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Health Care Services Branch
Quality and Member Relations Improvement Section
P. O. Box 700190
Kapolei, Hawaii 96709-0190

April 13, 2023

MEMORANDUM

MEMO NO.
QI-2308

TO: Adult Day Care Providers
Adult Day Health Providers
Assisted Living Facility Providers
Community Care Family Foster Home Providers
Expanded Adult Residential Care Home Providers

FROM: Judy Mohr Peterson, PhD JMP
Med-QUEST Division Administrator

SUBJECT: HOME AND COMMUNITY BASED SERVICES SETTINGS FINAL RULE
PROVIDER IMPLEMENTATION AND ONGOING COMPLIANCE MONITORING

On January 16, 2014, the Centers for Medicare and Medicaid (CMS) published the Home and Community-Based Services (HCBS) Settings Final Rule 42 CFR §441.301(c)(4)/42 CFR §441.710(a)(1).

The Med-QUEST Division (MQD) is issuing this memorandum to inform HCBS providers of the revised processes related to provider contracting, quality assurance activities, and provider training requirements.

Active HCBS providers that were assessed and validated from December 2015 to December 2017 must continue to demonstrate ongoing compliance with HCBS Settings Final Rule requirements to continue to be paid.

New HCBS providers from January 2018 forward must be able to demonstrate compliance with the HCBS Settings Final Rule requirements.

Summary of HCBS Settings Final Rule Requirements

All settings where HCBS are provided and where HCBS members live must:

- Be integrated in and support full access to the greater community to the same degree of access individuals not receiving Medicaid HCBS, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community.
- Be selected by the member from among options, including non-disability specific settings, and an option for a private unit in a residential setting.
- Ensure member's rights of privacy, dignity and respect, and freedom from coercion and restraint.
- Optimize member's initiative, autonomy, and independence in making life choices.
- Facilitate member's choice about services and supports, and who provides them.

Additional requirements for provider-owned or controlled residential settings such as Community Care Foster Family Homes (CCFFH), Expanded Adult Residential Care Homes (EARCH), and Assisted Living Facilities (ALF) include:

- The member has a lease or legally enforceable Residency Agreement providing protections that address eviction processes.
- The member has privacy in their unit, including:
    - lockable doors, with member and appropriate staff having keys to doors as needed, and
    - the member sharing units have a choice of roommates and freedom to furnish or decorate the unit within the legal agreement.
- The member controls his/her own schedule and activities and has access to food at any time.
- The member can have visitors at any time.
- The setting is physically accessible.

Any modification or limitations to the above requirements for provider-owned or controlled residential settings such as CCFFH, EARCH, and ALF must be:

- Supported by a specific assessed need of the member
- Documented and justified in the Person-Centered Health Action Plan

Documentation in the Person-Centered Health Action Plan of any modifications or limitations includes:

- Specific individualized assessed need of the member.
- Prior interventions and supports that were tried including less intrusive methods.

- Description of the condition is consistent to the specific assessed need of the member (i.e. the modification or limitation is aligned with the specific need of the member)
- Ongoing monitoring of the modification or limitation to measure the effectiveness in meeting the specific need of the member.
- Established time limits for periodic review of the modification or limitation to determine if they are still necessary or can be terminated.
- Member's or Authorized Representative's informed consent.
- Assurance that interventions and supports will not cause harm to the member.

New Provider MQD Validation and Health Plan Credentialing Process

- A new provider must adhere to Health Plan policies and procedures for compliance with the HCBS Settings Final Rule before being awarded a contract.
    - The Health Plan will prescreen new providers to ensure that the provider has:
        - an approved Medicaid Identification number issued by MQD,
        - a completed Provider Self-Assessment Survey (Attachment A), and
        - a validation check on file with MQD.
- A new provider must create a new account and register on MQD's web-based provider enrollment system, HOKU, at https://medquest.hawaii.gov/en/plans-providers/Provider-Management-System-Upgrade.html.
    - Click on the '**Training**' tab for available Instructional Slides and Training Videos.
    - Keep username, password, email address, and HOKU application identification number to log into your application in HOKU.
    - The provider will need to upload a copy of the Provider Self-Assessment Survey in Step 10 by selecting:
        - Document Type (drop-down): Choose "Other";
        - Document Name (drop-down): Choose "Miscellaneous"; and
        - Remarks (box): Enter "Provider Self-Assessment Survey".
    - Onsite validation checks may be conducted under the discretion of MQD. The onsite validation check may be conducted by MQD or its delegate.

