MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES
MI CHOICE PROVIDER MONITORING PLAN

ON-SITE PROVIDER REVIEWS

Waiver agency staff conducts annual on-site monitoring reviews for a minimum of 15% of enrolled providers of recurrent services. This includes adult day health, chore, community living supports, counseling, fiscal intermediary, home delivered meals, transportation, nursing facility transition, nursing services, personal emergency response systems, private duty nursing, in-home and out-of-home respite, supports coordination when not using agency employees, and training. This monitoring plan is to ensure:

- Provider compliance to minimum service standards and conditions of participation*. This includes compliance to the CMS regulations regarding home and community-based services settings as defined in 42 CFR 441.301(c)(4).
- Delivery of services according to the authorized MI Choice participant plan of services
- Provider maintenance of adequate staff recruitment, training plans and staff supervision
- Provider maintenance of participant case record documentation to support provider claims

Waiver agency staff evaluates providers of non-recurrent services (durable medical equipment, medical supplies, goods and services, and home modifications) based on frequency and volume of usage at least once every two years to ensure:

- Provider compliance to minimum service standards and conditions of participation*
- Delivery of services according to the authorized MI Choice participant plan of service
- Provider maintenance of participant case record documentation to support provider claims

METHODOLOGY

The waiver agency assigns one or two staff with primary responsibility for conducting provider reviews using the standardized monitoring tool developed for this purpose (Appendix 1). The waiver agency notifies providers in writing at least two weeks in advance of the date scheduled for review. The waiver agency selects a sample of 10 participant case records or 15% of the provider case records (whichever is greater) to

* Minimum standards and conditions of participation established by the U.S. Department of Health and Human Services, Center for Medicare and Medicaid Services (CMS) and the Michigan Department of Health and Human Services.

evaluate. The waiver agency staff reviews three months of provider billings to payments for each case record. The waiver agency may choose to monitor more providers as necessary to assure the quality of services delivered to MI Choice participants. Additionally, not included in the sample indicated above, the waiver agency must perform monitoring of 100% of provider-owned/controlled settings and must utilize the Residential and Non-Residential surveys provided by MDHHS.

Provider records to review include participant case record documentation, service claims, and reimbursements. The waiver agency compares payment records to MI Choice plan of service authorizations and MI Choice case record documentation. Waiver agency reviewers evaluate provider records for date of service, time of service delivery, staff providing the service, supervision of staff providing the service, and any discrepancies noted during the review.

The waiver agency reviewers provide written findings of the review and corrective action requirements (as necessary) to the provider within thirty days following completion of the initial review. **The waiver agency sends all provider monitoring reports to the Michigan Department of Health and Human Services (MDHHS) within 30 days of completion of the monitoring process.** The written review includes citations of both positive findings and areas needing corrective action.

Regarding the home and community-based (provider owned and controlled) settings, if the setting remains compliant, the waiver agency only needs to maintain the surveys in a file at the waiver agency. The waiver agency must send to MDHHS the completed home and community-based settings survey in the following circumstances:

- The setting is a new setting and has not had a previous survey completed and reviewed by MDHHS and deemed compliant.
- There has been a change in ownership for the setting.
- There have been major changes in how the setting operates their business.

The waiver agency notifies MDHHS immediately of any provider owned setting that is no longer compliant with the home and community-based services settings regulations as assessed using the Residential Survey for MI Choice Waiver or the Non-Residential Survey for MI Choice Waiver as appropriate. Provider-owned settings include licensed and non-licensed assisted living, adult foster care, or homes for the aged, and adult day health providers. The notification will include the corrective action plan and timeline for implementing the corrective action plan. The waiver agency will be responsible for assuring the corrective actions have been implemented in a subsequent in-person visit to the setting. The waiver agency will forward the results of the subsequent in-person visit to MDHHS within 10 days of completing the visit. The waiver agency will immediately notify MDHHS if the subsequent visit indicates the provider continues to be non-compliant with the ruling and will require MI Choice participants to transition from the setting.

When results of the initial case record/bill review indicate any irregularities, the reviewer and waiver agency financial staff conducts further review of provider case records covering a specified time. Waiver agency staff may opt to conduct a complete audit of all case records. Following a second review, a written report of the findings is prepared with appropriate corrective actions and sent to the provider and MDHHS within 30 working

days following completion of the review. Waiver agency staff schedules a follow-up review within a three (3) to six (6) month timeframe for providers deficient in any part of the review to assure that the provider initiates and implements corrective action.

Service issues/activities identified for corrective action require the waiver agency to:

- Clearly identify formal findings, state compliance issues, and provide recommendations for corrective action.

- Establish due dates when the provider is scheduled to be in full compliance with the standards and conditions for continued participation.

- Monitor the provider's performance in completing the necessary corrective action.

