PART II

POLICIES AND PROCEDURES
For
HCBS STATE TRANSITION PLAN PROVIDER GUIDANCE



GEORGIA DEPARTMENT OF COMMUNITY HEALTH

DIVISION of MEDICAL ASSISTANCE PLANS

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TABLE OF CONTENTS

Policy Revision Record 3
HCBS Statewide Transition Plan Provider Guidance 4
601. Executive Summary 4
602. Background 4
603. Settings Rule 4
604. About this Guidebook 4
605. How to use this Guidebook 5
606. Additional Guidance 5
607. Glossary of Guidance Terms 5
608. Scope of Services 7
609. Non-residential Service Settings 8
610. Being Person-Centered 9
611. Member's Choice and Health and Safety Concerns 10
612. What is a Person-centered Plan/Care Path and Individual Service Plan? 11
613. Provider/Case Manager/Support Coordinator Responsibility 11
614. Consent 12
615. Additional Guidance 13
616. Requirements that only apply to Residential Providers 13
617. Lease or Residency Agreement 13
618. Lockable door, Roommates, and Decorations 18
619. Daily Schedule 22
620. Visitors 25
621. Accessibility 27
622. Employment 28
623. Community Life 29
624. Control of Money 33
625. Privacy 34
626. Dignity and Respect 36
627. No Coercion/Restraint 37
628. Independent Choices 38
629. Setting Choice 40
630. Choice of Service and Support 42
Appendix A 44

Continuing Education Learn More 44
Appendix B 45
Person Centered Service Plan (PCSP) 45
Appendix C 53
HCBS Settings Rule Member Questionnaire 53
Appendix D 55
HCBS STP Community Integration Plan 55

Policy Revision Record
from 2025 to Current[1]

REVISION DATE	SECTION	REVISION DESCRIPTION	REVISION TYPE	CITATION
			A=Added **D**=Deleted **M**=Modified	(Revision required by Regulation, Legislation, etc.)
1/1/2026	N/A	No Changes this quarter		
10/1/2025	N/A	No Changes this quarter		
7/1/2025	Appendix D	HCBS STP Community Integration Plan	A	Policy
7/1/2025	Appendix C	Revised form submission instructions	M	Policy
4/1/2025	617	Corrected Link to GA Landlord-Tenant Handbook	M	Policy
4/1/2025	Appendix B	Person Centered Service Plan Form	A	Policy
4/1/2025	Appendix C	HCBS Settings Rule Member Questionnaire	A	Policy

[1] The revisions outlined in this Table are from 2025 to current. For revisions prior to 2025, please see prior versions of the policy.

HCBS Statewide Transition Plan Provider Guidance

601. Executive Summary

This provider and member's guide contains informational guidance, best practices, and examples to assist waiver service providers and members in understanding each of the new home and community-based services (HCBS) requirements and to help generate ideas of HCBS-compliant practices. This guidance should be used in conjunction with program policy. Continued updates to this manual will be made as additional information is developed and approved within the Statewide Transition Plan.

602. Background

This document is for Georgia's home and community-based services (HCBS) waiver providers (Elderly and Disabled Waiver Program- EDWP, Independent Care Waiver Program-ICWP, Comprehensive Services and Support-COMP, and New Options Waiver-NOW). Specifically, if your service delivery is in the following areas- Adult Day Health, Alternative Living Services, Community Access Group, Community Residential Alternatives, Pre-Vocational Services, Supported Employment Group, and Respite Out-of-Home Care. This guidance will help you comply with relevant requirements as discussed in the Final Settings Rule 2014.

603. Settings Rule

The final rule amends the regulations for the 1915(c) HCBS waiver program, authorized under section 1915(c) of the Social Security Act (the Act), in several important ways designed to improve the quality of services for individuals receiving HCBS. Specifically, it establishes requirements for home and community-based settings in Medicaid HCBS programs operated under sections 1915(c), 1915(i), and 1915(k) of the Act, defines person-centered planning requirements, provides states with the option to combine multiple target populations into one waiver to facilitate streamlined administration of HCBS waivers, clarifies the timing of amendments and public input requirements when states propose modifications to HCBS waiver programs and service rates, and provides CMS with additional compliance options for HCBS programs. For more detail, please refer to the 1915(c)-fact sheet at https://dch.georgia.gov/about-us/publications/fact-sheets

To address the requirements of the new federal HCBS rule, DCH collaborated with all stakeholders including member and provider organizations, sister agencies, workgroup members and individuals to further expand choice and autonomy for people who receive HCBS. The HCBS rule will change the way some providers offer services. It aims to ensure HCBS waiver services do not isolate a person from the community. Whereas DCH has reviewed all options presented that afford a member expanded choices, DCH remains committed to ensuring that the waiver programs are programmatically and fiscally compliant.

603.1. Equitable Allocation of Resources - Because the State is required to provide for the care and treatment of a large and diverse population of persons with disabilities, available resources will be allocated in as equitable a manner as possible, considering the needs of consumers already being served and those waiting for services.

604. About this Guidebook

Although some settings may already offer services that promote community inclusion, other settings may need to make changes to allow full community inclusion. This document contains information

gathered from member/provider feedback, frequently asked questions, CMS guidance, best practices, and examples to help you understand each of the new HCBS requirements. It is the intent of this document to also aid in the stimulation of creative strategies that will help providers improve their settings as they become compliant and improve the quality of care received by its members. DCH stresses that compliance for each setting may differ as population make-up and needs may dictate strategies with the requirements, but the intention remains the same: to provide choices and protections to people and ensure they receive services in the most appropriate integrated setting.

605. How to use this Guidebook

The design of this guidebook is to provide a practical and real-world example as they relate to CMS ruling. Each section will outline the Centers for Medicare & Medicaid Services (CMS) requirement identified first. This is what providers are required to do and during state audits will serve as a required deliverable of each setting surveyed. These requirements are numbered and in the same order as the Provider and Member surveys. Each requirement is then followed by DCH' s interpretation of what that requirement is trying to achieve, labeled "Provider expectations." The guidebook will also outline how DCH interprets the requirement may look like in an individual setting. Again, compliance may look slightly different as settings and members' needs will differ. Finally, we include some best practice suggestions for each requirement. Many of these were suggested by providers in each of the various settings, provider organizations, and through feedback from the HCBS Advisory Groups and Public Comment periods as ways to meet the requirements. The DCH encourages providers to develop their own unique and creative ways of meeting the requirements that are designed to meet the needs of the people being served.

606. Additional Guidance

Georgia waiver policies will be revised, effective July 1, 2021, to comply with the HCBS rule requirements. You can find more information regarding the policy revisions on the Georgia Fiscal Intermediary (Gainwell technologies) website at www.mmis.georgia.gov.

607. Glossary of Guidance Terms

The following terms and definitions are used within this document to define the unique and specific points the Statewide transition plan exhibits. This glossary is used to ensure that all stakeholders (members and providers) understand what is meant by the terminology, acronyms, and phrases used inside the settings rule, its requirements and overall guidance.

607.1. What makes an activity "age-appropriate?"

Age Appropriateness refers to activities and interactions that are designed specifically to suit the age and cognitive ability of the disabled person. Providers may find it challenging to encourage adults to participate in an environment that is suited to their chronological age, specifically when cognition is an issue. A disabled child is often kept busy with toys, a disabled adult, on the other hand, deserves and demands respect and a variety of activities that can interest and engage them.

The rule of thumb, while designing an age-appropriate environment for disabled person is to address in the following manner, "Is this something that a person without a disability might do?" If the answer is yes, then you might be on the right track. Remember, such activities are required to be simple, uncomplicated, engaging, inclusive and above all, respectful of the age of the person.

For example, people of all ages may enjoy working on puzzles. If this is an activity offered in an HCBS setting, then the image on the puzzle should be reflective of the interests of that age group. Children may prefer images of cartoon characters, while adults may prefer landscapes. Similarly, if a provider organizes a community outing to a movie theater, the provider should consider the interests of the people going when selecting the movie. A young adult may prefer to see the newest superhero action movie rather than an animated children's film. Art and craft activities can also be age appropriate. For example, crafts with materials like a child modeling clay, pasta and paper plates with pipe cleaners, popsicle sticks and pom-poms are likely not age-appropriate for adults.

607.2. What is an integrated setting?

Georgia's Olmstead Strategic Plan defines the most integrated setting as that which is Most appropriate to Individual Needs – Consumers should be assessed for the most integrated setting appropriate to their individual needs. In that process, consumers are afforded an informed choice about service options appropriate to their service needs.

607.3. What is a segregated setting?

Segregated settings often have qualities of an institutional nature. Segregated settings include, but are not limited to:

607.3.1. The congregate settings populated exclusively or primarily with people with disabilities.

607.3.2. Congregate settings characterized by regimentation in daily activities, lack of privacy or autonomy, policies limiting visitors, or limits on people's ability to engage freely in community activities and to manage their own activities of daily living.

607.3.3. Settings that provide for daytime activities primarily with other people with disabilities.

607.4. What does "to the same degree as" mean?

The Centers for Medicare and Medicaid Services (CMS), defines, "to the same degree as" to mean people who access Medicaid-funded HCBS have the same opportunities for inclusion, access, choices, and integration as all members of their community. When you consider whether people share in the hallmarks of community living to the same degree as people who do not require services and support, it is helpful to compare how you live your own life. Think about this in the following manner:

607.4.1. How do you make day-to-day choices and compromises in your home, workplace, and community?

607.4.2. What negotiations are necessary to develop and pursue your own interests and important relationships?

We can also consider the rights and responsibilities we experience every day (e.g.,

having consideration for people with whom we live, having a job and going to work, fulfilling a work or volunteer commitment, respecting coworkers, making choices within our income/budget) as we support people to navigate community life and consider benefits and consequences of their actions. The expectations for the people you serve should be the same as for any person living in the community. All people have the responsibility to consider the thoughts and needs of others while exercising their own rights, priorities, and preferences. We also must consider the limitations people have that may restrict their choices (e.g., fiscal restrictions, physical restrictions, etc.).

607.5. What is an informed choice?

DCH believes the more information a member/caregiver has in services available within their plan and the opportunities available within the community, the more likely they are to create choices that will enhance their quality of life as they develop their respective care plans. It is DCH's intent to always:

607.5.1. Informing people through appropriate modes of communication about the opportunities to exercise informed choice, including the availability of support services for people who require assistance in exercising informed choice.

607.5.2. Assisting people in exercising informed choice in making decisions

607.5.3. Providing or assisting people in acquiring information that enables them to exercise informed choice in the development of their individualized plans with respect to the selection of outcomes, supports and services, service providers, the most integrated settings in which the supports and services will be provided and methods for obtaining services.

607.5.4. Developing and implementing flexible policies and methods that facilitate the provision of support and services and afford people meaningful choices.

607.5.5. Ensuring the availability and scope of informed choice is consistent with the obligations of the respective agencies.

608. Scope of Services

This guidance incorporates recommendations from the HCBS C.A.R.E committee, people with disabilities and their families, as well as what DCH has learned through the provider survey process. This guidance applies to provider owned and/or controlled residential settings and group-based day service settings. CMS presumes services provided in a person's private home have the qualities of HCBS.

