DHS Oregon Department of Human Services

Seniors and People with Disabilities

Action Request Transmittal

James Toews
Authorized Signature

Number: **SPD-AR-05-069**
Issue Date: 10/07/2005

Topic: Developmental Disabilities

Due Date: On or before 1/31/06

Subject: HCBS Waiver Review Checklist: Statewide Sample

Applies to (check all that apply):

- ☐ All DHS employees
- ☐ Area Agencies on Aging
- ☐ Children, Adults and Families
- ☒ County DD Program Managers
- ☐ County Mental Health Directors
- ☐ Health Services
- ☒ Seniors and People with Disabilities
- ☒ Other (please specify): DD Support Service Brokerage Directors DD QA Coordinators

Action Required: Community Developmental Disability Programs (CDDPs) must complete file reviews to determine whether certain Centers for Medicare/Medicaid Services conditions for participation in the Title XIX comprehensive and support waiver services are met. Reviews involve initial examination of CDDP records---and certain Support Services Brokerage records----and follow-up to confirm corrections when needed. Initial examination results must be submitted to Seniors and People with Disabilities on or before January 31, 2006.

SPD has chosen a sample of individuals who receive waiver services and who are to be included in this statewide review. SPD will send each CDDP and brokerage an appropriate list from this sample. The form to be used to document each review---the **Home and Community Based Services Waiver Review Checklist**---and instructions for completing the form are attached to this Action Request.

Support Services Brokerages are asked to assist with reviews related to individuals in support services by making available to CDDP staff: 1) quarterly reviews of individual plans; 2) annual reviews of individual plans; 3) written grievances and complaints; 4) resolution of written grievances and complaints. CDDP staff must inform Brokerage Directors of results of reviews of records for individuals enrolled in support services. Brokerage Directors are in turn expected to communicate information about timelines and completion of corrective activities to CDDP staff conducting the review.

Reason for Action: The Centers for Medicare/Medicaid Services (CMS) requires Seniors and People with Disabilities to collect, analyze, and act upon information to maintain and improve quality in waiver services. SPD has made contract arrangements to support statewide and local waiver quality assurance processes through specific resources located in CDDPs. This annual sample review of individual files is a primary means of assessing SPD compliance with basic Medicaid requirements for individuals waiver services.

Field/Stakeholder review: ☐ Yes ☒ No

If yes, reviewed by:

If you have any questions about this action request, contact:

Contact(s):	Victoria Storie		
Phone:	(503) 945-6976	**Fax:**	(503) 373-7591
E-mail:	Victoria.Storie@state.or.us		

Seniors and People with Disabilities

Home and Community Based Services Waiver Review Checklist

PLEASE PRINT LEGIBLY

CDDP/Other Program:		**Brokerage:**
Individual:	**Prime No.:**	**Personal Agent:**
Service Coordinator:	**Reviewer:**	**Review Date:**

Part I. Title XIX File Review

1. Is the individual's annual plan current? **Yes** ☐ **No** ☐

2. Waiver Services	**Service Rec'd**	**Cons't w/ Waiv.Form Y / N**	**Cons't w/AP Y / N**	**Notes**	**Corrective Action**
Foster Home (Ad. or Ch.)					
24-Hour Residential					
Supported Living					
Employment/Alternatives					
Support Services (Adults)					
Comp. In-Home (Adults)					
Family Support > $20K/year					
Children's Int. In-Home					
Crisis/Diversion					

	Yes	**No**	**N/A**	**Notes**	**Corrective Action**
3. If annual plan is not current, there is record of reason for delay and date by which the meeting will be held.					
4. Annual plan, meeting notes, and/or brokerage goal survey reflect discussion of: (a) need for evaluations; (b) health care needs; (c) previous and proposed plans; (d) individual preferences, how met/not met and why.					
5. Changes to the annual plan are recorded on either the ISP or amendment.					
6. CDDP files for individuals in 24-hour residential or foster home services contain evidence that service coordinators have monitored services per OAR 411-320-0130.					
7. Title XIX Waiver Form is located in the central records system.					

Part II. Title XIX Waiver Form Review

	Yes	**No**	**N/A**	**Notes**	**Corrective Action**
1. Form Item 11: Service Client is Currently Receiving.					