- Suspend new referrals to the provider agency or transfer participants to another provider when findings warrant immediate action to protect the participant's health or welfare.

- Adjust provider billings on the agency's information system using individual adjustments to date of service or gross adjustment. Deduct overpayments made to a provider from the next warrant issued the provider from the waiver agency. Adjust encounter data submitted to the Community Health Automated Medicaid Payment System (CHAMPS) to accurately reflect adjustments made to provider billing.

- Suspend or terminate the providers who demonstrate a failure to correct deficiencies following a second review. The waiver agency can reinstate providers after verifying the provider corrected deficiencies and/or changed procedural practices as required.

IN-HOME PARTICIPANT VISITS

To gauge the effectiveness of service delivery accurately, it is necessary to obtain comments regarding service provision from the perspective of the participant and caregiver. From the sample of participant case records reviewed, the waiver agency reviewer selects a minimum of two waiver participants with which they shall conduct home visits. These visits determine participant satisfaction with supports coordination activities and services and verify that providers deliver services as planned.

The in-home visit may correspond to a time when the provider is working in the participant's home. The scheduling of a participant home visit in tandem with the actual service provision allows the waiver agency reviewer to observe the provider employee at work and the interaction between the worker and the participant. The reviewer interviews the provider employee to determine his or her understanding of the tasks they should perform as specified in the plan of service and MI Choice work order. The reviewer also verifies with the participant and caregiver that the provider is delivering services as planned.

The waiver agency reviewer ensures the participant's supports coordinator is aware of pertinent information such as concerns regarding service delivery that the reviewer gathers during the home visit interviews. Supports coordinators follow-up with participant concerns identified during the home visits.

For participants who reside in provider-owned settings (assisted living, AFC, HFA, etc.) complete the additional questions at the end of the participant survey. Any "No" answers provided by the participant (or their authorized representative) require follow up with the provider to assure continued compliance to the home and community based services setting requirements.

COORDINATION WITH SUPPORTS COORDINATORS

Before or immediately after conducting the on-site provider review, the waiver agency reviewer meets with supports coordinators to discuss utilization of the provider and any problems encountered in using the provider. Additionally, the waiver agency reviews MI Choice participant case records and other documentation to evaluate the interaction with the provider and determine the frequency of "missed" visits or "no shows" by the provider as related to the plan of service and the MI Choice work order. The review of MI Choice case records assists the waiver agency reviewer to measure provider adherence to the authorized plan of service.

COORDINATION WITH OTHER WAIVER AGENCIES

To the extent feasible and possible, waiver agencies should coordinate monitoring visits to providers that contract with more than one waiver agency. MDHHS encourages waiver agencies to combine efforts to monitor providers under contract with more than one waiver agency. Any time a waiver agency finds rationale to terminate a provider from the provider network the waiver agency must notify other waiver agencies of the findings and the reason for terminating the contract. This is to mitigate potential harm to other MI Choice participants. Waiver agencies must also notify MDHHS of any contract terminations and the reasons for doing so.

MONITORING SCHEDULE

The waiver agency develops a yearly schedule of provider monitoring reviews to conduct monthly throughout the fiscal year, October 1 to September 30. The schedule is submitted to MDHHS by December 1st each year.

MI CHOICE PROVIDER MONITORING TOOL

PROVIDER: _____

ADDRESS: _____

DIRECTOR: _____

PROGRAM/AGENCY PARTICIPANTS: _____

_____

_____

ASSESSMENT DATE: _____

CONTRACT PERIOD COVERED: FROM _____ TO _____

TYPE OF AGENCY: (Check all that apply)

_____	Private Duty	_____	Medicare Skilled
_____	Private for Profit	_____	Private Nonprofit
_____	Public	_____	Hospital-Based
_____	Hospice and/or Palliative Care Certified	_____	Other (explain): _____

SERVICE CATEGORY(S) BEING MONITORED:

_____	All listed	_____	Home delivered meals
_____	Community Living Supports	_____	Nursing Services
_____	In-home respite	_____	Adult day Health
_____	Chore Services	_____	Private duty nursing
_____	Transportation	_____	Counseling
_____	PERS	_____	Other _____

ASSESSMENT CONDUCTED BY: _____

DATE FEEDBACK SENT: _____

DATE REPORT SENT TO MDHHS: _____

MI CHOICE PROVIDER MONITORING TOOL

GENERAL INFORMATION

1. Purchase agreement current (updated)? Y_____ N_____
2. Have conditions of agreement been reviewed with local staff? Y_____ N_____
3. Does the provider agency maintain program books and records relevant to purchase agreement for at least six years? Y_____ N_____
4. Is the provider agency aware of contract amendment and /or revised procedures as required by MDHHS that may have been implemented during the contract year? Have these been addressed? Y_____ N_____ Y_____ N_____
5. Does the provider agency maintain the following insurance? (Visually verify)

