NC DHHS
HOME AND COMMUNITY BASED SETTINGS (HCBS)
SELF-ASSESSMENT

Compliance with Statewide Transition Plan Alignment with CMS HCB Setting Regulation Requirements
(42 CFR Sections 441.301 (c) (4) - (6); Section 441.302 and 441.530)

LME/MCO or Local Lead Agency (Case Management Entity)_____

Subcontractor (if applicable)_____ **NPI#:** _____ **MHL License # (if applicable)** _____

Site Name/Address_____

HCBS Service Type: **Residential** ☐ **Day Supports/Adult Day Health** ☐ **Supported Employment** ☐

Facility Type: _____ **Bed Size/Facility Capacity:** _____

Number of Persons Supported Through HCBS Waiver: _____

- ***Before completing self-assessment, indicate the intent to comply with all HCBS Setting Rule Requirements: Yes___ No ____***
- ***If Yes, continue. If No, enter the number of individuals through Medicaid HCBS that will need to be transitioned: ____***
- ***Self-Assessment must be completed for each site providing HCBS Service(s), submitting one for an organization will not be accepted.***

Section I: Settings That Are Not Home And Community Based:

1. Is the facility one of the following? • *Nursing facility* • *Institution for Mental Diseases* • *Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID)* • *Hospital* **If any of these are checked yes, the facility cannot meet HCBS Criteria for community based settings.**	☐ **Yes** ☐ **No** ☐ **Yes** ☐ **No** ☐ **Yes** ☐ **No** ☐ **Yes** ☐ **No**
2. Is the facility in one of the following locations? • *a building that is also a publicly or privately operated facility that provides inpatient institutional treatment*	☐ **Yes** ☐ **No** ☐ **Yes** ☐ **No**

• *a building on the grounds of, or immediately adjacent to, a public institution* • *a setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS* **If any of these are checked yes, the setting is presumed to not meet HCBS Criteria for community based settings, and would require approval of the Secretary of the United States Department of Health and Human Services (HHS).**	☐ **Yes** ☐ **No** ☐ **Yes** ☐ **No**

SPECIAL NOTE FOR SECTION II AND SECTION III:

All elements for each characteristic must be met for the response to be Yes. Evidence of support should be submitted in circumstances where element(s) of a characteristic is/are met, but a plan of action/correction is required for any element(s) that is/are not met. This will ensure monitoring only occurs for the area(s) that is/are out of compliance.

Section II: General HCBS Criteria

1. The setting is integrated in and supports full access to the greater community (work, live, recreate, and other services). There are opportunities to seek employment and work in competitive integrated settings, engage in community life, and control personal resources, and receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS. • *Are transportation and other supports provided so that people can regularly access services similar to those used by the community at large?*	☐ **Yes** ☐ **No** **If Yes, provide evidence to support:** **If No, provide proposed remedial measures/plan of correction:**

• *Can people regularly interact directly with other members of the community who are not paid to do so?*	
2. The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board. • *The setting is selected by people from among residential and day options that include generic settings.* • *Do people choose their rooms (if residence) or the area they work in, etc.?*	☐ **Yes** ☐ **No** **If Yes, provide evidence to support:** **If No, provide proposed remedial measures/plan of correction:**
3. Ensures the rights of privacy, dignity and respect, and freedom from coercion and restraint. • *Do people have the space and opportunity to speak on the phone, open and read mail, and visit with others, privately?* • *Do people have a place and opportunity to be by themselves during the day?* • *Is **informed** consent obtained **prior to** implementation of intrusive medical or behavioral interventions?* • *For any restrictions imposed on the person, is there a plan for restoring the right/fading the restriction?* • *For people using psychotropic medications, is the use based on specific psychiatric diagnoses?* • *Do people receive the fewest psychotropic meds possible, at the lowest dosage possible?*	☐ **Yes** ☐ **No** **If Yes, provide evidence to support:** **If No, provide proposed remedial measures/plan of correction:**

4. Optimizes, but does not regiment, independent initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact. • *Do people receive only the level of support needed to make their own decisions?* • *Do people exercise their rights as citizens to: voice their opinions, vote, and move about the community, associate with others, practice their religion, access their money, make personal decisions, and other rights that are important to them?* • *Do people choose their daily activities, their schedules, and locations of the activities?*	☐ **Yes** ☐ **No** **If Yes, provide evidence to support:** **If No, provide proposed remedial measures/plan of correction:**
5. Individuals are free and supported to control their own schedules and activities as well as have access to food at all times. • *Do people choose their daily activities, their schedules, and the locations of the activities as opposed to being "told" what they are to do?* • *Do people receive support needed to make choices about the kinds of work and activities they prefer?* • *Is there evidence of personal preference assessments to identify the kinds of work and activities people want?* • *Do the individuals have meals at the times and places of their choosing?* • *Are snacks accessible and available at all times?*	☐ **Yes** ☐ **No** **If Yes, provide evidence to support:** **If No, provide proposed remedial measures/plan of correction:**

