# Home- and Community-Based Services (HCBS)
# 2016 Provider Quality Management Self-Assessment

**This form is required for entities enrolled to provide services in Section B under the following waivers/programs:**

- Health and Disability Waiver
- AIDS/HIV Waiver
- Elderly Waiver
- Children's Mental Health Waiver (CMH)
- Intellectual Disability Waiver (ID)
- Brain Injury Waiver (BI)
- Physical Disability Waiver (PD)
- HCBS Habilitation Services (Hab)

Each provider is required to submit one, five-section self-assessment by **December 1, 2016**. **Incomplete self-assessments will not be accepted**. This form is set up as a fillable pdf to be completed and submitted via email using the "submit" button located at the end of the form. For assistance, visit the Provider Quality Management Self-Assessment[1] webpage.

**Section A.** Identify the agency submitting this form.

**Section B.** Identify the programs and services your agency is enrolled to provide. If you are uncertain which services you are enrolled for, contact Iowa Medicaid Enterprise (IME) Provider Services at 800-338-7909, option 2 or imeproviderservices@dhs.state.ia.us.

**Section C.** Select the response option from the "Response Option" column that indicates the most accurate response for each item. If required areas are incomplete, the self-assessment will be returned to the agency and must be resubmitted.

**Section D.** Please complete and sign as directed.

**Section E.** Please fill out the information as requested.

Questions should be directed to the HCBS Specialist assigned to the county where the parent agency is located. For a complete list of HCBS Quality Oversight Unit contacts and a list of HCBS Specialists by region, please go to the DHS webpage HCBS Waiver Provider Contacts[2]

[1] https://dhs.iowa.gov/ime/providers/enrollment/provider-quality-management-self-assessment
[2] http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hcbs/hcbs-contacts

# Section A. Agency Identification

Please identify your agency by providing the following information. Please type using the text entry fields below.

<table>
<tr><td colspan="6">Employer ID number (EIN) (9-digits):</td></tr>
<tr><td colspan="6">Agency name (as registered to EIN indicated above):</td></tr>
<tr><td colspan="3">Administrator/CEO:</td><td colspan="3">Title:</td></tr>
<tr><td colspan="3">Mailing address:</td><td colspan="3">Agency address:</td></tr>
<tr><td>City:</td><td>State:</td><td>Zip:</td><td>City:</td><td>State:</td><td>Zip:</td></tr>
<tr><td colspan="3">County:</td><td colspan="3">County:</td></tr>
<tr><td colspan="4">Name of person responsible for agency quality improvement activities:</td><td colspan="2">Phone number:<br>Ext:</td></tr>
<tr><td colspan="4">Title of person responsible for agency quality improvement activities:</td><td colspan="2">Fax number:</td></tr>
<tr><td colspan="3">Quality coordinator’s email address:</td><td colspan="3">Administrator’s email address:</td></tr>
<tr><td colspan="6">Agency website address:</td></tr>
</table>

## Section B. Service Enrollment

Indicate *each* of the programs and corresponding services your agency is **enrolled** to provide (regardless of whether or not these services are currently being provided). If your agency is not enrolled for any of the services in this section, you are not required to submit the *2016 Provider Quality Management Self-Assessment.* If you are uncertain as to the services your agency is enrolled for, please contact the IME Provider Services as explained on page one.

| Program | AIDS/HIV Waiver | BI Waiver | CMH Waiver |
|---|---|---|---|
| Services | ☐ Adult day services<br>☐ Agency Consumer-Directed Attendant Care (CDAC)<br>☐ Counseling<br>☐ Respite | ☐ Adult day services<br>☐ Behavior programming<br>☐ Agency Consumer-Directed Attendant Care (CDAC)<br>☐ Family counseling and training<br>☐ Interim Medical Monitoring and Treatment (IMMT)<br>☐ Prevocational services<br>☐ Respite<br>☐ Supported Community Living (SCL)<br>☐ Supported Employment (SE) | ☐ Family and community support services<br>☐ In-home family therapy<br>☐ Respite |

| Program | Elderly Waiver | Health and Disability Waiver | ID Waiver |
|---|---|---|---|
| Services | ☐ Adult day services<br>☐ Agency Consumer-Directed Attendant Care (CDAC) (includes assisted living providers)<br>☐ Assisted Living Service<br>☐ Case management<br>☐ Mental health outreach<br>☐ Respite | ☐ Adult day services<br>☐ Agency Consumer-Directed Attendant Care (CDAC)<br>☐ Counseling<br>☐ Interim Medical Monitoring and Treatment (IMMT)<br>☐ Respite | ☐ Adult day services<br>☐ Agency Consumer-Directed Attendant Care (CDAC)<br>☐ Day habilitation<br>☐ Interim Medical Monitoring and Treatment (IMMT)<br>☐ Prevocational services<br>☐ Residential-Based Supported Community Living (RBSCL)<br>☐ Respite<br>☐ Supported Community Living (SCL)<br>☐ Supported Employment (SE) |

| Program | PD Waiver | Habilitation Services |
|---|---|---|
| Services | ☐ Agency Consumer-Directed Attendant Care (CDAC) | ☐ Day habilitation<br>☐ Home-based habilitation<br>☐ Prevocational habilitation<br>☐ Supported employment habilitation |

# Section C. State and Federal Standards

For each of the following standards, the agency must select a response from the column beneath the heading **"Response Option."** Do not select more than one response per standard.

- Indicating "**Yes**" means the agency currently has in place policies and/or practices meeting the proposed standards and can provide documented evidence verifying such.
- Indicating "**No**" means the agency does not currently have policies, practices, and documented evidence in place. When a "**No**" is indicated, the agency must document in the space provided at the end of each area or requirement plans to meet the standards. The plan must identify the agency's timeline for meeting the standards. Implementation of corrective action to address current Code of Federal Regulations (CFR), Iowa Code, or Iowa Administrative Code (IAC) standards must be completed within 30 days of the date in Section E of this form.
- The selection of **"NA"** indicates the item is not applicable to the programs and services your agency is enrolled for, and is not applicable in accordance to Centers for Medicare and Medicaid, Code of Federal Regulations, Iowa Code, or IAC.

This *2016 Provider Quality Management Self-Assessment* will be returned to the agency if all sections are not completed, responses chosen are not compliant with Code of Federal Regulations, Iowa Code, or IAC, or otherwise deemed unacceptable.