	Yes	No	N/A	Notes	Corrective Action
2. Form Item 12: Choice Offered.					
3. Form Item 13: Fair Hearing					
4. Form Item 14: Client/ Guardian Signature.					
5. Form Box 15: Annual Ongoing Verification of Need for ICF/MR/Hospital Level of Care.					
6. Waiver Form Box 16: Review and Verification of Need for ICF/MR/Hospital Level of Care.					

Part III. Other Review Information

1. DD Eligibility Documentation: ☐MR ☐DD only	**Yes**	**No**	**Notes**	**Corrective Action**
2. Eligibility determination based on:				
a. Full Scale IQ				
b. Documentation of disability other than MR				
c. Adaptive Score				
d. Other records: Date: Location:				
3. For CIIS only---MFCU or CIIS initial entry criteria present with re-evaluation according to Administrative Rules.				
4. Have there been any grievances or complaints made by the individual, family or other? If yes, indicate date of the complaint and date of resolution.			**Complaint Date:**	**Date Resolved:**

Part IV. Correction Follow-Up: Corrections Required? ☐Yes ☐ No

SECTIONS NEEDING CORRECTION (CIRCLE):

By CDDP:	**By Brokerage:**
TXIX File Review: 1 2 3 4 5 6 7	**TXIX File Review:** 1 2 3 4 5 6 7
TXIX Waiver Form Review: 1 2 3 4 5 6	**TXIX Waiver Form Review:** 1 2 3 4 5 6
Other Review Information: 1 2 3 4	**Other Review Information:** 1 2 3 4

Checklist findings reported to: • CDDP/Other: _____ • Brokerage: _____	All corrective actions to be complete: • CDDP/Other: _____ • Brokerage: _____
Corrective actions reviewed by:	Date reviewed:

Notes:

Retain completed HCBS Waiver Review Checklist in individual case file.

Seniors and People with Disabilities
Developmental Disability Services

Home and Community Based Services Waiver Review Checklist
2005 Statewide Sample

The annual statewide sample file review is an important means for SPD to check whether certain basic Centers for Medicare and Medicaid Services (CMS) requirements for providing Medicaid waiver services are met. To complete this activity for 2005, community developmental disability programs (CDDPs) and other programs that provide service coordination for individuals in DD waiver services must:

- Review files for individuals selected by SPD from those open in waiver services as of August 2005;
- Document review results for each individual using the HCBS Waiver Review Checklist; and
- Submit individual results to SPD by January 31, 2006 for entry into a statewide information database.

SPD will accept results of reviews conducted throughout calendar year 2005 for the SPD-designated individuals as long as the Checklist used is 7/04A version distributed for the 2004 and 2005 reviews.

CDDPs and service coordination programs conducting the review must retain original completed Checklists, submit copies to SPD for entry into the statewide database, and provide copies of Checklists related to individuals in Support Services to the Directors of the individuals' Support Service Brokerages. Questions and copies of completed Checklists should be directed to:

Victoria Storie, QA Coordinator
Seniors and People with Disabilities
500 Summer St. NE, E-19
Salem OR 97310-0175
Fax: (503) 373-7591
Victoria.Storie@state.or.us

Thank you for your assistance!

General Instructions

Complete all sections of the form. Type entries or print clearly. Use NOTES fields adjacent to questions if necessary to clarify findings. Use NOTES section at end of form to record observations and recommendations about the review process. When **NO** box has been checked (or NO or N written in), use Corrective Action boxes to record dates when steps have been initiated to correct what can be corrected and prevent similar problems in the future.

Basic Information Section

FIELD	ENTER
CDDP/Other Program	Name of Community Developmental Disability Program (county name), Children's Intensive In-Home Support Program (CIIS), Children's Residential Services (CRS), or other program completing the review
Brokerage	Support Service Brokerage in which individual is enrolled (if applicable)
Individual	Name of person with developmental disabilities whose records are being reviewed
Individual Prime No.	Medicaid prime number assigned to individual
Personal Agent	Name of individual's Brokerage Personal Agent (if applicable)
Service Coordinator	Name of CDDP/Other Program Service Coordinator assigned to the individual
Reviewer	Name of CDDP/Other Program employee reviewing individual records to complete the Checklist.
Review Date	Date individual records are reviewed to complete the Checklist

Part I. Title XIX File Review

1. Is the individual's annual plan* current? (Annual plan may be called individual support plan, child and family support plan, plan of care, or other annual plan named in administrative rules governing the service.)

