Home and Community-Based Waivers

(Rev 1/2025)

MONITORING PROTOCOL

VERSION 7.0

CALIFORNIA DEPARTMENTS OF DEVELOPMENTAL SERVICES AND HEALTH CARE SERVICES

HOME AND COMMUNITY-BASED SERVICES WAIVERS MONITORING PROTOCOL

Overview of the California Home and Community-Based Service Waiver

Medicaid, known as Medi-Cal in California, is a jointly funded, federal-State health insurance program for certain low income and needy people that includes long-term care benefits. Before 1981, the long-term care benefits were limited to care provided in an institutional setting such as a hospital, nursing home, or intermediate care facility for individuals with developmental disabilities (ICF- DD[1]). In 1981, President Reagan signed into law the Medicaid Home and Community-Based Services (HCBS) Waiver program, section 1915c of the Social Security Act. The legislation provided a vehicle for states to offer services, not otherwise available through the Medicaid program, to support people (including individuals with developmental disabilities) in their own homes and communities. The HCBS Waiver program recognizes that many individuals at risk of being placed in medical facilities can be cared for in their homes and communities, preserving their independence and ties to family and friends at a cost no higher than that of institutional care.

California was approved for its first Waiver for the developmental disabilities service system in 1982 with a total enrollment cap of 3,360.

In 2018, California received approval for a second 1915(c) waiver for the developmental disabilities service system. The approval of this waiver, which has budgetary authority, launched the Self-Determination Program. In accordance with Welfare and Institutions Code section 4685.8(a), the SDP is available statewide as of July 1, 2021 on a voluntary basis to all individuals who are eligible.

A condition of Waiver approval is agreement to comply with required federal assurances:

1. Necessary safeguards have been taken to protect the health and welfare of persons receiving services under the HCBS Waiver;

2. Plans of care are responsive to Waiver participant needs;

3. Only qualified providers support Waiver participants;

4. Level of care need determinations are consistent with the need for institutional care;

5. The State Medicaid Agency retains administrative authority over the Waiver program; and

6. The State provides financial accountability for the Waiver.

[1] The term ICF-DD used throughout the document includes ICF-DD, ICF-DD Habilitation, and ICF-DD Nursing facilities.

In addition, the Self-Determination Program Waiver, or SDP Waiver, has two State assurances:

1. The individual budget was determined appropriately; and

2. Prior to enrolling in the SDP Waiver, participants have attended an orientation.

Administration of the California Waivers

Department of Health Care Services (DHCS)

- Medicaid Single State agency
- Responsible for oversight and monitoring of programmatic and fiscal aspects of Home and Community-Based Services Waivers

Department of Developmental Services (Department)

- Operates the SPA under DHCS supervision
- Serves as fiscal intermediary in payment for services
- Oversees and monitors Waiver implementation in regional centers

Regional Centers

- Non-profit community-based corporations under contract with the Department
- Coordinates, provides, arranges or purchases all Waiver services
- Responsible for service provider contracts and payments

Quality Assurance and Monitoring

Centers for Medicare and Medicaid Services (CMS) and the States are responsible for quality assurance in Home and Community-Based Service (HCBS) Waiver programs. The CMS monitoring protocol explains the respective scopes of responsibility as, *"States have first-line responsibility for quality assurance in the Waiver programs, and that the RO reviewers' (CMS) responsibility is to evaluate whether and to what extent the States are meeting their responsibilities. The States should be conducting front-line monitoring activities; the RO (CMS) review should be more of a "look behind" review."*

States spell out how they will address the assurances in their approved HCBS waivers. CMS considers the State's compliance with the assurances as the core for their Waiver review. Thus, the current CMS monitoring protocol focuses on the design and implementation of the State's quality assurance system in each of the assurance areas.

The administrative structure for California's HCBS Waivers places responsibility for quality assurance and monitoring at all three levels. DHCS has principal responsibility for ensuring that the design and operation of the Waivers are consistent with the assurances in the approved Waivers and with Medicaid law and regulation. The Department is responsible for overseeing the overall design and operation of the quality assurance program and for monitoring the implementation of the Waivers. The regional centers are responsible for implementing the Waivers through establishing Waiver eligibility, developing plans of care, providing or purchasing needed services and supports, and vendorizing and overseeing providers of services and supports.

One way that DHCS and the Department monitor compliance with the HCBS Waiver requirements is through joint biennial monitoring reviews of the regional centers. The biennial reviews are conducted in accordance with the process set forth in this Protocol.

Overview of the Home and Community Based Services Waiver Monitoring Process

Collaborative reviews of regional centers are conducted every two years. Each review has three phases: pre-review, on-site and/or desk review, and post review. Pre-review activities include notification of the regional center, sending out the regional center self-assessment tool and selecting a sample of Waiver participants. The desk review includes the review of records for individuals supported by the regional center through an Home and Community-Based Services (HCBS) Waiver and interviews with the regional center service coordinators, clinical services staff, and quality assurance staff, the on-site review includes residential facilities and day programs; interviews with individuals receiving HCBS Waiver services; interviews with service providers and direct support staff; program/facility reviews; and a review of special incident reports. The post review includes developing the report of the review that delineates areas that regional centers need to address and receiving and reviewing a plan of action from the regional center.

Sampling Procedure

Developmental Disabilities Waiver:

The Department reviews a representative sample of individuals receiving Home and Community-Based Services (HCBS) Waiver services. The statewide sample size will produce results with a 95% confidence level and no more than 5% margin of error. The sample for the two-year review cycle consists of a statewide sample of 350 Waiver participants selected at random from each of three major residence types: Own Home-Parent, Community Care Facility, and Independent Living or Supported Living. The combined sample for the three residence types is 1050 participants. The size of the sample for each regional center will vary and matches the regional center's percentage of the statewide total Waiver participants within each residence type. The procedure to produce a list of Waiver participants to be reviewed is shown below.

1. The review begins by calculating the actual percentage of all Waiver participants in each residence type for the regional center that is the subject of the Waiver review. This is done by calculating the regional center's percentage of the statewide total of Waiver participants in each residence type. The calculation is made using data preceding the start of the monitoring cycle.

2. Multiplying the regional center's percentage for each residence type by 350 derives the number of Waiver participants to be reviewed in each residence type. For example, Regional Center X support 10 percent of all Waiver participants in the State who reside in CCFs, 20 percent of all Waiver participants who reside in their own home, and 10% of all Waiver participants who reside in ILS or SLS settings. The regional center's sample would

include 35 participants in CCFs (10% x 350), 70 participants who live at home (20% x 350), and 35 participants (10% x 350) who live in Independent or Supported Living settings for a total sample of 140 participants.

3. The next step is to create a list of Waiver participants for review. The list is created by randomly selecting the number of participants in each residence type. The actual number of selected individuals of each residence type should be 20 percent larger (or contain at least 10 more individuals) than the actual number required. This allows for substitutions in the event a participant is not available for the review. The additional participants should be reviewed only if participants selected earlier cannot be reviewed.

Self-Determination Program Waiver

The statewide sample size will produce results with a 95% confidence level and no more than 5% margin of error. For example, with an estimated 5,000 recipients, the sample size would be 357. The sample for the two-year cycle consists of a statewide sample of Self-Determination Program (SDP) Waiver participants selected at random

1. The review begins by calculating the actual percentage of all SDP Waiver participants for the regional center that is the subject of the Waiver review. This is done by calculating the regional center's percentage of the statewide total of Waiver participants in SDP. The calculation is made using data preceding the start of the monitoring cycle.

2. The next step is to create a list of SDP Waiver participants for review. The list is created by randomly selecting the number of participants. The actual number of selected individuals should be 20 percent larger (or contain at least 10 more individuals) than the actual number required. This allows for substitutions in the event a participant is not available for the review. The additional participants should be reviewed only if participants selected earlier cannot be reviewed.

Qualified Provider Sub-Sample

The SDP Waiver contains a performance measure to review that non-licensed/non-certified providers, including providers not vendored by the regional center, initially and continually meet all required standards. This measure looks at service providers providing services to a sub-sample of the SDP Waiver participants selected for the SDP Waiver review at each regional center.

1. The sample for this measure at each regional center consists of 9 SDP Waiver participants selected from the full regional center sample of SDP Waiver participants. Participants will be randomly selected to represent as many different Financial Management Service (FMS) providers as possible. The FMS is the only provider required to be vendored by a regional center and makes payment on behalf of the participant to the other providers. This is critical so that all providers of services to the SDP Wavier participant can be reviewed. The

review for this monitoring criterion requires a review of the provider files maintained by the FMS.
    a. If there are fewer than 9 SDP Waiver participants in the overall regional center SDP sample, all SDP Waiver participants will be in this sub-sample.
2. Unlike other criteria in the waiver reviews, this sub-sample may have multiple denominators to each SDP Waiver participant.
    a. Typically, for each review criteria, if any part of the monitoring criteria is unmet, the rating would be 0 of 1.
    b. For this measure, if a selected participant has 5 providers, there will be a rating assigned to each of the 5 providers. Meaning, if 3 of the 5 providers meet the required standards, the scoring would be positive for 3 out of 5.

3. Report processes and the statewide sample size mirror those noted above in the overall sampling procedure for SDP Waiver.

HCBS Monitoring Follow-up Reviews

During the off year of this two-year cycle, follow-up reviews will be conducted, as needed, focusing on issues that were identified in the previous review.

The Department follow-up actions may include the following:

Compliance Under 86% and Follow-up Action Plan

First Year of Non-Compliance:

A regional center is under 86% in one or more areas, for one cycle. (For example, a review ended 12/31/2024, report issued 3/31/2025, the first year of non-compliance would have been the CY 2024)

- Follow-up monitoring and compliance review is required one year after regular monitoring review. The regional center board is informed of the non-compliance.

Second Year of Non-Compliance:

When a follow-up review is completed in one or more areas regarding health and safety of individuals served and the follow-up shows no significant improvement.

- Regional center will be required to submit a Plan of Correction (POC) to the Department. The Department will review and approve the agreed upon plan. POC needs to specify timelines for improvement.
- Regional center will meet quarterly with The Department to review milestones and progress.
- Executive management at the regional center, the Department and the regional center board president are informed of the continued non-compliance.

Third Year of Non-Compliance:

A regional center is under 86% compliance in one or more areas regarding health and safety of individuals served, for two cycles.

- Follow-up monitoring and compliance review is required one year after regular monitoring review.
- Regional center to assess internally why the POC is not working and what changes are needed. If not already in the POC, the Department will recommend that regional center consult with ARCA and/or contract with a consultant to evaluate the effectiveness of the POC.
- Executive management at regional center, the Department and the regional center board president are informed of continued non-compliance.
- Executive management at the Department will meet with the regional center executive director and the regional center board of directors.

Fourth Year of Non-Compliance

When a follow-up review is completed in one or more areas regarding health and safety of individuals served and the follow-up shows no significant improvement for two cycles.

- Regional center will review the POC and revise as necessary and submit to the Department. The Department will review and approve the agreed upon plan.
- Regional center will meet monthly with the Department to review milestones and progress.

Five or More Years of Non-Compliance

A regional center is under 86% compliance in one or more areas regarding health and safety of individuals served for three or more cycles.

- Regional center will provide monthly updates on all individuals requiring quarterly face to face meetings.
- Regional center will meet weekly with the Department, providing information on compliance activities to increase compliance.
- Executive management at regional center, the Department and the regional center board president are informed of continued non-compliance.
- The Department determines if additional measures are needed for compliance including but not limited to applying subsequent provisions of Welfare and Institutions Code section 4635.

When the regional center has reached compliance for a monitoring review or follow-up review, the regional center will submit a maintenance plan to the Department. The Department will reduce or discontinue meetings with the regional center. If the regional center's next monitoring review results in non-compliance, the POC with the regional center and meetings with the Department will resume.

Scope of Review

The regional center, community care facility (CCF) and day program records of individuals will be reviewed for participants in the sample. An attempt will be made to interview all participants in the sample. Participation in the interview is voluntary. All

reviews will include interviews with regional center service coordinators, clinical staff and quality assurance staff. Interviews are also conducted with service providers and direct support staff. A physical inspection is conducted at CCFs and day programs. Special incident reports are reviewed for compliance with reporting and follow-up requirements.

Review and Data Collection Instruments

Section I Regional Center Self-Assessment

The Centers for Medicare and Medicaid Services (CMS) requires all States to provide six assurances as a condition of Waiver approval. The assurances are for the health and welfare of Waiver participants, for plans of care responsive to Waiver participant needs, that only qualified providers support Waiver participants, that the State conducts level of care need determinations consistent with need for institutionalization, that the State Medicaid Agency retains administrative authority over the Waiver program, and that the State provides financial accountability for the Waiver. Department of Health Care Services (DHCS) is the State Medicaid Agency. The Department of Developmental Services (Department) has responsibility for the operational aspects of implementing the Waiver. All Waiver services are provided through the regional center system. As such, regional centers have a role in carrying out the Waiver assurances. The purpose of the regional center self-assessment is to gain assurance from the regional center that it has written policies, procedures and practices and a system to assure compliance in areas associated with the Home and Community-Based Services (HCBS) Waiver assurances. The regional center assurances are limited to areas where the Department does not routinely collect information from the regional centers. The report to the regional center on the results of the review will contain comments and recommendations for those regional center assurances where there is a need for improvement.

Section II Regional Center Record Review

The individual's record is the key document used to monitor regional center compliance with the HCBS Waiver requirements. It is the collection of documents in the record that are reviewed by the Department /DHCS monitoring team during compliance reviews. In the Department /DHCS review, the individual's record also establishes the baseline for the interview with the individual, the service coordinator interview, the service provider interview, the direct care staff interview, the community care facility record review, the day program record review and the Special Incident Report (SIR) review. The record review consists of criteria associated with waver eligibility certification and recertification, choice, fair hearings, health status, Individual Program Plan (IPP) development and implementation, and monitoring of services. The report to the regional center will address those areas where there were negative findings.

Responsibilities of the Regional Centers

During the review, it is vital that all relevant documentation is made available to the Department one week prior to the planned monitoring review. To complete a

thorough and accurate monitoring review, the Department requires access to all records related to all individuals in the sample. For any parts of the monitoring review done remotely, the Department requires complete access to all case management systems or other electronic systems housing relevant documentation, or a complete copy of all required documentation contained in those electronic systems. Findings may be issued if missing documents prevent a full review of an individual's record. It is also vital that a designated and knowledgeable regional center representative be available for any questions, meetings, or follow-up during the entire monitoring review.

Responsibilities of the Department of Developmental Services

The Department will assign a dedicated and knowledgeable staff to work with the regional center for the duration of the monitoring review and will schedule meetings to provide information, answer any questions, and discuss the expectations of the review, including any information and documents needed to prepare and complete all components of the monitoring review. Documentation needed for the review will be given to the regional center, in a list, one month prior to the scheduled monitoring review. The Department will review the records provided from the regional center and work with the regional center representative, to help ensure the regional center has all documentation important for the monitoring review available and ready for review.

Section III Community Care Facility Record Review

The HCBS Waiver review evaluates how the regional center supports the services individuals receive in the community to assure that: they are living in safe environments; receiving the services on their IPPs; being treated with respect and dignity; they are aware of their rights; and their health is safeguarded. The review criteria for CCF records of individuals cover documentation, Individual Program Plan (IPP) implementation, health and safety, medication safeguards, quarterly and semiannual reports, and special incident reporting. The report to the regional center will address those areas where there were negative findings.

Section IV Day Program Record Review

The HCBS Waiver review evaluates how the regional center supports the services individuals receive in the community to assure that they are receiving day services in safe, productive environments that will assist in achieving the goals and objectives on their IPPs. The criteria in Section IV address the day program requirements for maintaining records of individuals and preparing written reports of the individuals progress toward achievement of (IPP) services for which the program is responsible. The report to the regional center will address those areas where there were negative findings.

Section V Observations and Interviews with Individuals

Individuals are interviewed and observed by the monitoring team at the day programs, residential homes, or other location of the individual's choosing. The

purpose of the interviews and observations is twofold. The interviews are conducted with individuals who are willing to participate to capture the individual's own feelings about his or her life. The interview format is designed to elicit information about the individual's satisfaction with their living arrangements and the staff who assist them in their residences; their school or day program and staff who assist them; choice; time spent with friends; food; recreation; interactions with the regional center; safety; and health. The results of the interviews for each question will be summarized in the report to the regional center.

The observations are conducted to verify that the individuals appear to be healthy and appropriately supported. A standardized checklist is used to document the observations. Any findings related to the observations will be included in the report to the regional center.

Section VI Interviews with Regional Center Staff

VI.A. Service Coordinator Interview

The service coordinator (SC) has an important role in the life of the individual. Among other things the SC is responsible for assessing the needs of the individual, facilitating the development of a person-centered IPP, linking the individual to services and supports on the IPP, monitoring progress and service delivery, monitoring health and safety, advocating for the individual and ensuring individuals have choices in their services and supports. The purpose of the interview is to determine how well the service coordinator knows the individual, the extent of the assessment process for the annual IPP development and/or review, the extent of plan participation, how the plan was developed, how services are monitored, how health issues are addressed and monitored, and how safety is monitored. The interview form is divided into two major categories. The questions in the first category are related to specific individuals. The questions in the second category are related to general questions. The ratings will be summarized in the report to the regional center.

