Home and Community-Based 1915(i) State Plan Amendment

(rev 1/1/2025)

MONITORING PROTOCOL

VERSION 1.0

CALIFORNIA DEPARTMENTS

OF DEVELOPMENTAL SERVICES

AND

HEALTHCARE SERVICES

HOME AND COMMUNITY-BASED SERVICES STATE PLAN AMENDMENT

MONITORING PROTOCOL

Overview of the Home and Community-Based Services State plan amendment

Established as part of the Deficit Reduction Act of 2005, section 1915(i) of the Social Security Act gives states the option to provide Home and Community-Based Services (HCBS) without a waiver. One of the key provisions of Section 1915(i) is that eligibility criteria for these services must be less stringent than the institutional level of care criteria required under waivers. The HCBS 1915(i) State Plan Amendment (SPA) allows the Department to access federal funding for community services provided to individuals who do not meet the eligibility criteria of the current HCBS Developmental Disabilities (DD) or Self-Determination Program (SDP) Waivers.

In contrast to the HCBS Waiver, the HCBS 1915(i) SPA does **not** require an individual to meet the criteria for institutional level of care. The HCBS 1915(i) SPA requires states to establish "needs-based eligibility criteria". This distinction allows states to offer HCBS to individuals who have a need for services, but whose needs are not severe enough to qualify them for institutional care or waiver services. The "needs-based eligibility criteria" for the HCBS 1915(i) SPA in California has been determined to mean those individuals eligible for regional center services. An individual on the HCBS 1915(i) SPA may not be on an HCBS Waiver, including the 1915(c) DD and the SDP Waivers.

Eligibility for the HCBS 1915(i) SPA

In order to be eligible for the HCBS 1915(i) SPA, an individual must:

1. Be eligible for regional center services based on a diagnosed developmental disability as defined in Welfare and Institutions Code 4512;
2. Be a Medi-Cal beneficiary (not through institutional deeming);
3. Reside in the community (own home, community care facility, etc.); and,
4. Have their Individual Program Plan reviewed annually.

Administration of the California State Plan Amendment

Department of Health Care Services (DHCS)

- Medicaid Single State agency
- Responsible for oversight and monitoring of programmatic and fiscal aspects of the State Plan Amendment (SPA)

Department of Developmental Services (Department)

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

Regional Centers

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

Overview of the Home and Community-Based Services Collaborative monitoring Process

Overview of the Home and Community-Based Services Collaborative monitoring reviews are conducted every two years for each regional center. Each review has three phases: pre-review, desk review, and post-review. Pre-review activities include notification of the regional center and selecting a sample of Home and Community-Based Services (HCBS) 1915(i) State Plan Amendment (SPA) participants. The desk review includes the review of records for individuals supported by the regional center through the HCBS 1915i SPA. 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

The Department of Developmental Services (Department) reviews a representative sample of individuals receiving 1915i State Plan Amendment (SPA) services. 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 40,000 recipients, the sample size would be 381. The sample for the two-year cycle consists of a statewide sample of 1915i SPA participants selected at random.

1. The review begins by calculating the actual percentage of all 1915i SPA participants for the regional center that is the subject of the review. This is done by calculating the regional center's percentage of the statewide total participants in the 1915i SPA. The calculation is made using data preceding the start of the monitoring cycle.

2. The next step is to create a list of SPA participants for review. The list is created by randomly selecting for the sample 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.

The State's collaborative-monitoring review activities for the HCBS 1915(i) SPA will incorporate information obtained from the concurrent HCBS Waiver monitoring reviews including: interviews with regional center clinical, service coordination, and quality assurance staff; interviews with direct support professionals; facility evaluations and reviews of special incident reports; HCBS Settings Requirements. Each of these activities is conducted using a standard interview format, standard interview questions, and checklists and/or standardized monitoring tools. The collaborative reviews are

conducted over the course of one to three weeks. The initial tasks of the review process include reviewing regional center individual records, service provider (vendor) files, and interviewing regional center personnel. Regional center personnel are interviewed to gather information and evaluate that they: are knowledgeable regarding the individual' services, health and safety, HCBS Settings Requirements and service needs; monitor service providers (vendors) in accordance with applicable law and follow-up on issues/deficiencies; are knowledgeable regarding special incident management, reporting, and individual risk mitigation; provide clinical consultation and oversight as needed to address individual needs; and provide individuals with information and access to due process procedures.

HCBS 1915i SPA 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 records will be reviewed for all participants in the sample. Special incident reports are reviewed for compliance with reporting and follow-up requirements.

Review and Data Collection Instruments

Review Section I Regional Center Record Review

The individual's record is the key document used to monitor regional center compliance with the 1915i SPA 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 Special Incident Report (SIR) review. The record review consists of 18 criteria associated with, 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 Center

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 II Special Incident Reports

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 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.

Section III 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; special incidents; documentation of problems relating to regional center procedures or systems that are currently in place; referrals to the Department of Developmental Services 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 Servies (DHCS). The review dates will be concurrent with the HCBS Wavier scheduled reviews.

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

3. HCBS Monitoring Section will request database information such as fair hearings, special incident reports, individual complaints, etc., for any individual in the HCBS 1915i (SPA) sample for pre-audit review and analysis.