Check **YES** Box if:	Check **NO** box if:
Date of signature of individual/legal representative on annual support plan found in individual's record and used to guide current services is no more than 12 months before the month of this review.	No annual plan in individual's record; Plan initiated and signed more than 12 months before month of this file review; or More than twelve months elapsed since individual (or legal representative) signed and initiated plan, but development of new plan has been scheduled and reasons for delay documented.

2. Waiver Services: Foster Home (adults or children); 24-Hour Residential (adults or children); Supported Living; Employment or Alternative to Employment; Support Services (for adults enrolled in Support Service Brokerages); Comprehensive In-Home Services (adults living at home w/ service cost over $20,000/year); Family Support (children living at home w/ service cost over $20,000/year); Children's Intensive In-Home Support; Crisis/Diversion.

Write **Yes** under **"Service Rec'd"** (Services Received) if individual was enrolled in a service during period covered by most recent support plan. For Foster Home, 24-Hour Residential, Supported Living, and Employment/Alternative services, possible services received are services described in applicable administrative rules. For Support Services, Comprehensive In-Home Support Services, Family Support Services, and Crisis/Diversion Services, possible services received are paid described in applicable administrative rules as well as other supports described in the current plan and goal survey.	
Write **YES** or **Y:**	Write **No** or **N:**
Under **"Cons't w/Waiv. Form"** (Consistent with Waiver Form) if services received were consistent with needs noted on individual's Title XIX Waiver Form.	Under **"Cons't w/Waiv. Form"** if services received were not consistent with needs noted on individual's Title XIX Waiver Form.
Under **"Cons't w/AP"** (Consistent with Annual Plan) if records* indicate paid services received were consistent with services outlined in the most recent annual support plan.	Under **"Cons't w/AP"** if records* indicate paid services received were not consistent with services outlined in the most recent annual support plan.

***** Records include service coordinator progress notes, service coordinator monitoring records, service coordinator plan reviews, and---for individuals in Support Services---personal agent plan reviews.

3. If annual plan is not current, there is record of reason for delay and date by which the meeting will be held.

Check **YES** Box if:	Check **NO** box if:	Check **NA** box if:
File includes reason for delay and date by which new annual plan meeting will be held AND proposed schedule should result in new annual plan, signed and dated by all parties, within 15 months of most recent annual plan.	One or more criteria for **YES** are not present.	The answer to Question 1---Is the annual plan current?---was **YES**.

4. Annual plan, meeting notes, and/or brokerage goal survey reflect discussion of: (a) need for evaluations; (b) health care needs; (c) previous and proposed plans; (d) individual preferences, how met/not met and why.

Check **YES** Box if:	Check **NO** box if:
Records of preparation for annual plan, plan meeting notes, or plan itself contain evidence that: ► Applicable professional, clinical, or educational evaluation needs were considered; ► Health care needs were identified and addressed; ► Previous plan activities and response were reviewed; ► Proposed plan activities were recorded; ► Individual preferences were identified and addressed; and ► if preferences were identified but are not clearly evident in services, records explain why and what was done to more closely align services to preferences.	There are no records of discussion of one or more issues listed in Item 4(a)-(d) in preparation for most recent plan on record, meeting discussions, or plan.

5. Changes to the annual plan are recorded on either the annual plan or amendment.

Check **YES** Box if:	Check **NO** box if:	Check **NA** box if:
Changes in type, scope, duration of services are recorded on annual plan or amendment to the plan and individual (or legal representative) has signed and dated the plan or amendment indicating approval of changes.	Changes in type, scope, duration of services are not recorded or have not been approved by the individual (or legal representative).	No changes have been made in type, scope, duration of services since most recent annual plan was initiated.

6. CDDP files for individuals in 24-hour residential or foster home services contain evidence that service coordinators have monitored services per OAR 411-320-0130.

Check **YES** Box if:	Check **NO** box if:	Check **NA** box if:
Individual receives 24-hour residential or foster home services as Checklist is being completed and individual's services have been monitored as specified in the Administrative Rule for the past twelve months.	Individual receives 24-hour residential or foster home services as Checklist is completed and monitoring is required, but there is no record of monitoring specified in Administrative Rule in the past twelve months.	Individual is not receiving 24-hour residential or foster home services at time Checklist is completed.