VI.B. Clinical Services Interview

Regional center clinical services staff and contractors provide support to individuals and service coordinators on matters affecting the health, safety and medical needs of individuals living in the community. An informational interview is conducted with the clinical staff to ascertain how the regional center has organized itself to provide the support. The interview questions ask what processes the regional center has in place for routine monitoring of individuals with medical issues, monitoring of medications, monitoring of behavior plans, coordination of medical and mental health, improvements in access to preventive health care resources, and the role of clinical services in special incident reporting and the Risk Management Committee. Since the interview is informational, no attempt will be made to assign a rating to each of the questions. The results of the interview, along with any findings, will be briefly described in the report to the regional center.

VI.C. Quality Assurance Staff Interview

Quality assurance (QA) is an important component in assuring the health and safety of individuals in the community and provider competence. An informational interview is conducted with QA staff to gain an understanding of how the regional center has organized itself to conduct: Title 17 monitoring of CCFs; two unannounced visits to CCFs; QA evaluations of CCFs; HCBS Settings Requirements and service provider training. The interview also inquires about verification of provider qualifications, resource development activities, and to ascertain what is done to assure quality among programs and providers where there is no regulatory authority to conduct QA monitoring. Since the interview is informational, no attempt will be made to assign a rating to each of the questions. The results of the interview, along with any findings, will be briefly described in the report to the regional center.

Section VII Interviews with Service Providers and Direct Support Professional

VII.A. Service Provider Interview

The service provider has a critical role in the life of the individual. The service provider is responsible for assessing the needs of the individual in their program, participating in the development of a person-centered IPP, provision of services and supports on the IPP, fostering individual independence, advocating for and ensuring that the health, safety, and rights of the individual are planned for and met. The purpose of the service provider interview is to determine if the service provider knows the individual needs and preferences of the person being supported, fosters an environment where the individual is treated with dignity and respect, provides supports in alignment with the IPP, ensures preparation and oversight of the individual's health and safety, and oversees the training and implementation of policies and procedures that ensure the site is providing supports in accordance with the HCBS Settings Requirements. The interview form asks general questions about the overall practices of the setting and questions related to specific individuals. Compliance in these areas will be summarized in the report sent to the regional center.

VII.B. Direct Support Professional Interview

Direct support professionals are the individuals who work with and assist the individuals in day programs and residential settings. Direct support professionals play an important role in the implementation of the IPP. The purpose of the interview is to determine the direct support professional's familiarity with the individual, understanding of the IPP, specifically the individual's goals and objectives, communication, level of preparedness to address safety issues, understanding of emergency preparedness, knowledge about safeguarding medications and that staff are meeting the HCBS Settings Requirements. The interview form is divided into two major categories. The questions in the first category are related to specific individuals. The questions in the second category are general questions. The ratings will be summarized in the report to the regional center.

Section VIII Vendor Program Monitoring Review

Residential programs and day programs are reviewed by the monitoring team utilizing a vendor settings monitoring review form consisting of review criteria derived from Title 42, Code of Federal Regulations, Title 17, California Code of Regulations, Health and Safety Code, and from the HCBS Waiver. The purpose of the program review is to ensure HCBS settings are compliant, that the individuals are supported in safe, healthy, positive environments where their privacy, rights and choices are respected. Each criterion is followed by verification instructions for determining compliance. The review is conducted through an inspection of the physical environment of the program, interviews with individuals, service provider, and direct support staff as well as observations during the site review. The results of the reviews will be summarized in the report to the regional center.

Section IX Special Incident Reports Review

Title 17, California Code of Regulations (CCR), § 54327 defines special incidents as those incidents that have occurred during the time the individual was receiving services and supports from any vendor or long term health care facility, including: the individual is missing and the vendor or long-term care facility has filed a missing person's report with a law enforcement agency; reasonably suspected abuse/exploitation; reasonably suspected neglect; a serious injury/accident; any unplanned or unscheduled hospitalization; and, regardless of when or where the following incidents occurred, the death of any individual regardless of cause and/or when the is the individual is the victim of a crime. The purpose of this section is to verify that special incidents have been reported within the timelines, that the documentation meets the requirements of Title 17, and that the follow-up was appropriate and complete. The report to the regional center will include those areas where there were negative findings.

Prior to Self-Determination Program (SDP) Waiver enrollment, and in accordance with WI&C Section 4685.8 (d)(3)(A) and the approved SDP Waiver, participants are required to receive an orientation which contains training/information on how to recognize and report instances of abuse, neglect, and exploitation.

Section X Supplementary Issues

This section contains any supplementary issues identified by the monitoring team during the review that are not specifically addressed by the standard review protocol criteria. The following are examples of issues that may be included in this section: follow-ups on specific issues relating to individuals; additional regional center follow-up on HCBS Settings Requirements; special incidents; documentation of problems relating to regional center procedures or systems that are currently in place; referrals to the Department Audit Section.

Review Process and Timelines

1. The Department of Developmental Services (Department) will notify the regional center of the review date and confirm the date in writing, with a copy provided to the Department of HealthCare Services (DHCS).

2. The Department will generate a sample of individuals based on selection criteria (60 days prior to the review).

3. The Department will transmit the Regional Center Self-Assessment to the regional center and request the regional center to identify a staff person to serve as the contact and review coordinator (60 days prior to the review)

4. The HCBS Monitoring team will request database information such as fair hearings, special incident reports, complaints of individuals supported, etc., for any individual in the HCBS Waiver sample for pre-audit review and analysis.

5. Thirty days prior to the date of the onsite review, the Department will electronically transmit the list of the individuals selected for review to the regional center.

6. The regional center's response to the self-assessment questions is returned to the Department 30 days prior to the review. The Department staff will review the self-assessment results and identify those areas where follow-up information and/or staff interviews are needed during the onsite review. A copy of the self-assessment responses and any information regarding complaints, fair hearing requests and special incident reports (SIRs) will be provided to DHCS. The Department staff will notify the regional center of the staff that need to be interviewed, and the nature of the additional information needed. DHCS will be provided with this information.

7. The monitoring team will coordinate logistics with the regional center to arrange times for provider site visits prior to the first week of the onsite review.

8. First week of the review:

    a. The monitoring team conducts an entrance conference with the regional center to introduce the Department/DHCS staff and explain the purpose, scope and duration of the review.

    b. The monitoring team meets with selected regional center management staff to review and discuss the self-assessment. Any clarifications and revisions are discussed and confirmed.

    c. The regional center records for individuals for the selected sample are reviewed for compliance with the criteria in the monitoring protocol.

    d. The monitoring team interviews service coordinators, a staff person from the clinical team and quality assurance staff assigned.

f. The monitoring team coordinates the site visits to the selected community care facilities (CCF) and day programs with the regional center.

9. Second week, the onsite review:

a. CCFs and day programs are visited by the monitoring team. An entrance conference is conducted to explain the purpose and scope of the review. A standardized interview is conducted with each service provider.

b. The monitoring team reviews the sample records of individuals supported maintained by the service provider for compliance with the criteria in the review protocol.

c. The monitoring team conducts standardized interviews with the individuals in the review sample.

d. The monitoring team conducts a program site inspection at each CCF and day program visited selected for a full scope review.

e. The monitoring team conducts an informal exit conference with the service provider and the regional center representative, if present. The team members discuss any problems and concerns that have been identified, and may request that follow-up actions be taken, if necessary.

f. Within two weeks following the onsite review, the monitoring team conducts an informal exit conference with the regional center to present preliminary information on the general review findings and identify any urgent issues that require immediate attention. The monitoring team also explains that, because of the numerous components of the review and the amount of information gathered, it is not possible to discuss detailed findings at this point in time. The details of the specific findings and recommendations will be provided to the regional center in a written report prepared jointly by the Department and DHCS within 90 days.

Monitoring Report

Findings and Recommendations

Within 90 days following the exit conference, the Department of Developmental Services (Department)/Department of HealthCare Services (DHCS) will submit a written report of the HCBS Waiver and SDP HCBS Waiver review findings and recommendations to the regional center. The Department will also submit the report findings and recommendations for the Targeted Case Management (TCM) and Nursing Home Reform (NHR) reviews that were conducted by the Department staff simultaneously with the HCBS Waiver review. The Department transmittal letter will

request the regional center to submit a written response and action plans for all of the recommendations within 30 days follow their receipt of the reports.

Regional Center Response and Action Plans

Upon receipt of regional center responses, the Department will review the responses and action plans to the recommendations in the HCBS Waiver, HCBS SDP Waiver, TCM, and NHR reports to ensure that all report recommendations have been appropriately addressed. The Department will notify the regional center in writing that their response has been approved or request additional information to document the regional center's actions regarding the report recommendations.

Monitoring Reports and Regional Center Response

Timeline of activities

- *Within two weeks* following the completion of the monitoring review, the exit conference with regional center.
- *Within four weeks* following the exit conference, HCBS Waiver draft report completed by the Department.
- *Within four weeks* following the exit conference, HCBS SDP Waiver draft report completed by the Department.
- *Within one month* following the completion of the monitoring review, TCM/NHR draft reports completed by the Department.
- *Within three weeks* following receipt of the first draft, HCBS Waiver and HCBS SDP Waiver reports reviewed and approved by DHCS.
- *Within two weeks* following receipt of the first draft, HCBS Waiver, HCBS SDP Waiver, TCM and NHR reports reviewed and approved by the Department Management.
- *Within 90 days* following the completion of the monitoring review, final draft sent to the regional center.
- *Within 30 days* of receipt of the draft reports from the Department, regional center response received by the Department.
- *Within 30 days* of receipt of the draft reports with the regional center responses, regional center response reviewed and approved by the Department.
- *Within two weeks* of the Department approval of regional center responses in the draft reports, final report sent to regional centers and Board of Directors.

SECTION I REGIONAL CENTER SELF-ASSESSMENT

Purpose

The Centers for Medicare and Medicaid Services (CMS) requires all States to provide assurances as a condition of Waiver approval. The assurances are for the health and welfare of Waiver participants, for plans of care responsive to Waiver participant needs, that only qualified providers support Waiver participants, that the State conducts level of care need determinations consistent with need for institutionalization, that the State Medicaid Agency retains administrative authority over the Waiver program, and that the State provides financial accountability for the Waiver. Department of Health Care Services (DHCS) is the State Medicaid Agency. The Department of Developmental Services (Department) has responsibility for the operational aspects of implementing the Waiver. All Waiver services are provided through the regional center system. As such, regional centers have a role in carrying out the Waiver assurances.

The purpose of the regional center self-assessment is to gain assurance from the regional center that it has written policies, procedures and practices and a system to assure compliance in areas associated with the Home and Community-Based Services (HCBS) Waiver assurances. The regional center assurances are limited to areas where the Department does not routinely collect information from the regional centers. The report to the regional center on the results of the review will contain comments and recommendations for those regional center assurances where there is a need for improvement.

Self-Assessment Tool

Regional Center Assurances

State conducts level-of-care need determinations consistent with the need for institutionalization

1.1. The regional center ensures that individuals meet ICF/DD, ICF/DD-H, or ICF/DD-N facility level-of-care requirements as a condition of initial and annual eligibility for the Home and Community Based Services (HCBS) Waiver Program.

1.2. The regional center ensures that the regional center staff responsible for certifying and recertifying individuals' HCBS Waiver eligibility meet the federal definition of a Qualified Intellectual/Developmental Disabilities Professional (QIDP).

1.3. The regional center ensures that individuals are eligible for full-scope Medi-Cal benefits before enrolling them in the HCBS Waiver.

Necessary safeguards have been taken to protect the health and welfare of persons receiving HCBS Waiver Services

1.4. The regional center takes action(s) to ensure individuals' rights are protected for individuals.

1.5. The regional center takes action(s) to ensure that the individuals' health needs are addressed.

1.6. The regional center ensures that behavior plans preserve the right of the individual to be free from harm.

1.7. The regional center maintains a Risk Management, Risk Assessment and Planning Committee.

1.8. The regional center has developed and implemented a Risk Management/Mitigation Plan.

1.9. The regional center provides training/information to Self-Determination Program (SDP) Waiver enrollees on how to recognize and report instances of abuse, neglect, or exploitation.

1.10. Regional centers and local Community Care Licensing offices coordinate and collaborate in addressing issues involving licensing requirements and monitoring of Community Care Facilities pursuant to the MOU between the Department and Department of Social Services.

1.11. The regional center has developed and implemented a quality assurance plan for Service Level 2 - 7 community care facilities.

1.12. The regional center reviews each community care facility annually to assure services are consistent with the program design and applicable laws and oversees development and implementation of corrective action plans as needed.

1.13. The regional center conducts not less than two unannounced monitoring visits to each CCF annually.

1.14. Service coordinators perform and document periodic reviews (at least annually) to ascertain progress toward achieving IPP objectives, and the individual's and the family's satisfaction with the IPP and its implementation.

1.15. Service coordinators have quarterly face-to-face meetings with individuals in CCFs, Family Home Agencies, and those receiving Supported and or Independent Living Services outside of the family home to review services and progress toward achieving the IPP objectives for which the service provider is responsible.

1.16. The regional center ensures that needed services and supports are in place when an individual moves from a developmental center (DC) to a community living arrangement.

1.17. Service coordinators provide enhanced case management to individuals who move from a DC by meeting with them face-to-face every 30 days for the first 90 days they reside in the community.

Only qualified providers support HCBS Waiver participants

1.18. The regional center ensures that all HCBS Waiver service providers have signed the "HCBS Provider Agreement Form" and meet the required qualifications at the time services are provided.

Plans of care are responsive to HCBS Waiver participant needs

1.19. The regional center ensures that all individuals on HCBS Waiver are offered a choice between receiving services and living arrangements in an institutional or community setting.

1.20. Regional centers ensure that planning for IPPs includes a comprehensive assessment and information-gathering process which addresses the total needs, preferences, strengths, and goals of individuals on HCBS Waiver and is completed at least every three years or at the time of the individual's IPP.

1.21. The IPPs of individuals on HCBS Waiver are reviewed at least annually by the planning team and modified, as necessary, in response to the individuals' changing needs, choices and health status.

1.22. The regional center uses feedback from individuals, families and legal representatives to improve system performance.

1.23. The regional center documents the manner by which individuals indicate choice and consent.

1.24. The regional center certifies on the individual budget that the amount to use by SDP participants would have been expended using POS funds regardless of participation in SDP.

The State provides financial accountability for the HCBS Waiver

1.25. The regional center conducts fiscal reviews of vendors.

1.26. The regional center retains the documentation required for the HCBS Waiver for a period of five years.

SECTION II

REGIONAL CENTER RECORD REVIEW

Purpose

The regional center maintains a record for each individual that contains relevant information. The record is established at the time the individual is made eligible for regional center services and is maintained throughout their life. All of the relevant information about the individual is documented in the record including the basis for initial eligibility for regional center services; Individual Program Plans (IPP) that are developed by the planning team to define and address service and support needs; running identification notes to document relevant contacts with and about the individual; purchase of services authorizations to establish a payment mechanism for the services and supports that are the responsibility of the regional center; periodic progress and monitoring reports; and initial and ongoing eligibility for both the Home and Community-Based Services (HCBS) 1915(c) Developmental Disabilities Program and Self-Determination Program (SDP) Waivers.

The record for the individual is the collection of documents used to monitor regional center compliance with the HCBS Waiver requirements. It is the collection of documents that is reviewed by the Department of Developmental Services (Department) and the Department of Health Care Services (DHCS) monitoring team as well as the Centers for Medicare and Medicaid Services (CMS) during compliance audits. In the joint Department/DHCS review, the record for the individual establishes the baseline for all other record reviews, interviews and monitoring elements associated with the monitoring review. The report to the regional center will address those areas where there were negative findings.

As of January 1, 2025, it is a requirement to use the Standardized Individual Program Plan (SIPP) for person centered planning and must reflect all of the required components. The components include an introduction of the individual, how the plan was developed, vision for the future, communication methods used by the individual, decision making, and the life areas that are important for the individual. The life areas must include what is currently happening, what is important to the individual and what is important for the individual to be successful.

The review criteria in Section II addresses the requirements for documentation contained in the regional center's records for individuals in the following areas: HCBS Waiver eligibility, individual choice, notification of proposed action and fair hearing rights, level-of-care, Standardized IPPs, assessment of needs, exceptions to the HCBS Final Settings requirements (if applicable) and periodic reviews and reevaluations of services. The criteria are derived from Title 22 California Code of Regulations, Title 42 in Code of Federal Regulations, HCBS 1915(c) Waiver requirements, CMS directives and guidelines relating to the provision of HCBS 1915(c) Waiver services. Each criterion is followed by verification instructions for determining compliance. In some cases, there is an explanation for the criterion.

Criterion

2.0 The individual is Medi-Cal eligible. *[42 C.F.R § 435.217) (2025)]*

Explanation

Medi-Cal eligibility is a basic requirement for participation in the HCBS Waiver. The purpose of this criterion is to verify that individuals in the review sample meet the requirement.

Verification Instructions

1. Prior to the review, the Department verifies the individual's Medi-Cal eligibility for the period being reviewed in the "Medicaid Waiver Eligibility Report".