If the agency requires technical assistance, contact the regional HCBS Specialist assigned to the parent agency (see page one).

## I. Providers are required to establish and maintain fiscal accountability
**IAC Chapters 78 and 79**

| ***At a minimum*, all providers will maintain evidence of:** | **Response Options:** |
|---|---|
| 1. The current rate setting system (*for example*, D-4s, fee schedules, County Rate Information System report) | ☐ Yes ☐ No |
| 2. Documentation to support planning and tracking the use of member support dollars that are incorporated into the rate for SCL, RBSCL, home-based habilitation, and family and community support services | ☐ Yes ☐ No ☐ N/A |
| 3. The maintenance of fiscal and clinical records for a minimum of five years | ☐ Yes ☐ No |
| **If indicating "No,"** describe plan to meet the standard(s) or other reason that you are not required to meet the standard(s): | |
| **If indicating "NA,"** you must describe why the standard(s) are not applicable to your agency: | |

## II. Providers are required to meet the following training requirements
**Iowa Code 235B.16, 232.69, IAC Chapter 77**

| Within 30 days of employment for full-time staff (unless otherwise indicated), the following training requirements must be met and documented for all staff providing services. Part-time staff must have these trainings documented and completed within 90 days of employment (unless otherwise indicated). Trainings are required for certain habilitation and waiver programs as listed below. It is recommended as a best practice that each waiver program provide all the trainings listed below. | **Response Options:** |
|---|---|
| 1. The curriculum used by the provider is approved by the Iowa Department of Public Health, and includes the following: | |
| a. Child and/or dependent abuse training completed within six months of hire (or documentation of current status) | ☐ Yes ☐ No |
| b. Training every five years | ☐ Yes ☐ No |
| 2. Member rights | ☐ Yes ☐ No ☐ N/A |
| 3. Rights restrictions and limitations | ☐ Yes ☐ No ☐ N/A |
| 4. Member confidentiality | ☐ Yes ☐ No ☐ N/A |
| 5. Provision of member medication (must include policy training within 30 days of employment; according to provider policy thereafter) | ☐ Yes ☐ No ☐ N/A |
| 6. Individual member support needs, including Behavior Intervention Plans (BIP) when applicable | ☐ Yes ☐ No ☐ N/A |
| 7. Incident reporting | ☐ Yes ☐ No ☐ N/A |
| 8. Brain injury training – required prior to service provision to members | ☐ Yes ☐ No ☐ N/A |
| 9. CMH Waiver: | |
| a. Staff must receive the following training within one month of employment and prior to providing direct service without the presence of experienced staff: | |
| 1) Orientation on provider's mission, policies, and procedures | ☐ Yes ☐ No ☐ N/A |
| 2) Orientation on HCBS philosophy and outcomes for rights and dignity | ☐ Yes ☐ No ☐ N/A |
| b. Staff must receive the following training within four months of employment and prior to providing direct service without the presence of experienced staff: | |
| 1) Training in serious emotional disturbance and provision of services to children with serious emotional disturbance | ☐ Yes ☐ No ☐ N/A |
| 2) Confidentiality | ☐ Yes ☐ No ☐ N/A |
| 3) Provision of medication according to agency policy and procedure | ☐ Yes ☐ No ☐ N/A |

| | | | |
|---|---|---|---|
| 4) Identification and reporting of child abuse | ☐ Yes | ☐ No | ☐ N/A |
| 5) Incident reporting | ☐ Yes | ☐ No | ☐ N/A |
| 6) Documentation of service provision | ☐ Yes | ☐ No | ☐ N/A |
| 7) Appropriate behavioral interventions | ☐ Yes | ☐ No | ☐ N/A |
| 8) Professional ethics training | ☐ Yes | ☐ No | ☐ N/A |
| c. Twenty-four hours of training during first year of employment in children's ID/DD/MH issues | ☐ Yes | ☐ No | ☐ N/A |
| d. Twelve hours of training every year thereafter in children's ID/DD/MH issues | ☐ Yes | ☐ No | ☐ N/A |
| 10. RBSCL | | | |
| a. Orientation on agency's purpose, policies, and procedures within one month of hire | ☐ Yes | ☐ No | ☐ N/A |
| b. Twenty-four hours of training during first year of employment in children's ID/DD/MH issues | ☐ Yes | ☐ No | ☐ N/A |
| c. Twelve hours of training every year thereafter in children's ID/DD/MH issues | ☐ Yes | ☐ No | ☐ N/A |
| 11. Prevocational Services | | | |
| a. A person providing direct support shall, within 6 months of hire or within 6 months of May 4, 2016, complete at least 9.5 hours of employment service training as offered through Direct Course or through the Association of Community Rehabilitation Educators (ACRE) certified training program. | ☐ Yes | ☐ No | ☐ N/A |
| b. Prevocational direct support staff shall complete 4 hours of continuing education in employment services annually | ☐ Yes | ☐ No | ☐ N/A |
| 12. Supported Employment | | | |
| a. Supported employment direct support staff shall complete 4 hours of continuing education in employment services annually | ☐ Yes | ☐ No | ☐ N/A |
| 1) Long-term job coaching | | | |
| i. A person providing direct support shall, within 6 months of hire or within 6 months of May 4, 2016, complete at least 9.5 hours of employment services training as offered through Direct Course or through the ACRE certified training program | ☐ Yes | ☐ No | ☐ N/A |
| ii. Employee must also hold or obtain, within 24 months of hire, nationally recognized certification in job training and coaching. | ☐ Yes | ☐ No | ☐ N/A |
| 2) Small-group supported employment | | | |
| i. A person providing direct support shall, within 6 months of hire or within 6 months of May 4, 2016, complete at least 9.5 hours of employment services training as offered through Direct Course or through the ACRE certified training program. | ☐ Yes | ☐ No | ☐ N/A |

| | |
|---|---|
| ii. Employee must also hold or obtain, within 24 months of hire, nationally recognized certification in job training and coaching. | ☐ Yes ☐ No ☐ N/A |
| 3) Individual supported employment | |
| i. Employee must also hold nationally recognized certification (ACRE or College of Employment Services (CES) or similar) as an employment specialist or must earn this credential within 24 months of hire | ☐ Yes ☐ No ☐ N/A |