7. Title XIX Waiver form is located in the central records system.

Check **YES** Box if:	Check **NO** box if:
Check **YES** box if individual's Title XIX Waiver Form is located in records related to individual and maintained by: ►CDDP, when individual receives Comprehensive In-Home Services, Family Support costing over $20,000 per year for children living at home, Crisis/Diversion services, Employment/Alternative to Employment, Supported Living, Foster Home, 24-Hour; Residential, Support Services; ►SPD Children's Intensive In-Home Support Unit when individual receives services provided by that Unit; or ► SPD Children's Residential Program when individual receives Children's 24-Hour Residential and Foster Care services through that program.	Check **NO** box if individual's current Title XIX Waiver Form cannot be located in records related to the individual and maintained by the appropriate agency.

Part II. Title XIX Waiver Form Review

Corrective activities in this section may include late entries for Title XIX Waiver Form items related to choice and request for fair hearing. In these cases, make a note of "late entry" directly on the TXIX Waiver Form, followed by appropriate record of offer of choice or notification of fair hearing rights. After the Title XIX Waiver Form is re-signed and re-dated by individual or legal representative, send a copy of the amended form to SPD's CMS Waiver and Federal Reporting Section and enter a case note in the individual's file.

1. Form Item 11: Service Client is Currently Receiving.

Check **YES** Box if:	Check **NO** box if:
►Services checked on TXIX Waiver Form are services individual currently receives---through any resources available to individual and are included in individual's annual plan or planning documents; or ►Documentation associated with TXIX Waiver Form indicates action taken in response to previous reviews, making waiver form and annual plan or planning documents consistent with services received.	Services checked on TXIX Waiver Form are NOT services individual receives---through any resources available to individual or ☛ are NOT included in individual's annual plan or planning documents.

2. Form Item 12: Choice Offered.

Check **YES** Box if:	Check **NO** box if:
►**YES** box on TXIX Waiver Form is checked indicating individual (or individual's legal representative) was offered choice among ICF/MR, Medical, or Community Program services and ► Date choice was offered is written on or near line provided and ►Community Program box is checked, indicating individual (or individual's legal representative) has chosen home and community based services. **OR** ►Records associated with TXIX Waiver Form indicate corrective action in response to previous reviews, resulting in documented offer of choice.	►**NO** box on TXIX Waiver Form is checked or ►Neither the YES or NO box is checked or ► No date has been entered on or near line provided or ►Community Program box has not been checked.

3. Form Item 13: Fair Hearing. Instructions for completion of this item may have changed during the period of review, affecting how this item is evaluated. The key difference in the two instructions: Situation 1---**YES** and **NO** boxes indicate whether individual requested a fair hearing when informed of right to fair hearing; and Situation 2---**YES** and **NO** boxes indicate whether individual has been informed of fair hearing rights.

Check **YES** Box if:	Check **NO** box if:
Situation 1. **YES** box is checked and date entered to indicate individual was informed of hearing rights, received an "Applicable Rules and Laws" form, and requested a hearing on that date or ► The **NO** box has been checked and date	**Situation 1 and 2.** Neither **YES** nor **NO** box has been checked; or ►no date of notification has been entered in space

Check **YES** Box if:	Check **NO** box if:
entered to indicate individual was informed of hearing rights, received "Applicable Rules and Laws" form, and did NOT request a fair hearing on that date. **Situation 2.** **YES** box has been checked indicating that individual (or individual's legal representative) has been notified of right to fair hearing and "Applicable Rules and Laws" form was provided at notification; ► date of notification is entered in space provided; and ► if hearing was requested at notification, the date and outcome of hearing is entered in space provided. **OR** Record indicates corrective action in response to previous reviews, resulting in documented and appropriate notification of fair hearing rights.	provided. **Situation 2.** The **NO** box has been checked; or ► no date of notification has been entered in the space provided.

4. Form Item 14: Client/Guardian Signature.

Check **YES** Box if:	Check **NO** box if:
► Individual has signed TXIX Waiver Form or ► Individual's legal representative has signed form or ►Documentation associated with TXIX Waiver Form indicates appropriate signatures have been obtained as part of corrective action taken in response to previous reviews.	► No signature of individual or legal representative or ►Signature on form is not that of the individual or legal representative or ► Individual's legal representative has not signed form.