2. Score as (+) if the individual is Medi-Cal eligible.

3. Score as (-) if the individual is not Medi-Cal eligible.

2.1 Each record contains a "Medicaid Waiver Eligibility Record," (DS 3770 form), signed by a Qualified Intellectual Disabilities Professional (QIDP), which documents the date of the individual's initial HCBS Waiver eligibility certification, annual recertification and the assessed needs that identify the level-of-care. *[42 C.F.R. § 483.430(a) (2025)]; [42 C.F.R. § 441.301(b)(1)(ii) (2025)]; [42 C.F.R. § 441.302(c)(1) (2025)]*

Explanation

To be eligible for the HCBS Waiver an individual must have substantial limitations in their present adaptive functioning that would qualify the individual for the level-of-care provided in an intermediate care facility.

There is a further requirement that initial level-of-care determination be certified and that there is an annual recertification.

The staff person that makes the level-of-care determination is required to meet the Federal qualifications of a QIDP that include 1 year of experience working directly with persons with intellectual disabilities or other developmental disabilities and is either an MD, RN, or an individual who holds at least a bachelor's degree in a professional category specified in the CFR 483.430(b)(5) that includes social work and related fields.

Short-term absence is defined as an absence when the individual was not eligible for Waiver participation due to loss of Medi-Cal or a temporary change of living arrangement to a hospital, intermediate care facility (ICF)or other location that is not covered by the Waiver. The current Waiver specifies that the DS 3770 form will be used to document the requirements.

2.1.a The DS 3770 is signed by a Qualified Intellectual Disabilities Professional and the title "QIDP" appears after the person's signature. *[42 C.F.R. § 483.430(b)(5) (2025)]*

Verification Instructions

1. Score as (+) if the DS 3770 form is signed (wet or electronic signature) and the QIDP title is included.
2. If the form is signed and the "QIDP" title is not included, inquire as to whether the person who signed the form meets the definition of a QIDP.
    a. If the person meets the definition of a QIDP make a note on the comment section of the form and score as (+). Inform the regional center of the omission.

    b. If the person does not meet the definition of a QIDP make a note on the comment section of the form and score as (-). Inform the regional center.

3. Score as (-) if the form is not signed.

2.1.b The DS 3770 form summarizes the individual's assessed needs and/or any special health care conditions for meeting the Title 22 level-of-care requirements. [Cal. Code. Regs tit. 22, § 51343(l)(5) (2025)]

Explanation

To be eligible for the HCBS Waiver an individual has to meet the level-of-care requirements for care provided in ICFs. The DS 3770 is the form that documents HCBS Waiver eligibility. California's definition of needs that satisfy the level-of-care determination for intermediate care facilities is described in Title 22, CCR, *§ 51343*, as having a minimum of two moderate-to-severe assessed needs. This definition aligns with federal requirements for Waiver eligibility.

Verification Instructions

1. Review the DS 3770 form to determine if there are at least two moderate-to-severe assessed needs that meet the level-of-care requirements.

2. Score as (+) if the DS 3770 form summarizes at least two of the assessed needs, and if applicable, special health care conditions, indicated in the Client Development Evaluation Report (CDER) that meet the level-of-care requirement used to determine the individual's HCBS Waiver eligibility.

3. Score as (-) if the DS 3770 form does not identify at least two assessed needs, and if applicable, special health care conditions, indicated in the CDER that meet the level-of-care requirement used

to determine the individual's HCBS Waiver eligibility. Comment on what is missing.

2.1.c The DS 3770 form documents annual recertifications. *[42, C.F.R § 441.302(c) (2025)]*

Explanation

Annual evaluations are required in order to determine if the individual continues to meet the level-of-care provided in in a hospital or an ICF and if not for the provision of Waiver services, would be institutionalized. The DS 3770 form verifies the level-of-care determination and recertification.

Verification Instructions

1. Score as (+) if the date of recertification is within 12-months of the last certification/recertification.

2. Score as (-) if the date of recertification is later than 12-months from the last certification/recertification or if there is no recertification date and there should be. Comment on how late the recertification was done or if it was not done and should have been.

3. Score NA if the Waiver participant has been on the HCBS Waiver for less than two years.

2.1.d The DS 3770 form documents when an individual has temporarily been hospitalized or placed in an ICF if applicable. *[42 § C.F.R. 441.301(b)(1)(ii) (2025)]*

Explanation

Medicaid Home and Community-Based Services are provided to individuals that are in a community setting. While an individual is an inpatient of a hospital or an ICF they are not eligible to receive Waiver services.

Verification Instructions

1. Review the record for any placement in a hospital or ICF that occurred prior to the date of the last recertification. Placements in a hospital or ICF that occur after the date of the last recertification are excluded from the scope of the review.

2. Score as (+) if applicable placements in a hospital or ICF are documented on the DS 3770 form.

3. Score as (-) if there are placements in a hospital or ICF identified in the record that are not documented on the DS 3770 form.

4. Score as (NA) if there were no placements in a hospital or ICF that occurred prior to the date of the last recertification

2.2.a Each record contains a dated and signed Medicaid Waiver Consumer Choice of Services/Living Arrangements form, (DS 2200). *[42 C.F.R. § 441.302(d) (2025)]*

Explanation

The HCBS Waiver requires that participants be given a choice of living arrangements. The DS 2200 form is used to document that the individual has been informed of any feasible alternative services under the HCBS Waiver and has been given a choice of receiving those services in a Community Care Facility (CCF), in-home living arrangement, or long-term health facility. The DS 2200 is required to be completed upon determination of eligibility, when a participant is disenrolled from the Waiver, then re-enrolled on the Waiver, when a minor turns 18-years old.

Verification Instructions

1. Review the DS 2200 form in the individual's record and determine if it has been dated and signed by the individual, parent of a minor, legal guardian/conservator, or appropriate representative of the individual at the time of the individual's initial HCBS Waiver eligibility, the date of reenrollment in the HCBS Waiver after a period of disenrollment, when a minor, who is on the Waiver, turns 18-years old.

2. Score as (+) if:

    a. the form is dated; **and**

    b. *for minors* - the parent/legal guardian/legal representative has made the choice in Section III, marked the box in Section I indicating who has made the choice, and signed and dated the form; **or**

    c. *for adults* - the individual has made their choice in Section III, signed and dated Section II.a, or made their mark that has been witnessed and dated (planning team member may be a witness); **or**

    d. *for adults who have a legal representative* - the legal representative has made the choice in Section III, marked box (b) in Section II, and signed and dated the form; **or**

    e. *for adults who are not able to indicate their choice and do not have a legal representative* - the parent, relative, or other person involved in the individual's IPP who represents the planning team has made the choice in Section III, marked box (c) in Section II, and signed and dated the form; **and**

    f. the person who has made the choice and signed the DS 2200 form is consistent with the person who has signed the individual's other

consent forms, release of information forms, etc., contained in the individual's record unless the conservatorship or power of attorney allows for more than one individual to sign.

3. Score as (-) if any of the elements in one of the applicable situations under #2 is not documented in the DS 2200 form and comment on what is missing.

2.2.b Each IPP includes documentation that the setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board. *[42, C.F.R. § 441.301(c)(4)(ii) (2025)]*

Verification instructions

1. Review the individuals IPP for documentation for choice of settings, services and supports available for the individual to make an informed decision about where they receive support and who provides the support.

2. Score as (+) if the choices of settings, services and supports provided to the individual are documented in the individual's IPP.

3. Score as (-) if there is no information about choice of settings, services and supports provided to the individual, documented in the individual's IPP.

2.3 There is written notification of a proposed action and documentation that the individual has been sent written notice of the fair hearing rights whenever choice of living arrangements is not offered, services or choice of services are denied or reduced without the agreement of the individual/authorized representative, or the individual/authorized representative does not agree with all, or part of the components in the individual's IPP, or the individual's Waiver eligibility has been involuntarily terminated and will result in the individual losing a regional center service, Medi-Cal benefits, or other generic services. *[42 C.F.R. Part 431, Subpart E (2025)], [W.I.C. 4710(a)(1) (2023)]*

Verification Instructions

1. Review the individual's DS 2200 and DS 3770 forms, IPP, interdisciplinary notes, purchase of service (POS) approvals and terminations, written notification of proposed actions and fair hearing rights, fair hearing requests, and any relevant letters, for documentation that services or choice of services has been denied, or the individual has voluntary disenrolled from the HCBS Waiver and will result in the individual losing a regional center service, Medi-Cal benefits, or other generic services.

2. Score as (+) if:

   a. the individual has lost a regional center service, Medi-Cal, or other generic service as a result of being disenrolled from the Waiver and has voluntarily disenrolled by signing the DS 2200 or has been sent a Notice of Proposed Action within 30 days of disenrollment. **or,**

   b. the individual **has been denied** a choice of services, type of service, service provider, type of provider, or amount of services; **or**

   c. the individual/parent/legal guardian or legal representative has disagreed with any of the components in the individual's IPP; **and**

   d. a Notice of Action was sent within 30 days of the denial of services and there is documentation that the regional center has notified the individual in writing of their fair hearing rights.

3. Score as (-) if:

   a. the individual has lost a regional center service, Medi-Cal, or other generic service as a result of being disenrolled from the Waiver and has not voluntarily disenrolled by signing the DS 2200 or has not been sent a Notice of Proposed Action within 30 days of disenrollment. **or,**

   b. the individual **has been denied** a choice of services, type of service, service provider, type of provider, or amount of services; **or**

   c. the individual/parent/legal guardian or legal representative **has disagreed** with any of the components in the individual's IPP; **and**

   d. Notice of Action was not sent within 30 days of the denial of services and there is no documentation that the regional center has notified the individual in writing of their fair hearing rights.

4. Score as (NA) if:

   a. the individual **has not been denied** a choice of services, type of service, service provider, type of provider, or amount of services; **and**

   b. the individual/parent/legal guardian or legal representative **has not disagreed** with any of the components in the individual's IPP.

2.4 The individual record contains a current Client Development Evaluation Report (CDER) that has been reviewed within 12-months of the prior CDER. Reevaluations, at least annually, of each individual receiving home or community-based services to determine if the individual continues to need

the level-of-care provided and would, but for the provision of Waiver services, otherwise be institutionalized. *[42 C.F.R. § 441.302(c)(2) (2025)]*

Explanation

The CDER is designated in the Waiver as the source of information for assessing the assessed needs and making level-of-care determinations. The HCBS Waiver requires that eligibility be reviewed at least annually.

Verification Instructions

1. Review the individual's most recent CDER and annual review documentation.

2. Score as (+) if:

    a. a new CDER with updated information has been completed within 12-months of the prior CDER; **or**

    b the "HCBS Waiver Standardized Annual Review Form" or other documentation indicates that the CDER has been reviewed within the past 12-months, and no changes were necessary.

    c. a CDER was completed within 30 days for an individual newly found eligible for regional center services or when a child newly transitions from early start to Lanterman services and enrolled in the HCBS Waiver, or when an individual transitions from the 1915i State Plan Amendment to the 1915c HCBS Waiver.

3. Score as (-) if either a. or b. under #2 is not documented. Note what is not documented.

2.5.a The individual's assessed needs and any special health care conditions used to meet the level-of-care requirements for care provided in an ICF-DD, ICF-DDH, ICF/DD-N facility are documented on the DS 3770 and in the individual's CDER). *[42 C.F.R. § 441.302(c) (2025)]; [*Cal. Code. Regs tit. 22, § 51343*(l) (2025)]*

Explanation

To be eligible for the HCBS Waiver an individual must meet the level-of-care requirements for care provided in intermediate care facilities. The DS 3770 is the form that documents HCBS Waiver eligibility. It is a requirement that the assessment used CDER to determine eligibility be reviewed annually. California's definition of needs that satisfy the level-of-care determination for intermediate care facilities is described in Cal. Code. Regs tit. 22, § 51343.

Verification Instructions

1. Review the most recent CDER to determine if at least two assessed needs and/or special health care conditions of sufficient severity to quality for the level-of-care provided in an intermediate care facility are identified.

2. Score as (+) if the CDER identify at least two assessed needs and/or special health care conditions, listed on the DS 3770, of sufficient severity to qualify for the level-of-care provided in an intermediate care facility and an evaluation has been completed within the year to verify eligibility.

3. Score as (-) if the CDER contain less than two sufficient assessed needs and/or special health care conditions, listed on the DS 3770 of sufficient severity to qualify for the level-of-care provided in an intermediate care facility or if an evaluation has not been completed within the year to verify eligibility. Comment on any work.

2.5.b The individual's assessed needs used to meet the level-of-care requirements for care provided in intermediate care facilities that is documented in the CDER and the DS 3770 are consistent with other information contained in the individual's records. *(HCBS Waiver Requirement)*

Explanation

The information used to determine waiver eligibility and level-of-care should be consistent with the other information in the individual's records including but not limited to vendor/provider reports, regional center reports, including IPPs, annual and quarterly review documentation.

Verification Instructions

1. Score as (+) if the assessed needs used to meet the level-of-care or special health care conditions documented in the CDER are consistent with information in the individual's other records.

2. Score as (-) if the assessed needs used to meet the level-of-care or special health care conditions are not consistent with information in the record. Provide specific comments and request a revaluation of the individual's level-of-care.

3. Score as (N/A) if there are no assessed needs that meet the level-of-care or special healthcare conditions documented in the DS 3770 or elsewhere in the record.

2.6.a The IPP for every individual is reviewed, and revised as appropriate, based upon the reassessment of functional need at least every 12-months by the planning team and modified, as necessary, in response to the individual's changing needs, wants, or health status. *[42 C.F.R. § 441.301(C)(3) (2025)]; [W.I.C. §4646.5(b) (2023)]*

Explanation

The IPP is the individual's plan that is used to translate the person's needs, wants and preferences into measurable objectives that are met through specified services and supports. The IPP is a product of a planning team that includes at a minimum the individual and a regional center representative. The IPP establishes the authority for regional centers to arrange and fund needed services and supports when there is no other source of funding. The IPP is not a static document and therefore it is necessary for the regional centers to review the document periodically and make necessary changes. For Waiver participants, the review must occur at least annually.

Verification Instructions

1. Review the record for both the most current IPP or annual review and the IPP or annual review completed 12-months prior.

2. Score as (+) if the IPP has been reviewed within 12-months of the last IPP or annual review **and**

    a. a new IPP or annual review has been completed, **or**

    b. the "HCBS 1915(c) Waiver Standardized Annual Review Form" documents the reason no changes are necessary to the existing IPP, **or**

    c. an addendum to the existing IPP has been completed in response to changes with the individual's needs, preferences, or health status. The addendum includes a review of the individual's needs, services and supports, progress on outcomes and health status.

3. Score as (-) if the IPP has not been reviewed within 12-months of the prior IPP or annual review.

2.6.b The HCBS Waiver Standardized Annual Review Form (SARF) is completed and signed annually by the planning team to document whether or not a change to the existing IPP is necessary, and that the individual's health status and Client Development Evaluation Report (CDER) have been reviewed. (*HCBS Waiver Requirement)*

Explanation

The HCBS Waiver SARF, or an annual review report that includes verification that the CDER was reviewed, a review of the individual's needs, outcomes, health status and IPP team signatures, is required only when a new or revised IPP was not developed as a part of the annual review.

Verification Instructions

1. Score as (+) if

a. the HCBS Waiver SARF was completed and signed at the time of the individuals IPP annual review when there was not a new or revised IPP. **or**

b. an annual review was completed and contains all of the required elements of the HCBS Waiver SARF which includes, verification that the CDER was reviewed, a review of the individual's needs, outcomes, health status and planning team signatures.

2. Score as (-) if:
   a. there is not a new or revised IPP and the form or annual review was not completed. **or**

   b. the form or the annual review is lacking any of the required elements and/or planning team signatures.
3. Score as (NA) if a new or revised IPP was developed as a part of the annual review.

2.7.a The IPP is prepared jointly with the planning team and a list of agreed upon services is signed, prior to its implementation, by an authorized representative of the regional center and the individual or, where appropriate, the individual's parents, legal guardian, conservator or the authorized representative. *[W.I.C. § 4646(d) (2023)]; [W.I.C. § 4646(i) (2023)]; [42 C.F.R. § 441.301(c)(1)(i) (2025)]; [42 C.F.R. § 441.301(c)(2)(ix) (2025)]*

Explanation

The IPP must be finalized and agreed upon with informed consent of the individual and signed by the individual or their legal representative. Signatures denote agreement with the plan.

Verification Instructions

1. Review the individual's current IPP and determine if the regional center representative and the individual or, where appropriate, their parents, legal guardian, conservator or authorized representative have signed and dated the IPP.

2. If the individual or, where appropriate, their parents, legal guardian, conservator or authorized representative, does not agree with all components of the plan, they **may** indicate that disagreement on the plan. Disagreement with specific plan components does not prohibit the implementation of services and supports agreed to by the individual, parents, legal guardian, conservator or authorized representative. If the individual or, where appropriate, their parents, legal guardian, conservator or authorized representative, does not agree with the plan in whole or in part, the individual shall be sent written notice of the fair hearing rights (see criterion 2.3).

3. Score as (+) if the regional center representative, and the individual or, where appropriate, their parents, legal guardian, or conservator or authorized representative, have signed the IPP prior to its implementation.

