Seniors and People with Disabilities
Developmental Disability Services

Home and Community Based Services Waiver Review Checklist
2006 Statewide Follow up Activity

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. The 2004 Statewide Sample established a baseline for accuracy and timeliness. The 2005 Statewide Sample data has been compiled and a report of findings should be available for stakeholders in the near future.

The 2006 Statewide Activity will be a review of corrective actions identified during the 2005 reviews. Seven questions on the checklist will be reviewed. To complete this activity, community developmental disability programs (CDDPs) and other programs that provide service coordination for individuals in DD waiver services must:

- Review the 2006 files for individuals identified as needing corrective actions from the 2005 Statewide Sample;
- Document review results for each individual using the modified 2006 HCBS Waiver Review Checklist; and
- Submit individual results to SPD by 5:00 PM on **May 4, 2007** for entry into a statewide information database.

CDDP's 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. Please submit them electronically or make sure the hand writing is legible. Questions and copies of completed Checklists should be directed to:

Dawn Andersson, CMS QA Coordinator
Seniors and People with Disabilities
500 Summer St. NE, E-19
Salem OR 97310-0175
Fax: (503) 373-7274 Attn: Dawn Andersson (Green 34)
Dawn.C.Andersson@state.or.us

Thank you for your assistance!

General Instructions

Complete all sections of the modified 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.

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.

NOTE: Please refer to 411-320-0130 Monitoring of Services (Effective 02/01/2006) and CDDP Annual Schedule to determine if the monitoring is in compliance. This means some placements may require monitoring less frequently than 12 times in a year.

Part II. Title XIX Waiver Form Review

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 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.	**Situation 1 and 2.** Neither **YES** nor **NO** box has been checked; or ►no date of notification has been entered in space provided. **Situation 2.** The **NO** box has been checked; or ► no date of notification has been entered in the space provided.

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:
Less 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.

NOTE: The Title XIX Waiver Form must be reviewed, updated, and signed by the QMRP/Service Coordinator with in 12 months from previous review.

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.

NOTE: Keep in mind if an individual's eligibility is based on MR then at minimum FSIQ should be available and based on DD should have at minimum Adaptive Score available.

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.