5. Form Box 15: Annual Ongoing Verification of Need for ICF/MR/ Hospital Level of Care.

Check **YES** Box if:	Check **NO** box if:	Check **NA** box if:
More than 12 months have passed since date Diagnosis & Evaluation Coordinator reviewed and verified need for ICF/MR Level of care and: ►Dates indicate that first verification is conducted by the end of the 12th month after D & E approval and subsequent reviews have been conducted at least annually in or before the same month or ►If more than 12 months have elapsed between verifications---reasons for any delays in review over last four years are noted **AND** Dates and QMRP/ Service Coordinator signatures are present.	More than 12 months have passed since the month of D & E approval and: ► Date of first ongoing verification is more than 12 months after the month of D & E approval or ► subsequent reviews have not been conducted at least annually in or before the same month or ► dates or QMRP/Service Coordinator signatures are missing and ► no previous reviews, corrective actions, reasons for delay are noted.	Less than 12 months have passed since original offer of choice.

6. Waiver Form Box 16: Review and Verification of Need for ICF/MR Level of Care.

Check **YES** Box if:	Check **NO** box if:
► **APPROVED** box checked and signatures and dates entered in lines provided or ►Documentation associated with TXIX Waiver Form indicates appropriate signatures have been obtained as part of corrective action taken in response to previous reviews.	►**APPROVED** box is NOT checked or ►Signatures and dates are missing.

Part III. Other Review Information

1. DD Eligibility Documentation.

Check the **MR** Box if:	Check the **DD only** box if:
Eligibility for developmental disability services is due to presence of mental retardation.	Eligibility is based on presence of developmental disability other than mental retardation.

2. Eligibility determination based on:

Check **YES** Box if:	Check **NO** box if:
► Information that must be considered according to Department policy has been used to determine eligibility, ► the information confirms eligibility, and ► the information is present in individual's record. If **YES** is checked next to **Other Records**, note date and location of these records.	► Eligibility has not been determined based on information that conforms to Department policy, ► information used is not present in the individual record or ► information used does not confirm eligibility.

3. For CIIS only---MFCU or CIIS initial entry criteria present with re-evaluation according to Administrative Rules. Cross this question out if the individual is not enrolled in Children's Intensive In-Home Support services.

Check **YES** Box if:	Check **NO** box if:
► Initial entry criteria document is present in individual record and ► re-evaluation and re-scoring of criteria has occurred with changes in status and at intervals required by applicable administrative Rules.	► Initial entry criteria document is not complete and present or ► re-evaluation and re-scoring of criteria has not occurred when applicable.

4. Has individual, family, or other representative made any written grievances or complaints about waiver services?

Check **YES** Box if:	Check **NO** box if:
A written complaint or grievance about the nature or provision of waiver services was submitted during the period covered by the most recent annual support plan. Write dates of complaint and resolution in space provided. Attach another page if necessary.	No written complaint or grievance about the nature or provision of waiver services was submitted during the period covered by the most recent annual support plan. Leave spaces provided for dates of complaint and resolution blank.

Part IV. Correction Follow-Up

Corrections Required? Mark the **Yes** box if this review discovered circumstances requiring action to correct or complete current records and avoid future errors. Mark the **No** box if no corrective or preventive action is required.

Sections Needing Correction. This part of the form summarizes items in each preceding section of the form that need corrective or preventive follow-up action. If the **YES** box has been marked at the beginning of this section:

1. Determine what agency has taken responsibility for the corrective or preventive action;
2. In the column headed **"By CDDP"** circle the number of each item to be corrected by the CDDP or other program providing service coordination;
3. In the column headed **"By Brokerage"** circle the number of each item to be corrected by a Brokerage.

Checklist findings reported to: This part of the form reports the name of the person who receives the report of HCBS Waiver Review Checklist local findings and has authority to see that corrective or preventive action is taken or that standards of performance related to this review continue to be met. Even if no corrective or preventive action is required:

1. When the individual is enrolled in any service other than SPD's Children's Intensive In-Home Support (CIIS) or Children's Residential Services (CRS), write in the name of the CDDP representative who receives the report of findings;
2. When the individual is enrolled in SPD's CIIS or CRS, write in the name of the manager of the program;
3. When the individual is enrolled in a Support Services Brokerage, write in the name of the Executive Director of the Brokerage and provide the Executive Director with a copy of the completed Checklist.

All corrective actions to be complete: This part of the form reports final dates by which the CDDP, Other Program, or Brokerage, depending which agency is responsible, expects to complete all corrective or preventive measures. Corrective or preventive action does not need to be complete before the HCBS Waiver Review Checklist findings are submitted to SPD, but projected completion dates should reflect reasonably prompt and responsive attention.

Corrective actions reviewed by (and date reviewed): This part of the form records the name of the CDDP/Other Program employee who reviews and confirms completion of corrective or preventive activities. Fill in that name and final review date when activities are complete.