4. Score as (-) if the regional center representative, and the individual or, where appropriate, their parents, legal guardian, conservator or authorized representative have not signed the IPP prior to its implementation. Comment on what is missing.

2.7.b IPP addenda are signed by an authorized representative of the regional center and the individual or, where appropriate, the individual's parents, legal guardian, conservator or authorized representative. *[W.I.C. § 4646(g) (2023)]; [42 C.F.R. § 441.301(c)(2)(ix) (2025)]*

Explanation

An IPP addendum is required whenever there is a new or changing assessed need, goal, service or other significant life event. The planning team makes the determination about changes or additions. The addendum becomes a part of the IPP. Signatures of the planning team and/or documentation of agreement are required prior to its implementation.

Verification Instructions

1. Score as (+) if the regional center representative, and the individual or, where appropriate, their parents, legal guardian, conservator or authorized representative, have signed the IPP addendum or there is documentation of planning team agreement prior to its implementation.

2. Score as (-) if the regional center representative, and the individual or, where appropriate, their parents, legal guardian, conservator or authorized representative, have not signed the IPP addendum or there is no documentation of planning team agreement. Comment on what is missing.

3. Score as (NA) if there are no IPP addendums for the review period.

2.8 The IPP includes a description of short and long-term visions based on the needs, preferences, and life choices of the individual. *[W.I.C. § 4646.5(a)(2) (2023)]*

Explanation

Visions should reflect what is important to the individual and help the individual develop objectives that provide opportunities in their community for work, leisure, housing, education, community participation and/or health.

Verification Instructions

1. Score as (+) if the IPP contains a description of short and/or long-term visions that address the individual's needs, preferences and life choices.

2. Score as (-) if the IPP does not contain a description of short and/or long-term visions that address the individual's needs, preferences and life choices. Comment on what is missing.

2.9 The IPP addresses all of the individual's goals and needs. The person-centered service plan must reflect the services and supports that are important for the individual to meet the needs identified through an assessment of functional need, as well as what is important to the individual with regard to preferences for the delivery of such services and supports. [*W.I.C. § 4646.5(a)(2) (2023)], [42 C.F.R. § 441.301(c)(2) (2025)]; (HCBS Waiver Requirement)*

Explanation

The IPP must address the individuals' assessed needs. The IPP must reflect the supports and services that will assist individuals to achieve their goals and should also identify the provider or providers of those services, paid or unpaid.

2.9.a The IPP addresses the assessed needs identified in the CDER and the DS 3770. *[42 C.F.R. § 441.301(c)(2)(iii) (2025)] (HCBS Waiver Requirement)*

Explanation

Verification Instructions

1. Review the individuals' assessed needs identified in the CDER. Assess and determine if the IPP includes services and supports for the assessed needs, and/or if there is documentation indicating that any of the needs are not a current priority for the individual.

2. Score as (+) if the IPP includes services and supports that address the individual's assessed needs identified in the CDER and the support provided for the level of need consistent with the CDER.

3. Score as (-) if the IPP does not contain services and supports to address any or all of the individual's assessed needs, or it has been documented that the need is not a current priority for the individual. Comment on what is missing.

4. Score as (N/A) if the CDER does not identify any assessed needs.

2.9.b The IPP addresses special health care requirements and safety risks. *[42 C.F.R. § 441.301(c)(2)(vi) (2025)]; (HCBS Waiver Requirement)*

Verification Instructions

1. Review the Client Development Evaluation Report (CDER) and the DS 3770 for any special health care requirements and/or safety risks. Review other information in the record for health status and safety risks. For the purposes of this criteria health status and needs may include current major health conditions that require ongoing treatment, monitoring or medication and safety risk that may require the need for additional monitoring and support.

2. Score as (+) if the individual has any identified special health care conditions and/or current major health conditions and/or safety risks and the IPP contains services and/or supports for the providers and/or regional center to address and/or follow up with them.

3. Score as (-) if the individual has any identified special health care conditions and/or current major health conditions, and/or safety risks and the IPP does not contain services and supports to address them. Comment on what is missing.

4. Score as (NA) if the individual does not have any identified special health care conditions, current major health conditions, or safety risks.

2.9.c The IPP reflects the services and supports that will assist the individual to achieve identified goals, and the providers of those services and supports. The administrator for each service level 2 and 3 facility shall be responsible for ensuring the preparation and maintenance of a written semi-annual report of progress toward achievement of each IPP objective for which the facility is responsible. The administrator for each service Levels 4 - 7 facility shall be responsible for ensuring the preparation and maintenance of a written quarterly report of progress toward achievement of each IPP objective for which the facility is responsible. *[42 C.F.R. § 441.301(c)(2)(v) (2025)]; [Cal. Code. Regs tit. 17, 56026(b)(c) (2023)]*

Explanation

The IPP is the document that drives the services and supports for individuals and should reflect the supports the CCF is responsible for providing.

Verification Instructions

1. Score as (+) if the IPP contains services and supports that meet the individual's service needs for which the CCF provider is responsible.

2. Score as (-) if the IPP does not contain specific services and supports for the CCF provider. Comment on which of the needs are not addressed.

3. Score as (NA) if the individual does not live in a CCF.

2.9.d The IPP reflects the services and supports that will assist the individual to achieve identified goals, and the providers of those services and supports. The vendor shall be responsible for establishing, maintaining, and modifying, as necessary, documentation regarding the manner in which it will assist each individual in achieving the individual's IPP objective(s) for which the vendor is responsible. *[42 C.F.R. § 441.301(c)(2)(v) (2025)]; [Cal. Code. Regs tit. 17, 56720(a) (2023)]*

Explanation

The IPP is the document that drives the services and supports for individuals and should reflect the supports the day program is responsible for providing.

Verification Instructions

1. Score as (+) if the IPP contains services and supports that meet the individual's service needs for which the day program provider is responsible.

2. Score as (-) if the IPP does not contain specific services and supports for the day program provider or, if applicable; the IPP does not identify areas for the individual service plan to address. Comment on which of the needs are not addressed.

3. Score as (NA) if the individual does not receive day program services.

2.9.e The IPP reflects the services and supports that will assist the individual to achieve identified goals for which the independent living service (ILS) or supported living service (SLS) agency is responsible. *[42 C.F.R. § 441.301(c)(2)(v) (2025)]*

Explanation

The IPP is the document that drives the services and supports for individuals and should reflect the supports the ILS and SLS agency is responsible for providing.

Verification Instructions

1. Score as (+) if the IPP contains services and supports that meet the individual's service needs for which the supported living or independent living agency is responsible

2. Score as (-) if the IPP does not contain specific services and supports for the supported living agency or independent living agency. Comment on which of the needs are not addressed.

3. Score as (NA) if the individual does not receive supported living services or independent living services.

2.9.f A statement of goals, based on the needs, preferences, and life choices of the individual with developmental disabilities, and a statement of specific, time-limited objectives for implementing the person's goals and addressing the person's needs. These objectives shall be stated in terms that allow measurement of progress or monitoring of service delivery. These goals and objectives should maximize opportunities for the individual to develop relationships, be part of community life in the areas of community participation, housing, work, school, and leisure, increase control over the individual's life, acquire increasingly positive roles in community life, and develop competencies to help accomplish these goals. *[W.I.C. § 4646.5(a)(2) (2023)]*

Verification Instructions

1. Review the vision statement that reflects preferences, needs and life choices in the individual's IPP.

2. Score as (+) if the IPP addresses the individual's identified needs, preferences and life choices.

3. Score as (-) if the IPP does not address the individual's identified needs, preferences and life choices. Comment on which of the needs, preferences and/or life choices are not addressed.

2.9.g When children with developmental disabilities live with their families, the individual program plan shall include a family plan component which describes those services and supports necessary to successfully maintain the child at home. Regional centers shall consider every possible way to assist families in maintaining their children at home, when living at home will be in the best interest of the child, before considering out-of-home placement alternatives. *[W.I.C. § 4685(c)(2) (2023)]*

Explanation

The family plan component describes those services and supports necessary to successfully maintain the child at home.

Verification Instructions

1. Score as (+) if the individual is under 18, lives with family and the IPP includes a family plan component.

2. Score as (-) if the individual is a minor and the IPP does not include a family plan component.

3. Score as (NA) if the individual is 18 or older.

2.9.h Regional centers shall implement the standardized individual program plan template and procedures no later than January 1, 2025. *[W.I.C. § 4435.1(d)]*

Explanation

As of January 1, 2025, regional centers are required to use the Standardized Individual Program Plan (SIPP), all of its components and in accordance with the developed procedures for all newly developed individual program plans (IPPs).

Verification Instructions

1. Score as (+) if the individual's IPP is the SIPP and includes all the required components.

2. Score as (-) if the individual's IPP is not the SIPP or if some of the required components are missing. Comment on what is missing.

3. Score as (NA) if the individual's IPP was completed prior to January 1, 2025.

2.10.a The IPP includes a schedule of the type and amount of all services and supports purchased by the regional center. *[W.I.C. § 4646.5(a)(5) (2023)]; [42 C.F.R. § 441.301(c)(2)(v) (2025)]*

Explanation

The IPP is required to describe all of the services and supports that help to achieve goals and objectives determined by the planning team. The IPP establishes the authority for regional centers to arrange and fund needed services and supports when there is no other source of funding. The schedule, type and amount of service and support is required to be on the IPP Agreement and Signature Form.

Verification Instructions

1. Review the billing reports for billed and unbilled services and/or supports reported to the Department. Review the current POS authorizations in the individual's record.

2. Score as (+) if the IPP identifies the type and amount of all services and supports purchased by the regional center for the review period.

3. Score as (-) if the IPP does not identify the type and amount of all services and supports purchased by the regional center for the review period. Comment on which services and/or supports are not identified in the IPP for the review period but were purchased by the regional center.

2.10.b The IPP includes a schedule of the type and amount of all services and supports obtained from generic agencies or other resources. *[W.I.C. § 4646.5(a)(5) (2023)]; [42 C.F.R. § 441.301(c)(2)(v) (2025)]*

Verification Instructions

1. Review the record for documentation of all services or supports that are obtained from generic agencies or other non-regional center sources such as the Department of Rehabilitation, Medi-Cal, a school district, private health care insurance, etc.

2. Score as (+) if the IPP identifies the type and amount of all services and supports being obtained from generic agencies or other resources as documented in the record.

3. Score as (-) if the IPP does not identify the type and amount of all services and supports obtained from generic agencies or other resources that are documented in the record. Comment on which services and supports are not identified in the IPP but are documented in the record.

2.10.c The IPP, or addenda, specifies the approximate scheduled start date for new services and supports purchased by the regional center. *[W.I.C. § 4646.5(a)(5) (2023)]*

Explanation

It is important for an individual's IPP or addenda to have the timelines necessary to begin a service. Any agreed upon service should specify the scheduled start date.

Verification Instructions

1. Score as (+) if the IPP or addenda specify an approximate scheduled start date for new services and supports.

2. Score as (-) if the IPP or addenda do not specify a scheduled start date for new services and supports.

3. Score as (NA) if the IPP or addenda do not contain new services and supports.

2.11 The IPP or addenda identifies the provider or providers of service responsible for implementing services and/or support, including, but not limited to, vendors, contracted providers, generic service agencies, and natural supports. *[W.I.C. § 4646.5(a)(5) (2023)]; [42 C.F.R. § 441.301(c)(2)(v) (2025)]*

Explanation

It is required that an individual's IPP or addenda identifies the provider responsible for the services and supports. This information is required to be on the IPP Agreement and Signature Form.

Verification Instructions

1. Score as (+) if the IPP or addenda identifies the provider or providers of service responsible for implementing services and/or support.

2. Score as (-) if the IPP or addenda does not identify the provider or providers of service responsible for implementing services and/or support. Comment on which providers of service and/or support are not identified in the IPP.

2.11.a (SDP only) A copy of the spending plan attached to the participant's IPP. *[W.I.C. § 4685.8(c)(7) (2023)].*

Verification Instructions

1. Score as (+) if the IPP or individual record contains a spending plan.

2. Score as (-) if the IPP or individual record does not contain a spending plan.

2.11.b (SDP only) The spending plan shall identify the cost of each good, service, and support that will be purchased with regional center funds. The total amount of the spending plan cannot exceed the amount of the individual budget. *[W.I.C. § 4685.8(c)(7) (2023)]*

Verification Instructions

1. Score as (+) if the spending plan does not exceed the amount of the certified budget, and the spending plan identifies the cost of each good, service, and support that will be purchased with regional center funds.

2. Score as (-) if the spending plan exceeds the amount of the certified budget, and the spending plan does not identify the cost of each good, service, and support that will be purchased with regional center funds.

2.11.c (SDP only) The IPP team determines that an adjustment to this amount is necessary due to a change in the participant's circumstances, needs, or resources that would result in an increase or decrease in purchase of service expenditures, or the IPP team identifies prior needs or resources that were unaddressed in the IPP, which would have resulted in an increase or decrease in purchase of service expenditures. When adjusting the budget, the IPP team shall document the specific reason for the adjustment in the IPP. *[W.I.C. § 4685.8(m)(1)(A)(ii)(I) (2023)]*

Explanation

The individual budget must be the total amount of the prior year's purchase of service (POS) expenditures. If an adjustment is made to the amount in the approved budget which increases or decreases the budget because of the

participant's circumstances, needs, or resources, the reason the adjustment was made is required to be documented in the IPP or in an addendum.

Verification Instructions

1. Score as (+) if the budget was adjusted within the budget year and the IPP or addenda specify justification for change in circumstance, change of resource or natural supports.

2. Score as (-) if the budget was adjusted within the budget year and the IPP or addenda do not specify justification for change in circumstance, change of resource or natural supports.

3. Score as (NA) if the individual budget was not changed within the budget year.

2.11.d (SDP only) Transfers in excess of 10 percent of the original amount allocated to any budget category may be made upon the approval of the regional center or the participant's IPP team. (Living Arrangement (SC 310-330); Employment & Community (SC 331-355); and Health and Safety (SC 356-399)) within the budget year. *[W.I.C. § 4685.8(n) (2023)].*

Verification Instructions

1. Score as (+) if the IPP or addenda documents IPP team approval.

2. Score as (-) if IPP or addenda does not document IPP team approval.

3. Score as (NA) if there were no individual budget transfers in excess of 10% within the budget year.

2.11.e (SDP only) Non-licensed/non-certified providers, including providers vendored by the regional center, initially and continually meet all required standards as outlined in the SDP Waiver and Department directives as verified by the Financial Management Services (FMS) vendored provider. *[W.I.C. § 4685.8(c)(1), (e), (v) (2023)], (HCBS Waiver Requirement)*

Explanation

FMS providers are required to assist the SDP participant in verifying provider qualifications in accordance with the approved SDP Waiver, including criminal background checks for those persons providing direct personal care. The review for this monitoring criterion requires a review of FMS files.

Verification Instructions

1. Review the qualifications for each non-licensed/non-certified provider identified in the participants spending plan for the review period and verify if each provider meets required standards and qualifications, including a background check for those who provide direct personal care. A (+) or (-)

will be scored for as many identified providers as are in the spending plan used. For example, the participant's spending plan has 3 non-licensed/non-certified providers. If 2 of the 3 providers met the required standards, the scoring would be 2 (+) and 1 (-) or 2/3.

2. Score as (+) for each non-licensed/non-certified provider, including providers vendored by the regional center, identified in the participant's most recent spending plan within the review period where the FMS has supporting documentation that the provider meets required standards in accordance with the SDP Waiver and SDP laws.

3. Score as (-) for each non-licensed/non-certified provider, including providers vendored by the regional center, identified in the participant's most recent spending plan within the review period where the FMS does not have supporting documentation to indicate the provider meets required standards in accordance with the SDP Waiver and SDP laws. Comment on what documentation is missing.

4. Score as N/A if the SDP participant has only licensed/certified providers in the spending plan being reviewed.

2.12.a Quarterly face-to-face meetings are completed with individuals living in community out-of-home settings, i.e., Service Level 2-7 CCFs family home agencies (FHA), or supported living and independent living settings. *[Cal. Code. Regs tit. 17, § 56047 (2023)]; [Cal. Code. Regs tit. 17, § 56095 (2023)]; [Cal. Code. Regs tit. 17, § 58680 (2023)]; (Contract requirement)*

Verification Instructions

1. Score as (+) if the individual lives in a Service Level 2-7 CCF, (FHA), SLS or ILS setting, and all four quarterly face-to-face meetings with the individual and the regional center service coordinator were completed within the required timeframes.

2. Score as (-) if the individual lives in a Service Level 2-7 CCF, FHA, or SLS or ILS setting, and quarterly face-to-face meetings were not completed within the required timeframes. Comment on which of the quarters are not documented.

3. Score as (NA) if the individual does not live in a Service Level 2-7 CCF, FHA, SLS or ILS setting.

2.12.b Quarterly reports of progress toward achieving IPP objectives are completed for individuals living in community out-of-home settings, i.e., service Level 2-7 CCF, family home agencies (FHA), or supported living and independent living settings. *[Cal. Code. Regs tit. 17, § 56047 (2023)]; [Cal.*

Code. Regs tit. 17, § 56095 (2023)]; [Cal. Code. Regs tit. 17, § 58680 (2023)]; (Contract requirement)

Verification Instructions

1. Score as (+) if the individual lives in a Service Level 2-7 CCF, FHA, SLS or ILS setting, and all four quarterly reports documenting progress toward achieving the IPP objectives for which the facility is responsible are documented.

