|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | What is the individual's ID number from the sample key? | |  | | | | | | |
|  | **Answer Key** | | **YES** | **NO** | | **NOT APPLICABLE**  **(NOT IMPORTANT TO OR FOR)** | | **ACTION TAKEN (REQUIRED FOR NEGATIVE OUTCOMES)** | |
| 1.002 | Is the individual able to make choices about their lives, including food, activities, snacks, etc.? | |  |  | |  | |  | |
| 1.003 | Is the individual participating in person centered planning? | |  |  | |  | |  | |
| 1.004 | Is the service delivery focused on the desired outcomes that are important to or for the individual? | |  |  | |  | |  | |
| 1.005 | Is the person competitively employed (e.g. same or similar benefits and wage as non-disabled co-workers) in an integrated community job? | |  |  | |  | |  | |
| 1.006 | Is the individual given opportunities for meaningful and productive activities in the community with individuals with and without disabilities (e.g. shopping, religious services, vacations, dating)? | |  |  | |  | |  | |
| 1.007 | Is the individual involved in relationships with individuals outside of service delivery? | |  |  | |  | |  | |
| 1.008 | The individual indicated that they are not mistreated. | |  |  | |  | |  | |
| 1.009 | The individual indicated that they were not hit or hurt by anyone. | |  |  | |  | |  | |
| 1.010 | Did you know you can change your provider/support staff if you want? | |  |  | |  | |  | |
| 1.011 | Is the individual satisfied with services (e.g. what is working for the individual and what is not working)? | |  |  | |  | |  | |
| 1.012 | Do you feel healthy and know what to do or who to talk to if you don’t feel well or want to go to the doctor? | |  |  | |  | |  | |
| 1.013 | Does the person have their own room? | |  |  | |  | |  | |
| 1.014 | Is the person able to get around their home? | |  |  | |  | |  | |
| **The following questions are for CMS data collection only and will come from the records review. Non-compliance in these answers should be reflected as non-compliance in the provider review tool.**  **(Data is being kept per person.)** | | | | | | | | | |
|  | **Answer Key** | | **YES** | **NO** | | **N/A** | |  | |
| 2.001 | Using person centered planning, has the plan been developed based on the results of the assessment as it relates to:   * Ensure health and welfare, * Assist the individual to engage in meaningful activities * Support community connections * Assist in improving self-advocacy skills * Ensure achievement of outcomes * Identify risks include supports to prevent or minimize risks   Are employment services consistent with the individual’s identified employment outcome? | |  |  | |  | |  | |
| 2.002 | Was the service plan reviewed annually? | |  |  | |  | |  | |
| 2.003 | Was the service plan revised based on the changes in the individuals needs/wants? | |  |  | |  | |  | |
| 2.004 | Was the individual’s PLOC/LOC reviewed at least annually and/or based on changes in the individual’s needs? | |  |  | |  | |  | |
| 2.005 | Does the waiver service delivery documentation for all waiver billing codes include scope? | |  |  | |  | |  | |
| 2.006 | Does the waiver service delivery documentation for all waiver codes include the type of service? | |  |  | |  | |  | |
| 2.007 | Does the waiver service delivery documentation for all waiver billing codes include the number of units (amount) provided? | |  |  | |  | |  | |
| 2.008 | Does the waiver service delivery documentation for all waiver billing codes include frequency? | |  |  | |  | |  | |
| 2.009 | Does the waiver service delivery documentation for all waiver billing codes include duration? | |  |  | |  | |  | |
| 2.010 | Was the “Freedom of Choice” form for this individual reviewed on an annual basis? | |  |  | |  | |  | |
| 2.011 | Did the county board comply with Free Choice of Provider requirements? | |  |  | |  | |  | |
| 2.012 | If the staff person administers medication does the person have the appropriate certification for:   * Oral or topical medications (Category 1) * G-tube/J-tube (Category 2) * Insulin injections (Category 3) | |  |  | |  | |  | |
| 2.013 | If the individual’s assessment indicates that they are unable to self-administer medication, does the service plan address their medication administration needs? | |  |  | |  | |  | |
| 2.014 | Does the ISP specify the provider type, frequency, and funding source for each service and activity? | |  |  | |  | |  | |
| **The following questions are for HCBS data collection only and will come from the observations and interview.**  **(Data is being kept per person.)** | | | | | | | | | |
|  | **Answer Key** | **YES** | | | **NO** | | **N/A** | |  |
| ~~2.015~~ | ~~Is the setting free from institutional qualities?~~ |  | | |  | |  | |  |
| ~~2.016~~ | ~~Does the setting not require improvement?~~ |  | | |  | |  | |  |
| ~~2.017~~ | ~~Does the individual reside in a setting which is not physically isolated from the community?~~ |  | | |  | |  | |  |
| ~~2.018~~ | ~~Does the individual reside in a setting that is not a disability-specific congregate setting?~~ |  | | |  | |  | |  |
| ~~2.019~~ | ~~Day services are not provided on or adjacent to this individual’s residential setting.~~ |  | | |  | |  | |  |
| ~~2.020~~ | ~~Does the setting promote community access?~~ |  | | |  | |  | |  |