Existing Provider and Health Plan Recredentialing Process

- An existing provider must demonstrate compliance with HCBS Settings Final Rule by providing evidence of policies, procedures, and operating practices implemented and evaluated during the credentialing and contracting process with the Health Plans.
    - This may include the submission of the Provider Self-Assessment Survey, Provider Attestation of ongoing compliance, and Evidence Packet with supporting documentation to the Health Plans.
    - Samples of Provider Attestation and Evidence Packets have been provided in Attachment B:
        - one packet for residential providers, and
        - one packet for non-residential providers.

- The Health Plans will have a validation process including quality monitoring tools that will be used to evaluate ongoing compliance.
    - The validation of settings compliance may be conducted in person or virtually.
- The Provider Attestation and Health Plan validation approval are valid for up to five years based on the discretion of the Health Plan.
- The Health Plans shall provide technical assistance to the provider related to contracting requirements, as needed.
- If a Health Plan determines that the provider does not demonstrate compliance, the provider shall notify all other Health Plans they are contracted with. The Health Plans will temporarily suspend new admissions and/or services until remediated.
- If the provider does not demonstrate compliance within the remediation timeframe, they will not receive reimbursements, *starting the day that they were found non-compliant,* from the Health Plans.
- If a Health Plan determines that the provider does not demonstrate compliance within the remediation timeframe, the provider shall notify all other Health Plans they are contracted with. The Health Plans shall terminate the contract.

Transition of Care for Members

- For providers that do not demonstrate ongoing compliance, the Health Plans will need to transition members to another compliant setting with the goal to ensure continuity of services for affected members.
- The Health Plan will develop a Transition of Care (TOC) plan for members.
- A TOC notification letter will be sent to the members and the provider.
- The Health Plan Health Coordinator will discuss different setting options in a Person-Centered planning meeting prior to the TOC.
- The member, Health Plan Health Coordinator, and support network will work collaboratively to transition the member to the member's setting of choice.

Existing Provider MQD Revalidation Process

- All providers must revalidate their provider registration in the HOKU system every 5 years.
- The provider must follow the same process for Step 10 in HOKU.
    - The provider will need to upload a copy of the Provider Self-Assessment in Step 10, under "Survey".
    - For HOKU provider enrollment questions, please email HCSBinquiries@dhs.hawaii.gov
- The provider will be contacted by MQD staff or its delegate for a validation check. The validation check may be conducted in person or virtually based on the discretion of the MQD.

Provider Training Requirements

All providers must complete required trainings when contracting with the Health Plans. Trainings include, but are not limited to:

- HCBS Settings Final Rule Overview (42 CFR §441.301(c)(4)/42 CFR §441.710(a)(1)) to review processes that ensure members:
    - have full access to the benefits of community living and are able to receive services in the most integrated setting; and
    - are informed and supported to exercise their freedom of choice in selecting between institutional or home and community-based waiver services.
- Person-Centered Thinking and Planning (42 C.F.R.441.301(c)(1)-(2)) to ensure that the members' Health Action Plan:
    - is driven by the member;
    - offer informed choice regarding services and supports the member receives and from whom;
    - reflect what is important to the member to ensure delivery of services in a manner reflecting personal preferences, strengths, and ensuring health and welfare;
    - identify strengths, preferences, needs, and desired outcomes of the member;
    - include goals and preferences which are related to relationships, community participation, employment, and health; and
    - any exceptions or modifications to the settings requirements must be documented in the Health Action Plan and meet the member's goals.

Providers must attest to having completed the trainings stated above as part of the health plan contracting requirement. The training may be taken online or in person, as needed. Fact sheets and past provider training resources are available on the My Choice My Way website "Resources" tab at https://medquest.hawaii.gov/en/members-applicants/already-covered/my-choice-my-way.html.