**If indicating "No,"** describe plan to meet the standard(s) or other reason that you are not required to meet the standard(s):

**If indicating "NA,"** you must describe why the standard(s) are not applicable to your agency:

## III. Providers are required to have policies and/or procedures for each of the following

**42 CFR 441-310 (c)(4), 42 CFR 441-710, 45 CFR 164.508, Iowa Code 135C.33, 232.69 and 235B.3, IAC Chapters 77 and 79**

| **Requirement A.** Intake, admission, service coordination, discharge and referral<br>***At a minimum*, there will be evidence of:** | **Response Options:** |
|---|---|
| 1. Intake/admission process | ☐ Yes ☐ No ☐ N/A |
| 2. Referral process | ☐ Yes ☐ No ☐ N/A |
| 3. Service coordination (activities designed to assist members and families locate, access and coordinate a network of supports and services within the community) | ☐ Yes ☐ No ☐ N/A |
| 4. Discharge process | ☐ Yes ☐ No ☐ N/A |

**If indicating "No,"** describe plan to meet the standard(s) or other reason that you are not required to meet the standard(s):

**If indicating "NA,"** you must describe why the standard(s) are not applicable to your agency:

| **Requirement B.** HCBS settings required for all providers<br>***At a minimum*, there will be evidence of:** | **Response Options:** |
|---|---|
| 1. Community integration supported by: | |
| a. The setting is integrated in, and facilitates the member's full access to, the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, like members without disabilities | |
| Adult Day Services | ☐ Yes ☐ No ☐ N/A |
| Agency Consumer-Directed Attendant Care (CDAC) | ☐ Yes ☐ No ☐ N/A |

| | | | |
|---|---|---|---|
| Assisted Living Service | ☐ Yes | ☐ No | ☐ N/A |
| Behavior Programming | ☐ Yes | ☐ No | ☐ N/A |
| Counseling | ☐ Yes | ☐ No | ☐ N/A |
| Day Habilitation | ☐ Yes | ☐ No | ☐ N/A |
| Family Counseling and Training | ☐ Yes | ☐ No | ☐ N/A |
| Family and Community Support Services | ☐ Yes | ☐ No | ☐ N/A |
| In-home Family Therapy | ☐ Yes | ☐ No | ☐ N/A |
| Interim Medical Monitoring and Treatment (IMMT) | ☐ Yes | ☐ No | ☐ N/A |
| Mental Health Outreach | ☐ Yes | ☐ No | ☐ N/A |
| Prevocational Services | ☐ Yes | ☐ No | ☐ N/A |
| Residential-Based Supported Community Living | ☐ Yes | ☐ No | ☐ N/A |
| Supported Community Living (SCL) | ☐ Yes | ☐ No | ☐ N/A |
| Supported Employment (SE) | ☐ Yes | ☐ No | ☐ N/A |
| Habilitation Services | | | |
| Day Habilitation | ☐ Yes | ☐ No | ☐ N/A |
| Home-based Habilitation | ☐ Yes | ☐ No | ☐ N/A |
| Prevocational Habilitation | ☐ Yes | ☐ No | ☐ N/A |
| Supported Employment Habilitation | ☐ Yes | ☐ No | ☐ N/A |
| **If indicating "No,"** describe plan to meet the standard(s) or other reason that you are not required to meet the standard(s): | | | |
| **If indicating "NA,"** you must describe why the standard(s) are not applicable to your agency: | | | |
| b. The setting is selected by the member among available alternatives and identified in the person-centered service plan | | | |
| Adult Day Services | ☐ Yes | ☐ No | ☐ N/A |
| Agency Consumer-Directed Attendant Care (CDAC) | ☐ Yes | ☐ No | ☐ N/A |
| Assisted Living Service | ☐ Yes | ☐ No | ☐ N/A |
| Behavior Programming | ☐ Yes | ☐ No | ☐ N/A |
| Counseling | ☐ Yes | ☐ No | ☐ N/A |
| Day Habilitation | ☐ Yes | ☐ No | ☐ N/A |
| Family Counseling and Training | ☐ Yes | ☐ No | ☐ N/A |
| Family and Community Support Services | ☐ Yes | ☐ No | ☐ N/A |
| In-home Family Therapy | ☐ Yes | ☐ No | ☐ N/A |
| Interim Medical Monitoring and Treatment (IMMT) | ☐ Yes | ☐ No | ☐ N/A |
| Mental Health Outreach | ☐ Yes | ☐ No | ☐ N/A |

| | | | |
|---|---|---|---|
| Prevocational Services | ☐ Yes | ☐ No | ☐ N/A |
| Residential-Based Supported Community Living | ☐ Yes | ☐ No | ☐ N/A |
| Supported Community Living (SCL) | ☐ Yes | ☐ No | ☐ N/A |
| Supported Employment (SE) | ☐ Yes | ☐ No | ☐ N/A |
| Habilitation Services | | | |
| Day Habilitation | ☐ Yes | ☐ No | ☐ N/A |
| Home-based Habilitation | ☐ Yes | ☐ No | ☐ N/A |
| Prevocational Habilitation | ☐ Yes | ☐ No | ☐ N/A |
| Supported Employment Habilitation | ☐ Yes | ☐ No | ☐ N/A |
| **If indicating "No,"** describe plan to meet the standard(s) or other reason that you are not required to meet the standard(s): | | | |
| **If indicating "NA,"** you must describe why the standard(s) are not applicable to your agency: | | | |
| c. A member's essential personal rights of privacy, dignity and respect, and freedom from coercion and restraint are protected | | | |
| Adult Day Services | ☐ Yes | ☐ No | ☐ N/A |
| Agency Consumer-Directed Attendant Care (CDAC) | ☐ Yes | ☐ No | ☐ N/A |
| Assisted Living Service | ☐ Yes | ☐ No | ☐ N/A |
| Behavior Programming | ☐ Yes | ☐ No | ☐ N/A |
| Counseling | ☐ Yes | ☐ No | ☐ N/A |
| Day Habilitation | ☐ Yes | ☐ No | ☐ N/A |
| Family Counseling and Training | ☐ Yes | ☐ No | ☐ N/A |
| Family and Community Support Services | ☐ Yes | ☐ No | ☐ N/A |
| In-home Family Therapy | ☐ Yes | ☐ No | ☐ N/A |
| Interim Medical Monitoring and Treatment (IMMT) | ☐ Yes | ☐ No | ☐ N/A |
| Mental Health Outreach | ☐ Yes | ☐ No | ☐ N/A |
| Prevocational Services | ☐ Yes | ☐ No | ☐ N/A |
| Residential-Based Supported Community Living | ☐ Yes | ☐ No | ☐ N/A |
| Supported Community Living (SCL) | ☐ Yes | ☐ No | ☐ N/A |
| Supported Employment (SE) | ☐ Yes | ☐ No | ☐ N/A |
| Habilitation Services | | | |
| Day Habilitation | ☐ Yes | ☐ No | ☐ N/A |
| Home-based Habilitation | ☐ Yes | ☐ No | ☐ N/A |
| Prevocational Habilitation | ☐ Yes | ☐ No | ☐ N/A |
| Supported Employment Habilitation | ☐ Yes | ☐ No | ☐ N/A |