608.1. Provider owned and/or controlled residential settings.

Definition

608.1.1. The HCBS provider leases from a third party or owns the property.

608.1.2. The HCBS provider has a direct or indirect financial relationship with

the property owner, unless the property owner or provider establishes that the nature of the relationship does not affect either the care provided or the financial conditions applicable to tenants.

Examples

608.1.3. Housing with services establishment where personalized living services is delivered by a comprehensive home care provider (Alternative Living Services)

608.1.4. Community Residential Alternatives

As outlined in the state's current policy manuals the following are the specific definitions and services provided for the provider owned and/or controlled residential settings:

608.2. Alternative Living Services An ALS-Group Model personal care home is a freestanding residence, non-institutional in character and appearance, and licensed to serve seven (7) to twenty-four (24) members. The provider leases, rents or owns a licensed personal care home. Responsibilities of the provider include member intake/assessment, nursing supervision, and daily administration of the program. The provider employs sufficient staff to directly provide medically oriented personal care and 24-hour supervision, seven days a week. The designated responsible staff person is on the premises 24 hours a day, seven days a week.

608.3. Community Residential Alternatives (CRA) services are designed for people who need concentrated levels of support. These services are a range of interventions that focus on training and support. Services are individually tailored to meet specific needs and assist with changes in service needs. The service needs may be addressed in one or more of the following areas: eating and drinking, toileting, personal grooming, and health care, dressing, communication, interpersonal relationships, mobility, home management, and use of leisure time.

609. Non-residential Service Settings

Nonresidential settings and services are HCBS services that are often provided in settings (facility in the community) where most people have a disability and will be able to come and go as desired.

609.1. Adult Day Health (ADH) is a community-based, medically oriented day program that provides social, health and rehabilitative services to individuals who are functionally impaired. ADH services support individuals living with chronic illness and assist individuals to recover from acute illnesses or injuries. The ADH program provides services that promote medical stability, maintain optimal capacity for self- care and maximize the individual's highest level of functioning and independence as reflected on the individual's Comprehensive Care Plan.

609.2. Community Access Group Services in facility-based and community-based settings outside the participant's own or family home or any other residential setting. Provision of oversight and assistance with daily living, socialization, communication, and mobility skills building and support in a group. Assistance in acquiring, retaining, or improving: Self-help, Socialization and Adaptive skills for active community participation and independent functioning outside the participant's own or family home, such as assisting the participant with money management, teaching appropriate

shopping skills, and teaching nutrition and diet information. Provided in a facility or a community as appropriate for the skill being taught or specific activity supported.

609.3. Pre-Vocational Services These services help people work towards paid or unpaid employment on a one-to-one basis or in a group setting outside of the person's home, family home or any other residential setting. The purpose of the service is to teach people the skills necessary to be successful in a job in the community. Examples of service activities include but are not limited to following rules, attendance, completing tasks, problem-solving, endurance, work speed, work accuracy, increased attention span, motor skills, safety, and social skills in the workplace.

609.4. Supported Employment Group (SE) Supported Employment is available to eligible individuals, who express a desire and have a goal for competitive employment in their Individual Service Plan and for whom the ability to perform in a regular work setting is likely to require the provision of supports because of their disabilities. Services to obtain and retain competitive employment include job location, job development, supervision and training and is based on the individual's strengths, preferences, abilities, and needs.

609.5. Out-of-Home Respite (RC) is a service that provides temporary relief to the caregiver(s) responsible for performing or managing the care of a functionally impaired person. Respite Care workers provide only non-skilled tasks and services that are normally provided by the caregiver specifically for the respite care client.

610. Being Person-Centered

As outlined in Georgia's National Center on Advancing Person-Centered Practices and Systems (NCAPPS) planning guide year-3, Georgia has developed a No Wrong Door (NWD) system of care across multiple care networks (Aging, Physical Disability, TBI/SCI, Behavioral health, Developmental Disability, Division of Family and Children Services, Adult Protective Services, Public Guardianship Office, and others). An imperative component to building a NWD system is the true integration of a person-centered philosophy into all networks to ensure the coordination and delivery of services to meet individual needs. The various systems serving families in Georgia have made significant strides in recent years to include person-centered principles in policy, practice, and training efforts. Georgia would like to synthesize these efforts in a coordinated manner, improving outcomes for families and maximizing resources within the various systems. There is a common thread across all systems, and everyone is held to the same standards. The vision for systems change is to strengthen a true no wrong door by weaving person-centered practices with one voice across networks and systems. To do this, we must have a person-centered support system that helps people:

610.1. Build or maintain relationships with their families and friends.

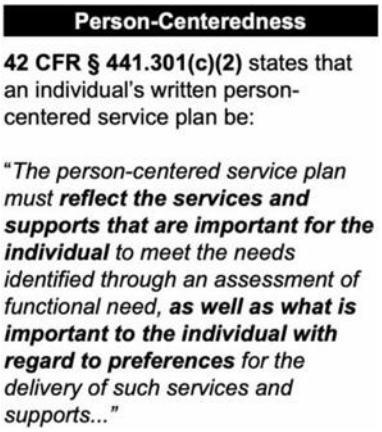
610.2. Live as independently as possible

610.3. Engage in productive activities, such as employment.

610.4. Participate in community life.

Find more information on Georgia's Person Center Activities you can review the National Center on Advancing Person-Centered Practices and Systems: Summary of Year Three Technical Assistance Activities by accessing the following link

https://ncapps.acl.gov/docs/NCAPPS_Y3TASummary_210310.pdf



611. Member's Choice and Health and Safety Concerns

While Freedom of Choice is statutorily based 42 CFR §431.51 Free choice of providers, many family members and even case managers attempt to persuade or dissuade a member in the choices they want during the development of a care plan. Each member has the right to make their own decisions and choices. However, the providers and case managers must maximize a person's ability to make choices while minimizing the risk of endangering the person or others. It is important to understand which rights can be modified. The HCBS rule specifies the following seven rights are rights that may be restricted under the rule:

611.1. Each person has at minimum the same responsibilities and protections from eviction that tenants have under the landlord/tenant law under a legally enforceable agreement.

611.2. Each person has privacy in their sleeping or living unit.

611.3. Units have entrance doors lockable by the person, with only appropriate staff having keys to doors.

611.4. People sharing units have a choice of roommates in that setting.

611.5. People have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.

611.6. People have the freedom and support to control their own schedules and activities, and they have access to food at any time.

611.7. People can have visitors of their choosing at any time.

To mitigate between member choices that may be harmful and the HCBS setting requirement the case manager, in collaboration with the member, natural supports and other members of the care team, may restrict that choice. For example:

611.8. If a person is diabetic and unable to make informed choices about their food, the case manager should document the need for a modification of this right and the provider

should ensure that the appropriate dietary/nutritional plan is established for the member and indicated in the Care Path or Individual Service Plan (ISP)

611.9. It is important to remember you should not restrict all people in your care just because one person in your setting needs to have a restriction put in place. Rights modifications should apply only to the person with the need for the modification.

It is important that the above referenced work together to design a plan that protects the members while still respecting the members' rights. If the modification is determined necessary and appropriate, the case manager/support coordinator must document it in the members CP or ISP.

612. What is a Person-centered Plan/Care Path and Individual Service Plan?

The person-centered care plan or Individualized Service Plan are crucial to ensure that members receive the right level of care and that it is given in line with their wishes and preferences. Care plans are based on individual needs and are consequently different from person to person. Although each care plan is unique, they all serve the same purposes, including:

612.1. Ensuring that you receive the same care regardless of which care worker is on duty.

612.2. Ensuring that the care you receive is recorded.

612.3. Supporting you to identify and manage your care needs.

Care plans are flexible, meaning that when or if the care needs change, the plan will be reviewed and adjusted accordingly to make sure it meets the members' needs and preferences.

Providers should be careful to refrain from designing care plans based upon what might be economical or what others in the same setting are receiving to standardize care.



613. Provider/Case Manager/Support Coordinator Responsibility

Any modification of the rights specified in HCBS rule must be supported by a specific assessed need

and documented in the person-centered plan. The case manager is responsible to coordinate with the provider to support these needs in the person's specific environment and to ensure implementation of the modification occurs only after both the person and the case manager agree to the provider's plan. DCH requires the case manager documents the following in the person-centered plan:

613.1. A specific and individualized assessed need

613.2. A clear description of the condition that is directly proportionate to the specific assessed need.

The provider must ensure all modifications are implemented in the least restrictive manner necessary to protect the person and provide support to reduce or eliminate the need for the modification in the most integrated setting and inclusive manner.

The provider is required to document the following and provide it to the case manager for inclusion in the person-centered plan/CP/ISP. The provider should also include this information in the service delivery plan:

613.3. Positive interventions and support used prior to any modifications to the service delivery plan.

613.4. Less intrusive methods of meeting the need that have been tried but did not work.

613.5. Regular collection and review of data to measure the ongoing effectiveness of the modification.

613.6. Established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.

613.7. An assurance that interventions and supports will cause no harm to the person.

614. Consent

Prior to implementing the modification of a person's right, the case manager must fully inform the person of the assessed need for the modification and how it will be implemented.

The case manager will discuss modifications with the person annually (and more frequently as necessary) so providers, the person and his or her person-centered planning team can determine if the modification is still needed or if revisions need to be made.

Best practice suggestions	Examples
Follow the clear policies and procedures that outline how and when you pursue approval for a modification (Monthly, Quarterly, Annual reviews, or change in conditions/Circumstances)	Jerome has Prader-Willi syndrome, a condition that causes him to ingest large quantities of food. He and his physician are working together to manage the condition. In the meantime, Jerome and his guardian have worked with his case manager and provider to determine that limiting his access to food items will help him remain healthy. Jerome's Alternative Living services provider will help Jerome build his skill set to work toward the ability to manage his food intake independently.
Maintain an open line of communication with the person and their guardian, when applicable	

In this example, the provider must work with the person, his/her case manager/support coordinator, and the person-centered planning team to address all requirements and steps necessary to implement a modification to a person's rights.

615. Additional Guidance

How do I request a modification for a person in my care?

If you are a residential services provider and have identified a health and safety risk to a person in your care, you need to collect documentation of the risk and contact the person's case manager/support coordinator. The case manager/support coordinator will work with the person, you, and other members of the person-centered planning team to ensure the appropriate information is documented on the person's support plan and the person has been informed and consented to the modification.
The following should not occur.

615.1. Modifying a person's rights because it is convenient for the provider or guardian.

615.2. Implementing a modification without consent of the person and his/her guardian (when applicable)

615.3. Implementing a modification for all people living in a setting, regardless of their individualized needs and abilities.

616. Requirements that only apply to Residential Providers

The federal requirements, expectations, and best practices in standards 1-7 only apply to provider-owned or controlled residential providers, Alternative Living Services and Community Residential Alternatives and supported living supports:
616.1. Lease or Residency Agreement

616.2. Lockable door

616.3. Roommates

616.4. Decorations

616.5. Daily schedule

616.6. Visitors

616.7. Accessibility

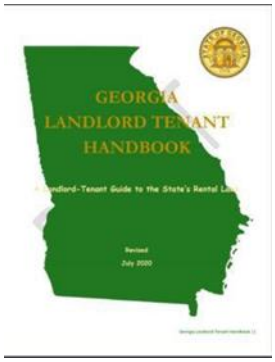
See the provider owned and/or controlled residential settings section for more information.