For HCBS Settings Final Rule questions, please email mychoicemyway@dhs.hawaii.gov.

c: QUEST Integration Health Plans

Attachments

Day Program Survey

How many clients do you currently provide services to?
Date you did this survey:

This survey will help us understand the services you provide at your day program. We want to hear about your services and how they help our clients to be independent, make decisions and choices.

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.

		YES	NO
CHOICE			
1. Day Program 	***Does your client(s)***		
	a. Know about his/her rights?	☐	☐
	b. Have a copy of his/her rights?	☐	☐
	Does your day program		
	c. Post the clients rights where they can see it?	☐	☐
	d. Talk to clients about making choices?	☐	☐
	e. Allow clients to go to voting sites?	☐	☐
2. Program Activities 	***Does your client(s) choose***		
	a. Their program activities?	☐	☐
	b. What time to do them?	☐	☐
	c. Who the activity is done with?	☐	☐
	Does your day program have		
	d. People without a disability at the activities?	☐	☐
	e. Volunteer opportunities?	☐	☐
	f. Job opportunities?	☐	☐
	g. A safe place to put their personal items?	☐	☐
	h. Activities that keep s/he involved and active?	☐	☐
	i. Activities that help s/he relax and slow down?	☐	☐
	j. Activities s/he can do alone?	☐	☐
	k. Group activities?	☐	☐
	l. Activities that encourage s/he to learn new things?	☐	☐
3. Meals & Snacks 	***Does your client(s) choose***		
	a. What s/he wants to eat?	☐	☐
	b. What time s/he wants to eat?	☐	☐
	c. Who s/he eats with?	☐	☐

		YES	NO
4. Person-Centered Plan 	***Does your client(s)***		
	a. Attend a Person-Centered Planning meeting?	☐	☐
	b. Pick the time, place, and who attends the meeting?	☐	☐
	c. Get to be in charge of their meeting?	☐	☐
	d. Have a person centered plan with his/her interests?	☐	☐
	e. Get to change the plan?	☐	☐
	Does your day program staff know when to		
	f. Help clients stay calm and relaxed?	☐	☐
	g. Help clients who are stressed and upset?	☐	☐
	h. Ask for clients consent before use of restraints and/or restrictive interventions?	☐	☐
PRIVACY			
5. At the program 	***Do you and other staff***		
	a. Provide care in private?	☐	☐
	b. Keep the client's personal and health information private?	☐	☐
	c. Know not to talk about the clients in front of other people?	☐	☐
	d. Have a place for the client to meet with their family and friends in private?	☐	☐
	e. Have a place for the client to talk on the telephone or use the computer (or other device) in private?	☐	☐
DIGNITY & RESPECT			
6. Respect 	***Do you and other staff***		
	a. Say hello and use the client's name?	☐	☐
	b. Talk to the client with respect?	☐	☐
	c. Use words that the client can understand?	☐	☐
7. Free from being bullied 	***Do you and other staff***		
	a. Know what to do if s/he has a problem with the staff or service?	☐	☐
	b. Know that his/her complaint is private?	☐	☐
	c. Listen to the client if s/he has concerns?	☐	☐

		YES	NO
ACCESS			
8. Inside the program 	***Does your day program***		
	a. Allow client(s) to get around safely?	☐	☐
	b. Have ramps, wide doorways, hallways, stair lift or elevator to help clients get around?	☐	☐
	c. Have any gates, Velcro strips, locked doors, or other things that stop clients from going in or out of places?	☐	☐
	d. Have locks or straps on the refrigerator or cabinets that make it hard for clients to get a snack or a drink?	☐	☐
	Does your client(s)		
	e. Have visitors at the day program?	☐	☐
	f. Have certain visitor hour?	☐	☐
9. Outside the program 	***Does your client(s)***		
	a. Have ramps, wide doorways, hallways, stair lift or elevator to help get inside the program?	☐	☐
	b. Have access to other houses, stores, and businesses?	☐	☐
	c. Have access to transportation?	☐	☐
10. Employment 	***Does your client(s)***		
	a. Have a job?	☐	☐
	b. If no, know who can help to find them a job?	☐	☐
	c. If yes, work with people who do not have a disability?	☐	☐
	d. Get paid $7.75 per hour (minimum wage) or more?	☐	☐
	e. Have a service worker at their job?	☐	☐
	f. Choose their work schedule?	☐	☐
	g. Volunteer?	☐	☐
11. Money 	***Does your client(s)***		
	a. Have a bank account?	☐	☐
	b. If no, want a bank account?	☐	☐
	c. If yes, know how to get money when s/he needs it?	☐	☐
	d. Pick the person to help manage his/her money?	☐	☐