| | | | |
|---|---|---|---|
| **If indicating "No,"** describe plan to meet the standard(s) or other reason that you are not required to meet the standard(s): | | | |
| **If indicating "NA,"** you must describe why the standard(s) are not applicable to your agency: | | | |
| d. Member initiative, autonomy, and independence in making major life choices, including but not limited to, daily activities, physical environment, and with whom to interact are optimized and not regimented | | | |
| Adult Day Services | ☐ Yes | ☐ No | ☐ N/A |
| Agency Consumer-Directed Attendant Care (CDAC) | ☐ Yes | ☐ No | ☐ N/A |
| Assisted Living Service | ☐ Yes | ☐ No | ☐ N/A |
| Behavior Programming | ☐ Yes | ☐ No | ☐ N/A |
| Counseling | ☐ Yes | ☐ No | ☐ N/A |
| Day Habilitation | ☐ Yes | ☐ No | ☐ N/A |
| Family Counseling and Training | ☐ Yes | ☐ No | ☐ N/A |
| Family and Community Support Services | ☐ Yes | ☐ No | ☐ N/A |
| In-home Family Therapy | ☐ Yes | ☐ No | ☐ N/A |
| Interim Medical Monitoring and Treatment (IMMT) | ☐ Yes | ☐ No | ☐ N/A |
| Mental Health Outreach | ☐ Yes | ☐ No | ☐ N/A |
| Prevocational Services | ☐ Yes | ☐ No | ☐ N/A |
| Residential-Based Supported Community Living | ☐ Yes | ☐ No | ☐ N/A |
| Supported Community Living (SCL) | ☐ Yes | ☐ No | ☐ N/A |
| Supported Employment (SE) | ☐ Yes | ☐ No | ☐ N/A |
| Habilitation Services | | | |
| Day Habilitation | ☐ Yes | ☐ No | ☐ N/A |
| Home-based Habilitation | ☐ Yes | ☐ No | ☐ N/A |
| Prevocational Habilitation | ☐ Yes | ☐ No | ☐ N/A |
| Supported Employment Habilitation | ☐ Yes | ☐ No | ☐ N/A |
| **If indicating "No,"** describe plan to meet the standard(s) or other reason that you are not required to meet the standard(s): | | | |
| **If indicating "NA,"** you must describe why the standard(s) are not applicable to your agency: | | | |
| e. Member choice regarding services and supports, and who provides them, is facilitated | | | |

| | | | |
|---|---|---|---|
| Adult Day Services | ☐ Yes | ☐ No | ☐ N/A |
| Agency Consumer-Directed Attendant Care (CDAC) | ☐ Yes | ☐ No | ☐ N/A |
| Assisted Living Service | ☐ Yes | ☐ No | ☐ N/A |
| Behavior Programming | ☐ Yes | ☐ No | ☐ N/A |
| Counseling | ☐ Yes | ☐ No | ☐ N/A |
| Day Habilitation | ☐ Yes | ☐ No | ☐ N/A |
| Family Counseling and Training | ☐ Yes | ☐ No | ☐ N/A |
| Family and Community Support Services | ☐ Yes | ☐ No | ☐ N/A |
| In-home Family Therapy | ☐ Yes | ☐ No | ☐ N/A |
| Interim Medical Monitoring and Treatment (IMMT) | ☐ Yes | ☐ No | ☐ N/A |
| Mental Health Outreach | ☐ Yes | ☐ No | ☐ N/A |
| Prevocational Services | ☐ Yes | ☐ No | ☐ N/A |
| Residential-Based Supported Community Living | ☐ Yes | ☐ No | ☐ N/A |
| Supported Community Living (SCL) | ☐ Yes | ☐ No | ☐ N/A |
| Supported Employment (SE) | ☐ Yes | ☐ No | ☐ N/A |
| Habilitation Services | | | |
| Day Habilitation | ☐ Yes | ☐ No | ☐ N/A |
| Home-based Habilitation | ☐ Yes | ☐ No | ☐ N/A |
| Prevocational Habilitation | ☐ Yes | ☐ No | ☐ N/A |
| Supported Employment Habilitation | ☐ Yes | ☐ No | ☐ N/A |
| **If indicating "No,"** describe plan to meet the standard(s) or other reason that you are not required to meet the standard(s): | | | |
| **If indicating "NA,"** you must describe why the standard(s) are not applicable to your agency: | | | |
| f. All rights restrictions must be time limited, contain member's informed consent, supported by a specific assessed need and documented in the person-centered service plan | | | |
| Adult Day Services | ☐ Yes | ☐ No | ☐ N/A |
| Agency Consumer-Directed Attendant Care (CDAC) | ☐ Yes | ☐ No | ☐ N/A |
| Assisted Living Service | ☐ Yes | ☐ No | ☐ N/A |
| Behavior Programming | ☐ Yes | ☐ No | ☐ N/A |
| Counseling | ☐ Yes | ☐ No | ☐ N/A |
| Day Habilitation | ☐ Yes | ☐ No | ☐ N/A |
| Family Counseling and Training | ☐ Yes | ☐ No | ☐ N/A |
| Family and Community Support Services | ☐ Yes | ☐ No | ☐ N/A |
| In-home Family Therapy | ☐ Yes | ☐ No | ☐ N/A |

| | | | |
|---|---|---|---|
| Interim Medical Monitoring and Treatment (IMMT) | ☐ Yes | ☐ No | ☐ N/A |
| Mental Health Outreach | ☐ Yes | ☐ No | ☐ N/A |
| Prevocational Services | ☐ Yes | ☐ No | ☐ N/A |
| Residential-Based Supported Community Living | ☐ Yes | ☐ No | ☐ N/A |
| Supported Community Living (SCL) | ☐ Yes | ☐ No | ☐ N/A |
| Supported Employment (SE) | ☐ Yes | ☐ No | ☐ N/A |
| Habilitation Services | | | |
| Day Habilitation | ☐ Yes | ☐ No | ☐ N/A |
| Home-based Habilitation | ☐ Yes | ☐ No | ☐ N/A |
| Prevocational Habilitation | ☐ Yes | ☐ No | ☐ N/A |
| Supported Employment Habilitation | ☐ Yes | ☐ No | ☐ N/A |