2. Score as (-) if the individual lives in a Service Level 2-7 CCF, FHA, SLS or ILS setting, and less than four quarterly reports of progress were completed. Note the quarterly report dates. the total number of expected reports and the dates of the missing reports.

3. Score as (NA) if the individual does not live in a Service Level 2-7 (CCF),FHA, SLS or ILS setting.

2.13 Face-to-face reviews are completed, no less than once every 30 days for the first 90 days, following the individual's move from a developmental center to a community living arrangement. *[W.I.C. § 4418.3 (2023)]*

Verification Instructions

1. Score as (+) if the Title 19 notes, or other documentation, indicates that the individual has been seen every 30 days in the first 90 days, after moving from a developmental center to a community living arrangement. In the comment section note the actual number of visits and the total number of expected visits (three).

2. Score as (-) if there is no documentation indicating that the individual has been seen every 30 days within the 90-day period. Comment on which instances are missing.

3. Score as (NA) if the individual has not moved from a developmental center during the review period.

SECTION III

COMMUNITY CARE FACILITY RECORD REVIEW

Purpose

The Home and Community-Based Services (HCBS) Waiver review follows individuals into the community to assure that: they are living in safe environments; their health is safeguarded; they are receiving the services on their Individual Program Plans (IPPs); they are being treated with respect and dignity; they have been informed of and understand their rights; and they have choices in their day-to-day activities. The information from the review of the individual regional center records is used as a baseline for the community care facility (CCF) record review. The report to the regional center will address those areas where there were negative findings.

The review criteria in Section III address the CCF requirements for maintaining records for individuals and preparing written reports of progress toward achievement of IPP services for which the facility is responsible. The criteria are derived from Title 17 California Code of Regulations, from Title 42 in Code of Federal Regulations, and from the HCBS Waiver requirements. Each criterion is followed by verification instructions for determining compliance.

Criterion

3.1 The CCF maintains a record for the individual that includes the documents and information specified in Title 17 and Title 42. *[Cal. Code. Regs tit. 17, § 56017(b) (2023)]; [Cal. Code. Regs tit. 17, § 56059(b) (2023)]; [42 C.F.R. § 441.301(c)(4)(iii) (2025)]*

Explanation

CCFs are required to maintain a record for each individual. The focus of the review is to assure that the individual is in a setting that can meet his or her ambulatory, health, safety and behavioral needs; is equipped with basic information to identify the individual to others in the event of an emergency; and current emergency notification information (i.e., family, physician, etc).

3.1.a The individual's record contains a statement of ambulatory or non-ambulatory status. *[Cal. Code. Regs tit. 17, § 56017(b)(3) (2023)]*

Verification Instructions

1. Score as (+) if the record contains a statement of ambulatory status.

2. Score as (-) if the record does not contain a statement of ambulatory status.

3.1.b The individual's record contains known information related to any history of aggressive or dangerous behavior toward self or others. *[Cal. Code. Regs tit. 17, § 56017(b)(5) (2023)]*

Verification Instructions

1. Score as (+) if the individual has a history of aggressive/dangerous behavior and information is contained in the record

2. Score as (-) if the individual has a history of aggressive/dangerous behavior and information is not contained in the record. .

3. Score as (NA) if the individual does not have a history of aggressive or dangerous behavior.

3.1.c The individual's record contains current health information that accurately describes and addresses the individual's medical, dental and other health conditions that require ongoing treatment, monitoring and/or medication. *[Cal. Code. Regs tit. 17, § 56017(b)(7) (2023)]*

Verification instructions

1. Score as (+) if the record contains current health information that accurately describes and addresses the individual's medical, dental and other health conditions that includes annual visit dates, physician orders, medications, allergies and other relevant information.

2. Score as (-) if the record does not contain information that accurately describes and addresses the individual's medical, dental and other health conditions or the information is not current (within the last year). Comment on what is missing.

3.1.d The individual's record contains current emergency information including the names and phone numbers for medical and dental providers, pharmacies, family members, conservators, legal representatives, etc. *[Cal. Code. Regs tit. 17, § 56059(b)(1) (2023)]*

Verification Instructions

1. Score as (+) if the record contains current emergency information.

2. Score as (-) if the record does not contain emergency information. Comment on what is missing.

3.1.e The individual's record contains a recent photograph and a physical description of the individual. *[Cal. Code. Regs tit. 17, § 56059(b)(2) (2023)]*

Verification Instructions

1. Score as (+) if the record contains a recent photograph and a complete physical description of the individual that includes height, weight, eye and hair color, eyeglasses, prominent marks, etc.

2. Score as (-) if the record is missing a recent photograph and/or physical description. Comment if the photograph is not recent and/or if the physical description does not include specific information regarding all of the individual's physical and distinguishing characteristics.

3.1.f The individual's record identifies and addresses the special safety and behavior needs of the individual. *[Cal. Code. Regs tit. 17, § 56017(b)(6) (2023)]*

Explanation

Some individuals have behaviors or health conditions that create a need for enhanced safety measures in the residence. The behaviors or health conditions should be identified in the regional center record and in the CCF record. Some examples are absent without leave behaviors, tendencies to choke on food, lack of awareness about street crossing, etc.

Verification Instructions

1. Review the functional capabilities description, IPP and other information in the CCF record and ongoing notes to identify special safety and behavior needs.

2. Score as (+) if the individual has special safety and/or behavior needs that are identified and addressed in the record.

3. Score as (-) if the individual has identified safety and/or behavior needs that are not addressed in the record. Comment on what information is missing.

4. Score as (NA) if the individual does not have special safety and/or behavior needs.

3.1.g There is documentation that the individual has been informed of their rights to privacy, dignity and respect as well as freedom from coercion and restraint. *[42, CFR, § 441.301(c)(4)(iii) (2025)]*

Verification Instructions

1. Score as (+) if there is documentation the individual has been informed their rights, which includes right to privacy dignity and respect, freedom from coercion and restraint.

2. Score as (-) if there is no documentation that individual has been informed of their rights which includes right to privacy dignity and respect, freedom from coercion and restraint.

3.2.a A written admission agreement is completed for the individual that is signed by the individual or their authorized representative, the regional center, the facility administrator that includes the certifying statements: No objection has been made to admission of the individual to the facility; The individual or the individual's authorized representative has been informed of the individual's rights as defined in Title 17 Section 56002; and the individual has a continuing right, which will be honored by all facility staff, to choose where they will live. *[Cal. Code. Regs tit. 17, § 56019(c)(1) (2023)]*

Explanation

The admission agreement is reviewed to verify that the individual chose to live in the facility and retains the right to change their living arrangement, the individual has been informed of their rights as defined in Cal. Code. Regs tit. 17, § 56002(a)(8), and that the individual has a right to choose where they live.

Verification Instructions

1. Score as (+) if there is an admission agreement that is signed by the facility administrator, the regional center and the individual or the individual's authorized representative, and includes statements certifying that:
    a. No objection has been made to the admission of the individual;
    b. The individual or authorized representative has been informed of the individual's rights defined in *Cal. Code. Regs tit. 17, §* 56002(a)(8); **and**
    c. The individual has a continuing right, which will be honored by all facility staff, to choose where they will live; **and**
2. Score as (-) if:
    a. there is no admission agreement, the agreement is not signed the facility administrator, the regional center and the individual or the individual's authorized representative, **or**
    b. one or more of the statements a. - c. under #1 is not included in the agreement. Comment on what is missing.

3.2.b In a provider-owned or controlled residential setting, the unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the State, county, city, or other designated entity. For settings in which landlord tenant laws do not apply, the State must ensure that a lease, residency agreement or other form of written agreement will be in place for each

HCBS participant, and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law. *[42, CFR, § 441.301(c)(4)(vi)(A) (2025)]*

Explanation

Individuals who reside in a provider owned facility have protections from eviction and the admission agreement, or other document, must include eviction and appeals processes.

Verification Instructions

1. Review the Admissions Agreement, lease agreement, or residential Agreement to verify there is documentation of agreement that includes eviction procedures and appeals process that are comparable to the jurisdiction's landlord tenant law.

2. Score as (+) There is documentation for eviction and appeals processes. If the admission agreement does not include eviction and appeals process, look for a lease, residency agreement, or other documentation that includes eviction and appeals processes.

3. Score as (-) if: There is no documentation for eviction procedure and appeals processes.

3.3 The facility has a copy of the individual's current IPP. *[Cal. Code. Regs tit. 17, § 56017(b)(1) (2023)]; [Cal. Code. Regs tit. 17, § 56022(c) (2023)]*

Verification Instructions

1. Compare the date of the facility's most recent copy of the individual's IPP and any addendums, if applicable, with the date of the most recent IPP and addendums that were found in the individual's regional center record. Review the date and signatures for the IPP planning team meeting that developed, reviewed, or revised the IPP.

2. Score as (+) if the facility has a copy of the individual's current IPP and any addendums.

3. Score as (-) if the facility does not have a copy of the individual's most recent IPP or addendums.

3.4. Service Level 2 and 3 facilities prepare and maintain written semiannual reports of the individual's progress. Semi-annual reports address and confirm the individual's progress toward achieving each of the IPP

objectives for which the facility is responsible. *[Cal. Code. Regs tit. 17, § 56026(b) (2023)]*

Verification Instructions

1. Score as (+) if the individual lives in a Service Level 2 or 3 facility and the provider prepares and maintains written semiannual reports of the individual's progress and the reports include date of completion of the report and the signature of the person preparing the report.

2. Score as (-) if

   a) the reports have not been completed semiannually and comment on which report periods are missing; **or**

   b) there are semiannual reports but one or more of the components in #2 above is missing. comment on what is missing.

3. Score as (NA) if the individual does not live in a Service Level 2 or 3 facility or the IPP does not identify objectives for which the facility is responsible.

3.5.a Service Level 4-7 facilities prepare and maintain written quarterly reports of the individual's progress that are completed within 30 days of the end of the quarter. *[Cal. Code. Regs tit. 17, § 56026(c) (2023)]*

Verification Instructions

1. Score as (+) if

   a) the individual lives in a Service Level 4-7 facility and the provider prepares and maintains quarterly reports of the individual's progress; **and**

   b) the individual's progress toward achievement of the specific IPP/behavior plan objectives for which the facility is responsible; **and**

   c) identification of barriers to individual progress and actions taken in response to these barriers; **and**

   d) the reports include date of completion of the report and the signature of the person preparing the report.

2. Score as (-) if

   a) the reports have not been completed quarterly and comment on which quarters are missing; **or**

b) there are quarterly reports but one or more of the components in #2above is missing. comment on what is missing.

3. Score as (NA) if the individual does not live in a Service Level 4-7 facility or the IPP does not identify objectives for which the facility is responsible.

3.5.b Quarterly reports include a summary of data collection for target behaviors. *[Cal. Code. Regs tit. 17, § 56026(c)(1) (2023)]*

Verification Instructions

1. Score as (+) if a data collection system is maintained and the quarterly report summarizes the data for the target behaviors.

2. Score as (-) if there is no data being collected and summarized for the target behaviors. Comment if the original or previous quarter's base lines cannot be determined.

3. Score as (NA) if there are no IPP/behavior plan target behaviors.

3.6. The facility prepares and maintains ongoing, written notes for individuals. *[Cal. Code. Regs tit. 17, § 56026(a) (2023)]*

Verification Instructions

1. Score as (+) if there are ongoing, up-to-date written notes for the individual that document the following activities and situations, if applicable:

   a. Community and leisure activities;

   b. Overnight visits away from the facility;

   c. Illness;

   e. SIRs, as defined in *Cal. Code. Regs tit. 17*, § 54327(b);

   f. Medical and dental visits; and

   g. The date and signature of the staff person making the entry.

2. Score as (-) if ongoing notes are not being maintained. Comment if the notes are not up-to-date, or if any of the applicable activities or situations under #1 a. - g. are not being documented.

3.7a Special incidents are reported to the regional center within 24 hours after learning of the occurrence of the special incident. *[Cal. Code. Regs tit. 17, § 54327(f) (2023)]*

Verification Instructions

1. Review the special incident reports (SIRs) that meet the Title 17 definition of reportable incidents completed by the CCF during the past 12 months. Interview the service provider and review available documentation determine when the facility reported the incident to the regional center. If possible, verbally verify the information with the regional center.

2. Score as (+) if the CCF reported the incident to the regional center within 24 hours after learning of the occurrence of the special incident. Comment on how this was determined, e.g., date in the SIR, notes documented for individuals, or service provider's statement. Identify the type of incident on the rating sheet.

3. Score as (-) if not reported within 24 hours. Comment on how this was determined, and if reported late or not reported. Identify the type of incident on the rating sheet.

4. Score as (NA) if there were not SIRs that met the Title 17 definitions for reportable incidents during the past 12 months.

3.7.b A written report of the special incident is submitted to the regional center within 48 hours after the occurrence of the special incident. *[Cal. Code. Regs tit. 17, § 54327(g) (2023)]*

Verification Instructions

1. Score as (+) if the CCF submitted a written SIR to the regional center within 48 hours after the occurrence of the special incident. The CCF may submit to the regional center a copy of the report submitted to Community Care Licensing if the report contains all of the information specified in *Cal. Code. Regs tit. 17,* § 54327(b)(1) through (e)(10).

2. Score as (-) if a written report was not submitted within 48 hours. Comment on whether the report was late, never submitted, or never received by the regional center.

3. Score as (NA) if there were no SIRs that met the Title17 definitions for reportable incidents during the past 12 months.

SECTION IV

DAY PROGRAM RECORD REVIEW

Purpose

The Home and Community-Based Services (HCBS) Waiver review follows individuals into the community to assure that: they are receiving the services on their Individual Program Plan (IPPs); being treated with respect and dignity; they have been informed of and understand their rights; and that their health is safeguarded. The information from the review of regional center records for individuals is used as a baseline for the day program record review. The report to the regional center will address those areas where there were negative findings.

The review criteria in Section IV address the day program requirements for maintaining records for individuals and preparing written reports of progress toward achievement of IPP services for which the program is responsible. The criteria are derived from Title 17 California Code of Regulations, from Title 42, Code of Federal Regulations, and from the HCBS Waiver requirements. Each criterion is followed by verification instructions for determining compliance.

Criterion

4.1. The day program maintains a record for each individual that includes the documents and information specified in Title 17. *[Cal. Code. Regs tit. 17, § 56730) (2023)]*

Explanation

Day programs are required to maintain a record for each individual. The focus of the review is to assure that the individual is in a setting that can meet his or her health, safety and behavioral needs; is equipped with basic information to identify the individual to others in the event of an emergency; current emergency notification information (i.e., family, physician, etc.); and progress toward the IPP objectives.

4.1.a The individual's record contains current emergency and personal identification information including the individual's address and telephone number; the names and telephone numbers of the residential care provider, relatives, and/or guardian or conservator; physician's name(s) and telephone number(s); pharmacy name, address and telephone number; and health plan, if appropriate. *[Cal. Code. Regs tit. 17, § 56730(c)(1)(A) (2023)]*

Verification Instructions

1. Score as (+) if the record contains current emergency and personal identification information

2. Score as (-) if the record does not contain complete information or if the information is not current (within the last year). Comment on what is missing.

4.1.b. The individual's record contains current health information that includes medical, dental and other health or safety needs of the individual including current medications, known allergies, medical diagnosis, infectious, contagious, or communicable conditions, special nutritional needs, and immunization records. *[Cal. Code. Regs tit. 17, § 56730(c)(1)(B) (2023)]*

Verification Instructions

1. Score as (+) if the record contains current health information

2. Score as (-) if the record does not contain complete information or if the information is not current (within the last year). Comment on what is missing.

4.1.c The individual's record contains psychological, social, or medical evaluations provided by the regional center that identify the individual's ability and functioning level. *[Cal. Code. Regs tit. 17, § 56730(c)(1)(C) (2023)]*

Verification Instructions

1. Score as (+) if the record contains one or more of the evaluations, including the Client Development Evaluation Report.

2. Score as (-) if the record does not contain any evaluations. Comment on any of the types of evaluations that are missing, but present in the regional center record for the individual.

4.1.d. The individual's record contains authorization for emergency medical treatment signed by the individual and/or the authorized representative of the individual. *[Cal. Code. Regs tit. 17, § 56730(c)(1)(D) (2023)]*

Verification Instructions

1. Score as (+) if the record contains a signed authorization for emergency medical treatment.

2. Score as (-) if the record does not contain a signed authorization.

3. Score as (NA) if the program is provided at a work site such as, work activity program or supported employment.

4.1.e The individual's record contains documentation that the individual and/or the authorized representative for the individual has been informed of his/her personal rights including an individual's rights of privacy, dignity and respect, and freedom from coercion

and restraint. *[Cal. Code. Regs tit. 17, § 56730(c)(1)(E) (2023)]; [42 C.F.R. § 441.301(c)(4)(iii) (2025)]*

Verification Instructions

1. Score as (+) if the record contains documentation that the individual has been informed of his/her rights.

2. Score as (-) if the record does not contain documentation that the individual has been informed of their rights.

4.1.f The individual's record includes data collection for IPP objectives. *[Cal. Code. Regs tit. 17, § 56730(c)(2)(C) (2023)]*

Verification Instructions

1. Score as (+) if the day program maintains copies of data collected that measures the individual's progress towards achieving IPP objectives, e.g., narrative notes, skills and task analysis charting, behavior frequency counts, etc.

