



Instructions to complete the Provider Self-Assessment for Adult Foster Care and Supported Living (SLS) Services

General instructions

1. Complete and submit a separate assessment for each home in which you provide adult foster care and/or SLS services.
2. Staff completing the assessment should have knowledge of the adult foster care and/or SLS services provided within the home.
3. Submit all provider self-assessments electronically on or before May 29, 2015
4. Additional instructions are available. We will update these instructions periodically to reflect questions and comments received.
5. A copy of the questions in this self-assessment are available at the end of these instructions. You may wish to review and/or print them prior to taking the assessment electronically.
6. Responses should be as accurate as possible. Immediate compliance with the new federal requirements is not required. The state will offer a transition period for providers who are not yet, but intend to, comply with the new requirements.
7. Address questions to the MHCP Provider Call Center at 651-431-2700 or 800-366-5411.

Purpose of the provider self-assessment

Centers for Medicare and Medicaid Services (CMS) issued a new rule governing home and community-based services (HCBS) waiver services effective March 17, 2014. The rule defines settings in which HCBS services may be delivered, settings that are not HCBS and settings that are presumed not to be HCBS. Minnesota submitted a transition plan to CMS indicating how it will come into compliance with the new rule.

The rule and the Minnesota transition plan require an assessment of all provider-owned and controlled settings to determine the level of compliance with the new requirements. CMS requires states to 1) follow-up with on-site monitoring and 2) assure on-going compliance. Completion of this provider self-assessment is the first step in the process.

The provider self-assessment is designed to:

1. Provide the state with information it will use to develop measurable criteria for settings where HCBS services are delivered.
2. Help providers understand changes they need to make to comply with the rule.
3. Identify sites that may not currently comply with the rule.
4. Identify settings that are presumed not to be HCBS for which additional work with CMS must be done.

Definitions for purposes of this assessment

CSSP addendum: Plans developed by the provider as required in Chapter 245D.

Home: Refers to the home licensed as adult foster care or community residential setting.

Intermediate care facility for individuals with intellectual disabilities (ICF/IID): Federal term and means the same as intermediate care facilities for persons with development disabilities (ICFs/DD).

Person(s): Person receiving services.

Plan refers to plans developed by the lead agency certified assessor or case manager. Any modification of rule requirements must be supported by an assessed need and contain required documentation in the person-centered service plan developed by the county, tribe or health plan.

Modifications of rule requirements must be supported by a specific assessed need and justified in the person-centered service plan. The following requirements must be documented in the person-centered service plan developed by the lead agency case manager or certified assessor:

- (1) Identify a specific and individualized assessed need.
- (2) Document the positive interventions and supports used prior to any modifications to the person-centered service plan.
- (3) Document less intrusive methods of meeting the need that have been tried but did not work.
- (4) Include a clear description of the condition that is directly proportionate to the specific assessed need.
- (5) Include regular collection and review of data to measure the ongoing effectiveness of the modification.
- (6) Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
- (7) Include the informed consent of the individual.
- (8) Include an assurance that interventions and supports will cause no harm to the individual.

Provider Plan. Plan developed by the provider consistent with and required to implement the ISP, CSP, CSSP or other plan developed by a lead agency or to meet any other licensing requirements.

Navigation

A toolbar at the bottom of each page will help you as you complete the assessment.

1. Please disable any pop-up blockers when completing this assessment.
2. To move between pages, use the BACK and NEXT buttons at the bottom of each page. **DO NOT USE THE BACK BUTTON ON YOUR WEB BROWSER!**
3. To reset your responses on a current page, use the RESET button at the bottom of the page.
4. Use the SAVE button to return to the assessment on the same computer later.
5. Use the PRINT button (found on the last page of the assessment) to print the completed responses for the assessment.
6. When you have completed the assessment, click the SUBMIT button at the bottom of the last page to return your completed responses to DHS.

Provider self-assessment questions

Demographic information

Q1 - Provider information

- **Name of enrolled provider:** Name of the provider enrolled with Minnesota Health Care Programs to provide adult foster care or SLS services.
- **Provider NPI/UMPI:** Ten (10) digit National Provider Identifier (NPI) or Unique Minnesota Provider Identifier (UMPI) number the provider used to enroll with Minnesota Health Care Programs to provide adult foster care or SLS services.

Q2 - Provider practice address

Complete these items for the lodging establishment:

- Name of foster care or supported living service home (if any)
- License number associated with foster care or SLS home
- Enter Adult Foster Care license number
- Enter CRS license number
- Street address of foster care or SLS home
- P. O. Box, if any (optional)
- City
- State
- Zip
- Taxonomy code if you have assigned to this specific to this location, if applicable. (Does not apply to providers using an UMPI)
- Provider FEIN. This is the federal employer identification number for the enrolled provider.
- Provider phone number (phone number associated with this NPI or UMPI with Provider Enrollment)
- Telephone number for the enrolled provider's representative at this home

Q3 - The following person provided information for this assessment. This individual has personal knowledge of the adult foster care or SLS services provided in this home due to on-going contact.