617. Lease or Residency Agreement

617.1. Federal requirement- 42 C.F.R. § 441.301 (c)(4)(vi)(A):

The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the

individual has, at a minimum, the same responsibilities, and protections from eviction that tenants have under the landlord/tenant law of the State, county, city, or other designated entity. For settings in which landlord tenant laws do not apply, the State must ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS participant, and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law. Review the GA DCA Landlord-Tenant Handbook and it appendices for policy and form examples in it's appendices.



Georgia Landlord-Tenant Handbook | Georgia Department of Community Affairs

Georgia regulations of Personal Care Homes allow for a landlord to give a notice of 30 days prior to terminating a residential agreement (Ga. Comp. R. & Regs. r. 111-8-62-.29(1)). These regulations also allow a member to be immediately discharged if their condition necessitates nursing home care or if their behavior or condition threatens other patients so long as certain procedures are followed (Ga. Comp. R. & Regs. r. 111-8-62-.28). A different law, the "Remedies for Residents of Personal Care Homes Act", grants tenants of personal care homes the right to file a grievance against or request a hearing regarding their treatment by a Personal Care Home (O.C.G.A. § 31-8-130 et seq.).

617.2. Provider expectations

This requirement ensures that people who live in a provider-owned or controlled residential setting have the same rights and protections as other community members.

The lease, Residency Agreement or Individual Resident Placement Agreement should contain the HCBS-required resident rights and informs the member and providers of their responsibilities under the agreement, such as:

617.2.1. Amount and due date for rent or room/board.

617.2.2. Person's responsibilities (i.e., maintaining his/her living space and not engaging in activities that disrupt or potentially cause harm to other residents)

617.2.3. Provider's timeframe for giving the person a notice of service termination and/or eviction.

617.2.4. Conditions under which a provider could initiate an involuntary termination of the lease/agreement.

617.2.5. A person's appeal rights information.

The provider must give a signed copy of the lease/Residency Agreement to the person and maintain a copy of the agreement in the member's records. Case Management/Support Coordination should also have a copy of this agreement.

Licensed programs must also refer to their applicable licensing/registration requirements regarding admission criteria/Residency Agreement requirements.

Best practice suggestions	Example
The provider can include information about rights in a resident handbook, but the lease/agreement must explicitly reference that the resident's rights are outlined in the handbook. The provider should explain the terms of the lease/agreement in a format the person can be easily understood. House Rules should be in a conspicuous area that can be seen and observed by all interested and disinterested people. Furthermore, a copy should be placed within the members' file and provided to them upon agreement to reside in the setting. A copy should also be made available to a member's legal guardian, representative and case manager.	Happy Home Alternative Living Service provider meets with Daphanie and her case manager to review the terms of the lease/agreement including her rights and responsibilities before Daphanie moves in so she can make an informed decision about where she wants to live. Nicole enters a PCH and receives a copy of the roommate agreement and the house rules which she may review prior to signing. She also asks that a copy be provided to her sister, who serves as her representative.

617.3. Does the lease agreement or Residency Agreement need to be completed annually, or just once with a review of rights annually?

For Personal Care Home Settings licensed under Georgia Stat. 111-8-62-16 Admission Agreement, A written admission agreement must be entered into between the governing body and the resident. Such agreement must contain the following:

617.3.1. A current statement of all fees and daily, weekly, or monthly charges; any other services which are available on an additional fee basis, for which the resident must sign; a request acknowledging the additional cost; and the services provided in the home for that charge.

617.3.2. A statement that residents and their representatives or legal surrogates must be informed, in writing, at least 30 days prior to any increase in established charges related to the provision of personal services and at least 60 days prior to any increase in charges for room and board.

617.3.3. The resident's authorization and consent to release medical information to the home as needed.

617.3.4. Provisions for the administrator or on-site manager's continuous assessment of the resident's needs, referral for appropriate services as may be required if the resident's condition changes and referral for

transfer or discharge if required due to a change in the resident's condition.

617.3.5. Provision for transportation of residents for shopping, recreation, rehabilitation, and medical services, which must be available either as a basic service or on a reimbursement basis. Provision must also always be made for access to emergency transportation.

617.3.6. A statement of the home's refund policy including but not limited to when a resident decides not to move into the home, dies, is transferred, or discharged.

617.3.7. A statement that a resident may not perform services for the home.

617.3.8. A copy of the house rules, which must be in writing and posted in the home. House rules must be consistent with residents' rights. House rules must include, but not be limited to, policies regarding the use of tobacco and alcohol, the times and frequency of use of the telephone, visitors, hours, and volume for viewing and listening to television, radio, and other audiovisual equipment, whether residents' personal pets or household pets are permitted and the use of personal property.

617.3.9. For residents first admitted after the effective date of these rules, a statement disclosing whether the home permits the resident to hire independent proxy caregivers, sitters, or requires the purchase of such services from the home or approved providers.

617.4. Additionally, the Personal Care Home Statue 111-8-62 updated on 11/17/21 contains Rules and Regulations for the Personal Care Homes and addresses member’s rights

617.5. Statue 111-8-62-07

The governing body is responsible for implementing policies, procedures and practices in the home that support the core values of dignity, respect, choice and independence and privacy of the residents in a safe environment and in accordance with these rules. At minimum, the policies and procedures that are developed must provide direction for the staff and residents.

617.5.1. House rules and their enforcement

617.5.2. Protecting the rights of the residents as set forth in these rules.

The member’s rights supersede any house rules that are developed by the provider.

617.6. This section 111-8-62-25 Supporting Residents Rights details how members can change or develop their own house rules.

617.6.1. Residents have the right to form a Resident Council and have the right to have meetings in the home outside the presence of owners, management, or staff members of the home.

617.6.2. Exercise the constitutional rights guaranteed to citizens of this state and this country including, but not limited to, the right to vote.

617.6.3. Choose activities and schedules consistent with the resident's interests and assessments.

617.6.4. Interact with members of the community both inside and outside the home and to participated fully in the life of the community.

617.6.5. Make choices about aspects of his or her life in the home that are significant to the Resident.

617.7. The following should not occur.

617.7.1. A provider forces a person to move out without due process including adequate notice.

617.7.2. A provider discharges/evicts a person for an issue that was not included or described in the admission agreement that was signed by the person or his/her legal representative.

617.7.3. A provider inappropriately uses a lease/Residency agreement to force a person to wave/modify certain rights, under "house rules" (e.g., A lease/Residency agreement cannot prohibit a person from having any visitors).

617.8. GA Code § 31-8-135 (2022) Hearing: Transfer of Residents

617.8.1. Any resident, the representative or legal surrogate of the resident, if any, or the state or community ombudsman, who believes the resident's rights have been violated by a personal care home, its governing body, administrator, or employee, shall have the right to request a hearing from the department pursuant to Chapter 13 of Title 50, the "Georgia Administrative Procedure Act."

617.8.2. No person shall be prohibited from requesting a hearing pursuant to subsection (a) of this Code section for failure to exhaust any rights to other relief granted under this article.

617.8.3. Except as provided in paragraph (2) of this subsection, the hearing provided for in subsection (a) of this Code section shall be conducted within 45 days of the receipt by the department of the request for a hearing. Where the state or community ombudsman has not already been involved in the matter at issue, the department may refer the request for a hearing to the state or community ombudsman for informal resolution pending the hearing. Such referral shall not extend the 45-day period in which the department shall conduct such hearing.

617.8.3.1. If a resident or a resident's legal surrogate or representative, if any, alleges that an action or failure to act by a personal care home or its governing body,

administrator, or employee is in retaliation for the exercise by that resident or his or her representative or legal surrogate, if any, of a right conferred by state or federal law or court order, the hearing provided for in subsection (a)of this Code section shall be conducted within 15 days of the receipt of the department of the request for a hearing. For such hearing, all pending requests for hearing by the resident or his or her legal surrogate or representative, if any, relating to such resident shall be consolidated.

617.9. No transfer of a resident shall take place until all appeal rights are exhausted, unless:

617.9.1. An immediate transfer is necessary because the resident develops a physical or mental condition requiring continuous medical or nursing care; or

617.9.2. The resident's continuing behavior or condition directly and substantially threatens the health, safety, and welfare of the resident or any other resident.

617.10. The department shall hold any hearing provided for in subsection (a) of this Code section at the personal care home upon the residents' request or as necessary due to the resident's physical condition. Where two or more residents of a personal care home allege a common complaint, the department may at the residents' request schedule a single hearing.

617.11. If the department finds no violations of this article, the resident and personal care home will be so informed. If a violation has occurred:

617.11.1. The hearing officer shall so notify the staff within the department responsible for the licensure of personal care homes.

617.11.2. The department shall order the personal care home to correct such violation; and

617.11.3. Upon failure of the personal care home to correct such violation within a reasonable time, the department may impose appropriate civil penalties as provided for in Code Section 31-2-8.

618. Lockable door, Roommates, and Decorations

618.1. Federal Requirements

618.1.1. Each person has privacy in his/her sleeping or living unit:

618.1.1.1. Units have entrance doors lockable by the person, with only appropriate staff having keys to doors as needed.

618.1.1.2. People sharing units have a choice of roommates in that setting.

618.1.2. People have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.

618.2. Provider Expectations

People who receive residential waiver services have the same rights as any of us in our own homes, rental or otherwise. These requirements ensure people have the privacy they desire. A person should be able to lock his/her door, and he/she should come and go as he/she chooses. No one wants to share a room with a stranger, so providers must have a process for people to choose their own roommates. Finally, these requirements ensure the person's living space feels like home and can be furnished or decorated as they choose, within the boundaries of the lease/Residency Agreement.