Comments:

If you have any questions, want more information or would like someone to contact you regarding your comments, please leave your name and most convenient way to contact you.

Name: _____

Phone: _____

Mailing address: _____

Email address: _____

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

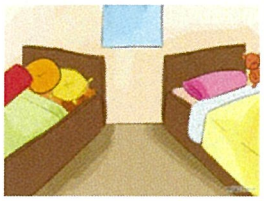
Primary Caregiver Residential Survey

How many clients do you currently provide services to?
How many beds or clients are you licensed or certified for?
If you are a certified CCFFH, did you provide care to any private-pay clients during the past year?
Date you did this survey:

This survey will help us understand the services you provide in the home. We want to hear about your services and how they help our clients to be independent, make decisions and choices.

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

1. Think about the home your client(s) **LIVE** in.
2. Tell us what it is like living in your **HOME.**
3. Tell us about the **CHOICES** your client(s) get to make.
4. Check the box to answer **YES**  or **NO**  to the questions.

		YES	NO
CHOICE			
1. Clients Home 	***Does your client(s)***		
	a. Have an agreement in writing for where s/he lives?	☐	☐
	b. Know the housing rights in regards to their agreement?	☐	☐
	c. Share a room?	☐	☐
	d. Choose their roommate?	☐	☐
	e. Get to decorate their room with their favorite things?	☐	☐
	f. Pick the clothes s/he wants to wear?	☐	☐
2. Going out 	***Does your client(s)***		
	a. Go out into the community?	☐	☐
	b. Pick how often s/he goes out?	☐	☐
	c. Choose what to do?	☐	☐
	d. Pick who goes out with him/her?	☐	☐
3. Schedule 	***Does your client(s) pick the time s/he***		
	a. Gets up and goes to bed?	☐	☐
	b. Takes a bath?	☐	☐
	c. Watches TV?	☐	☐
	d. Talks on the phone?	☐	☐
	e. Goes on the computer?	☐	☐
4. Meals & Snacks 	***Does your client(s) choose***		
	a. What s/he wants to eat?	☐	☐
	b. What time s/he wants to eat?	☐	☐
	c. Where s/he sits to eat?	☐	☐
	d. Who s/he eats with?	☐	☐
5. Person-Centered Plan 	***Does your client(s)***		
	a. Attend a Person-Centered Planning meeting?	☐	☐
	b. Pick the time, place, and who attends the meeting?	☐	☐
	c. Get to be in charge of their meeting?	☐	☐
PRIVACY			
6. Inside your home 	***Does your client(s)***		
	a. Have a key to the home?	☐	☐
	b. Close and lock the bedroom door?	☐	☐
	c. Have a key to their bedroom?	☐	☐
	d. Close and lock the bathroom door?	☐	☐