2. Score as (-) if the day program does not maintain copies of data collected or the data is not up to date. Comment on what is missing or if the data is not up to date.

4.1.g The individual's record contains case notes reflecting important events or information not documented elsewhere. *[Cal. Code. Regs tit. 17, § 56730(c)(2)(B) (2023)]*

Verification Instructions

1. Score as (+) if the day program maintains up-to-date case notes.

2. Score as (-) if the day program does not maintain case notes collected or if the notes are not up to date. Comment on what is missing.

4.2 The day program has a copy of the individual's current IPP. *[Cal. Code. Regs tit. 17, § 56730)(c)(1)(F) (2023)]*

Verification Instructions

1. Compare the date of the day program's most recent copy of the individual's IPP and any addendums, if applicable, with the date of the most recent IPP and addendums found in the individual's regional center record. Review the date and signatures for the IPP planning team meeting that developed or revised the IPP.

2. Score as (+) if the day program has a copy of the individual's most recent IPP and any addendums.

3. Score as (-) if the day program does not have a copy of the individual's most recent IPP.

4.3. The day program develops, maintains, and modifies, as necessary, documentation regarding the manner in which it will assist the individual in achieving the IPP/individual service plan (ISP) objectives for which the day program is responsible and is consistent with the individual's IPP objectives for which the day program is responsible. *[Cal. Code. Regs tit. 17, § 56720)(a)(b) (2023)]*

Verification Instructions

1. Score as (+) if the day program maintains documentation regarding the manner in which it will assist the individual in achieving the IPP/ISP objectives for which the day program is responsible. This documentation includes, but is not limited to, ISPs, task analysis, skills-training curriculum, classroom lesson plans, and/or behavior plans and is consistent with the IPP objectives for which the day program is responsible.

2. Score as (-) if there is no specific program plan(s) or other documentation describing how the day program will assist the individual in achieving the IPP/ISP objectives or if the IPP identifies day program objectives that are different from the ones contained in the ISP.

3. Score as (NA) if the IPP does not identify objectives for which the day program is responsible.

4.4. The day program prepares and maintains written semiannual reports of the individual's performance and progress and address the individual's performance and progress toward achieving each of the IPP objectives for which the day program is responsible. *[Cal. Code. Regs tit. 17, § 56720(c)(1) (2023)]*

Verification Instructions

1. Score as (+) if the day program prepares and maintains written semiannual reports of the individual's performance and progress and addresses specific IPP objectives for which the day program is responsible.

2. Score as (-) if

   a) the reports have not been completed semiannually and comment on which report periods are missing; **or**

   b) there are semiannual reports does not address specific IPP objectives for which the day program is responsible. Comment on what is not being addressed.

3. Score as (NA) if the IPP does not include objectives for which the day program is responsible.

4.5.a Special incidents are reported to the regional center within 24 hours after learning of the occurrence of the special incident. *[Cal. Code. Regs tit. 17, § 54327(f) (2023)]*

Verification Instructions

1. Review the special incident reports (SIRs) that meet the Title 17 definition of reportable incidents completed by the day program during the past 12-months. Interview the service provider and review available documentation to determine when the day program reported the incident to the regional center. If possible, corroborate with information from the regional center.

2. Score as (+) if the day program reported the incident to the regional center within 24 hours after learning of the occurrence of the special incident. Comment on how this was determined, e.g., date in the SIR, notes in the record for the individual, or service provider's statement. Identify the type of incident in the rating sheet table.

3. Score as (-) if not reported within 24 hours. Comment on how you determined this and if reported late or not reported. Identify the type of incident in the rating sheet table.

4. Score as (NA) if there were no SIRs that meet the Title 17 definitions for reportable incidents during the past 12-months.

4.5.b A written report of the special incident is submitted to the regional center within 48 hours after the occurrence of the special incident. *[Cal. Code. Regs tit. 17, § 54327(g) (2023)]*

Verification Instructions

1. Score as (+) if the day program submitted a written SIR to the regional center within 48 hours after the occurrence of the special incident. The day program may submit to the regional center a copy of the report submitted to Community Care Licensing if the report contains all of the information specified in *Cal. Code. Regs tit. 17,* § 54327(b)(1) through (e)(10).

2. Score as (-) if a written report was not submitted within 48 hours. Comment on whether the report was late, never submitted, or never received by the regional center.

3. Score as (NA) if there were no SIRs that meet the Title 17 definitions for reportable incidents during the past 12-month.

SECTION V

INTERVIEWS WITH INDIVIDUALS RECEIVING SERVICES

Purpose

Interviews

Individuals are interviewed by the monitoring team at the day programs, residential homes or a community location of their choosing. The interviews are conducted with individuals who are willing to participate to capture the individual's feelings about their own life. The interview questions are designed to elicit information about the individual's satisfaction with their living arrangements, school, work or day program and the people who support them daily. In addition, the interview seeks to understand if the individual has opportunities to engage in their community, make choices about the services and supports they receive, spend time with friends, make choices about the food they eat, and the recreational opportunities they engage in. The interview also seeks to understand if they feel supported by the regional center, safe, healthy and treated with dignity and respect. The results of the interviews will be summarized in the report to the regional center and used to confirm individuals are satisfied with services and supports, feel supported in their life choices and/or to validate service providers are compliant with Home and Community Based Settings Requirements.

Observations

When an interview is declined or not possible, an observation may be conducted to verify that the individual appears to be healthy and appropriately supported. A standardized checklist is used to document the observations. Any findings related to the observations will be included in the report to the regional center.

Minors

The parents of individuals under 18 are interviewed by the monitoring team over the phone to ascertain parent and child satisfaction regarding communication with their service coordinator and the services provided by the regional center.

Instructions

These questions are a guide to elicit information in each area, but the interviewer should feel free to ask other questions that support the individual to engage in the conversation so information about how the individual feels about their own life can be gathered. The focus should be on listening carefully to the conversation and responses given by the individual, in order to rate each area. Indicate in the comments if an individual did not respond or give enough information to determine if the area was met.

Observation:

The purpose of the observation of the individual is to verify that the individual appears to be healthy, is supported in caring for their hygiene with regard to skin, nails, teeth and

clothing; and is dressed and groomed in a manner that will not set them apart from others in the community. The observation should be completed discretely, and it is important to remember that the individual has the right to make choices with respect to their style of clothing and appearance. When in doubt about the appropriateness of the clothing or other aspects of their appearance, the interviewer should inquire discretely from the individual about their role in choosing clothing, hair style, etc.

Interview questions:

5.1: Access to the Community/Opportunities/Personal Resources (SLS/ILS, CCF, OWN and Day Program Only, FR-1)

Sample Questions

1. Are you able to go out in the community if you want?
2. Do you work or attend a day program?
3. Are you able to choose where you go when you go out in the community?
4. Where do you like to go when you go out?
5. How do you get there?
6. Do you choose how you spend your money? (If the answer is no, who decides?)
7. How and for what do you spend your money?
8. Do you have or want a job?

5.2: Choice of Setting (SLS/ILS, CCF and Day Program Only, FR-2)

The setting/service is selected by the individual from among various options, including non-disability specific options and an option for a private room in a residential setting. The options are identified and documented in the Individual Program Plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.

Sample Questions:

1. Do you like living at _____ or attending _____ program?
   If that changed, who would you talk to

5.3: Right to be Treated Well (SLS/ILS, CCF and Day Program Only, FR-3)

The setting/service ensures an individual's rights of privacy, dignity, respect, and freedom from coercion and restraint.

Sample Questions:

1. Do you have the privacy you want? (to talk on the phone, spend time with a visitor or by yourself)
2. Have you ever been asked to do something you felt unsafe or uncomfortable doing?

5.4: Independence (SLS/ILS, CCF, OWN and Day Program Only, FR-4)

The setting/service optimizes but does not regiment individual initiative, autonomy and independence in making life choices, including daily activities, physical environment and with whom to interact.

Sample Questions:

1. If you wanted to try something new, who would you talk to?
2. Have you gone anywhere to try something new recently?

5.5: Choice of Services and Supports (SLS/ILS, CCF and Day Program Only, FR-5)

The setting/service facilitates individual choice regarding services and supports, and who provides them.

Sample Questions:

1. Is the staff (at home or day program) nice to you?
2. Do you get to choose your activities at home or at day program?
3. Who would you talk to if you wanted a change or didn't like something?
4. Do you get to choose which staff helps you at home or at day program or out in the community?

5.6: Privacy (CCF Only) (FR-7)

Each individual has privacy in their sleeping or living unit: 1. Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors as needed. 2. Individuals sharing units have a choice of roommates in that setting. 3. Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.

Sample Questions:

1. Do you have a key to your bedroom door? If no, ask why or if they want one.
2. (If shares a bedroom) Are you ok sharing and do you like your roommate?
3. Did you get to choose the furniture for your bedroom and decorate it the way you like?

5.7: Schedule and Access to Food (CCF Only) (FR-8)

Individuals have the freedom and support to control their own schedules and activities and have access to food at any time.

Sample Questions:

1. Are you able to choose what you eat, when you eat, and where you eat?
2. Are you able to choose what you wear?
3. Do you get to choose when you go to sleep at night? Who decides when you go to bed?
4. Can you get together with your family who live close to you whenever you want?
5. Do you have a phone or a phone you can use? If yes, can you call friends and family any time you want?
6. Are you able to listen to music or watch tv when you want?

5.8: Right to Visitors (CCF Only) (FR-9)

Individuals are able to have visitors of their choosing at any time.

Sample Questions:

1. Can you have visitor when you want?
2. Can you have overnight guests?

5.9: Accessibility (CCF Only) (FR-10)

The setting is physically accessible to the individual.

Sample Questions:

1. Is it easy for you to get around in your home?
2. Is there anywhere in your home that you can't get to because it's too hard to do?
3. Are you able to read all the material posted in your home that you want to?
4. Are you able to hear everything said to you?
5. Do you receive supports in a language that is understandable to you?

5.10: Regional Center Satisfaction (all interviews)

Sample Questions:

1. Do you know who your service coordinator is at your regional center?
2. Are you happy with your service coordinator? If not, have you asked to get a different service coordinator?
3. Can you talk to your regional center service coordinator when you need to?
4. Are you happy with the services you receive from the regional center?
5. Do you feel you got to choose the services you receive from the regional center?

SECTION VI.A.

SERVICE COORDINATOR INTERVIEW

Purpose

The service coordinator (SC) has an important role in the life of the individual. Among other things the SC is responsible for assessing the needs of the individual, facilitating the development a person-centered Individual Program Plan (IPP), linking the individual to services and supports on the IPP, monitoring progress and service delivery, monitoring health and safety, and ensuring individuals have a choice in services and supports and that those services comply with the HCBS Settings requirements. The purpose of the interview is to determine how well the service coordinator knows the individual, the extent of the assessment process for the annual IPP development and/or review, the extent of plan participation, how the plan was developed, how services are monitored, how health issues are addressed and monitored, and how safety is monitored. The interview form is divided into two major categories. The questions in the first category are related to specific individuals. The questions in the second category are related to general questions. The ratings will be summarized in the report to the regional center.

Instructions: The interview is divided into two major categories: 1. questions that apply to a particular individual and 2. general questions. There are areas of interest under each of the categories with a series of questions to test the knowledge of the staff person. The series of questions are related and are offered as a guide to the topics that should be covered. At times it will not be necessary to ask each individual question. The focus should be on listening carefully to the response given and making an assessment as to whether the topic has been fully explained. The interviewer is free to ask follow-up questions if there is a need for further clarification or to skip questions that have been answered as a part of a previous response. Each area of interest is to be rated by the interviewer based upon the answers to the series of questions. There are four ratings to each group of questions. The rating matrix defines the criteria for the responses. After you interview the person please check the appropriate rating for each question.

Interview questions:

6.A.1 Questions in the context of Individual #____

6.A.1.a Questions to determine how well the SC knows the individual

1. Can you tell me about _____? [Strengths, needs, preferences, etc.?
2. How do you communicate with the individual?

3. How does the individual indicate needs, wants and preferences?
4. How does the individual indicate agreement?

6.A.1.b Questions to determine the extent of the assessment process for the annual plan development/review

1. Describe how you gathered information on individual #___ preferences and personal goals, needs and abilities, health status and other available supports for the annual review.
2. What do you look for and gather during discussions, and in reports/records or other documents?

6.A.1.c Questions to determine extent of plan participation

1. Who did you invite to participate in the annual plan development/review meeting?
2. Who participated in the plan development meeting?
3. Did the individual choose who participated in the meeting, including family or others who support them?
4. What determines when the meeting will be scheduled?
5. What happens when there are people the individual would like to attend but they are unavailable at the scheduled time?

6.A.1.d Questions to determine how the plan was developed

1. Discuss how and why the individual goals and specific objectives were selected.
2. How did you support the individual to lead the planning process?
3. How did the individual choose particular services and providers? What options were explored?
4. How did the individual indicate understanding of the IPP goals and objectives?
5. Does the individual have access to all needed services?
6. Was there general agreement on the final plan? If not, how was the matter resolved?
7. How do you incorporate person centeredness in the development of the individuals IPP?
8. How would you follow-up if you see a setting is not compliant?
9. Are there any modifications to the settings requirements in place to support the individual's health and safety? (DP and CCF only) examples might be does the individual not have a lock on their door? Does the individual not have access to food at any time due to dietary restrictions? *(if yes) How did you document the modification in the IPP.*

6.A.2 General Questions [some questions ask for information on a specific individual

6.A.2.a Questions to determine how services are monitored

1. What means do you use to monitor services and supports? How often do you see individuals supported?
2. How do you assess the effectiveness of services being provided?
3. How do you determine whether there has been progress in meeting the individual's goals and objectives?
4. How do you evaluate if the individual is receiving the supports and services based on their needs, choices and preferences?
5. How do you use the information gained in reviewing the IPP?
6. What do you do if the individual/family is not satisfied with the services and supports?

6.A.2.b Questions to determine how health issues are addressed and monitored

1. Does the individual have any health concerns that need to be addressed [including health, mental health and dental] and how are they addressed?
2. What criteria do you use to determine when an individual needs a clinical team referral?
3. What training have you received regarding medications and side effects?
4. How often is the health status of an individual reviewed? What is done with the information?

6.A.2.c Questions to determine how safety is monitored

1. What kind of assessments do you do to determine whether the individual is in a safe environment?
2. What actions do you take if you feel that the individual's environment is becoming less safe? How often in the past year have you had experience with this?
3. How do you monitor the effectiveness of behavior plans and reports?
4. Has the individual had any reportable SIRs within the last year? If so what were they?
5. What is the regional center's process for follow-up actions and documentation after the SIR incident has been resolved?
6. Do you get SIR information from the Risk Management/Mitigation system? How frequently? If so, what do you do with it?

Supplementary Service Coordinator Interview Questions

Do you have any specific concerns regarding the health and welfare of the individuals being visited by the monitoring team? Is there anything the monitoring team should be aware of when observing and/or interviewing any of the individual[s], i.e., individual preferences, communication challenges, behavior challenges, etc.?

SECTION VI.B

CLINICAL SERVICES STAFF INTERVIEW

Purpose

Regional center clinical services staff and contractors provide support to individuals and service coordinators on matters affecting the health, safety and medical needs of individuals living in the community. An informational interview is conducted with the clinical staff to ascertain how the regional center has organized itself to provide the support. The interview questions ask what processes the regional center has in place for routine monitoring of individuals with medical issues, monitoring of medications, monitoring of behavior plans, coordination of medical and mental health, improvements in access to preventive health care resources, and the role of clinical services in special incident reporting and the Risk Management Committee. Since the interview is informational, no attempt will be made to assign a rating to each of the questions. The results of the interview, along with any findings, will be briefly described in the report to the regional center.

Interview Form

Instructions: Since the interview is informational, no attempt is made to assign a rating to each of the questions. The results of the interview, along with any findings, will be briefly described in the final report to the regional center.

Regional Center: Interviewer(s):

Clinical Staff Interviewed: Date:

6.B.1. How does the clinical staff monitor individuals with medical issues? If so, what criteria are used to determine which medical issues should be monitored and the frequency of monitoring?

6.B.2. How and when does the clinical staff monitor medications? If so, what criteria are used to determine the medications to be monitored?

6.B.3. How and when does the clinical staff review and monitor behavior plans?

6.B.4. What role does clinical services play in ensuring coordination of medical and mental health care for individuals?

6.B.5. Under what circumstances does clinical services initiate action with respect to a medical or behavior issues?

6.B.6. What clinical supports does the regional center have in place to assist service coordinators to carry out their responsibilities?

6.B.7. How has the regional center improved access to preventive health care resources?

6.B.8. Do you have any role in the regional center Risk Management Committee? If so will you please describe what you do?