People have lockable bedroom doors or a lockable front door to their unit (if shared unit, lockable bedroom door)	Staff consider roommate compatibility and give the person an opportunity to provide input in the decision.
People have control over their privacy and the option to lock their bedroom or unit door from the inside and outside	Staff inform people how they can request a choice of or change in roommates.
People have their own key/fob to their bedroom or unit	People receive written notice when the provider plans to add a roommate or move the person to a different unit.
If there are circumstances that would prevent an individual from having a locked bedroom/unit door these are discussed during the person-centered planning process and described and documented in the person-centered plan and provider service delivery plan	People can decorate their room as desired by choosing decorations or furnishing their room within their budget.
The staff person(s) allowed to have keys/fob to a person's room is determined by the provider and the person and should be documented in the person-centered plan and provider service delivery plan.	There are clear policies and procedures in place to support these requirements
Staff respect the person's privacy by requesting entry to the bedroom or unit (e.g., staff will knock or request to enter a room and receive the person's permission prior to entering)	Staff only access a person's bedroom or unit as needed to address health and safety concerns

To comply with these requirements, providers will ensure:
Licensed programs must also refer to their applicable licensing/registration requirements regarding lockable doors, roommates and decorations (county fire and safety codes)

Best practice suggestions	Examples
Locks are standard on all bedroom unit	Laura lives in an alternative living setting

doors, and a person can choose whether to use them	and has a lock on her bedroom door. Only Laura and appropriate staff have a key to her lock.
Staff or other residents knock and receive permission before entering a person's room	Sally and Jane share a unit in a customized living setting. They do not get along. The provider reminds Bashar and Jim of the policy for requesting a new living situation and helps them follow the process to request new roommates.
People who live in the home can come and go from the residence even if the front door is locked (e.g., ring a bell, have their own key, or request a key prior to leaving)	Janice really enjoys the Atlanta Braves. She chooses to decorate her room with Braves curtains, pillows and throw rugs she has purchased.
People can state their rights when asked or know where to find a copy of their rights	Marisol enjoys seeing pictures of her grandchildren. She can hang pictures of her family on her walls as desired.
Staff are trained on a safety plan for use in an emergency if a person's bedroom or bathroom door is locked	Tony has a seizure disorder that requires frequent checks. Tony's person-centered plan clearly instructs staff to knock on his door before entering to allow privacy, except during sleep times. The plan maximizes Tony's right to privacy while supporting his health need for uninterrupted sleep.
People are allowed to bring their own furniture to this setting, such as a favorite chair or comfortable bed	Joe loves the Atlanta Braves. He is allowed to decorate his bed and room with items showing his team spirit and interest in the team.
The provider creates a process that allows people to meet potential roommates.	Joe schedules a visit to his potential personal care home to meet with the other members of the house before deciding.

618.3. Additional Guidance

618.3.1. Where do individual rights intersect with health and safety under this regulation?

Providers have a responsibility to protect the health and safety of the people in their care. When there is a medical issue or an identified health or safety concern, the provider needs to share their concern with the person's case manager. The case manager must document the modification of rights in the person-centered plan/Community Services and Support Plan (CSSP).

All people have the right to privacy unless that privacy creates an identified and documented health and safety concern. People may have differing values, religious orientations, sexual orientations, or political beliefs. The provider must respect those differences because they most likely will not pose a health or safety risk.

618.3.2. Can we have a policy for secured memory care that covers everyone in that setting?

No, providers cannot have a blanket policy that covers everyone in a setting. Every person in the setting must have an assessment that shows his or her need for a secure environment. The case manager must document the modification in every person's support plan. If a person is living in a secure unit but able to come and go safely, he or she needs a method to move freely about the building.

618.3.3. What type of lock needs to be available to the person?

There is no CMS guidance on the type of lock. The person needs to have control over his or her privacy by locking the door from the inside or outside. The provider should choose a lock that will respect the person's need for privacy and fit the needs of the residence.

618.3.4. If a person has never had a lock on their door, do we need to install a lock on his/her door?

This requirement starts with the expectation that everyone can have lockable bedroom door. When a person has an assessed need for a modification to this requirement, the case manager will document that restriction in the person's support plan. The support plan will follow the rights restrictions process (i.e., documentation of how other less restrictive options could not meet the assessed need, objective measures and regular evaluations).

When the assessed need identifies the person should not have a lock installed on his/her bedroom door, the provider may uninstall the lock until a future time when the rights restriction is lessened or lifted through the rights restriction process. If the restrictions are lessened or lifted based on assessed need of the person, the provider may (re)install the lock on the door.

618.3.5. The following should not occur:

618.3.5.1. A provider says, "I can't let this person lock his door because he may watch something inappropriate on his TV, Tablet or Computer." Everyone has the right to privacy unless there is an identified and documented health and safety concern.

618.3.5.2. The setting has a policy that bedroom locks are not allowed for anyone living there.

618.3.5.3. The setting locks the front doors at a certain time each night and everyone must be inside before that time.

618.3.5.4. People living in the residence meet a new roommate the

day that person is moving in, and there is no process in place to make changes if that relationship does not work out.

618.3.5.5. A person's bedroom is furnished by the provider with no input from the person, and decorations are restricted beyond normal landlord-tenant norms.

618.3.5.6. Bedrooms are pre-furnished, and all rooms look identical. People do not have the option to personalize the space.

618.3.5.7. Staff enters a person's bedroom without knocking and receiving permission (unless there is an emergency or health and safety concern)

618.3.5.8. Staff shows another staff member a person's room without that person's permission.

619. Daily Schedule

619.1. Federal Requirement

People have the freedom and support to control their own schedules and activities, and they have access to food at any time.

619.2. Provider Expectations

People control their day-to-day lives in the same way other community members do. This includes control over when they like to wake up and get ready, as well as when and what they eat.

619.2.1. To comply with this requirement, providers will ensure:

619.2.1.1. People have freedom to control their own schedule and activities (e.g., they do not have to adhere to a set schedule of waking, bathing, exercising, or participating in activities)

619.2.1.2. Support activities are flexible and work around the person's preferred schedule. People do not have to follow one "set schedule" for all living in the setting.

619.2.1.3. People have access to food (meals or snacks) and a place to store snacks (e.g., bedroom, kitchen), if desired

619.2.1.4. People have choices of when, where and with whom they would like to eat (e.g., no set "mealtimes" or assigned seats, a person can request alternative meals if desired, etc.)

619.2.1.5. People can eat a meal or snack at any time (e.g., if they miss a meal due to an activity, they do not have to wait for the next meal to eat; the provider can set aside a plate for them to reheat later or provide an alternate meal when they return)

619.2.1.6. People have the right to refuse to participate in activities the rest of the people in the setting want to experience.

Licensed programs must also refer to their applicable licensing/registration requirements regarding control of schedules.

Best practice suggestions	Examples
People are supported in planning their day-to-day activities and schedules (i.e., when to wake up, eat and go to bed)	Erik lives in a community residential setting and has a part-time job early in the morning a few days a week. He has to wake up very early and misses breakfast on those days. The provider accommodates Erik's schedule by helping him set his alarm clock and creating flexible mealtimes.
Providers are flexible when planning meetings and other activities so people can coordinate their schedules. People can ask for assistance if they would like to schedule appointments for services in the community or arrange for transportation	Catherine lives in a personal care home setting, and she has a number of medical appointments each week. Some of the other residents living in the setting enjoy going to the library and the community center often. The provider sits down with the group each Sunday to plan their weekly activities so Catherine and the other people in the group can attend the activities that are important to them.
The provider creates an activity calendar each week so people can make decisions about activities in which they would like to participate. People can help develop the week's grocery list for the week or activity options. People are encouraged to share ideas and make choices about setting activities based on their	A large, customized living building does not keep its commercial kitchen operating 24-hours a day. To ensure people have 24-hour access to food, the provider permits people to have a small refrigerator in their living quarters for keeping snacks they have purchased with their own monies. People also have access to a kitchen facility (with plates, utensils and microwave) if they would like to prepare their own

own personal preferences and interests	snacks between meals.

619.3. Additional Guidance

619.3.1. Does this requirement mean I have to leave the kitchen open 24 hours a day or cook a variety of meals?

Not necessarily. You may opt to leave the kitchen accessible to residents who would like to prepare a snack or small meal between regular mealtimes. Alternatively, you can allow residents to keep their own food items in their living quarters or in designated. cupboards/ spaces in the pantry that they can access whenever they want.

619.3.2. How can I help members remain healthy when they often make poor food choices. Do they have to have 24-hour access to food?

A provider may not limit a person's access to food unless there is an identified and documented risk to the person's health or safety that requires rights modification. A provider may not limit a person's access to food items solely based on:

619.3.2.1. Whether the food is deemed "junk food"

619.3.2.2. The provider's personal beliefs

619.3.2.3. The provider's assumption that a person is not a healthy weight.

The provider should focus instead on helping the person learn to make better food choices if that is an agreed upon goal in his/her service plan. There may be instances in which 24-hour access to food poses a health or safety risk to a person. In that case, the provider may need to limit access to food. A modification to this right must be implemented and documented in agreement with the person and his/her case manager.

619.3.3. The following should not occur.

619.3.3.1. The provider requires people to participate in activities.

619.3.3.2. The provider restricts a person's access to food because of the provider's personal belief that the food choice is not appropriate or healthy.

619.3.3.3. The provider only makes food available or accessible to people when the provider prepares regular meals or supplies a snack.

619.3.3.4. The provider places restrictions on whether a person eats dessert based on whether he/she finishes dinner.

619.3.3.5. The provider requires people to be awake and dressed at

the same time as others.

619.3.3.6. The provider requires “lights out” or “bedtime” at a certain time.



620. Visitors

620.1. Federal requirement

People can have visitors of their choosing at any time.

620.2. Provider expectations

People should have the opportunity to develop close, private, and personal relationships without unnecessary barriers or obstacles imposed on them. HCBS federal rules require that people be able to have visitors at any time without restriction, just as anyone would have in their own home or rental unit. Providers should also not screen the person’s visitors. This requirement does not mean people can be inconsiderate of others’ rights or the need for quiet and safety in the residence. It is intended to ensure people who live in adult foster homes/community residential settings and customized living settings have the same freedoms with relationships and visitors in their homes.

620.2.1. To comply with this requirement, providers will ensure:

620.2.2. People can choose their visitors and have no restrictions on visit times. People may have overnight guests.

620.2.3. People have access to unrestricted visitor areas. People have the right to privacy during visits.

Licensed programs must also refer to their applicable licensing/registration requirements regarding visitors

Best practice suggestions	Examples
The policy and procedures for visits should include the person’s right to:	Sonia lives in a personal care home. Sonia’s friend Jackie likes to stop by at

Have visitors of their choosing at any time and privacy during the visit.	random times to visit when she is in the area. The setting allows visitors to visit at any time. If Jackie visits after a certain time and the doors to the home are locked, Jackie must use the doorbell and sign in and out on the visitor log by the front door. If Jackie comes to visit and other people are sleeping, the provider expects Jackie to be quiet and respectful of all people who live in the home.
The person's right to have visitors of their choosing at any time must be contained in the resident rights document, the resident handbook, or the lease/Residency Agreement	
The provider directly addresses health and safety concerns with the person and shares them with the person's case manager. If visit modifications are implemented, the modifications are documented and implemented in collaboration with the person and the provider	

620.3. Additional Guidance

Visitors should have access to all appropriate areas when visiting and should not be denied entry to common areas or the person's room. The setting may require visitors to sign in and/or notify the provider that they are in the residence. The setting may also require visitors to complete other procedures to ensure the safety and welfare of the people who live and work there. However, the procedures should not restrict visitors unnecessarily for the convenience of staff or restrict the person from freedom of association with those they choose.

It is understood that in a shared living situation, the needs of other people living in the home must also be respected. If there are concerns from other people living in the home about a visitor(s), the provider should facilitate communication between the affected parties.

At times during the day, there are no staff members in the home because of appointments, shopping, meetings, etc. Must I allow anyone to visit this home when the staff is not present? If so, how can we protect the safety, security and privacy of the people present and the security of the home? Is there a way to limit visitation to times when staff members are present and still complying with the new rule?

People should have the opportunity to develop close, private, and personal relationships without unnecessary barriers or obstacles imposed on them. HCBS federal rules require people to be able to have visitors at any time without restriction, just like anyone else would have in their own home or rental unit. Providers should not screen the person's visitors. This does not mean that people may be inconsiderate of others' rights or the need for quiet and safety in the residence.