- Name
- Title
- How frequently is this person on-site? Click the response that best reflects how often this person is at this home on average.

Q4 - DHS should contact the following person with any follow up questions:

- Name (if different from above) (Optional field)
- Title (if different from above) (Optional field)
- Telephone number (required)
- Email address (required) Please double-check for accuracy

Providers are invited to specify whom in their organization they wish DHS to contact with any follow up questions. This often varies within different provider organizations. If the name and title are left blank, DHS will contact the person listed in Q3 & 4 using the telephone and/or email provided in Q5.

Q5 - What services do you (or are you enrolled and licensed to) provide in this home (Check all that apply):

- Supported living services (SLS)
- Adult foster care services (AFC)
- Child foster care services (CFC)
- Family adult day services ((FADS)
- Respite care services

Q6 - Please answer each question about this home:

Are these foster care or SLS services provided in a building that also provides licensed services as a hospital, nursing facility, intermediate care facility for individuals with intellectual disabilities (ICF/DD) or institution for mental diseases (IMD)?

If hospital, nursing facility (home), ICF/DD or IMD services are provided in the same building, you must check “Yes.”

Are these foster care or SLS services provided in a building, on the grounds of or immediately adjacent to a publicly owned and operated hospital, nursing facility, ICF/DD or IMD?

For a facility to be “publicly owned and operated” it must be:

1. Owned by a (federal, state, county, city or other) public entity and also
2. Operated by a (federal, state, county, city or other) public entity. This means that the service license holder is a public entity.

Q7 - Please answer each question about this home:

The following questions are about how the housing (not services provided within the housing) are/were funded. The term “disability” applies to any person or group of people covered by the Americans with Disabilities Act or any other federal or state definition of disability.

- Does funding for this **housing** limit it to people with disabilities?
- Does funding for this **housing** require that 80% of residents be seniors be at least 55 years of age or older?
- Does funding for this **housing** require that 80% of residents be either seniors at least 55 years of age or older or people with disabilities?
- Are there (any) other residences (such as apartment buildings or single or multiple family dwelling units) within a 3-block radius of this home?

Q8 - What is the licensed capacity of this home under the following licenses?

- Adult Foster Care (enter number)
- 245D-CRS (Community Residential Settings) (enter number)

Q9 - Please indicate yes or no if funding for housing is limited to people with disabilities.

Q10 - Location of home. Please answer this question based on average proximity (within 5 blocks, 10 blocks, 2 miles or more than 2 miles) of the home to typical community businesses

- Bank
- Doctor's office/clinic
- House of worship
- Grocery store(s)
- Public transportation
- Restaurants
- Other retail businesses

The following questions are about **FOSTER CARE AND SUPPORTED LIVING SERVICES** that are paid for by the Elderly, Community Alternatives for Disabled Individuals, Community Alternative Care, Developmental Disability or Brain Injury Waivers.

Q11 - Please check all licenses, registration or designations that apply to services provided in this home:

- 245D program license CRS (Community Residential Setting)
- Housing with services establishment registration
- Child foster care license
- Basic or Class B home care license
- Board (food) license
- Board (food) and lodging license
- Lodging (hotel/motel) license
- Adult foster care license
- Assisted living (designation on housing with services registration)
- Special care unit – Alzheimer's or related condition (designation on housing with services registration)
- 245D – Mental health certification

Q12 - How many people are receiving the following services?

- Adult Foster Care (BI, CAC, CADI Waivers) (Insert number)
- Adult Foster Care (EW Waiver) (Insert number)
- Supported Living Services (DD Waiver) (Insert number)

Q13 - Please estimate the percentage of people currently served based on their primary disability or condition.

Please indicate by percentage (less than 25 percent, between 25-75 percent and greater than 75 percent), the primary disabilities or conditions of people served at this site/program. If this program does not serve people with a certain type of disability or condition, please indicate, "do not currently serve" in response to Q10. "Other" is an optional field.

- Brain injuries
- Chemical health conditions
- Chronic health conditions
- Dementias or memory losses

- Developmental Disabilities
- HIV/AIDS
- Mental illnesses
- Physical disabilities (including but not limited to mobility challenges)
- Other (optional)

Answer the following questions for people receiving Adult Foster Care or Supported Living Services in this home.

Q14 - How many bedrooms are available for people receiving Adult Foster Care or Supported Living Services?