6.B.9. What role do you have in special incidents?

6.B.10. What issues/problems, if any, is the regional center experiencing regarding Medi-Cal providers in your catchment area? Are there any gaps in specialty provider groups?

6.B.11. Is the regional staff aware of any provider concerns/issues with billing Medi-Cal services?

SECTION VI.C.

QUALITY ASSURANCE STAFF INTERVIEW

Purpose

Quality assurance (QA) is an important component in assuring the health and safety of individuals in the community and provider compliance. An informational interview is conducted with QA staff to gain an understanding of how the regional center has organized itself to conduct: Title 17 monitoring of community care facilities (CCFs); two unannounced visits to CCFs; QA evaluations of CCFs; HCBS Settings Requirements and service provider training. The interview also inquires about verification of provider qualifications, resource development activities, and to ascertain what is done to assure quality among programs and providers where there is no regulatory authority to conduct QA monitoring. Since the interview is informational, no attempt will be made to assign a rating to each of the questions.

The results of the interview, along with any findings, will be briefly described in the report to the regional center.

Interview Form Instructions: The quality assurance (QA) interview is an informational interview. Since the interview is informational, no attempt is made to assign a rating to each of the questions. The results of the interview, along with any findings, will be briefly described in the final report to the regional center.

Regional Center: Interviewer(s):

QA Staff Interviewed: Date:

6.C.1. Who participates in the Title 17 reviews?

6.C.2. What information do you review or gather prior to conducting the Title 17 review?

6.C.3. Are Title 17 reviews generally scheduled at times when individuals are at home?

6.C.4. What kinds of consultation or technical assistance do you provide during reviews?

6.C.5. Describe the regional center’s process for issuing sanctions for CCFs.

6.C.6. How do you follow-up and verify that the issues related the sanctions have been resolved?

6.C.7. Does regional center staff receive training in identifying substantial inadequacies and immediate dangers?

6.C.8. Who is responsible for conducting the two unannounced visits to CCFs?

6.C.9. What is done with the information from the unannounced visits and Title 17 reviews?

6.C.10. Who participates as evaluation team members in the QA reviews of CCFs?

6.C.11. What kind of training do team members receive?

6.C.12. What information do you review prior to the QA review?

6.C.13. What roles are assigned to the various team members?

6.C.14. What actions have you taken as a result of the QA reviews?

6.C.15. What follow-up actions have you taken?

6.C.16. Are CAPs written and given to the provider at the conclusion of the review?

6.C.17. What, if anything, do you do to assure quality among programs and providers where there is no regulatory authority to monitor?

6.C.18. How do you verify the qualifications of providers?

6.C.19. What kind of training do you give to providers?

6.C.20. How do you assure quality in resource development?

6.C.21. What role does QA staff play in investigating and following-up on SIRs?

6.C.22. Do QA staff participate as a member of the Risk Management Committee?

6.C.23. What SIRs data do you routinely use?

6.C.24. Do you have a role in distributing SIRS information or analyses?

6.C.25 Describe the regional center’s process for ensuring that Community Care Facilities and Day Programs are in compliance with HCBS Settings requirements.

SECTION VII

INTERVIEWS WITH PROVIDER ADMINISTRATORS AND DIRECT SUPPORT PROFESSIONALS

VII.A PROVIDER ADMINISTRATOR INTERVIEW

Purpose

The service provider has a critical role in the life of the individual. The service provider is responsible for assessing the needs of the individual in their program, participating in the development of a person-centered Individual Program Plan (IPP), provision of services and supports on the IPP, fostering individual independence, advocating for and ensuring that the health, safety, and rights of the individual are planned for and met.

The purpose of the service provider interview is to determine if the service provider knows the individual needs and preferences of the person being supported, fosters an environment where the individual is treated with dignity and respect, provides supports in alignment with the IPP, ensures preparation and oversight of the individual's health and safety, and oversees the training and implementation of policies and procedures that ensure the site is providing supports in accordance with the Home and Community Based Settings Requirements. The interview form asks general questions about the overall practices of the setting and questions related to specific individuals. Compliance in these areas will be summarized in the report sent to the regional center.

Instructions: The interview asks questions that apply to a particular individual and general questions about the setting and the role of the service provider. There are a series of bolded questions addressed to the interviewer that indicate the overall question that needs to be answered. The series of questions that follow are offered as a guide to elicit information from the service provider that will help the interviewer to answer the overall question. The focus should be on listening carefully to the conversation and responses given and make an assessment as to whether the overall question can be fully answered. The interviewer is not limited to questions from the list to ask in each area and is free to ask additional questions that might clarify or gather the information needed to address the main question.

Interview questions:

7.A.1 Does the service provider know the individual needs and preferences of the person being supported?

Sample Questions

1. Can you tell me about _____? [Strengths, needs, preferences, etc.]
2. How do you communicate with the individual?

3. How does the individual indicate their needs, wants and preferences?
4. How does the individual indicate agreement or disagreement?

7.A.2 Does the service provider prepare for the annual plan development/review and participate in the development of the person centered IPP?

Sample Questions

1. Do you participate in the IPP process? If not, what information do you provide the RC to support that process?
2. How do you prepare for the IPP or ISP? What do you look at? Who do you talk to? What do you gather?
3. How do you ensure that the ISP reflects the supports that your program is responsible for in the IPP?

7.A.3 Does the service provider address and monitor health issues?

Sample Questions

1. As a program/facility what is your system for knowing that the overall health needs are being taken care of? What is your system for training staff to know?

7.A.4 Does the service provider ensure emergency preparedness?

Sample Questions

1. Describe your procedures in the event of natural disasters and public emergencies.
2. How often do you review and practice the emergency procedures?
3. What would you do for example if there were an electrical problem that forced evacuation of the facility/program site for 24 hours or more?

7.A.5 Does the service provider monitor safety?

Sample Questions

1. As a program/facility, what is your system for knowing that the overall and individual safety needs of the individuals you serve are being addressed? What is your system for training staff to know?
2. Describe the conditions under which you would report a special incident to the regional center.
3. Has individual #_____ had any reportable SIRs within the last year? If so, what were they and what did you do? [If the individual has not required an SIR in the last year, please describe another individual not using their name or any personally identifiable information.]
4. How do you train staff to respond to incidents that require an SIR?

7.A.6 Community Access (FR-1)

The setting/service is integrated in and supports full access to the greater

community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving regional center services.

Sample Questions

1. Do individuals have the opportunity to participate in individual and group outings and activities in the community at the frequency and for the amount of time desired by the individual?
2. How is transportation handled for community access? Do individuals have options?
3. Are individuals supported to seek employment if they want to?

7.A.7 Right to be treated well (FR-3)

The setting/service ensures an individual's rights of privacy, dignity, respect, and freedom from coercion and restraint.

Sample Questions

1. How are staff trained to ensure that individuals understand they have a right to privacy, dignity and respect? Are there policies and procedures in place?
2. How does the facility ensure staff is knowledgeable about the capabilities, preferences, interests, and needs of the individuals they serve?
3. Does the setting use any kind of restraint (physical, mechanical or chemical)? If yes, is the use of the restraint individualized, based on a specific assessed need and clearly documented in the IPP?

7.A.8 Independence (FR-4)

The setting/service optimizes but does not regiment individual initiative, autonomy and independence in making life choices, including daily activities, physical environment and with whom to interact.

Sample Questions

1. How does the facility support individual’s autonomy to make personal decisions such as practicing religion or voting?
2. How does the provider structure its support so that individuals are able to interact with people they choose to interact with, both at home and in community settings including non-disabled peers other than paid staff and volunteers?
3. How does the provider structure their support so that the individual is able to participate in activities that interest them and correspond with their IPP goals?

7.A.9 Choice of services and supports (FR-5)

The setting/service facilitates individual choice regarding services and supports, and who provides them.

Sample Questions

1. Are individuals involved in choosing which staff provides their care? For example, if they have preferences of gender or language.
2. Is there a way for individuals to request a change of service provider or support staff?
3. Are individuals required to work or go to day program? Could they retire if they want or go part time and be home during the day?

RESIDENTIAL ONLY

7.A.10.a Privacy (FR-7)

Each individual has privacy in their sleeping or living unit: 1. Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors as needed.

Sample Questions

1. When an individual chooses to lock their room, who has keys and access to the room?
2. What protocols are in place to ensure staff follow policies about entering an individual's room and respecting privacy?

7.A.10.b Individuals sharing units have a choice of roommates in that setting.
(Ask only if individuals share rooms in the home)

Sample Questions

1. Do individuals get to participate in choosing their roommate(s) if they don't have private accommodations? How does the site assist in the process?
2. For people who have had the same roommate for some time, how do you confirm satisfaction of the individual with the current arrangements?
3. Do individuals have the option to change roommates, if desired

7.A.11 Schedule and Access to Food (FR-8)

Individuals have the freedom and support to control their own schedules and activities and have access to food at any time.

Sample Questions

1. Are individuals allowed to set their own daily schedule in terms of eating times, bedtimes, outings etc.?

7.A.12 Right to Visitors (FR-9)

Individuals are able to have visitors of their choosing at any time.

Sample Questions

1. Are visitors welcome to visit the home at any time or are visiting hours restricted?
2. Can individuals go with visitors outside of the home like for a meal, shopping, weekend or holiday visit?

SECTION VII.B.

DIRECT SUPPORT PROFESSIONAL INTERVIEW

Purpose

Direct support professionals (DSP) are the individuals who work with and assist the individuals in day programs and residential settings. Direct support professionals play an important role in the implementation of the individual program plan (IPP). The DSP is responsible for supporting the specific needs of the individual in their program, implementing services and supports on the IPP, fostering individual independence, advocating for and ensuring that the health, safety, and rights of the individual are supported.

The purpose of the interview is to determine the DSP's familiarity with the individual, understanding of the IPP, specifically the individual's goals and objectives, communication, level of preparedness to address safety issues, understanding of emergency preparedness, and knowledge about safeguarding medications and that staff are meeting the Home and Community-Based Services Settings Requirements. The ratings will be summarized in the report to the regional center.

Instructions: The interview asks questions that apply to a particular individual and general questions about the setting and the role of the DSP. There are a series of bolded questions addressed to the interviewer that indicate the overall question that needs to be answered. The series of questions that follow are offered as a guide to elicit information from the service provider that will help the interviewer to answer the overall question. The focus should be on listening carefully to the conversation and responses given and make an assessment as to whether the overall question can be fully answered. The interviewer is not limited to questions from the list to ask in each area and is free to ask additional questions that might clarify or gather the information needed to address the main question.

Interview questions:

7.B.1 Information and familiarity with the individual served (FR-1)

Is the direct support professional able to supply information about the individual to show familiarity?

Sample Questions

1. Tell me about _____.
2. How long have they lived here, attended this program?
3. How do you communicate?
4. What are some likes/dislikes?
5. Any medical/medication concerns/need to know?

6. Is ___ interested in finding work/a job? If no, ask IF they did want to look for a job, are there resources to assist and/or who the staff would notify regarding the request.

7.B.2 IPP/Goals/Objectives

Is the direct support professional aware of the individual's goals/objectives?

Sample Questions:

1. What goals/objectives is the individual working on as per their IPP? How do you know what the individual's goals and objectives are?
2. What do you do when the needs or preferences of the individual change?

7.B.3 Community Access: Does the direct support professional facilitate the individual's access to the community? (FR-1)

Do the direct support professional foster choices on where to go, when and to what activities?

Sample Questions

1. Are individuals able to get out into the community to the degree they'd like?
2. How do they get there? Walk, public transit, vendor?
3. What kind of things do they like to do? Do they get to choose?
4. What kind of activities are their favorites?
5. Do individuals use their own money for purchases? How do they access their money?

7.B.4 Choice (FR-4, FR-5, FR-8)

Do the direct support professional foster opportunities for individuals to make choices? When necessary, do they assist individuals to understand their right to choose?

Sample Questions

1. Give an example of providing a choice for _____. **(FR-4)**
2. Can they choose to attend outings, go to day program, other daily activities? **(FR-4)**
3. Can a person choose their support staff? How do you accommodate requests? **(FR-5)**
4. How do you accommodate mealtimes? Can they eat alone or with others if requested? **(FR-8 CCF Only)**
5. If they miss a meal, can they eat at another time, or have food whenever they like? **(FR-8 CCF Only)**
6. Can individuals specify certain food/meals? Input for menus? **(FR-8 CCF Only)**
7. Can individuals choose when to bathe, watch TV, access a phone? **(FR-8 CCF Only)**

7.B.5 Privacy (FR-3)

Does staff ensure privacy for individuals?

Sample Questions

1. Do you feel individuals' right to privacy is respected? Please give an example.
2. Do you knock on doors before entering (bedroom, bathroom)?

7.B.6 Safety

Is staff aware of safety needs for individuals living in the home/attending the day program?

Sample Questions

1. Are there any medical conditions or medications, special diets/allergies you need to be aware of? If so, how do you handle those?
2. Is there a plan to evacuate non-ambulatory individuals? (If applicable)
3. What would you do if there were a fire? An earthquake?

7.B.7 Medication

Questions to determine the direct support professional's knowledge regarding safeguarding and assisting with self-administration of medications. Does support staff demonstrate knowledge and safety awareness with administering medication?

Sample Questions

1. Do you help the individual to take their medications? Are you aware of any potential side effects?
2. Are there any special precautions that you take with any of the medications, for example, taken only with food?
3. Describe what assistance you provide. What do you do to assist the individual to take their medications? What are the steps that you take?
4. How do you make sure that the person gets the right medication at the right time?
5. What would you do if a mistake was made, and the person got the wrong medicine?
6. How do you dispose of expired or discontinued medications?

SECTION VIII

VENDOR PROGRAM MONITORING REVIEW

Purpose

Residential programs and day programs are reviewed by the monitoring team utilizing a vendor settings monitoring review form consisting of review criteria derived from Title 42, Code of Federal Regulations, Title 17, California Code of Regulations, Health and Safety Code, and from the HCBS Waiver. The purpose of the program review is to ensure HCBS settings are compliant, that the individuals are supported in safe, healthy, positive environments where their privacy, rights and choices are respected. Each criterion is followed by verification instructions for determining compliance. The review is conducted through an inspection of the physical environment of the program interviews with individuals, service provider, and direct support staff as well as observations during the site review. The results of the reviews will be summarized in the report to the regional center. The Vendor Program Monitoring Review Rating Sheet is at the end of this section.

Criterion

8.1 Federal Requirement #1: Access to the Community/opportunities/personal resources

The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS. *(Title 42, CFR, § 441.301(c)(4)(i))*

Verification Instructions

1. Review interviews with the individual, the service provider and direct support staff from the site being reviewed, to confirm individuals have access to the community and are able to engage in community life at the day program or at their residence. The residential providers support individuals to receive services in the community, such as going to a salon or grocery store, or other businesses in the community. Individuals have the opportunity to seek employment if they choose. Individuals have control over and have access to their personal resources, such as their cash, or the opportunity to have a bank account.

2. Score as (+) if interviews verify individuals have access to community, employment and opportunities for engagement in their community, and they have control of their personal resources.

3. Score as (-) if interviews indicates that individuals do not have access to community, do not have opportunity for employment and/or opportunities for engagement in their community, or they do not have control of their personal resources. Comment on what is non-compliant.

8.2 Federal Requirement #2: Choice of Setting

The setting/service is selected by the individual from among various options, including non-disability specific options and an option for a private room in a residential setting. The options are identified and documented in the Individual Program Plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board. *(Title 42, CFR, § 441.301(c)(4)(ii))*

Verification Instructions

1. Review the regional center record review form, criterion 2.2.b, to verify there is documentation in the IPP that the individual had a choice in selecting the services they receive and the setting where they are receiving the service. Review the Community Care Facility (CCF) record review for, criterion 3.3, or the day program record review form, criterion 4.2, to confirm the facility has a copy of the current IPP.

2. Score as (+) if there is documentation of choice in the IPP that the individual was able to make the decision of the services they receive and the setting where they receive their service.

3. Score as (-) if there is no documentation of choice in the IPP that the individual was able to make the decision of the services they receive and the setting where they receive their service.

Note: Responding "No" to this question does not mean the provider is out of compliance.

8.3 Federal Requirement #3: Right to be Treated Well

8.3.a Individuals have a right to privacy, dignity and respect, and freedom from coercion and restraint. *(Title 42, CFR, § 441.301(c)(4)(iii))*

Verification Instructions

1. Observe if interactions between staff and the individuals at the facility are considerate, respectful and free from coercion and restraint. In addition, review interviews with the individual, the service provider and direct support staff to confirm compliance.

2. Score as (+) if the individuals supported appear comfortable with staff, interactions between staff and individuals indicate that individuals are treated with dignity and respect, and interviews with the individual, the service provider and direct support staff confirm compliance.

3. Score as (-) if the individuals supported do not appear comfortable with staff, or interactions between staff and individuals indicate that individuals are not treated with dignity and respect, or interviews with the individual, the service provider and direct support staff do not confirm compliance. Comment on what is non-compliant.

8.3.b There is documentation that the individual has been informed of their rights. *(Title 42, CFR, § 441.301(c)(4)(iii))*

Verification Instructions

1. Review the community care facility record review form, criterion 3.1.g or day program record review form, criterion 4.1.e, to verify there is signed documentation that the individual has been informed of their rights.