4. Thirty days prior to the start of the review, the Department will electronically transmit the list of the individuals selected for review to the regional center.

5. 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 regional center individual records for the selected sample are reviewed for compliance with the criteria in the monitoring protocol.

c. Within two weeks following the onsite review, the monitoring team conducts an 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/DHCS will submit a written report of the 1915i SPA review findings and recommendations to the regional center. 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 the regional center's response and actions plans to the recommendations in the HCBS 1915i SPA report, the Department will review the response and action plans 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 Report 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 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 (IPPs) that are developed by the planning team to define and address his or her service and support needs; running ID 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 elements supporting the initial and ongoing eligibility for the Home and Community-Based Services (HCBS) 1915(i) State Plan Amendment (SPA).

The individual record is the collection of documents used to monitor regional center compliance with the HCBS 1915(i) SPA requirements. It is the collection of documents that is reviewed by the Department of Developmental Services (Department) monitoring team as well as the Centers for Medicare and Medicaid Services (CMS) during compliance audits. 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 I address the requirements for documentation contained in the regional center's individual records in the following areas: notification of proposed action and fair hearing rights, Individual Program Plans (IPPs), assessment of needs, and periodic reviews and reevaluations of services. The criteria are derived from federal/state statutes and regulations, and from CMS directives and guidelines relating to the provision of HCBS 1915(i) SPA services. Each criterion is followed by verification instructions for determining compliance. In some cases, there is an explanation for the criterion.

Criterion

1.0 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 1915 (i) State Plan Amendment (SPA). 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.

1.2 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 Individual Program Plan (IPP), *[W.I.C. 4710(a)(1) (2023)]*

Verification Instructions

1. Review the individual's 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 correspondence for documentation that services or choice of services has been denied.

2. Score as (+) if:

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

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

   c. 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 been denied** a choice of services, type of service, service provider, type of provider, or amount of services; **or**

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

   c. a 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.

1.3 The IPP for every individual is reviewed, and revised as appropriate, 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 plan that is used to 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 system recognizes that 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 HCBS 1915(i) 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 document has been completed, **or**

b. An annual review form has been completed documenting why 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.

1.4.a The IPP is prepared jointly with the planning team and 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, or 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, or conservator or authorized representative. If the individual or, where appropriate, their parents, legal guardian, or 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 1.2.)

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, or conservator or authorized representative, have not signed the IPP prior to its implementation. Comment on what is missing.

1.4.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.

1.5 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.

1.6 The IPP addresses 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 identified needs 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)]*

Explanation

1.6.a The IPP addresses special health care requirements and safety risks. *[42 C.F.R. § 441.301(c)(2)(vi) (2025)]*

Verification Instructions

1. Review the Client Development Evaluation Report (CDER) for any special healthcare 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.

1.6.b The IPP reflects the services and supports that will assist the individual to achieve identified goals, for which the community care facility (CCF) 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 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.

1.6.c The IPP reflects the services and supports that will assist the individual to achieve identified goals for which the day program 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 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.

1.6.d 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 services (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 ILS or SLS agency is responsible

2. Score as (-) if the IPP does not contain specific services and supports for which the ILS or SLS agency is responsible. Comment on which of the needs are not addressed.

3. Score as (NA) if the individual does not receive ILS or SLS.

1.6.e 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.

1.6.f 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, lives with family and the IPP does not include a family plan component.

3. Score as (NA) if the individual is 18 or older or if the individual does not live at home.

1.6.g 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.

1.7.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 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 being 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.

1.7.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 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 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 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 that are documented in the record.

1.7c 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.

1.8 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 supports.

2. Score as (-) if IPP or addenda does not identify the provider or providers of service responsible for implementing services. Comment on which objectives do not identify the provider or providers of service responsible for implementing the services.

1.9.a Quarterly face-to-face meetings are completed with individuals living in community out-of-home settings, i.e., Service Level 2-7 community care facilities (CCF), family home agencies (FHA), or supported living (SLS) and independent living settings (ILS). *[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 representative were completed within the required timeframes.

2. Score as (-) if the individual lives in a Service Level 2-7 CCF, FHA, 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.

1.9.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 community care facilities (CCF), family home agencies (FHA), or supported living (SLS) and independent living settings (ILS) . *[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.

SECTION II

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 receiving services regardless of cause and/or the individual is the victim of a crime. Title 17 requires all vendors to report special incidents to the regional center 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 the 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 been reported within the timelines, that the documentation meets the requirements of Title 17, and that the follow-up was complete. The report to the regional center will include those areas where there were negative findings.

Criterion

2.0 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 1915i SPA status “code 7”, (closed/deceased) individuals in the Client Master File (CMF) for the 12-month review period.

2. Special Incident Reports (SIRs) of HCBS 1915i SPA 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” SPA individuals in the CMF.

2. Score as (+) if the SPA 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 SPA participant has a status “code 7” in the CMF. Comment on the number of unreported deaths.

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

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

Sample

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

Verification Instructions

1. Compare SIRs in the sample of SPA individual records selected for the regional center SPA 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's list of reported SIRs for the individuals.

2.2.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

Five SPA participants 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 and the date of the report to the regional center in the comment section.

2.2.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

Five SPA participants 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 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.

2.3 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

Five SPA participants who had special incidents pursuant to Cal. Code. Regs tit. 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 III 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.