A case manager, in collaboration with a provider, may modify the person's right to have visitors at any time basis based on the person's assessed needs. This right should be modified on an individual basis, not throughout the entire setting.

620.3.1. The following should not occur.

620.3.1.1. The provider determines who may or may not visit based on their own feelings about the visitor's character.

620.3.1.2. The setting has scheduled visitation hours.

621. Accessibility

621.1. Federal Requirement

The setting is physically accessible to the person.

621.2. Provider Expectations

To comply with this requirement, providers must ensure a person's physical environment meets his or her needs. For example, people must be able to use common areas in the home, such as the kitchen, dining area, laundry area and shared living space, to the extent they desire.

People must have the right to move about the setting and not be confined to any one defined area. They should have unobstructed access to all areas of the common living space they wish to access.

Licensed programs must also refer to their applicable licensing/registration requirements regarding accessibility.

Best practice suggestions	Examples
Have a conversation with a person about accessibility needs upon move-in	Jada wants to move to a personal care home. She completed a walkthrough of the common areas and living quarters with her case manager. This helps her identify any potential issues and needs for environmental accessibility adaptations to meet her mobility needs if she chose that home as her new residence
Ensure the physical environment meets the needs of people who live in the setting (e.g., common areas are accessible to all residing in the home such as laundry, kitchen, dining area as desired)	
People are notified that they may request a reasonable accommodation, and the provider explains how to make such a request	
Regularly check for fall or trip hazards (loose rugs, uneven surfaces, etc.) As needed, the provider installs grab bars, ramps, adapted furniture, etc., to ensure access to desired areas and household items.	

621.2.1. The following should not occur.

621.2.1.1. The provider limits people who require the use of a wheelchair or walker to only their bedroom and the dining hall because the doorways to the kitchen and

activity room are too narrow.

621.2.1.2. People living in the home are not able to maintain independence as desired due to physical accessibility issues in the home.

621.2.1.3. The provider uses gates or other barriers to rooms to prevent access to common areas.

621.3. Standards that apply to all HCBS providers

621.3.1. The federal requirements, expectations, and best practices in standards 8-16 below apply to all providers of HCBS services:

621.3.1.1. Employment

621.3.1.2. Community life

621.3.1.3. Control of money

621.3.1.4. Privacy

621.3.1.5. Dignity and respect

621.3.1.6. No coercion/restraint

621.3.1.7. Independent choices

621.3.1.8. Setting choice

621.3.1.9. Choice of services and support.

622. Employment

622.1. Federal requirement

The setting is integrated and supports full access to the greater community for people who receive HCBS services. This includes opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as people who do not receive HCBS.

622.2. Provider expectations

To comply with this requirement, the provider must engage with the person and his/her support team by using person-centered thinking to ensure:

622.2.1. A person's needs, desires and choice to work are assessed and the person can make decisions through an informed choice process, which includes having actual community experiences on which to base decisions.

622.2.2. People have opportunities to explore, seek and experience employment,

including work in a competitive integrated setting if desired.

Licensed programs must also refer to their applicable licensing/registration requirements regarding access to the community, including employment.

Best practice suggestions	Examples
If the person receives services in a residential setting, the lease/Residency Agreement or recipient rights document notes a person's right to hold a job, engage in community life, control personal resources, and receive services in the community. People know how to request support to pursue a job change if interested.	Staff help Mai explore her skills and interests to help her identify potential job opportunities in the community. Then, they research the wages and benefits for those opportunities and conduct a benefit analysis to see if there would be any negative impacts on the public benefits she receives. Through this process, she can make an informed decision.
The provider identifies employment resources (e.g., training programs and educational programming opportunities) The provider may refer or use the resources available through the Georgia Vocational rehabilitation Agency, Statewide Independent Living Council, or local Center for Independent Living	James is unsure of job opportunities in his area. His supported employment provider coordinates opportunities for James to sample some community job sites and visit businesses that are of interest to James. This way, he has some real-life experiences on which he can base his decision.
For people who choose employment, the first and expected option is competitive, integrated employment	

623. Community Life

623.1. Federal requirement

The setting is integrated in and supports full access to the greater community for people who receive HCBS. This includes providing opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as people who do not receive HCBS.

623.2. Provider expectations

People who receive HCBS must have equal access to the same community resources and activities as the greater community. Providers should not have rules that restrict or obstruct community access. It is critical to ensure service and support delivery practices do not isolate older adults and people with disabilities from the community. Providers must also ensure service and support practices do not create an environment that is institutional in nature.

Providers must support people in their desires to participate in community.

To engage with the person and the support team, the provider should use person-centered thinking to:

623.2.1. Ensure people have opportunities and support they need to be fully included in their community, individually and in groups, as desired.

623.2.2. Identify, develop, and make available information on transportation options for community access.

623.2.3. Assist people with developing meaningful relationships with other members of the community.

623.2.4. Ensure people have services, resources and support to help them explore or maintain meaningful activities.

Licensed programs must also refer to their applicable licensing/registration requirements regarding access to the community, including engagement in community life.

Best practice	Examples
If the person receives services in a residential setting, the lease/Residency Agreement or recipient rights document includes a person's right to engage in community life and receive services in the community.	An adult day provider in Tifton plans a trip to the county fair. The provider arranges for interested staff and family members or natural support of the people to come as well. The provider transports the people to the county fair and tells everyone when and where they will be picked up. The provider assigns staff and/or natural supports as needed to individual people or small groups so the people can pursue their own interests/activities while at the fair.
The direct care staff adhere to a clear expectation about the services and activities identified in the person's support plan and honor his/her rights under the HCBS requirement	Raymond attends an adult day program. He is working on a goal to increase his social interactions with peers, so he and an adult day staff member go to the park where Raymond is encouraged to join others in conversation.
The provider organizes a variety of age- appropriate activities with input from the people each week to take place both inside and outside of the setting. Age-appropriate activities are activities that correspond with an individual's chronological age. •If applicable to the service the	Tisha and Lawrence live in an assisted living setting in Cedartown. The activities coordinator asks Tisha and Lawrence which activities they would be interested in for the following month. They are not sure, so they go to the "What's Happening" pages in the local newspaper. the "Patch" calendar

provider delivers, people have opportunities for recreation or physical activity, creative activities (e.g., to cook, craft, paint and play musical instruments) as well as learning and education (e.g., learn to use a computer, sew, or knit)	of events, church newsletters with community event information and the "Local Eventbrite" page on the internet to see what piques their interest. After viewing their options, Tisha and Lawrence tell the activities coordinator they would like to see a new movie in the theater next week. The activities coordinator adds the movie to the list of upcoming activities in which all can participate.
Staff document community engagement activities with progress notes, activity and transportation logs, calendars, or implementation plans People can come and go from the setting at any time. Transportation options are available (e.g., city bus, volunteer drivers, Metro Mobility, etc.)	Michelle lives in a personal care home in Albany. She enjoys quilting as one of her preferred activities. Michelle does not require constant supervision, and her support plan documents that Michelle is able to walk to a nearby community center independently to join a quilting circle group. During the meetings, she will have an opportunity to quilt and interact with other community members.
The provider holds planning meetings with people to discuss strategies for the coming weeks to ensure and support community integration (e.g., plan trips into the community.)	
People interact with members of the community through religious services, shopping, appointments, etc., to build community relationships	
People have opportunities to attend religious activities of their choice.	
Staff encourage people to try new things and share information with them about opportunities in which the person may be interested.	

623.3. Additional Guidance

623.3.1. How can a rural setting meet this requirement?

Integration is different in communities across Georgia. What can happen for a member in Atlanta will look very different in Crisp County. A very rural setting may have fewer opportunities for people to participate in community events or gatherings, but this is also true for the public in that

rural community. The key is to be sure people have the same access to the community as others who live in that rural setting.

623.3.2. Is integration different for everyone?

Yes, each person may have different needs and different desires. Providers are trained to address individual needs and desires and find a way to help every person meet those needs and desires to the greatest possible extent. Also, keep in mind that one person's needs should not limit another person's freedoms. For example, if one person cannot use revolving doors, the provider should not avoid group outings to places where there are revolving doors. This limitation of one person limits everyone's options for community engagement.

623.3.3. What are the expectations for day providers regarding "individual community opportunities?"

Do you expect us to provide one-on-one community activities? Day services (adult day health, prevocational and structured day services) are not required to support a person with one-on-one community access. However, the provider should talk to people about their likes, dislikes and interests and make sure they have opportunities to participate in activities that match their preferences. Providers should also share community activity information to raise awareness of and access to the broadest array of activities that may occur inside and outside the setting. It is not acceptable for providers to offer only on-site activities or only bring community members into the facility.

623.3.4. A note to providers

To support full community integration, providers must facilitate regular age-appropriate activities for people with others who do not receive HCBS (not including paid staff). In residential settings, if access to the community is limited due to geography or location, the provider should facilitate access to transportation however possible. For example:

623.3.4.1. The person can contact a natural support for transportation.

623.3.4.2. The provider can post information about bus schedules or phone numbers for taxi services, ride share opportunities when appropriate.

623.3.4.3. The provider can help the person use community transportation (i.e., MARTA Mobility or County/Regional Transit.

Ideally, there should also be some community activities at which a person can choose to spend their own money, as well as provider-sponsored or no-cost activities. The provider should share community activity information to encourage awareness and access to the broadest

array of activities inside and outside of the setting.

623.3.5. The following should not occur.

623.3.5.1. The provider creates physical barriers or obstructions that isolate the person from full access to the community. The setting lacks staffing to support opportunities for community access, or the staff does not work to find and use creative and effective solutions to barriers. (e.g., identifying people in the community or natural supports who might be willing to assist)

623.3.5.2. For residential settings, the provider creates an admission agreement that imposes limitations on integration and community access (e.g., a prohibition on being employed or a requirement that residents must receive other services on-site as a condition of residing there)

623.3.5.3. People have separate options (e.g., certain activities, living spaces or opportunities) based on their funding source.

624. Control of Money

624.1. Federal requirement

The setting is integrated in and supports full access of people receiving Medicaid HCBS 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 to the same degree of access as people who do not receive Medicaid HCBS.

624.2. Provider expectations

624.2.1. Provider expectations (if money management is a provider duty):

624.2.2. People have control over their personal funds and access to information about their income.

624.2.3. The provider identifies roles and responsible parties as they relate to money management.

624.2.4. Staff are trained to safeguard funds and follow the person's plan with respect to funds, if such a plan is in place.

Licensed programs must also refer to their applicable licensing/registration requirements regarding control of personal resources/management of funds.

Best practice	Examples

The lease/Residency Agreement or recipient rights document includes a person's right to control his/her personal resources. People have a way to access their money when they choose, not just during a set timeframe or business office hours.	Hartry lives in a personal care home in Augusta. One evening, his friend Butch shows up unexpectedly. Hartry has not seen Butch in six months and is excited to be able to spend time with him to catch up. Hartry and Butch decide it would be fun to go to the 7:00 p.m. movie. Hartry now has access to his funds when needed and spontaneously can go to the movies with his friend Butch.