**If indicating "No,"** describe plan to meet the standard(s) or other reason that you are not required to meet the standard(s):

**If indicating "NA,"** you must describe why the standard(s) are not applicable to your agency:

| **Requirement B. "g." through "n." applies to services in provider-owned or controlled settings. As indicated in the approved statewide transition plan (STP), services are provider-owned or provider-controlled if the following conditions are present:**<br>If the HCBS provider leases from a third party or owns the property, this would be considered provider-owned or controlled. If the provider does not lease or own the property, but has a direct or indirect financial relationship with the property owner, it would be presumed that the setting was provider-controlled unless the property owner or provider establishes that the nature of the relationship did not affect either the care provided or the financial conditions applicable to tenants. If the member leases directly from the third party that has no direct or indirect financial relationship with the provider, the property is not considered provider-owned or controlled. | **Response Options:** | | |
|---|---|---|---|
| g. In provider-owned or provider-controlled setting, each member has privacy in their sleeping or living unit | | | |
| Agency Consumer-Directed Attendant Care (CDAC) | ☐ Yes | ☐ No | ☐ N/A |
| Assisted Living Service | ☐ Yes | ☐ No | ☐ N/A |
| Residential-Based Supported Community Living | ☐ Yes | ☐ No | ☐ N/A |
| Supported Community Living (SCL) | ☐ Yes | ☐ No | ☐ N/A |
| Habilitation Services | | | |
| Home-based Habilitation | ☐ Yes | ☐ No | ☐ N/A |

| | | | |
|---|---|---|---|
| **If indicating "No,"** describe plan to meet the standard(s) or other reason that you are not required to meet the standard(s): | | | |
| **If indicating "NA,"** you must describe why the standard(s) are not applicable to your agency: | | | |
| h. In a provider owned or provider controlled setting, members sharing units have a choice of roommates in that setting | | | |
| Agency Consumer-Directed Attendant Care (CDAC) | ☐ Yes | ☐ No | ☐ N/A |
| Assisted Living Service | ☐ Yes | ☐ No | ☐ N/A |
| Residential-Based Supported Community Living | ☐ Yes | ☐ No | ☐ N/A |
| Supported Community Living (SCL) | ☐ Yes | ☐ No | ☐ N/A |
| Habilitation Services | | | |
| Home-based Habilitation | ☐ Yes | ☐ No | ☐ N/A |
| **If indicating "No,"** describe plan to meet the standard(s) or other reason that you are not required to meet the standard(s): | | | |
| **If indicating "NA,"** you must describe why the standard(s) are not applicable to your agency: | | | |
| i. In a provider-owned or provider-controlled setting, members have the freedom and support to control their own schedules and activities, and have access to food at any time | | | |
| Adult Day Services | ☐ Yes | ☐ No | ☐ N/A |
| Agency Consumer-Directed Attendant Care (CDAC) | ☐ Yes | ☐ No | ☐ N/A |
| Assisted Living Service | ☐ Yes | ☐ No | ☐ N/A |
| Behavior Programming | ☐ Yes | ☐ No | ☐ N/A |
| Counseling | ☐ Yes | ☐ No | ☐ N/A |
| Day Habilitation | ☐ Yes | ☐ No | ☐ N/A |
| Family Counseling and Training | ☐ Yes | ☐ No | ☐ N/A |
| Family and Community Support Services | ☐ Yes | ☐ No | ☐ N/A |
| In-home Family Therapy | ☐ Yes | ☐ No | ☐ N/A |
| Interim Medical Monitoring and Treatment (IMMT) | ☐ Yes | ☐ No | ☐ N/A |
| Mental Health Outreach | ☐ Yes | ☐ No | ☐ N/A |
| Prevocational Services | ☐ Yes | ☐ No | ☐ N/A |
| Residential-Based Supported Community Living | ☐ Yes | ☐ No | ☐ N/A |
| Supported Community Living (SCL) | ☐ Yes | ☐ No | ☐ N/A |

| | | | |
|---|---|---|---|
| Supported Employment (SE) | ☐ Yes | ☐ No | ☐ N/A |
| Habilitation Services | | | |
| Day Habilitation | ☐ Yes | ☐ No | ☐ N/A |
| Home-based Habilitation | ☐ Yes | ☐ No | ☐ N/A |
| Prevocational Habilitation | ☐ Yes | ☐ No | ☐ N/A |
| Supported Employment Habilitation | ☐ Yes | ☐ No | ☐ N/A |

**If indicating "No,"** describe plan to meet the standard(s) or other reason that you are not required to meet the standard(s):