6. Facilitates choice regarding services, supports, and who provides them. • *Do people select the services/supports that they receive (generic community services e.g., barber, restaurant, etc.)?* • *Do people select the provider from a choice of providers?*	☐ **Yes** ☐ **No** **If Yes, provide evidence to support:** **If No, provide proposed remedial measures/plan of correction:**
7. The setting is physically accessible to the individual. • *Have modifications been made to promote maximum access and use of physical environment for the person, if needed and requested?*	☐ **Yes** ☐ **No** **If Yes, provide evidence to support:** **If No, provide proposed remedial measures/plan of correction:**

Section III: Residential HCBS Criteria – In a provider-owned or controlled residential setting, in addition to the qualities listed above, the following additional conditions must be met:

8. Individuals have privacy in their sleeping or living unit. • *Can the individual close and lock their bedroom door?* • *Is the furniture arranged as the individual prefers and does the arrangement assure privacy and comfort?*	☐ **Yes** ☐ **No** **If Yes, provide evidence to support:**

	If No, provide proposed remedial measures/plan of correction:
9. The unit or dwelling can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services and the individual has the same responsibilities and protections from eviction that tenants have under landlord/tenant law. For settings in which landlord tenant laws do not apply, there must be a lease, residency agreement or other form of written agreement in place for each HCBS participant. The document must provide protections that address eviction processes and appeals comparable to those provided under landlord/tenant law. • *Do people have the same responsibilities that other tenants have under landlord/tenant laws?* • *Are people provided the same protections from eviction that other tenants have under landlord/tenant laws?*	☐ **Yes** ☐ **No** **If Yes, provide evidence to support:** **If No, provide proposed remedial measures/plan of correction:**
10. Units have entrance doors lockable by the individual with only appropriate staff having keys to doors. • *Each person living in the unit has a key or keys for that unit.* • *Is there evidence that efforts are being made to teach use of a key to anyone who does not understand how to do this?*	☐ **Yes** ☐ **No** **If Yes, provide evidence to support:** **If No, provide proposed remedial measures/plan of correction:**

11. Individuals sharing units have a choice of roommates in the setting. • *Do people choose their roommates?*	☐ **Yes** ☐ **No** **If Yes, provide evidence to support:** **If No, provide proposed remedial measures/plan of correction:**
12. Individuals are free to furnish and decorate sleeping and living units. • *Does each person pick the decorative items in their own private bedroom?* • *Do people living in the same unit participate in the choices of decorative items in the shared living areas of the unit?*	☐ **Yes** ☐ **No** **If Yes, provide evidence to support:** **If No, provide proposed remedial measures/plan of correction:**
13. Individuals are free to have visitors of their choosing at any time. • *Are people supported in having visitors of their own choosing and to visit others frequently?* • *Are people satisfied with the amount of contact they have with their friends?*	☐ **Yes** ☐ **No** **If Yes, provide evidence to support:**

	If No, provide proposed remedial measures/plan of correction:
14. Any modification of the additional conditions (1-13 in this document) for provider owned or controlled residential setting must be supported by a specific assessed need and justified in the person-centered plan. The following requirements must be documented in the person-centered plan. 1. *Identify a specific and individualized assessed need.* 2. *Document the positive interventions and supports used prior to any modifications to the person-centered service plan.* 3. *Document less intrusive methods of meeting the need that have been tried but did not work.* 4. *Include a clear description of the condition that is directly proportionate to the specific assessed need.* 5. *Include regular collection and review of data to measure the ongoing effectiveness of the modification.* 6. *Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.* 7. *Include the informed consent of the individual.* 8. *Include an assurance that interventions and supports will cause no harm to the individual.*	☐ **Yes** ☐ **No** **Yes confirms that all requirements are met and are contained in the person-centered plan(s).** **If No, provide proposed remedial measures/plan of correction:**

Additional Comments:

I certify that the above information is true and correct. I further understand that any false or misleading information may be cause for denial or termination of participation as a Medicaid Provider.

_____	_____	_____
Printed Name/Title	**Signature**	**Date**

Contact Number: _____