

HOME AND COMMUNITY-BASED SERVICES (HCBS) COMPLIANCE REVIEW REQUEST
For Pending and Licensed Adult Family Homes (3-4 Residents), Community-Based Residential Facilities, and Certified Residential Care Apartment Complexes

- Whether or not the facility is found to be HCBS compliant, it is still subject to all requirements of state licensure or certification.
- An “HCBS compliant” decision does not guarantee a contract with Wisconsin waiver agencies to provide services under the Wisconsin Medicaid adult long-term care waiver programs --- Family Care, Family Care Partnership, IRIS (Include, Respect, I Self-Direct), Community Integration Program, Community Options Program, or Children’s Long-Term Support Waiver.
- For more information, see:
 - <https://www.dhs.wisconsin.gov/regulations/assisted-living/hcbs.htm>
 - <https://www.dhs.wisconsin.gov/hcbs/index.htm>
 - <https://www.medicaid.gov/medicaid/home-community-based-services/index.html>

The HCBS Compliance Review Process includes:

1. Submission of this completed form and specified documentation to the appropriate Bureau of Assisted Living (BAL) regional office. See: <https://www.dhs.wisconsin.gov/dqa/bal-regionalmap.htm>. Questions regarding this process should be directed to the regional office that serves the county in which your facility is located.
2. A desk review will be completed by BAL staff. If it is found that this form is incomplete, the form will be returned. If documentation revisions are required to meet HCBS criteria as defined by Department of Health Services (DHS), BAL staff may contact you and request a revision. Only one update or revision request will be made prior to making the final HCBS compliance decision.
3. If it is determined that the facility meets the definition of [heightened scrutiny](#), this form will be forwarded to the Division of Medicaid Services (DMS). DMS will complete the HCBS compliance review working with the Centers for Medicare & Medicaid Services (CMS).
4. The decision regarding facility HCBS compliance will be sent to the facility mailing contact. All Wisconsin waiver agencies will receive a copy of the decision notification.
5. Facilities found to be HCBS-compliant will be made public by the Department of Health Services (DHS). The information will appear on the next upload of facility information to DHS websites, including the DHS Provider Search webpage, located at <https://www.dhs.wisconsin.gov/guide/provider-search.htm>, and in the “Statewide Assisted Living Directories” available at <https://www.dhs.wisconsin.gov/guide/assisted-living.htm>.

Name – Facility	DQA License or Certification No.
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Street Address – Facility	City	State	Zip Code	County
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<input type="checkbox"/> Yes <input type="checkbox"/> No	A. Is the facility within (under the same roof as) a building that houses a publicly or privately operated facility which provides inpatient institutional care [skilled nursing facility (SNF), intermediate care facility for individuals with intellectual disabilities (ICF/IID), institute for mental disease (IMD), hospital]? <i>42 CFR § 441.301(c)(5)(v)</i>
<input type="checkbox"/> Yes <input type="checkbox"/> No	B. Is the facility located on the grounds of, or immediately adjacent to, a building that is a public institution which provides inpatient institutional care [skilled nursing facility (SNF), intermediate care facility for individuals with intellectual disabilities (ICF/IID), institute for mental disease (IMD), hospital]? <i>42 CFR § 441.301(c)(5)(v)</i>

Attest that the following HCBS requirements have been implemented at the facility by checking each individual checkbox.

<input type="checkbox"/>	1. The setting is integrated in and supports access of individuals 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 individuals not receiving Medicaid HCBS. <i>42 CFR § 441.301(c)(4)(i)</i>
<input type="checkbox"/>	A policy informing residents and legally responsible parties that employment paychecks and other types of income are not required to be signed over or given to the facility <input type="checkbox"/> If not applicable, provide explanation:
<input type="checkbox"/>	A policy that ensures personal funds of residents are not held by the facility unless requested to do so by the resident or legally responsible party <input type="checkbox"/> If not applicable, provide explanation:
<input type="checkbox"/>	A policy for residents to access their personal funds and resources to the extent of their functional capability, in a manner of their choosing, and at times agreed upon between the provider and the resident and his or her legal representative, as applicable <input type="checkbox"/> If not applicable, provide explanation:
<input type="checkbox"/>	2. An individual’s rights of privacy, dignity, and respect are ensured. Individuals are free from coercion and restraint. <i>42 CFR § 441.301(c)(4)(iii)</i>
<input type="checkbox"/>	The owner, administrator, and any others providing care (including nurses) to the resident(s) complete new hire and annual resident rights training.