**If indicating "NA,"** you must describe why the standard(s) are not applicable to your agency:

| | | | |
|---|---|---|---|
| j. In a provider-owned or provider-controlled setting, members are able to have visitors of their choosing at any time | | | |
| Adult Day Services | ☐ Yes | ☐ No | ☐ N/A |
| Agency Consumer-Directed Attendant Care (CDAC) | ☐ Yes | ☐ No | ☐ N/A |
| Assisted Living Service | ☐ Yes | ☐ No | ☐ N/A |
| Behavior Programming | ☐ Yes | ☐ No | ☐ N/A |
| Counseling | ☐ Yes | ☐ No | ☐ N/A |
| Day Habilitation | ☐ Yes | ☐ No | ☐ N/A |
| Family Counseling and Training | ☐ Yes | ☐ No | ☐ N/A |
| Family and Community Support Services | ☐ Yes | ☐ No | ☐ N/A |
| In-home Family Therapy | ☐ Yes | ☐ No | ☐ N/A |
| Interim Medical Monitoring and Treatment (IMMT) | ☐ Yes | ☐ No | ☐ N/A |
| Mental Health Outreach | ☐ Yes | ☐ No | ☐ N/A |
| Prevocational Services | ☐ Yes | ☐ No | ☐ N/A |
| Residential-Based Supported Community Living | ☐ Yes | ☐ No | ☐ N/A |
| Supported Community Living (SCL) | ☐ Yes | ☐ No | ☐ N/A |
| Supported Employment (SE) | ☐ Yes | ☐ No | ☐ N/A |
| Habilitation Services | | | |
| Day Habilitation | ☐ Yes | ☐ No | ☐ N/A |
| Home-based Habilitation | ☐ Yes | ☐ No | ☐ N/A |
| Prevocational Habilitation | ☐ Yes | ☐ No | ☐ N/A |
| Supported Employment Habilitation | ☐ Yes | ☐ No | ☐ N/A |

**If indicating "No,"** describe plan to meet the standard(s) or other reason that you are not required to meet the standard(s):

| | | | |
|---|---|---|---|
| **If indicating "NA,"** you must describe why the standard(s) are not applicable to your agency: | | | |
| k. In provider-owned or provider-controlled setting, the setting is physically accessible to the member | | | |
| Adult Day Services | ☐ Yes | ☐ No | ☐ N/A |
| Agency Consumer-Directed Attendant Care (CDAC) | ☐ Yes | ☐ No | ☐ N/A |
| Assisted Living Service | ☐ Yes | ☐ No | ☐ N/A |
| Behavior Programming | ☐ Yes | ☐ No | ☐ N/A |
| Counseling | ☐ Yes | ☐ No | ☐ N/A |
| Day Habilitation | ☐ Yes | ☐ No | ☐ N/A |
| Family Counseling and Training | ☐ Yes | ☐ No | ☐ N/A |
| Family and Community Support Services | ☐ Yes | ☐ No | ☐ N/A |
| In-home Family Therapy | ☐ Yes | ☐ No | ☐ N/A |
| Interim Medical Monitoring and Treatment (IMMT) | ☐ Yes | ☐ No | ☐ N/A |
| Mental Health Outreach | ☐ Yes | ☐ No | ☐ N/A |
| Prevocational Services | ☐ Yes | ☐ No | ☐ N/A |
| Residential-Based Supported Community Living | ☐ Yes | ☐ No | ☐ N/A |
| Supported Community Living (SCL) | ☐ Yes | ☐ No | ☐ N/A |
| Supported Employment (SE) | ☐ Yes | ☐ No | ☐ N/A |
| Habilitation Services | | | |
| Day Habilitation | ☐ Yes | ☐ No | ☐ N/A |
| Home-based Habilitation | ☐ Yes | ☐ No | ☐ N/A |
| Prevocational Habilitation | ☐ Yes | ☐ No | ☐ N/A |
| Supported Employment Habilitation | ☐ Yes | ☐ No | ☐ N/A |
| **If indicating "No,"** describe plan to meet the standard(s) or other reason that you are not required to meet the standard(s): | | | |
| **If indicating "NA,"** you must describe why the standard(s) are not applicable to your agency: | | | |
| l. Provider-owned or provider-controlled home is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the member receiving services, and the member has, at a minimum, the same responsibilities and protections from eviction that the tenants have under the landlord/tenant laws of the state, county, city, or other designated entity | | | |
| Agency Consumer-Directed Attendant Care (CDAC) | ☐ Yes | ☐ No | ☐ N/A |

| | | | |
|---|---|---|---|
| Assisted Living Service | ☐ Yes | ☐ No | ☐ N/A |
| Residential-Based Supported Community Living | ☐ Yes | ☐ No | ☐ N/A |
| Supported Community Living (SCL) | ☐ Yes | ☐ No | ☐ N/A |
| Habilitation Services | | | |
| Home-based Habilitation | ☐ Yes | ☐ No | ☐ N/A |

**If indicating "No,"** describe plan to meet the standard(s) or other reason that you are not required to meet the standard(s):

**If indicating "NA,"** you must describe why the standard(s) are not applicable to your agency:

| | | | |
|---|---|---|---|
| m. Provider-owned or provider-controlled home has entrance doors to the member's living and sleeping unit which can be locked by the individual with only appropriate staff having keys | | | |
| Agency Consumer-Directed Attendant Care (CDAC) | ☐ Yes | ☐ No | ☐ N/A |
| Assisted Living Service | ☐ Yes | ☐ No | ☐ N/A |
| Residential-Based Supported Community Living | ☐ Yes | ☐ No | ☐ N/A |
| Supported Community Living (SCL) | ☐ Yes | ☐ No | ☐ N/A |
| Habilitation Services | | | |
| Home-based Habilitation | ☐ Yes | ☐ No | ☐ N/A |

**If indicating "No,"** describe plan to meet the standard(s) or other reason that you are not required to meet the standard(s):

**If indicating "NA,"** you must describe why the standard(s) are not applicable to your agency:

| | | | |
|---|---|---|---|
| n. In a provider-owned or provider-controlled home members have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement | | | |
| Agency Consumer-Directed Attendant Care (CDAC) | ☐ Yes | ☐ No | ☐ N/A |
| Assisted Living Service | ☐ Yes | ☐ No | ☐ N/A |
| Residential-Based Supported Community Living | ☐ Yes | ☐ No | ☐ N/A |
| Supported Community Living (SCL) | ☐ Yes | ☐ No | ☐ N/A |
| Habilitation Services | | | |
| Home-based Habilitation | ☐ Yes | ☐ No | ☐ N/A |

**If indicating "No,"** describe plan to meet the standard(s) or other reason that you are not required to meet the standard(s):