2. Score as (+) if the facility record review verifies that the individual has been informed of their rights.

3. Score as (-) if there is no documentation in the facility record that the individual has been informed of their rights.

8.3.c Individuals are entitled to privacy for activities such as spending time alone or with visitors, making and receiving telephone calls, reading correspondence, completing personal activities such as toileting, bathing and dressing. Individuals have a place to store their belongings in a secure place. *(Title 42, CFR, § 441.301(c)(4)(iii)), (W&I § 4503(d)(e))*

Verification Instructions

1. Observe the setting of the individual to ensure they have space to have visitors, have private calls, read correspondence privately, complete personal activities and a place to store their own belongings (examples include, their own nightstand, their own closet space or a lockbox). If the individual does not have their own bedroom, ask where in the house individuals can have privacy for time alone or time to complete personal activities like dressing and see where they are able to store their personal items. In addition, review interviews with individual and direct support staff to confirm compliance.

2. Score as (+) if individuals have privacy for personal activities, as stated above, and have a place to store personal items.

3. Score as (-) if individuals do not have privacy for personal activities, as stated above, and/or do not have a place to store personal items. Comment on what is non-compliant.

8.4 Federal Requirement #4: Independence

The setting/service optimizes but does not regiment individual initiative, autonomy and independence in making life choices, including daily activities, physical environment and with whom to interact. *(Title 42, CFR, § 441.301(c)(4)(iv))*

Verification Instructions

1. Review interviews with the individual, the service provider and direct support staff from the site being reviewed to confirm individuals are able to make choices in how they spend their time and the activities they engage in.

2. Score as (+) if interviews verify individuals have independence to make choices in how they spend their time, their activities and who they interact with, and that the individuals are able to participate in activities that they are interested in.

3. Score as (-) if interviews indicate that there is daily or weekly schedule staff complete and individuals are unable to make choices in how they spend their time, their activities and who they interact with, and if individuals are unable to participate in activities that they are interested in.

8.5 Federal Requirement #5: Choice of Services and Supports

The setting/service facilitates individual choice regarding services and supports, and who provides them. *(Title 42, CFR, § 441.301(c)(4)(v))*

Verification Instructions

1. Review interviews with the individual, the service provider and direct support staff from the site being reviewed to confirm individuals are able to make choices in which staff provide care and assistance, for example, a preferred gender staff member or a preferred language.

2. Score as (+) if interviews verify individual have a choice in who provides their care.

3. Score as (-) if interviews indicate individuals are unable to choose who provides their care.

8.6 Federal Requirement #6: Residential Agreement

The unit or dwelling is a specific physical place that can be owned, rented or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord tenant law of the State, county, city or other designated entity. For settings in which landlord tenant laws do not apply, the State must ensure that a lease, residency agreement or other form of written agreement will be in place for each participant and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law. *(Title 17, CCR, § 56019(c)(1))* (*Title 42, CFR, § 441.301(c)(4)(vi)(A))*

Verification Instructions

1. Review the community care facility record review form, criterion 3.2.b to confirm there is documentation of a signed admission agreement, lease or residency agreement that details protections that address an eviction process and appeals that are comparable to landlord tenant laws.
2. Score as (+) if there is documentation of a signed admission agreement, for their current address, lease or residency agreement that details protections that address an eviction process and appeals that are comparable to those provided under the jurisdiction's landlord tenant laws.

3. Score as (-) if there is no documentation of a signed admission agreement, lease or residency agreement that details protections that address an eviction process and appeals that are comparable to those provided under the jurisdiction's landlord tenant laws.

8.7 Federal Requirement #7: Privacy

8.7.a Bedroom doors are lockable by the individual with only appropriate staff having keys to doors. *(Title 42, CFR, § 441.301(c)(4)(vi)(B)(1))*

Verification Instructions

1. Observe if the bedroom door has a lock to ensure individuals have the ability to lock their door if and when they choose. If there is no lock review the IPP for documentation of a modification. Review interviews with the individual and service provider from the site being reviewed, to confirm that there is a process in place that details who has access to keys of bedrooms and to confirm compliance.

2. Score as (+)

    a. if individuals who reside in the home have doors that are lockable and only the resident and there is a process in place that details which staff has access to keys or,
    b. if an individual does not have a door that is lockable and there is a modification documented in the IPP.

3. Score as (-) if an individual does not have a door that is lockable and there is no modification documented in the IPP, or there is a lock on the door and there are no parameters around who has access to the key. Comment on what is non-compliant.

8.7.b Individuals sharing units have a choice of roommates in that setting. *(Title 42, CFR, § 441.301(c)(4)(vi)(B)(2))*

Verification Instructions

1. Observe if the individual has a shared bedroom. Review interviews with the individual and the service provider from the site being reviewed to confirm that the setting supports individuals who share rooms to make choices regarding who their roommates are.

2. Score as (+) if the interviews confirm that the setting has a process in place for individuals to make choices about who they share a room with.

3. Score as (-) if the interviews do not confirm that the setting does not have a process in place for individuals to make choices about who they share a room with.

8.7.c Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement. *(Title 42, CFR, § 441.301(c)(4)(vi)(B)(3))*

Explanation

Individuals in residential settings have the freedom and right to a home that is decorated and furnished that reflect the tastes and desires of the individuals living there without an institutional feel.

Verification Instructions

1. Observe if the home, bedrooms and living spaces of the residents are decorated with personalized decorations and reflect the taste of the individuals who live in the home.

2. Score as (+) if the home, bedrooms and living spaces of the residents are decorated with personalized decorations and reflect the taste of the individuals who live in the home.

3. Score as (-) if the bedroom and living spaces have an institutionalized looking décor and furnishings. Comment on what is non-compliant.

8.8 Federal Requirement #8: Freedom to Control Schedule and Access to Food

Individuals have the freedom and support to control their own schedules and activities and have access to food at any time. *(Title 42, CFR, § 441.301(c)(4)(vi)(C))*

Verification Instructions

1. Review interviews with the individual, the service provider and direct support staff, from the site being reviewed to confirm individuals are able to set their own schedule, say no to group activities if they choose, have access to food at any time, decide when and where they eat, have access in all common areas in the home, and have access to transportation if they want to go out into the community. Examples of transportation are bus or ridesharing service such as Uber.

2. Score as (+) if individuals have opportunities to set their own schedule, have full access to food, common areas, such as the kitchen, dining and laundry rooms and individuals have access to use transportation such as public transportation or other transportation resources.

3. Score as (-) if individuals are not able to eat when they want, have access to all common areas in their home, or are unable to go out to the

community when they want and/or restricted from using public transportation.

8.9 Federal Requirement #9: Right to Visitors

Individuals are able to have visitors of their choosing at any time. *(Title 42, CFR, § 441.301(c)(4)(vi)(D))*

Verification Instructions

1. Observe to see if there are any house rules posted in the home and if the rules indicate restricted visiting hours. Review interviews with the individual and the service provider from the site being reviewed, to confirm individuals are able to have visitors in the home, including overnight, and are able to leave the home with a visitor at any time.

2. Score as (+) if individuals are able to have visitors at any time, including overnight, or leave the home to spend time with visitors at any time and if there are no house rules that include such restrictions.

3. Score as (-) if individuals are restricted from having visitors, including overnight, or unable to leave the home to spend time with visitors.

8.10 Federal Requirement #10: Accessibility

The setting is physically accessible to all individuals, including appliances and amenities. Equipment and supplies will be maintained and in good repair at all times to accommodate the needs of all individuals, including those who utilize mobility and other devices. For example, durable medical equipment assistive equipment, such as wheelchairs, walkers, braces, standers, bath/safety products such as grab bars, patient lifts, and communication boards, etc. *(Title 42, CFR, § 441.301(c)(4)(vi)(E)); (HCBS Waiver Requirement)*

Verification Instructions

1. Score as (+) if the facility has ramps, handrails, and/or other equipment accessible, available, and in good repair, to meet the needs of all individuals, including those who require specialized equipment.

2. Score as (-) if the facility does not have ramps, handrails, and/or other equipment accessible, available, and in good repair, to meet the needs of all individuals, including those who require specialized equipment. Comment on what is non-compliant.

8.11 Medication

8.11.a Medication will be maintained in a safe and locked location, which is inaccessible to persons other than employees responsible for the supervision of the medication. Each individuals' medication will be stored in its original container. All medications will be labeled, and no person other than the dispensing pharmacist will alter a

prescription label. Medications will not be transferred between containers. (*HCBS Waiver Requirement)*

Verification Instructions

1. Score as (+) if medications are locked and stored safely, stored in its original container, and labeled, with no alterations to the label.

2. Score as (-) if medications are not locked and stored safely, not stored in its original container, there is no label, or the label has been altered. Comment on what is non-compliant.

3. Score as NA if the facility does not support individuals who require medication.

8.11.b A list of medications and all medication records will be maintained by the residential facility for each individual. *(HCBS Waiver Requirement)*

Verification Instructions

1. Review the Medication Administration Record (MAR) or medication list and the medications for the individual to verify all current medications are listed in the MAR.

2. Score as (+) if there is a list of medications and it is maintained by the facility.

3. Score as (-) if there is a not list of the medications and/or it is not maintained by the facility. Comment on what is non-compliant.

4. Score as (NA) if the facility does not support individuals with their medication.

8.12 The facility will be in good repair and safe at all times for the well-being of individuals, employees and visitors. Indoor and outdoor passages, fire exits, will be free of hazards, and obstruction with no areas in need of repair: windows, doors, walls, plumbing, electrical or natural gas. Fireplaces and open-faced heaters will be inaccessible to individuals. Area/throw rugs should have non-slip backing and should not pose a tripping hazard. Bodies of water should have a cover or fence surrounding the body of water; pool covers shall be strong enough to completely support the weight of an adult and shall be placed on the pool and locked while the pool is not in use. *(HCBS Waiver Requirement)*

Verification Instructions

1. Score as (+) if the facility is in good repair with no odors of gas or other chemicals, no hazards or obstructions in any passageways or walkways, or fire exits, and rugs have nonslip materials, no areas in need of repair,

including fire exits: windows, doors, walls, plumbing, electrical or natural gas, if applicable, any body of water has a strong cover to support weight of an adult and locked while the pool is not in use.

2. Score as (-) if the facility is not in good repair has odors of gas or other chemicals, hazards or obstructions are in passageways or walkways or fire exits, and/or rugs do not have nonslip materials, there are areas in need of repair: windows, doors, walls, plumbing, electrical or natural gas, if applicable, swimming pool does not have a strong cover to support the weight of an adult and/or there is no lock or the lock is broken and cannot be locked when not in use. Comment on what is in disrepair.

8.13 Soaps, detergents, cleaning solutions, or similar substances will be stored in areas separate from food supplies. *(HBCS Waiver Requirement)*

Verification Instructions

1. Score as (+) if cleaning solutions and detergents are kept separate from areas where food is kept and, in an area to prevent danger.

2. Score as (-) if cleaning solutions and detergents are in areas where food is kept and out where it could pose a danger to individuals in the home.

SECTION IX

SPECIAL INCIDENT REPORTS

Purpose

California Code. Regs tit. 17, § 54327 defines special incidents as those incidents that have occurred during the time the individual was receiving services and supports from any vendor or long term health care facility, including: the individual is missing and the vendor or long-term care facility has filed a missing persons report with a law enforcement agency; reasonably suspected abuse/exploitation; reasonably suspected neglect; a serious injury/accident; any unplanned or unscheduled hospitalization; and, regardless of when or where the following incidents occurred, the death of any individual regardless of cause and/or the individual is the victim of a crime. Title 17 requires all vendors to report special incidents be reported to the regional center in not more than 24 hours after learning of the occurrence to be followed with a written report to the regional center within 48 hours after the occurrence, unless the initial report contained all of the required information. The regional centers are required to report these special incidents to Department of Developmental Services (Department) electronically. Reporting of follow-up of special incidents is an important safeguard for individuals living in the community. The purpose of this section is to verify that special incidents have reported within the timelines, that the documentation meets the requirements of Cal. Code. Regs tit. 17, and that the follow-up was complete. The report to the regional center will include those areas where there were negative findings.

Criterion

9.0 **A special incident is completed for all individual deaths and reported to the Department.** *[Cal. Code. Regs tit.17, § 54327.1 (2023)]* Note: This is completed prior to the on-site review.

Sample

1. All HCBS Waiver status “code 7”, (closed/deceased) individuals in the Client Master File (CMF) for the 12-month review period.

2. SIRs of HCBS Waiver individual deaths submitted by the regional center during the 12-month review period.

Verification Instructions

1. Compare the SIRs deaths reported to the Department for the 12-month review period with the list of status “code 7” Waiver individuals in the CMF.

2. Score as (+) if the Waiver participant has a status “code 7” in the CMF and a SIR of the individual’s death was submitted to the Department.

3. Score as (-) if a SIR was not submitted and the Waiver participant has a status “code 7” in the CMF. Comment on the number of unreported deaths.

4. Score as (NA) if there were no HCBS Waiver status “code 7”, closed/deceased, individuals in the CMF for the 12-month review period.

9.1 The regional center reports special incidents to the Department. *[Cal. Code. Regs tit. 17, § 54327.1 (2023)]*

Sample

1. The sample of HCBS Waiver individual records selected for the regional center HCBS Waiver review.

2. A list of SIRs submitted to the Department pursuant to Cal. Code. Regs tit. 17 requirements during the 12-month review period for the sample of HCBS Waiver individual records selected for the regional center HCBS Waiver review.

Verification Instructions

1. Compare SIRS in the sample of HCBS Waiver individual records selected for the regional center HCBS Waiver review with the list of SIRs reported to the Department.

2. Score as (+) if the SIRs in the individual records match the Department list.

3. Score as (-) if the individual records contain SIRs that do not match the Department list.

4. Comment on unreported SIRs. Review unreported SIRs and documentation of any follow-up activities or reports.

5. Score as (NA) if there were no SIRS in the record or on the Department list of reported SIRS for the individual.

9.2.a The vendors report special incidents to the regional center within the timeframe specified in Title 17. *[Cal. Code. Regs tit. 17, § 54327.1 (2023)]*

Explanation

The vendor shall submit a written report of the special incident to the regional center within 48 hours after the occurrence of the special incident.

Sample

Ten HCBS Waiver individuals who had special incidents pursuant to Cal. Code. Regs tit. 17 reported to the Department within the 12-month review period.

Verification Instructions

1. Compare the date of the incident with the date the incident was reported to the regional center.

2. Score each special incident as (+) if the incident was reported to the regional center within the specified timeframe.

3. Score each special incident as (-) if the incident was not reported to the regional center within the specified timeframe. Place the date of the incident of the report and the date of the report to the regional center in the comment section.

9.2.b The regional center reports special incidents to the Department within the timeframe specified in Title 17. *[Cal. Code. Regs tit. 17, § 54327.1 (2023)]*

Explanation

Regional centers are required to submit an initial report to the Department of any special incident defined in Cal. Code. Regs tit. 17 within two working days following receipt of the report, or where a report has not been submitted to the regional center, within two working days of learning of the occurrence.

Sample

Ten HCBS Waiver individuals who had special incidents pursuant to Title 17 reported to the Department within the 12-month review period.

Verification Instructions

1. Compare the date of the incident with the date the incident was reported to the Department.

2. Score each special incident as (+) if the incident was reported to the Department within the specified timeframe.

3. Score each special incident as (-) if the incident was not reported to the Department within the specified timeframe. Place the date of the receipt of the report and the date of the report to the Department in the comment section.

9.3 The regional center documents follow-up activity. *[Cal. Code. Regs tit. 17, § 54327.1 (2023)]*

Explanation

Regional centers are required to document follow-up activities taken in response to the special incident. The purpose of the follow-up activity is to assure that special preventative actions are taken to mitigate or reduce future risk including delineation of outcomes and actions taken in response to the incident.

Sample

Ten HCBS Waiver individuals who had special incidents pursuant to Title 17 reported to the Department within the 12-month review period.

Verification Instructions

1. Review all documentation related to each of the special incidents in the sample for timeliness, appropriate to the situation and resulting in an outcome that ensures that individuals are protected from adverse consequences, potential risk factors are explored, and risks are either minimized or eliminated.

2. Score as (+) if the subsequent activities have been documented and are timely, appropriate to the situation and result in an outcome that ensures that individuals are protected from adverse consequences, potential risk factors are explored, and risks are either minimized or eliminated.

3. Score as (-) if:

    a. the subsequent activities were not documented or were not timely. Comment on why the activities were not timely, **or**

    b. the subsequent activities were not documented or were not appropriate to the situation. Comment on why the activities were not appropriate to the situation.

SECTION X

SUPPLEMENTARY ISSUES

Purpose

This section contains any supplementary issues identified by the monitoring team during the review that are not specifically addressed by the standard review protocol criteria or directly related to the individuals selected for the review but should be reviewed and addressed by the regional center.

The following are examples of issues that may be included in this section: follow-ups on specific issues relating to individuals; additional regional center follow-up on special incidents; documentation of problems relating to federal requirements, regional center procedures or systems that are currently in place; referrals to the Department Audit Section.