provider agency (Ex: a street with multiple care homes, in a row, owned by same provider)?	<input type="checkbox"/>	<input type="checkbox"/>
	71. Surrounded by high walls, high fences, security locks or gates?	<input type="checkbox"/>	<input type="checkbox"/>
	72. Located in a community with other private homes, retail businesses, food establishments, and other community resources?	<input type="checkbox"/>	<input type="checkbox"/>
	73. If "yes" to any question from #68-#71 and/or "no" to #72, provide explanation in the comment box.		
Comment:			



HCBS Non-Residential Provider Self-Attestation Survey

State of Hawai'i Department of Human Services
Med-QUEST Division Health Care Services Branch
P.O. Box 700190 Kapolei, Hawaii 96709-0190

Provider Name: _____

Describe/explain how your service and setting will achieve full compliance with the HCBS Setting Final Rule or My Choice My Way. Do not leave blank.

When is a modification or limitation to the requirements allowed and what needs to be done? Do not leave blank.

Thank you for participating and your answers are very important to us!