		YES	NO
6. Inside your home 	***Do you and other caregiver(s)***		
	e. Knock and ask permission to enter the client's bedroom or bathroom?	☐	☐
	f. Provide care in private?	☐	☐
	g. Keep the client's personal and health information private?	☐	☐
	h. Know not to talk about the clients in front of other people?	☐	☐
	i. Know not to talk about other people in front of the client?	☐	☐
	j. Have a place for the client to meet with their family and friends in private?	☐	☐
	k. Have a place for the client to talk on the telephone or use the computer (or other device) in private?	☐	☐
DIGNITY & RESPECT			
7. Respect 	***Do you and other caregiver(s)***		
	a. Say hello and use the client's name?	☐	☐
	b. Talk to the client with respect?	☐	☐
	c. Use words that the client can understand?	☐	☐
8. Free from being bullied 	***Do your client(s)***		
	a. Know what to do if s/he has a problem with the caregiver or service?	☐	☐
	b. Know that his/her complaint is private?	☐	☐
	c. Listen to the client if s/he has concerns?	☐	☐
ACCESS			
9. Inside your home 	***Does your home***		
	a. Allow client(s) to get around safely?	☐	☐
	b. Have ramps, wide doorways or hallways to help the client get around the home?	☐	☐
	c. Have any gates, Velcro strips, locked doors, or other things that stop clients from going in or out of some places?	☐	☐
	d. Have locks or straps on the refrigerator or cabinets that make it hard for the client to get a snack or a drink?	☐	☐
	Does your client(s)		
	e. Use the kitchen when s/he wants?	☐	☐

		YES	NO
9. Inside your home 	f. Get scolded for getting a snack or drink when s/he wants?	☐	☐
	g. Use the washer and dryer when s/he wants?	☐	☐
	h. Have visitors in your home?	☐	☐
	i. Have certain visitor hours?	☐	☐
	j. Have internet connection that s/he can use?	☐	☐
10. Outside your home 	***Does your client(s)***		
	a. Have access to other houses, stores, and businesses?	☐	☐
	b. Know their neighbors?	☐	☐
	c. Neighbors say hello or greets him/her?	☐	☐
	d. Have access to transportation?	☐	☐
	e. Have a curfew or a rule that says what time s/he will have to be back?	☐	☐
11. Employment 	***Does your client(s)***		
	a. Have a job?	☐	☐
	b. If no, know who can help them to find a job?	☐	☐
	c. If yes, work with people who do not have a disability?	☐	☐
12. Money 	***Does your client(s)***		
	a. Have a bank account?	☐	☐
	b. If no, want a bank account?	☐	☐
	c. If yes, know how to get money when s/he needs it?	☐	☐
	d. Pick the person to help manage his/her money?	☐	☐

Comments:

If you have any questions, want more information or would like someone to contact you regarding your comments, please leave your name and most convenient way to contact you.

Name: _____

Phone: _____

Mailing address: _____

Email address: _____

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

Attachment B

HCBS Final Rule Compliance: Residential Provider Attestation and Evidence Tool

Instructions: This is completed by a licensed/certified residential care setting (e.g., CCFFH, EARCH, or ALF). The setting must be integrated, least restrictive, and affords the member to have full access to the benefits of community living.

Complete each section by providing a YES, NO, or NA answer, if applicable. The provider must demonstrate compliance with HCBS setting rules by completing this attestation form. This form will serve as evidence of compliance to policies, procedures, and operating practices implemented and evaluated during the credentialing and contracting process with a health plan.

Any "Yes" response, the provider must provide evidence to demonstrate compliance. Evidence documentation includes, but is not limited to:

- Provider policies and procedures
- Member rights and responsibilities
- Member residency or legal agreement (blank or redacted)
- Example of member choice of activities and schedules
- Example of member transportation log
- Example of member visitor log
- Member individualized schedules (redacted)
- Member Health and Functional Assessment (redacted)
- Member Health Action Plan (redacted)
- Member Rights Modification Plan (redacted)
- Photos and/or architectural renderings of physical space
- Training curriculum and materials

Any "No" response with no health and safety risk preventing the member from exercising the right, the provider must provide a copy of documentation that the health plan reeducated the member of their individual rights, informed member of the intent of the HCBS final rule, and/or discussed person-centered goal setting. ****** Applies to HCBS Questions 1-26 only. ******

Any "No" response with a health and safety risk preventing the member from exercising the right, the provider must provide a copy of the risk modification plan, section entitled 'Member's Rights Modification Plan' of Health Action Plan. ************** The completion of a modification plan applies to HCBS Questions 27-36 only. **************

EXAMPLE: A provider responded "No" to HCBS Requirement 10 Physical Accessibility. A member with Alzheimer's has a health and safety risk which limits access to areas of the setting. The provider shall submit to the health plan, but not limited to:

1) Policies and procedures to address individual rights and modifications process to HCBS Requirement 10 Physical Accessibility.
2) Member rights and responsibilities
3) Member residency or legal agreement (blank or redacted)
4) Member Health and Functional Assessment (redacted)
5) Member Health Action Plan (redacted)
6) Member Rights Modification Plan (redacted)

Please attach full copies of each evidence document referenced. For each evidence line, please provide the name of the document, the specific excerpt or language from that document that demonstrates compliance, and cite the section, page number, or other appropriate reference from the document.

