Appendix 12—Facility Based Community Settings Questionnaire (CSQ)

Please complete this form:

1. Annually;
2. When a participant changes providers or adds an additional provider; or
3. During the monitoring visit when new rules/requirements implemented by the service provider.

The following settings do not meet the definition of Community Setting and are not approved locations for receiving Home and Community-Based Services:

Please ensure the setting is not one of the following:

1. Nursing Facility;
2. An institution for mental diseases;
3. An intermediate care facility for individuals with intellectual disabilities;
4. A hospital providing long term care services; or
5. Any other locations that have qualities of an institutional setting. This includes the following:
    a. A setting located in a building that is also a publically or privately operated facility that provides inpatient institutional treatment;
    b. A setting in a building on the grounds of or immediately adjacent to a public institution; or
    c. Any other setting that has the effect of isolating individuals receiving Medicaid HCBS; from the broader community.

Auto-populate/Display DOB and Age

Please answer the following questions regarding the applicant/participant's day activities.

1. Access to the greater community:
    a. Does the participant have the opportunity to seek employment if they choose?
    Yes☐ No☐
    b. Is the participant able to engage in community life in the way they choose? Is the participant able to go out into the community during the day if they want to? Yes☐ No☐
2. Rights:
    a. Are there systems to ensure the participant's rights of privacy, dignity and respect are being met?
    Yes☐ No☐
    b. Were these systems reviewed with the participant? Yes☐ No☐
    c. How are the participant's rights of privacy, dignity, and respect ensured?

    d. Does the day setting appear free of coercion or restraint? Yes☐ No☐
    e. How is freedom of coercion and restraint ensured?

3. Is the participant offered choices about what they want to do during the day? Yes☐ No☐
4. Can the participant choose who provides their services in this setting? Yes☐ No☐
5. Are participants informed about freedom of choice of providers and given options to change their services if they desire?
    Yes☐ No☐
6. Does the participant control their own schedule? Yes☐ No☐
7. Is the setting physically accessible for the participant? Yes☐ No☐

Please explain how you have verified 1-7 *above. Please note that verification should include:*

- *a site visit,*
- *discussion with the participant during the person-centered planning process,*
- *a review of relevant documents such as the activities schedules, meeting minutes, provider policies, or other documents,*
- *photographs or direct observation of the accessibility features,*
- *and/or discussion with family or other representatives.*

Please note that verification solely through provider report is not sufficient. Verification must be noted in order for a determination to be made. Incomplete verification information will be returned for clarification.

<u>If any of the above answers to questions are no, please provide documentation in the Plan of Service or Person Centered Plan that:</u>

1. Identified a specific and individualized assessed need to support modifications to the HCBS conditions.
2. Shows the positive intervention and supports used prior to modifications to the person-centered service plan.
3. Identifies less intrusive methods for meeting the need that have been tried but did not work.
4. Includes a clear description of the condition that is directly proportionate to the specific assessed need.
5. The Plan of Service/Person-Centered Plan must:
    a. Include regular collection and review of data to measure the ongoing effectiveness of the modification;
    b. Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated;
    c. Include the informed consent of the participant; and
    d. Include an assurance that interventions and supports will cause no harm to the participant.

Appendix 13 Residential Based Community Settings Questionnaire (CSQ)

Please complete this form:

1. Annually;
2. When a participant moves; or
3. During the visit, if there is a change in residence or living situation such as:
    a. A new roommate or
    b. New rules/regulations in the residence.

The following settings do not meet the definition of Community Setting and are not approved locations for receiving Home and Community-Based Services. Please ensure the setting is not one of the following:

1. Nursing Facility;
2. An institution for mental diseases;
3. An intermediate care facility for individuals with intellectual disabilities;
4. A hospital providing long term care services; or
5. Any other locations that have qualities of an institutional setting. This includes the following:
    a. A setting located in a building that is also a publically or privately operated facility that provides inpatient institutional treatment;
    b. A setting in a building on the grounds of or immediately adjacent to a public institution; or
    c. Any other setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community.

Auto-populate/Display DOB and Age

Please answer the following questions regarding the applicant/participant's community residence.

Is the residence:

1. A home owned or leased by the participant or their family member? Yes □ No □
2. An apartment with an individual lease, with lockable access and egress, and which includes living, sleeping, bathing, and cooking areas over which the participant or the participant's family has domain and control? Yes □ No □
3. Other shared housing, chosen by the individual, not owned or controlled by a provider? Yes □ No □
    a. Number of unrelated people living together at this address or in this setting: _____
4. Do any unrelated individuals receive services or supports in this setting? Yes □ No □
    a. If yes, please describe below:

If the answers to 1 or 2 = yes and 3 and 4 = No, then auto-approve as a community setting.
If 3 or 4 are yes, trigger additional questions.

5. Access to the greater community:
    a. Does the participant have the opportunity to seek employment if they choose? Yes □ No □
    b. Is the participant able to engage in community life in the way they choose? Yes □ No □
    c. Does the participant have control over personal resources? Yes □ No □
6. Did the participant choose the residence? Yes □ No □
7. Rights of the participant:
    a. Are there systems to ensure the participant's rights of privacy, dignity and respect are being met? Yes □ No □
    b. How are the participant's rights of privacy, dignity, and respect ensured?

c. Does the residential situation appear free of coercion or restraint? Yes □ No □
d. How is freedom of coercion and restraint ensured?

8. Does the participant feel they are independent in making life choices (with or without the assistance of a chosen representative)? Yes □ No □
9. Can the participant choose who provides their services in this setting? Yes □ No □
10. Are participants informed about freedom of choice of providers and given options to change their services if they desire? Yes □ No □
11. Does the participant have a lease or other legally enforceable agreement? Yes □ No □
12. Privacy:
    a. Can the participant lock their door? Yes □ No □
    b. Did the participant have a choice of their roommate or private room if they can afford one? Yes □ No □
    c. Does the participant have the freedom to decorate? Yes □ No □
13. Freedom:
    a. Does the participant control their own schedule? Yes □ No □
    b. Does the participant have access to food at any time? Yes □ No □
14. Can the participant have visitors at any time? Yes □ No □
15. Is the setting physically accessible for the participant? Yes □ No □
16. Does the participant interact with community members who do not receive services? Yes □ No □

Please explain how you verified numbers 1-16 above. Please note that verification should include:

- *a site or home visit,*
- *discussion with the participant during the person-centered planning process,*
- *a review of relevant documents such as the signed lease or house rules documents,*
- *photographs or direct observation of the locks and accessibility features,*
- *and/or discussion with family or other representatives.*

Please note that verification solely through provider report is not sufficient. Verification must be noted in order for a determination to be made. Incomplete verification information will be returned for clarification.

If any of the above answers to questions are no, please provide documentation in the Plan of Service or IEP/ Person Centered Plan that:

1. Identified a specific and individualized assessed need to support modifications to the HCBS conditions.
2. Shows the positive intervention and supports used prior to modifications to the person-centered service plan.
3. Identifies less intrusive methods for meeting the need that have been tried but did not work.
4. Includes a clear description of the condition that is directly proportionate to the specific assessed need.
5. The Plan of Service/Person-Centered Plan must:
    a. Include regular collection and review of data to measure the ongoing effectiveness of the modification;
    b. Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated;
    c. Include the informed consent of the participant; and
    d. Include an assurance that interventions and supports will cause no harm to the participant.