Q15 – Answer the following questions for people receiving Adult Foster Care or Supported Living Services in this home:

- Do you have policies supporting choice of roommates and document roommate preferences in the person’s provider plan? (Yes or No)
- Does each person have a lock on their bedroom door and a key (or fob) to open it with only appropriate staff having keys unless specified in their plan? (Yes or No)
- Does each person have a key (or fob) to open the outside door of their home and/or apartment building unless specified in their plan? (Yes or No)
- Does each person have access to a telephone in a private area? (Yes or No)
- Do all bathrooms shared by more than one person have a lock unless specified in each person’s plan? (Yes or No)
- Does each person have a place to secure their personal property with only appropriate staff or others having access? (Yes or No)
- Do your policies support each person having control of their own medications (with exception of Schedule II controlled substances) with minimally restrictive safeguards such as a locked medication administration device in their private bedroom unless specified in their plan? (Yes or No)

Q16 - The following question addresses unrestricted facility access.

Please check if each facility feature is physically accessible and if the policy supports unrestricted use. Does each person in have access to and unrestricted use of each of the following unless specified in their plan? Please indicate on the grid if the *feature exists*; is *physically accessible*; and if the *policy supports unrestricted use* by checking the appropriate boxes

- Common areas inside of the home
- Common outdoor areas
- Cooking appliance, i.e. microwave oven
- Dining area
- Laundry area with washer and dryer
- Refrigerator with freezer for private food storage

Q17 - The following address person-centered choices required in the federal rules.

Person-Centered Choices. Please indicate if written policies, documented staff training and performance evaluation systems are or will be in place that cover the following *unless specified in a person’s plan*. Policies should explicitly address each area to assure consumer choice.

Check “currently implemented” if written policies, documentation of staff training and current performance evaluation systems are currently in place, Check “Will be implemented by January 1 2017 if you intend for ___ to be in compliance by that date, Check “Do not know” if you are unsure as to whether ___ can or will be in compliance by January 1 2017.

Answer these questions based on the number of people indicated in Q12 regardless of payment source.

- Each person is free to come and go from their home
- Each person is free to move in and around the community
- Each person can close and lock their bedroom door.
- Each person may have any visitor of their choice
- Each person may have visitors at any time
- **Each person has choice of:**
 - Hair style and color
 - Where, when and who provides their hair care
 - What personal clothing and accessories they wear on a daily basis
 - Possessions and personal furnishings within their bedroom
 - Décor n their bedroom
 - Where they eat (i.e. common dining area, kitchenette, living room)
 - With whom they eat or to eat alone
 - What they want to each within options available
 - When they eat
 - When they go to bed and get up
 - When and how they bathe
 - How often they participate in social/community activities Types of Community activities
 - Types of social activities

Q18 - The following address a person's rights to personal privacy, security and respect.

Rights, personal privacy, security and respect. Please indicate if written policies, documented staff training and performance evaluation systems are or will be in place that cover the following *unless specified in a person's plan*. Policies should explicitly address each area to assure a person's choice.

Check “currently implemented” if written policies, documentation of staff training and current performance evaluation systems are currently in place, Check “Will be implemented by Jan. 1 2017, if you intend for ___ to be in compliance by that date, Check “Do not know” if you are unsure as to whether ___ can or will be in compliance by Jan. 1 2017. Answers these questions based on the total number of people indicated in Q12 regardless of payment source.

- All incidents of lost or stolen property are documented and investigated
- Appointment schedules, medications lists and all other personal information is private. This means the information is not visible to other program participants or visitors in public areas
- Each person has a place to secure their personal property
- Each person has access to a telephone in a private area
- Staff treat each person with respect in interpersonal communications (i.e. people addressed by their proper or preferred name, staff use respectful tone when speaking to people)
- Type, amount and process for staff sharing information assures the privacy and respect of each person
- When a person needs assistance with person care, it is provided in private.

Q19 - Community Access. Please indicate for people in Q12, the average frequency people are interacting with community members by type of community interaction (onsite, community-based enrichment or skill development).

If there are other types of community interaction, briefly describe.

Responses should be based on a typical week of service delivery (1 day per week, 2-3 days per week, 4 or more days per week, less than one day per week).

If you indicated that people interact with community members less than one day per week, briefly explain why within a limited number of characters.

Person's satisfaction

Q20 - The following questions address a person's satisfaction with services/supports.

- Do you have way to get feedback on overall satisfaction at least annually and maintain the documentation? (Yes or No)
- Do people know where to go to report dissatisfaction/concerns? (Yes or No)
- Do you have a way to document and address concerns or dissatisfaction people report formally or share informally with any of your staff (Yes or No)

Final steps

After you have printed this assessment, click the **SUBMIT** button to complete the assessment process.

Please respond to this assessment by May 29, 2015.

Thank you for completing this assessment!