<input type="checkbox"/>	<input type="checkbox"/>	Documentation of resident rights training for all staff and caregivers
<input type="checkbox"/>	<input type="checkbox"/>	Policy to ensure resident rights are regularly reassessed for compliance and effectiveness and amended as necessary.
<input type="checkbox"/>	3.	Individuals have the freedom and support to control their own schedules and activities, and have access to food at any time. <i>42 CFR § 441.301(c)(4)(vi)</i>
<input type="checkbox"/>	<input type="checkbox"/>	Provide lockable key entry doors on all resident rooms and individual keys to all residents.
<input type="checkbox"/>	<input type="checkbox"/>	Policy ensuring that staff uses facility keys to enter a resident's room only under circumstances agreed upon with the resident
<input type="checkbox"/>	<input type="checkbox"/>	Residents have the freedom to furnish and decorate their sleeping or living units within the bounds of the lease or other written legal agreement.
<input type="checkbox"/>	<input type="checkbox"/>	Residents have choice of roommates.
<input type="checkbox"/>	<input type="checkbox"/>	Individuals are able to have visitors of their choosing at any time in a private, unsupervised space.
<input type="checkbox"/>	4.	Any modification in implementing HCBS criteria for a resident is supported by a specific, assessed need and justified in the person-centered service plan. The following requirements are documented in the person-centered service plan. <i>-42 CFR § 441.301(c)(2)(xiii)</i>
<input type="checkbox"/>	<input type="checkbox"/>	A specific and individualized need is identified.
<input type="checkbox"/>	<input type="checkbox"/>	The positive interventions and supports used prior to any modifications to the person-centered service plan are documented.
<input type="checkbox"/>	<input type="checkbox"/>	Less intrusive methods of meeting the needs that have been tried, but did not work, are documented.
<input type="checkbox"/>	<input type="checkbox"/>	A clear description of the condition that is directly proportionate to the specific assessed need is included.
<input type="checkbox"/>	<input type="checkbox"/>	Regular collection and review of data to measure the ongoing effectiveness of the modification is included.
<input type="checkbox"/>	<input type="checkbox"/>	Established time limits for periodic reviews to determine if the modification is still necessary or can be terminated are included.
<input type="checkbox"/>	<input type="checkbox"/>	The informed consent of the individual is included.
<input type="checkbox"/>	<input type="checkbox"/>	An assurance that interventions and supports will cause no harm to the individual is included.

The signatory of this document is duly authorized by the licensee / certificate holder to sign this agreement on its behalf. The licensee / certificate holder hereby accepts responsibility for knowing and ensuring compliance with all licensing, operational, and HCBS requirements for this facility.

I attest, under penalty of law that the information provided above is truthful and accurate to the best of my knowledge. I understand that knowingly providing false information or omitting information may result in denial of licensure, a fine of up to \$10,000 or imprisonment not to exceed six years, or both [Wis. Stat. § 946.32]

SIGNATURE (<i>in full</i>) – Licensee or Designee	Date Signed (<i>MM/dd/yyyy</i>)
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Name – Signatory (<i>Print or type.</i>)	Title (<i>must be owner or board member</i>)
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DQA/DMS USE ONLY		
Heightened scrutiny review completed by: <input type="checkbox"/> DMS Only <input type="checkbox"/> DMS/CMS		
Heightened scrutiny criteria determination (DMS): <input type="checkbox"/> Not institutional in nature; not subject to a heightened scrutiny review <input type="checkbox"/> Institutional in nature; subject to a heightened scrutiny review		
Complete if “Institutional in nature; subject to a heightened scrutiny review” is checked above: Heightened scrutiny review and HCBS compliance decision (DMS/CMS): <input type="checkbox"/> Facility is HCBS compliant <input type="checkbox"/> Facility is HCBS non-compliant		
Comments		
Name – Signatory (<i>Print or type</i>)	Title	Date Signed (<i>MM/dd/yyyy</i>)