624.3. Additional guidance

624.3.1. The following should not occur.

624.3.1.1. The provider requires people to sign over their paycheck or another form of payment/income as a condition of receiving services (unless required by a state-funded program)

624.3.1.2. People have limited access to their funds for provider convenience.

625. Privacy

625.1. Federal requirement

Ensure a person's rights of privacy, dignity and respect and freedom from coercion and restraint.

625.2. Provider expectations

Provider expectations are to ensure people:

625.2.1. Have the right to privacy.

625.2.2. Have the right to have their information kept private.

625.2.3. Have the right to have personal care provided in private.

The provider must respect the privacy of a person in all aspects of life. Preservation of a person's right to privacy is a basic human dignity. Staff must ensure the person's need for privacy is respected and protected. This includes being able to have private conversations, having a say in who has access to his/her personal possessions and living space and having privacy during activities of daily living such as bathing, grooming, and dressing.

Licensed programs must also refer to their applicable

licensing/registration requirements regarding a person's privacy rights.

Best practice suggestions	Examples
Providers do not discuss a person in the open or within earshot of those who do not need to hear the discussion. The person has access to make and receive private telephone calls and access to personal communication via text, email or other personal communication methods. In any setting, people's full names or personal or health information are not left in public for others to see	Vonnie lives in a community residential setting in Brunswick. She has many friends all over the world with whom she likes to keep in contact via text, email, and social media. Vonnie uses her cell phone or computer to communicate daily with her friends and family without being required to have staff present
Staff are trained in confidentiality policies and practices. The provider keeps personal information private and does not share it with others without the person's expressed consent. People have access to spaces for private conversations or quiet time (e.g., a place to be alone if someone is upset or wants to relax in a quiet area).	Jerome lives in a customized living setting and chooses to eat his lunch in the main dining area so he can visit with Fred. After Jerome finishes eating, he is scheduled to take his noon medications. The provider asks Jerome if he would like to take his noon medications in the privacy of his unit, or if he prefers to take them at the dining table. Jerome reports that he prefers to take them at the dining table because he and Fred plan to play their daily card game.
	Marilyn receives services at a setting in Decatur. Marilyn and her staff run into Marilyn's cousin, Fergie, while walking to the library. Fergie asks the staff about Marilyn's medication and if it is helping her. Marilyn's guardian has not signed a release of information allowing staff to share this information with Fergie. The staff respects Marilyn's privacy by informing Fergie that the information she requested is private and confidential. The staff tells her to contact

	Marilyn's guardian if she would like information about her medications.

625.3. Additional guidance

625.3.1. The following should not occur.

625.3.1.1. People must perform/receive personal care outside of a private space without the expressed consent of the person.

625.3.1.2. Staff open mail or other forms of communication without the consent of the person or his/her guardian

625.3.1.3. Staff share a person's private information without the consent of the person or his/her guardian.

626. Dignity and Respect

626.1. Federal requirement

Ensure a person's rights of privacy, dignity and respect, and freedom from coercion and restraint.

626.2. Provider expectations

The provider should treat people with respect and dignity in all aspects of life. Respecting a person for who they are is a basic human dignity. The provider must ensure the people they serve are always treated with dignity and respect. This includes respecting people's likes and dislikes, talking with people in a way that makes them feel respected and heard and assisting people with personal care in a compassionate manner that preserves their dignity.

Licensed programs must also refer to their applicable licensing/registration requirements regarding a person's right to be treated with dignity and respect.

Best practice suggestions	Examples
Staff assist people with all personal care needs in a dignified manner	Shana receives adult day services in Snellville. Shana has a very creative personality and style of clothes reflects her creativity. The staff at Shana's adult day services enjoy her expressive personality and compliment her on outfit combinations.
During mealtimes, staff do not require people to wear bibs or use disposable cutlery, plates, and cups. People can choose clothes and hairstyles that meet their personal preferences. People are dressed in clothes that their	Jeannie Ruth Jones prefers to be called Ruth and often states that her name is J. Ruth Jones. Staff comply with this request by calling her Ruth.

meet personal preferences, fit and are clean and appropriate for the time of day and weather	
	Lena receives prevocational services in Reynolds. Lena's favorite place to eat lunch on her break is around the corner from the center. Lena has limited small motor dexterity that often causes her to spill or drop her fork of food on her clothes. The staff planned with Lena and had her bring a few extra outfits to have on hand at the center. When Lena returns to the prevocational center after lunch, the staff ask Lena if she would like to put on a clean outfit before she resumes her activities.
People are addressed by their preferred name, not "hon," "sweetie" or similar name. Staff do not discuss a person who is present like he/she is not there. They include the person in conversation. Staff converse respectfully with people while providing care and assistance, regardless of the person's ability to vocalize a response	Ruby is 80 years old. The staff insist on referring to her as darling or Hon. When questioned they assert that this is a term of endearment for folks in the south. They are asked to quickly refrain from use of these terms by management and reminded during the annual training session

627. No Coercion/Restraint

627.1. Federal requirement

For licensed residential facilities The Department of Community Health Healthcare Facility Regulation Division provides very clear statutory laws regarding a member's right to privacy, dignity and respect and freedom from coercion and restraint.

627.2. Those guidelines can be found here:

627.2.1. Adult Day Centers-

https://dch.georgia.gov/document/document/adult-day-centers- chapter-111-8-1/download

627.2.2. Personal Care Homes-

https://dch.georgia.gov/media/53121/download

627.2.3. Community Living Arrangements (Community Access Group)

http://rules.sos.state.ga.us/gac/290-9-37

Best practice suggestions	Examples
The provider develops a habit to periodically inform people of their rights (house meetings) The provider gives people and/or their guardians information about filing a complaint upon service initiation and upon request thereafter. The complaint policy includes a statement that no retaliation will occur if a complaint is filed. Staff receives training on the setting's complaint and grievance policies.	Gracie would like to file a complaint about access to the kitchen and bathrooms. She can find information easily about filing a complaint because her provider posted it in an obvious location and in a format she easily understands. Gracie informs her case manager that she understands she has the right to file a complaint. She can complete the process on her own, or she can ask for assistance if needed.

Types of Restraints not allowed.

Physical	**Environmental**
Restraining limbs e.g., 4 persons to provide care. Moving a person to another location against their will	Seclusion room Half doors, barricades Wander Guard Secure Units Removal of cane or walker
Mechanical	**Pharmacologic (when not prescribed)**
Limb, waist, and trunk Back-fastening seat belt Full bed-side rails Chair with locking table Broda/Geri	Antipsychotics Antidepressants Sedatives Benzodiazepines Over-the-Counter sleep aids

627.2.4. The following should not occur.

627.2.4.1. Staff gives people over-the-counter drugs to make people sleepy for the convenience of the provider.

627.2.4.2. Staff post sensitive member information on bulletin boards for other staff members to view for ease of communication.

628. Independent Choices

628.1. Federal requirement

The setting optimizes but does not regiment individual initiative, autonomy, and independence in making life choices. This includes but is not limited to daily activities, physical environment and with whom a person interacts.

628.2. Provider expectations

People retain the ability to make choices about how they spend their time in any given setting and have opportunities to participate in age-appropriate activities.
Providers should engage with the person and the team using person-centered thinking to ensure:

628.2.1. The provider supports people in life-informed "real" choices and autonomy. The provider offers people actual experiences on which they can base future choices.

628.2.2. The provider creates plans for the appropriate balance between autonomy and safety.

628.2.3. The provider gives the person's personal preferences priority over a guardian's or provider's preferences (unless for a documented health and safety reason)

628.2.4. People feel supported and inspired to work toward their goals, dreams, and priorities.

Best practice suggestions	Examples
The provider supports people to participate in age-appropriate activities of their choice that are consistent with the goals and objectives identified in their plan of service. This includes activities within the setting, as well as provider-organized activities in the community	Jill has a goal of learning how to use money to shop. Jill's Community Access Group services provider brings her to a store to shop instead of always using pretend money or a toy cash register.
The provider is encouraged to use the natural environment as frequently as possible to help people learn new skills. Learning a skill in the natural environment is often more effective than "classroom" training	Carolyn has expressed her desire to seek employment. Her Pre-vocational rehab provider identifies volunteer opportunities for Carolyn to gain real experience working in her desired work setting.
The provider creates a decision-making process that supports people in making activity choices freely and fairly. People can access things like a radio or television, and they can choose other leisure activities if desired	The personal care home provider establishes a list of activities that the members can select and allows the members to coordinate a schedule to participate in the activities of their choice.
The physical setting can support a variety of individual goals and needs, such as having space for people to move about and accommodating individual and group activities. People can choose with whom	

they would like to do activities. People can provide suggestions about activities through a comment box, small group sessions or by meeting with the activity's coordinator.	

628.3. Best practice suggestions Examples

628.3.1.1. The following should not occur.

628.3.1.2. The provider forces or coerces a person to participate when he/she does not wish to participate in an activity.

628.3.1.3. The provider punishes a person for not participating in an activity.

628.3.1.4. The provider makes activity schedules without input from the people in the setting.



629. Setting Choice

629.1. Federal requirement

The person selects the setting from options including non-disability specific settings and private units in residential settings. the case manager identifies and documents setting options in the person-centered service plan. These options are based on the person's needs, preferences and, for residential settings, resources available for room and board.

629.2. Provider expectations

This requirement applies to service plan development and to those entities responsible for person-centered planning such as case managers and care coordinators. Providers are expected to deliver services in accordance with the person-centered

plan/Community Services and Support Plan (CSSP).

This requirement ensures people are aware of and have an opportunity to select where they would like to receive their HCBS services from the variety of setting options available, and that their case manager documents their choices as part of their service plan.

People can make an informed choice of where they live, work, and receive services based on needs, preferences, financial resources and availability of settings, services and service providers. The case manager should give priority to the person's preferences, not the provider or guardian's preferences (unless for health and safety reasons).

Best practice suggestions	Examples
People know how to make a request for a new setting and/or changes to current services and support. People and their support team have opportunities for feedback and input regarding settings, services, and service providers. The case manager provides people with information about identifying, choosing, and changing settings in a manner or format they can understand	Florence is transitioning from a Nursing facility under the MFP program. She tells her case manager and transition coordinator that her new setting should be in the city close to her family and church. Florence works with her transition coordinator and case manager to develop a list of possible settings that meets her needs based on her assessment and preferences. Some of her choices include a personal care home. They schedule a time to visit her choices so she can view her selections and meet the providers, see the home, and make an informed decision.
People are encouraged to ask questions about their setting options.	
People can visit or view a setting as part of their informed decision-making process. If a person wants to change their setting choice(s), their case manager supports them in that process.	

629.3. Additional guidance

629.3.1. What is a non-disability specific setting?

"Non-disability-specific", in the context of the HCBS settings rule means that among the options available, the individual must have the option to select a setting that is not limited to people with the same or similar types of disabilities. This could include services based out of a private home or a provider-controlled setting that includes people with and without disabilities. People may receive services with other people who have either the same or similar disabilities but must have the option to be served in a setting that is not exclusive to people with the same or similar disabilities.