*****PLEASE ENSURE PROTECTED HEALTH INFORMATION/PERSONAL INFORMATION IS REDACTED FROM EVIDENCE*****

HCBS Final Rule Compliance: Residential Provider Attestation and Evidence Tool

Date:	
Health Plan Name: (Check all that apply)	AlohaCare ..... ◯ HMSA ..... ◯ Kaiser Permanente ..... ◯ Ohana ..... ◯ UnitedHealth Care ◯
Medicaid Provider Name:	
Medicaid Provider ID#:	
NPI#: (if applicable)	
Phone:	
Email:	
Servicing Address:	

I, _____, attest to have reviewed the HCBS Settings Final Rule requirements
(Name of Authorized Person)
and understand the expectations as a Medicaid provider. The evidence presented to the health plans as part of credentialing is true, accurate and complete and understand that any falsification or omission of information may warrant further evaluation by the health plan.

_____ _____ _____
Signature of Authorized Person Title Date

HCBS Requirement - Physical Location: Home and community-based settings do not include nursing facilities, institutions for mental diseases, intermediate care facilities for individuals with intellectual disabilities, hospitals, settings that isolate members from the broader community, or any other locations that have qualities of an institutional setting.
**Responses to this section is based on the provider evaluation of the servicing address.*

	HCBS Requirement - Physical Location: Home and community-based settings do not include nursing facilities, institutions for mental diseases, intermediate care facilities for individuals with intellectual disabilities, hospitals, settings that isolate members from the broader community, or any other locations that have qualities of an institutional setting. **Responses to this section is based on the provider evaluation of the servicing address.*	**Mark the answer that applies**	
		Yes	**No**
A	The setting is NOT located in a building, attached to a building, on the grounds of, or immediately adjacent to a publicly or privately operated facility that provides inpatient institutional treatment (e.g., nursing home, hospital)		
B	The setting is NOT located where there are multiple settings serving people with disabilities co-located and operated or controlled by the same provider agency (e.g., a street with multiple care homes, in a row, owned by same provider)		
C	The setting is NOT surrounded by high walls, high fences, security locks or gates.		
D	The setting IS located in a community with other private homes, retail businesses, food establishments, and other community resources.		

HCBS Final Rule Compliance: Residential Provider Attestation and Evidence Tool

Requirement 1: The setting is integrated in the community and supports the same access for Medicaid and non-Medicaid enrollees receiving HCBS services. [42 CFR 441.301 (c)(4)(i)]		**Mark the answer that applies**		
		NA	**Yes**	**No**
1.	Are Members able to control their own daily schedules and activities?			
2.	Are Members able to come and go (with or without supports) from the setting at any time without restrictions?			
3.	Are Members supported to explore and pursue competitive integrated employment in the community if Members choose to do so?			
4.	Are Members supported to engage in off-site community activities based on their individual preferences, such as shopping, dining, religious activities, voting, volunteering, personal appointments?			
5.	Are Members provided (or supported to access) transportation to/from the setting for community and social activities of their choosing?			
6.	Are Members supported to access and keep/carry their own money?			
7.	Are Members supported to control their own personal belongings and resources?			
HCBS Requirement 2: Person-centered plan is based on the individual's needs and preferences. [42 CFR 441.301 (c)(4)(ii)]			**Yes**	**No**
8.	Are Members supported to lead and actively participate in their person-centered planning process, including pre-planning and planning meetings?			
9.	Do Members have regular opportunities to update their plan, including their activities and preferences, or when there is a change in their needs?			
10.	Are Members able to receive services and supports in location(s) of their choosing?			
HCBS Requirement 3: Right to privacy, dignity, and respect and freedom from coercion and restraint. [42 CFR 441.301 (c)(4)(iii)]		NA	Yes	No
11.	Are Members supported to know and understand their program rights, including access to a copy of the rights in a manner and format that is accessible and understandable for them?			
12.	Do Members know what to do if Members have a problem with support staff or their services (i.e., do Members know how to reach out to their case manager, or how to file an anonymous complaint)?			
13.	Are Members supported to access information on resources like the Hawaii Disability Rights Center (HDRC) and Adult Protective Services (APS)?			
14.	Do Members feel that support staff interact and communicate with Members respectfully and in a manner that Members would like to be addressed?			
15.	Do Members know that support staff are trained on appropriate use of restrictive interventions if written in individualized plan?			
16.	Do Members know if their personal information is kept private and maintained in a secure location?			
17.	Do Members have privacy when personal care is provided?			
18.	Do Members have support staff promote informed decision-making?			
19.	Do Members have privacy when using the phone or internet?			