**If indicating "NA,"** you must describe why the standard(s) are not applicable to your agency:

| **Requirement C.** Person centered planning for all providers ***At a minimum*, there will be evidence of:** | **Response Options:** | | |
|---|---|---|---|
| At a minimum, person centered planning will be supported by: | | | |
| a. Provider participation in interdisciplinary team meetings | ☐ Yes | ☐ No | ☐ N/A |
| b. The member's file contains a copy of the written person centered plan | ☐ Yes | ☐ No | ☐ N/A |
| c. The provider's plan is consistent with the case manager's person centered plan | ☐ Yes | ☐ No | ☐ N/A |
| d. The provider's service plan includes interventions and supports needed to meet member goals with incremental action steps, as appropriate | ☐ Yes | ☐ No | ☐ N/A |
| e. The provider's plan reflects desired member outcomes | ☐ Yes | ☐ No | ☐ N/A |
| f. The provider's service plan includes documentation of all rights restrictions, the need for the restriction and a plan to restore those rights or a reason why a plan is not necessary or appropriate | ☐ Yes | ☐ No | ☐ N/A |

**If indicating "No,"** describe plan to meet the standard(s) or other reason that you are not required to meet the standard(s):

**If indicating "NA,"** you must describe why the standard(s) are not applicable to your facility:

| **Requirement D.** Documentation required for all providers | **Response Options:** | |
|---|---|---|
| 1. At a minimum, service documentation shall include: | | |
| a. Specific location, date, and times of service provision | ☐ Yes | ☐ No |
| b. Service(s) provided | ☐ Yes | ☐ No |
| c. Member's first and last name | ☐ Yes | ☐ No |
| d. Staff providing service(s), including first and last name, signature and professional credentials (if any) | ☐ Yes | ☐ No |
| e. Specific interventions, including name, dosage, and route of medications administered | ☐ Yes | ☐ No |
| f. Any supplies dispensed as part of the service | ☐ Yes | ☐ No |
| g. Member's response to staff interventions | ☐ Yes | ☐ No |
| h. Process to ensure units of service billed for payment are based on services provided with substantiating documentation | ☐ Yes | ☐ No |

**If indicating "No,"** describe plan to meet the standard(s) or other reason that you are not required to meet the standard(s):

| **Requirement E.** Personnel records required for all providers<br>***At a minimum*, there will be evidence of:** | **Response Options:** |
|---|---|
| 1. Completion of the following requirements is required prior to date of hire | |
| a. Dependent adult and child abuse checks | ☐ Yes ☐ No |
| b. Criminal history background and Department of Human Services (DHS) evaluation where applicable | ☐ Yes ☐ No |
| c. Documentation of follow-through on any employment restrictions as stated in DHS evaluation | ☐ Yes ☐ No |
| 2. Verification of Office of Inspector General (OIG) excluded individual search Social Security Act, Sections 1128 and 1156 | ☐ Yes ☐ No |
| 3. Job performance evaluations | ☐ Yes ☐ No |
| **If indicating "No,"** describe plan to meet the standard(s) or other reason that you are not required to meet the standard(s): | |

| **Requirement F.** Abuse reporting required for all providers<br>***At a minimum*, there will be evidence of:** | **Response Options:** |
|---|---|
| 1. Process staff must follow the agency's procedure to report allegations immediately (oral report within 24 hours; written report within 48 hours) to Department of Human Services (DHS) or Department of Inspections and Appeals (DIA) when the environment is certified or licensed by this entity | ☐ Yes ☐ No |
| 2. Process staff must follow the agency's procedure to ensure the member's safety upon learning of an allegation | ☐ Yes ☐ No |
| 3. Process the provider will follow when the alleged perpetrator is an employee | ☐ Yes ☐ No |
| 4. Process for ensuring staff receive a statement of the abuse reporting requirements within one month of employment | ☐ Yes ☐ No |
| **If indicating "No,"** describe plan to meet the standard(s) or other reason that you are not required to meet the standard(s): | |

| **Requirement G.** Incident reporting required for all providers<br>***At a minimum*, there will be evidence of:** | **Response Options:** |
|---|---|
| 1. What constitutes an incident in accordance with the IAC definition | ☐ Yes ☐ No |
| 2. The mechanism for ensuring the routing of incidents to the: | |
| a. Supervisor by the end of the next calendar day after the incident (major); within 72 hours (minor) | ☐ Yes ☐ No |
| b. Case manager/service worker by the end of the next calendar day after the incident (major) | ☐ Yes ☐ No |
| c. Legal guardian by the end of the next calendar day after the incident (major) | ☐ Yes ☐ No |
| d. Member by the end of the next calendar day after the incident if the incident took place outside service provision (major) | ☐ Yes ☐ No |

| | |
|---|---|
| e. Bureau of Long-Term Care or appropriate entity by the end of the next calendar day after the incident via direct data entry into Iowa Medicaid Portal Access (IMPA) or as determined by the department | ☐ Yes ☐ No |
| 3. The centralized location for the filing of incident reports | ☐ Yes ☐ No |
| 4. The process for noting the completion of an incident report form in the member record | ☐ Yes ☐ No |
| 5. The submission of follow-up reports as requested by case manager/service/integrated health home care coordinator (major) | ☐ Yes ☐ No |
| **If indicating "No,"** describe plan to meet the standard(s) or other reason that you are not required to meet the standard(s): | |

| **Requirement H.** Safeguarding consumer information required for all providers<br>***At a minimum*, there will be evidence of:** | **Response Options:** |
|---|---|
| 1. Process for maintaining confidential records and safeguarding personal member information | ☐ Yes ☐ No |
| 2. If a release of information form is utilized, an expiration date or event is identified. | ☐ Yes ☐ No |
| **If indicating "No,"** describe plan to meet the standard(s) or other reason that you are not required to meet the standard(s): | |

| **Requirement I.** Contracts with members<br>***At a minimum*, the agency shall have written procedures which provide for the establishment of an agreement between the member and the provider and evidence will be supplied that:** | **Response Options:** |
|---|---|
| 1. The agreement shall define the responsibilities of the provider and the member, the rights of the member, the services to be provided to the member by the provider, all room and board and co-pay fees to be charged to the member and the sources of payment | ☐ Yes ☐ No ☐ N/A |
| 2. Contracts shall be reviewed at least annually | ☐ Yes ☐ No ☐ N/A |
| **If indicating "No,"** describe plan to meet the standard(s) or other reason that you are not required to meet the standard(s): | |
| **If indicating "NA,"** you must describe why the standard(s) are not applicable to your agency: | |

## IV. The agency has a systematic, organization wide, planned approach to designing, measuring, evaluating, and improving the level of its performance