629.3.2. What does it mean for someone to have an option for a private/single room?

This means residential setting options should include settings that offer private units. It does not mean all residential providers are required to offer private units. In some cases, a person may not be able to afford a private unit. A person must consider his/her income and resources in deciding where to live, just as any community member would. The case manager should support people and/or their guardians in identifying residential settings that meet their needs. Options for single/private rooms are provided on the agreement with the provider.

629.3.3. The following should not occur.

629.3.3.1. People are required to select a particular disability-specific setting solely based on their diagnosis. The case manager should offer choices for service settings that best meet the needs and preferences of the person during the person-centered planning meeting.

630. Choice of Service and Support

630.1. Federal requirement

Providers facilitate individual choice regarding services and support and who provides them.

630.2. Provider expectations

People are free to choose who provides the services they receive and where they receive those services. People are not coerced or forced to obtain services in a particular setting. They may instead choose to go out into the community for the same services.

If a person's assessed needs allow for him or her to receive services one-on-one with a provider, that choice should always be available and not modified to suit the provider's need.

It is important for people and/or their guardians to know the person-centered plan is in place to address their needs. If people are not happy with their current services for any reason, the provider should direct them to the right person (e.g., case manager) who can help them make changes to the plan.

Best practice suggestions	Examples
People have opportunities to choose whether they want to receive services, and they can choose from available alternatives when appropriate. The case manager encourages people to make individual choices whenever possible, but especially in relationship to services and supports and who provides them.	Jackie requires physical therapy for an injured knee. A physical therapist comes to the personal care home setting where she lives to provide physical therapy. She can choose to access the therapist for physical therapy on-site, or she may choose to see a different therapist in the community with

Staff takes the time to understand fully what services or supports the person would like to receive off-site and provide the support needed to ensure that can happen when feasible.	whom she is familiar. The provider owns a Structured Family Caregiving service agency and an Adult Day Health Center. Providers cannot force members or their caregivers to receive Adult Day Care services from the same location for respite. If a family desires a respite, they are provided with all options and can select their choice.

630.3. Additional guidance

630.3.1. If someone is unhappy with my service, what should I do?

First, the provider should try to understand why the person is unhappy. If the issue is something that the provider can correct or easily address, the provider's first step should be to do so. If the provider cannot correct or address the issue, the provider should acknowledge that sometimes a service or service provider is not the best fit for a person. The provider should then encourage the person to contact his/her case manager to discuss possible changes.

630.3.2. What role does the person-centered service plan have in meeting this requirement?

The service plan is the central place where the case manager should document and honor the person's choices for services, supports and who provides them. If a person is unhappy with his/her services and support, the provider should encourage the person to contact his/her case manager to discuss possible changes.

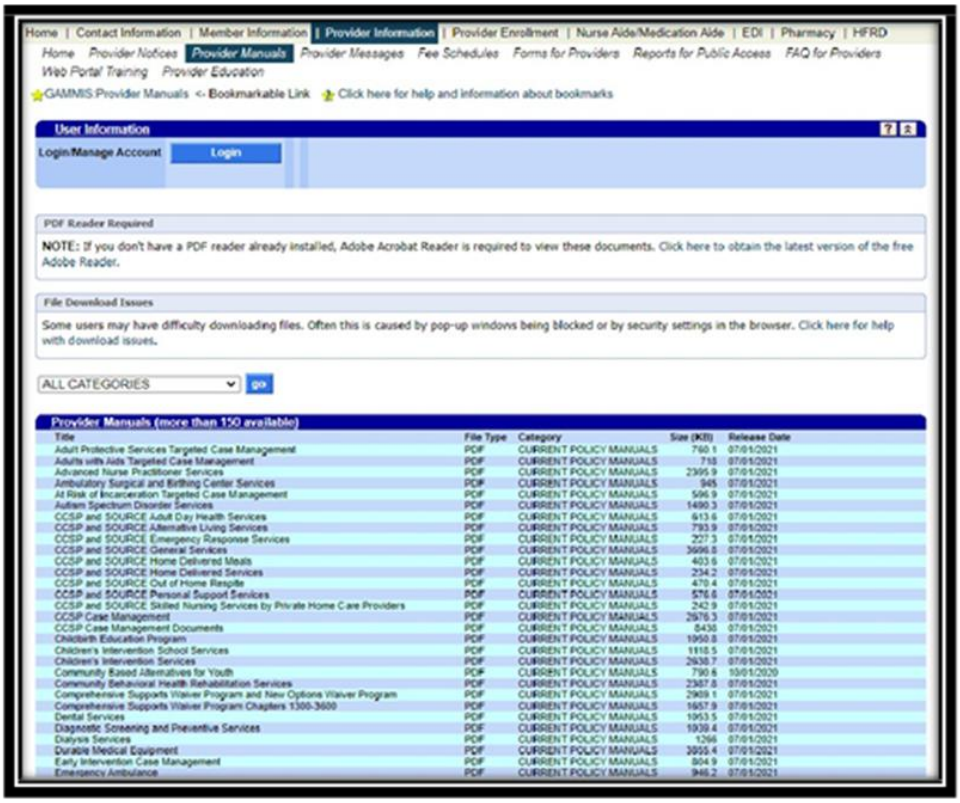
630.3.3. The following should not occur.

630.3.3.1. The provider creates policy and/or procedures that say a person must obtain a particular service in-house or on-site and that he/she cannot utilize external providers for those services (e.g., people are pressured to use the provider's onsite salon and therapy services instead of being given options for community service providers, provider owns another business that can serve the member and forced to use).

Appendix A
Continuing Education Learn More

A. More Information Online

Waiver policy manuals are updated quarterly and are available to anyone by accessing https://www.mmis.georgia.gov/ and selecting the applicable waiver program.



Additional opportunities for providers to learn more regarding best practices and the Final Settings rules will be provided during quarterly Train-the-Trainer, Case Management, provider network meetings and Medicaid Fairs.

B. Contact DCH

There are three ways to send us your questions, give us your feedback, or request training to present to your organization.

i. Email HCBSTransition@dch.ga.gov

ii. Send a letter to:

Georgia Department of Community Health
2 Martin Luther King Jr. Drive, East Tower
19th Floor
Atlanta, GA 30334
Attention: HCBS Rule Transition Plan

Appendix B
Person Centered Service Plan (PCSP)

Authorization Period:_____ Date Issued:_____

Name:		Date of Birth:	
Address:			
Phone Number:		Preferred Language:	
Email Address:			

If you have a question or a problem regarding your services, call your Care/Case Manager:
[Care/Case Manager name] at (xxx) xxx-xxxx

Preferences:

Ask the person about the things they like and dislike. Input their responses here as well as any other known preferences of the person. Include any preferences they may have for the delivery of their services.

Strengths:

Ask the person about the things they're good at. Input their responses here as well as any other known strengths of the person.

Goals/Desired Outcomes:

Use the space below to identify the person's health care and social goals/desired outcomes. Goals may be long-term or short-term with measurable outcomes. Where applicable, indicate which unmet service need the goal ties into. Include strategies to achieve desired outcome. [Add boxes for additional outcomes as needed].	
Goal/Desired Outcome	
Goal/Desired Outcome	

Goal/Desired Outcome	

Description of Services:

Identify services the person is currently receiving. [Duplicate boxes below as needed].

Name of Service:			
Scope/Description of Service			
Unit and Frequency of Service		Provider:	
Duration/Authorization Period		Contact Information:	
Assessment Identifying Need		Authorizing Entity:	
Desired Outcome/Goals			

Name of Service:			
Scope/Description of Service			
Unit and Frequency of Service		Provider:	
Duration/Authorization Period		Contact Information:	
Assessment Identifying Need		Authorizing Entity:	
Desired Outcome/Goals			
Name of Service:			
Scope/Description of Service			
Unit and Frequency of Service		Provider:	
Duration/Authorization Period		Contact Information:	
Assessment Identifying Need		Authorizing Entity:	
Desired Outcome/Goals			

Unmet Service Needs:

Identify any services the person needs but does not have. [Duplicate boxes below as needed].

Service Need		Assessment/Date Identified:	
Justification for Service			
Reason Need is Unmet			
Plan to Address			

Need			
Service Need		Assessment/Date Identified:	
Justification for Service			
Reason Need is Unmet			
Plan to Address Need			

Informal Supports:

Identify unpaid supports and their relationship to the person. [Duplicate boxes below as needed.]

Name:			
Relationship/Title:		Contact Information:	
Service(s) Provider/Support Role:			
Unit and Frequency of Service:			

Name:			
Relationship/Title:		Contact Information:	
Service(s) Provider/Support Role:			
Unit and Frequency of Service:			

Name:			
Relationship/Title:		Contact Information:	
Service(s) Provider/Support Role:			
Unit and Frequency of Service:			

The person's information			
Primary Care Manager:		Secondary Care Manager:	
Organization:		Organization:	
Primary Care Provider (PCP)			
PCP Contact Information			
Medicaid/CIN#:			
Primary Insurance Agency		Secondary Insurance Agency	
Enrollee ID		Enrollee ID	

Residential Setting and Supports:

Use this section to confirm that the individual's residential setting meets the HCBS Settings Rule.

Is the residence integrated in and does it support full access to the greater community?	Yes ☐ No ☐

Was the residence selected from among options by the person?	Yes ☐ No ☐
Does the residence ensure the person's rights of privacy, dignity and respect, and freedom from coercion and restraint?	Yes ☐ No ☐
Does the resident optimize the person's autonomy and independence in making life choices?	Yes ☐ No ☐
Does the residence facilitate the person's choice about services and who provides them?	Yes ☐ No ☐
Is the residence physically accessible to the person?	Yes ☐ No ☐
Can the person control personal resources?	Yes ☐ No ☐
Did the person participate in the person-centered planning process, leading the process whenever possible?	Yes ☐ No ☐
Did the person choose where they live now?	Yes ☐ No ☐
Can the person easily move around their home and other places where services are received?	Yes ☐ No ☐
Can the person participate in the activities such as work, volunteer, attending school, etc., when they like inside and outside of their home? If not, is there a modification noted properly below? (See Residential and Non-Residential Modifications Section below)? (Note: modifications are only applicable for provider-owned or controlled residential or non-residential settings, not private homes) Yes ☐ No ☐	Yes ☐ No ☐
Can the person visit friends and family if/when they want? If not, is there a modification noted properly below? Yes ☐ No ☐	Yes ☐ No ☐
For provider-owned or controlled residential settings, is there a lease/occupancy agreement in place that gives the person the same rights and protections afforded to anyone in that jurisdiction, i.e., no rules are in the written agreement that would not be in a common lease, including the ability to furnish and decorate sleeping or living unit? If not, is there a modification noted properly below? Yes ☐ No ☐	Yes ☐ No ☐
Use the space provided below for additional comments if the answer to any of the questions above is "No".	

Assessment Information:
Include all applicable assessments. [Duplicate boxes below as needed].