	HCBS Requirement 4: Individual initiative, autonomy, and independence in making life choices including but not limited to daily activities, physical environment, and with whom to interact. [42 CFR 441.301 (c)(4)(iv)]	Yes	No
20.	Do Members have individualized and variable schedules that change (daily or weekly) consistent with their individual preferences and needs?		
21.	Are Members supported to make informed choices, and to exercise those choices, about opportunities to participate in activities of interest, both within the setting and in the broader community?		
22.	Are Members supported if Members want to use, or learn how to use, public transportation options (e.g., bus schedules, training to use the bus, etc.)?		
23.	Do Members have opportunities to develop and maintain relationships with people from the broader community, including people without disabilities?		
	HCBS Requirement 5: Choice regarding services, supports, and who provides them. [42 CFR 441.301 (c)(4)(v)]	Yes	No
24.	Are Members asked about their needs and preferences, and are Members provided support to understand their choices and make informed decisions?		
25.	Are Members supported to know how to request a change in service provider, setting, or support staff?		
26.	Do Members know how to relocate or request new day program if Members choose to move?		

HEALTH AND SAFETY RISKS

	***HCBS Requirement 6:** Lease or other legally enforceable agreement providing the same responsibilities and protections from eviction that tenants have under state landlord or local landlord tenant laws. [42 CFR 441.301 (c)(4)(vi)(A)]	Yes	No
27.	Do Members have a legally enforceable residential agreement with the same responsibilities and protections from evictions that tenants have under state or local landlord-tenant laws?		
	***HCBS Requirement 7:** Right to privacy in their living unit [42 CFR 441.301 (c)(4)(vi)(B)(1)], [42 CFR 441.301 (c)(4)(vi)(B)(2)], [42 CFR 441.301 (c)(4)(vi)(B)(3)]	Yes	No
28.	Are Members able to close and lock doors to their personal or private spaces in the setting, including their bedroom and bathroom, with only appropriate staff able to access keys?		
29.	Do Members have the opportunity to choose to have a private room if one is available?		
30.	Do Members have the opportunity to choose and change their roommate situation?		
31.	Are Members able to furnish and decorate their personal or private spaces as Members choose, as described within the lease or residential agreement?		
	***HCBS Requirement 8:** Freedom and support [42 CFR 441.301 (c)(4)(vi)(C)]	Yes	No
32.	Are Members able to control their own daily schedules and activities?		
33.	Do Members have access food of their choosing at any time, without restrictions? (e.g., without limitations on where food can be consumed, or offering substitute meal options in residential settings)		
	***HCBS Requirement 9:** Right to visitors and access to family and friends. [42 CFR 441.301 (c)(4)(vi)(D)]	Yes	No
34.	Are Members allowed to have visitors at any time, without restrictions?		
35.	Do Members have a comfortable private place for Members to meet with visitors?		
	***HCBS Requirement 10:** Physically accessible to the member. [42 CFR 441.301 (4)(vi)(E)]	Yes	No
36.	Do Members have physical access to areas around the setting (i.e., are Members able to maneuver through the hallways, doorways, bathrooms, and common areas with or without assistive devices such as walkers and wheelchairs)?		