**IAC Chapter 77**

| **Requirement A.** Quality Improvement (QI)<br>**At a minimum, the plan will identify the:** | **Response Options:** |
|---|---|
| 1. Ongoing schedule or timeline for quality improvement activities, to include the specific timeframes for data collection, data analysis, and to identify entities with whom results will be shared | ☐ Yes ☐ No ☐ N/A |
| 2. Discovery | |
| a. Collecting and reviewing data to identify issues to be monitored for quality improvement to include sample size and acceptable thresholds | ☐ Yes ☐ No ☐ N/A |
| b. Ongoing review of responses to all member/stakeholder input to determine the need for systemic changes | ☐ Yes ☐ No ☐ N/A |
| c. Ongoing review of member records to include medication management, health and safety, incident reporting, and documentation | ☐ Yes ☐ No ☐ N/A |
| 3. Remediation. The development of a plan to address areas of improvement identified during discovery to include specific timelines for development and completion of action steps | ☐ Yes ☐ No ☐ N/A |
| 4. Improvement. Summary of QI activities to include monitoring the impact of remediation plan | ☐ Yes ☐ No ☐ N/A |
| **If indicating "No,"** describe plan to meet the standard(s) or other reason that you are not required to meet the standard(s): | |
| **If indicating "NA,"** you must describe why the standard(s) are not applicable to your facility: | |

## Section D. Guarantee of Accuracy

In submitting this Self-Assessment or signing this Guarantee of Accuracy, the agency and all signatories jointly and severally certify that the information and responses on this Self-Assessment are true, accurate, complete, and verifiable. Further, the agency and all signatories each acknowledge (1) familiarity with the laws and regulations governing the Iowa Medicaid program; (2) the responsibility to request technical assistance from the appropriate regional HCBS Specialist (see contact instructions on page one) in order to achieve compliance with the standards listed within this assessment; (3) the Department, or an authorized representative, may conduct desk or on-site reviews on a periodic basis, as initiated by random sampling or as a result of a complaint. **NOTICE: Any person that submits a false statement, response, or representation, or any false, incomplete, or misleading information, may be subject to criminal, civil, or administrative liability.**

Indicate which accreditation, licensure or certification held, including those which qualify your agency to provide HCBS. Include dates of accreditation/licensure/certification for each selection chosen (MM/YY begin – MM/YY end):

- ☐ Council on Accreditation
- ☐ CARF International
- ☐ Iowa Department of Public Health
- ☐ HCBS Certification
- ☐ The Council on Quality and Leadership (CQL)
- ☐ Department of Inspections and Appeals
- ☐ The Joint Commission (TJC)
- ☐ Chapter 24
- ☐ Other:

Is your organization in good standing with the accreditation/licensing/certifying organization? ☐ Yes ☐ No

**If your organization received less than a three year accreditation/certification, the review results and corrective action plan must accompany the completed *2016 HCBS Provider Quality Management Self-Assessment*.**

Is this organization in good standing with the Iowa Secretary of State's Office? ☐ Yes ☐ No

Does your organization attest to being compliant with HCBS Settings Rule 42 CFR 441.301(c)(4) and 42 CFR 441.710(a), or have a plan to come into compliance with this rule prior to March 17, 2019? ☐ Yes ☐ No

**If your organization is not currently fully in compliance with CMS requirements for provider-owned and provider-controlled settings, your organization must submit your plan to become compliant with HCBS Settings Rule 42 CFR 441.301(c)(4) and 42 CFR 441.710(a).**

**PRINT NAME** of ***Agency***

**PRINT NAME** of ***Executive Director***

**SIGNATURE** of ***Executive Director*** ***Date***

**PRINT NAME** of ***Chairperson, Board of Directors***

**SIGNATURE** of ***Chairperson, Board of Directors*** ***Date***

## Section E. Direct Support Professional Workforce Data Collection

**Agency Name**

**NPI Provider Number(s)**
(Complete only one form and list all NPI Numbers)

**Instructions**
For the purposes of these questions, a direct support professional is an individual who provides supportive services and care to people who are elderly, experiencing illnesses, or disabilities. This definition *excludes* individuals working as nurses, social workers, counselors, and case managers.

Individuals providing the following waiver services should be considered direct support professional workers:

- Adult Day Services
- Behavioral Programming
- CCO
- CDAC
- Family and Community Support Services
- Home Health
- Homemaker
- Interim Medical Monitoring and Treatment
- Prevocational Services
- Respite
- Residential SCL
- SCL
- Supported Employment

1. Please list your organization's total number of full-time and part-time employees (including contract employees).

   Total number of full-time and part-time employees

   Of this total, please list the number of full-time and part-time employees providing direct support services according to the definition provided above. Please include supervisors and coordinators who provide direct support services.

   Number of full-time direct care workers (including contract employees)

   Number of part-time direct care workers (including contract employees)

2. The U.S. Department of Labor utilizes the following three titles and definitions to gather information on the direct support professional workforce.

   Please list the number of individuals you employ in the following three categories. Choose the category that best reflects services provided. Individuals do not need to be certified as a home health aide or nurse aide to be included in those categories. An individual cannot be counted in more than one category.

   **Personal and Home Care Aides**

   Often called direct support professionals, these workers provide support services such as implementing a behavior plan, teaching self-care skills, and providing employment support, as well as providing a range of other personal assistance services. They provide support to people in their homes, residential facilities, or in day programs, and are supervised by a nurse, social worker, or other non-medical manager.

   Number of personal and home care aides (including contract employees)

   **Home Health Aides**

   Home health aides typically work for home health or hospice agencies and work under the direct supervision of a medical professional. These aides provide support to people in their homes, residential facilities, or in day programs. They help with light housekeeping, shopping, cooking, bathing, dressing, and grooming, and may provide some basic health-related services such as checking pulse rate, temperature, and respiration rate.

   Number of home health aides (including contract employees)

   **Nursing Aides**

   Most nursing aides have received specific training for the job and some have received their certification as a Certified Nursing Assistant (CNA) in Iowa. According to the Department of Labor, nursing aides provide hands-on care under the supervision of nursing and medical staff in hospitals and nursing care facilities, although they do work in home- and community-based settings as well. Nursing aides often help members eat, dress, and bathe, and may take temperature, pulse rate, respiration, or blood pressure, as well as observing and recording members' physical, mental, and emotional conditions.

   Number of nursing aides (including contract employees)

SUBMIT