[Insert Assessment Name]	Date of Initial Assessment	XX/XX/XXXX	Most Recent Assessment Date	XX/XX/XXXX
	Anticipated Reassessment Date	(Month/Year)		
[Insert Assessment Name]	Date of Initial Assessment	XX/XX/XXXX	Most Recent Assessment Date	XX/XX/XXXX
	Anticipated Reassessment Date	(Month/Year)		
[Insert Assessment Name]	Date of Initial Assessment	XX/XX/XXXX	Most Recent Assessment Date	XX/XX/XXXX
	Anticipated Reassessment Date	(Month/Year)		
Diagnosis				

Risk Management and Safeguards:
Identify risks to the person's health/wellbeing, potential triggers, the person's previous responses to triggers, measures in place to minimize risks, and safeguards. Safeguards detail the support needed to keep the person safe from harm and actions to be taken when their health and welfare is at risk (please refer to guidance for more information).

RISK	
Trigger(s):	
Known Response(s):	
Measure(s) in place:	
Safeguard(s):	
RISK	
Trigger(s):	
Known Response(s):	
Measure(s) in place:	
Safeguard(s):	

RISK	
Trigger(s):	
Known Response(s):	
Measure(s) in place:	
Safeguard(s):	

Backup Plan:

A plan in place to ensure that needed assistance will be provided if the regular services and supports in the person's person-centered service plan are temporarily unavailable. The backup care plan may include electronic devices, relief care, providers, other individuals, services, or settings. Individuals available to provide temporary assistance include informal caregivers such as a family member, friend or another responsible adult. Include contact information as appropriate.

Self-Directed Services:

Fill out this box for a person self-directing their services under a 1915(c) or 1915(k) authority such as the Consumer Directed Personal Assistance Program (CDPAP) through the Community First Choice Option or under the state plan but as a waiver enrollee. If this information is documented in another place, place attestation to this PCSP. [Duplicate service description portion for each self-directed service].
☐ I, _____, choose to self-direct some or all of my services. ☐ _____, may also act on my behalf to self-direct some or all of my services. This means that I have the right to recruit, hire, fire, supervise, and manage my own staff. Alone, or with the help of my supports, I can choose the duties, schedules, and training requirements of my staff. This also includes the right to evaluate staff, decide their rate of pay, and review/approve payment requests. I will follow all laws and regulations when exercising these rights and responsibilities. The services I choose to self-direct are as follows:
Service:
Method of Self-Direction (self or designated representative):
Risk Management Techniques:
Process for Transitioning out of Self-Direction:

Residential and Non-Residential Modifications (applies when HCBS provider owns or controls the Residential or Non-Residential setting):

Fill out these boxes for special populations receiving HCB services under 42 CFR 441 Subparts G, K, or self-directed 1905(a) state plan services, including the Consumer Directed Personal Assistance Program (CDPAP). Such residential modifications described here may relate to a change in status of written, legal agreements to live in the current setting; privacy; sleeping/living unit having lockable entrance doors with the only the person and appropriate staff keeping keys; choice of roommate(s); freedom to furnish/decorate within legal agreements; and for both residential and non-residential settings, control of schedules, activities, and access to food at all times; or the ability to receive visitors of the person's choosing at any time. [Duplicate modifications box if needed for multiple modifications].
☐ **I, _____, understand the information below and agree to the use of the modification(s) required to address my assessed risks and needs. I know that I can change my mind and will tell my Care/Case Manager if I do.**
Modification:
Specific Individualized Assessed Need (Note: a diagnosed disability is not a specific assessed need):
Positive Interventions and Supports used Before this Modification:
Diagnosis/Condition Related to the Modification:
Method for Collection and Review of Data for Effectiveness:
Timeframes/Limits for Review and Determination of Need for Modification:
Assurance that the Modification will Cause no Harm:

Person-Centered Service Planning Process Information:

Complete the table below with meeting information as appropriate. Include signatures and information indicated in boxes below for all persons responsible for writing and implementing this plan. Acceptable methods of agreement with the PCSP from the person or designated representative are: (1) wet signature on the PCSP, either in person or mailed or (2) wet signature on a separate page with language indicating agreement with the current PCSP, either in person or mailed. All attempts to obtain signature should be documented on the PCSP by the Care/Case Manager.

Meeting Date:		Meeting Time:	
Meeting Location:			
Was this meeting held at a place and time of the person's choosing?			Yes ☐ No ☐
Did the person lead the meeting to the best of their ability?			Yes ☐ No ☐
Did the person choose who was invited to/in attendance at the meeting?			Yes ☐ No ☐

Name	Title/Relationship	Agency	Date
	[e.g. Care/Case Manager]		
	[e.g. Provider]		
	[e.g. Provider		
	[e.g. Informal Support]		
	[e.g. Informal Support]		

Acknowledgement:
I have been a part of the Person-Centered Planning process to the best of my ability. I agree with what is written in my plan. I understand my rights and/or I have someone I trust who can help me with them. I understand that my plan will be reviewed regularly and that I can ask for it to be reviewed sooner. I agree to this plan being shared with the people that need it to provide my services. I was given a choice of my service providers. I know who to talk to if I want to change my services or my Person-Centered Service Plan.

_____ _____
Enrollee/Recipient or Designated Representative Signature Date
Attachments to Person-Centered Service Plan: [Name(s) of Attachment(s)].

Appendix C
HCBS Settings Rule Member Questionnaire

Instructions:
Each provider and their case managers must help each member complete this questionnaire for every service location. Members should answer the questions freely and without any pressure. When completed and executed a copy should be kept in each member's case file attached to their Person Centered Care Plan. The questionnaire must be signed by the member and, if needed, their legal guardian or a family member. For each question, check the box that matches the member's honest and independent answer.

Section 1: General Information
• Member Name: _____
• Service Location: _____
• Case Manager Name: _____
• Date of Completion: _____

Section 2: Access to the Community
• Do you feel this place lets you take part in community activities, like working, going to events, or using community services, just like people who don't get Medicaid services? □ Yes □ No □ I'm Not Sure o If no, please explain: _____

• Do you have chances to work in a regular job with people who don't have disabilities? □ Yes □ No □ Not Applicable
• Can you do things outside of this place that you enjoy? □ Yes □ No □ I'm Not Sure

Section 3: Choosing Your Setting
• Did you choose this place from different options? □ Yes □ No □ I'm Not Sure
• Were you told about places that aren't just for people with disabilities or about private rooms if this is a residential place? □ Yes □ No □ I'm Not Sure
• Is this place listed in your personal care plan? □ Yes □ No □ I'm Not Sure

Section 4: Independence and Freedom
• Can you make your own choices about what you do every day, like meals, routines, or activities? □ Yes □ No □ I'm Not Sure
• Do you feel like you have control over your surroundings? □ Yes □ No □ I'm Not Sure
Can you choose who you spend your time with? □ Yes □ No □ I'm Not Sure

Section 5: Choices About Services and Support
• Do you get to decide what services and help you receive? □ Yes □ No □ I'm Not Sure
• Can you choose who provides your services? □ Yes □ No □ I'm Not Sure

Section 6: Residential Settings *(If Applicable)*
• If you share a room, can you choose your roommate? □ Yes □ No □ Not Applicable
• Can you make your own schedule and pick the activities you want to do? □ Yes □ No □ I'm Not Sure

Acknowledgment and Signature I confirm that I have completed this form freely and honestly. I understand that my answers will help make sure this place follows the HCBS Settings Rule and provides quality services.
Member Signature: _____ Date: _____

Legal Guardian/Family Member Signature (if applicable): _____ Date: _____

Case Manager Signature: _____ Date: _____

Important Notice to Providers and Case Managers: DCH requires that signed copies of these questionnaires, along with each member's person-centered care plan, are placed within the member's record for further review by the medical management agency or DCH. Time designated by DCH

Appendix D
HCBS STP Community Integration Plan

DCH HCBS STP Community Integration Plan (CIP) Template

Instructions: CIP to be completed at admission and annually by the ALS, ADH, or Out of Home Respite Service Provider.

Individual's Name:
Date of Plan Development:
Medicaid ID:
Waiver Program:
Case Manager:
Service Provider:

==========**1. Individual's Profile**

a) **Current Living Situation:** (e.g., nursing home, hospital, intermediate care facility)
b) **Desired Community Setting:** (e.g., independent living, assisted living, family home) If a change is indicated, review available options and document the change.
c) **Primary Support System:** (e.g., family, friends, legal guardian)
d) **Current Medical/Behavioral Health Needs:**
e) **Goals for Community Integration:**

==========**2. Person-Centered Goals & Services**

Housing & Living Arrangements

a) Preferred housing type:
b) Housing assistance needed? (Yes/No)
    a. If yes, specify: Rental assistance, home modifications, accessibility support, etc.
    b. Steps taken to meet goal:
    c. Outcome/Results:
c) Projected Move-in Date if alternate housing acquired:

Healthcare & Behavioral Support

a) Current medical services provided: (e.g., primary care, specialists, in-home care)
b) Additional medical services needed? If yes, specify the service and actions taken by provider to ensure medical care.
c) Current Behavioral health services provided:
    a. If yes, specify: Therapy, case management, crisis intervention, etc.
d) Additional behavioral health services needed? If yes, specify the service and actions taken by provider to ensure behavioral health services.

e) Outcome/Results:

Daily Living & Support Services

a) Personal Care Assistance provided? (Yes/No)
b) Change to personal care assistance needed? (yes/no)
c) Actions taken to modify personal care assistance.
d) Outcomes/Results:

Transportation Support

a) Transportation support currently provided:
b) Change to transportation support requested: (Yes/No)
c) Actions taken to obtain requested transportation support:
d) Outcomes/Results:

Meals/Nutrition Support

a) Meals/Nutrition support provided? (Yes/No)
b) Dietary restrictions? (yes/no)
c) Change to meals/nutrition support requested? (yes/no)
d) Actions taken to address and change meals/nutrition support requested:
e) Outcomes/Results:

Employment and Community Engagement

a) Goals: (e.g. employment, volunteering, and extracurricular activities, etc.)
b) Support needed for goals: (Yes/No) If yes, specify: Job coaching, skills training, workplace accommodations
c) Service provider actions taken to assist with employment and community engagement:
d) Outcomes/Results:

Facility social and recreational activities of interest

a) Social & recreational activities of interest:
b) Actions taken by service provider to provide requested activity:
c) Outcomes/Results:

==========**3.**

Transition Plan & Responsibilities

Task	**Responsible Party**	**Deadline**	**Status**
Identify housing resources	Care team	MM/DD/YYYY	Pending/In Progress/Completed

Task	Responsible Party	Deadline	Status
Apply for rental assistance	Individual/informal support	MM/DD/YYYY	Pending/In Progress/Completed
Arrange transportation services	Care team	MM/DD/YYYY	Pending/In Progress/Completed
Set up medical appointments	Individual/informal support	MM/DD/YYYY	Pending/In Progress/Completed
Secure employment opportunities	Individual/informal support	MM/DD/YYYY	Pending/In Progress/Completed

==========**4. Monitoring & Follow-Up**

a) Check-in Schedule: (e.g., weekly, biweekly, monthly)
b) Care Team Contacts:
    - Case Manager:
    - Service Provider:
    - Medical Provider:
    - Family/Guardian/informal supports:
    - Other Key Contacts:
c) Review & Update Plan Date: (minimum annual revision)

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