				Expiration Date
a.	Worker's Compensation	Y_____	N_____	_____
b.	Unemployment	Y_____	N_____	_____
c.	General Liability	Y_____	N_____	_____
d.	Facility/Property Insurance	Y_____	N_____	_____
e.	No-Fault Vehicle Insurance	Y_____	N_____	_____
f.	Fidelity Bonding (for persons handling cash)	Y_____	N_____	_____
g.	Malpractice/Liability	Y_____	N_____	_____
h.	Professional/Liability	Y_____	N_____	_____
i.	Other: _____	Y_____	N_____	_____

PROGRAM SPECIFICATIONS

1. What are the agency's procedures for documenting hours of service provided by employees for billing purposes?
_____
_____
_____
_____

2. How does the agency verify that hours of service are actually provided?_____
_____
_____
_____
_____

3. Participant Records (Review 10 files or 10% whichever is greater) for the following contents.

		% COMPLIANT
a.	Assessment/reassessments?	_____
b.	Service plan (work order)?	_____
c.	Service plan adjustments?	_____
d.	Progress Notes?	_____
e.	Release of information (if necessary)?	_____
f.	Accident reports (if necessary)?	_____
g.	Termination records (if necessary)?	_____
h.	Other (describe): _____	

COMMENTS: _____
_____
_____
_____
_____

MI CHOICE PROVIDER MONITORING TOOL

4. Does the agency use the MI Choice assessment? Y_____ N_____
   a. If NO, does the agency conduct a supplemental assessment only? Y_____ N_____
   b. If NO, does the agency conduct a complete assessment? Y_____ N_____
5. Does the agency have its own service plan? Y_____ N_____
   If YES, does the agency service plan correspond to the waiver agency work order? Y_____ N_____

6. If the agency is a Medicare/Medicaid certified agency with a private duty component, does the agency bill either source for non-skilled services provided to waiver participants through "Management & Evaluation?" Y_____ N_____

7. How does the provider assure confidential participant files are kept secure? (Describe the methods of storing confidential information, controlled access to computer information) _____

8. Does the provider have policies and procedures for: (visual verification and review of policies required)

   a. Participant confidentiality? Y_____ N_____
   b. Participant appeals/grievances? Y_____ N_____
   c. Participant feedback/evaluation? Y_____ N_____
   d. Participant's rights and responsibilities? Y_____ N_____
   e. Reporting suspected abuse, neglect, exploitation or other critical incidents? Y_____ N_____
   f. Participant health, welfare, and safeguards? Y_____ N_____
   g. Emergencies in participant's home? Y_____ N_____
   h. Personnel? Y_____ N_____
   i. Recruitment, training, and supervision? Y_____ N_____
   j. Date of last revision of policy manual _____

9. Agency Documentation:

   a. Do provider records specifically identify participants being served through the agreement with the waiver agency? Y_____ N_____
   b. Does the documentation contain the state minimum requirements of "Date of Service," "Start and Stop Times " of service provision, and "Written Summary" of services and tasks performed? Y_____ N_____
   c. Is the signature of the employee providing the service included on the documentation? Y_____ N_____
   d. Does the provider use and maintain an "In-Home Journal" as required in the agreement? May include electronic system. Y_____ N_____
      i. If YES, is the in-home journal available for review in the participant's home by the supports coordination staff? Y_____ N_____
      ii. Does the in-home journal contain the minimum requirements of the "Date of Service," "Start and Stop Times" of service provision, and "Written Summary" of services and tasks performed, pertinent information regarding the participant's routine, health status, nutritional status, and changes or problems encountered? Y_____ N_____
      iii. Is the signature of the employee providing the service included on the documentation? Y_____ N_____
      If NO, explain: _____

      iv. Is the signature of the participant receiving the service included on the documentation? Y_____ N_____
      If NO, explain: _____

COMMENTS: _____

MI CHOICE PROVIDER MONITORING TOOL
STAFFING

1. Is the following information in paid staff employee files:
   a. Reference checks? Y_____ N_____
   b. TB test results (card)? Y_____ N_____
   c. Copy of certification/license/registration for professional employees? Y_____ N_____
   d. Copy of a valid driver's license and automobile insurance, if applicable? Y_____ N_____

2. Does the provider conduct a criminal history review on new employees? Y_____ N_____
   If yes, are these conducted prior to the employee entering the participant's home? Y_____ N_____

3. Does the provider conduct reference checks prior to paid staff entering the participant's home? Y_____ N_____

4. Describe the agency's procedures for introducing the caregiver staff to participants: _____

5. Do caregivers wear pictured identification? Y_____ N_____

   If NO, what form of agency identification is presented to participants? _____

6. What type of orientation program is set up for new staff? (Ask for outline or copy of training program) _____

7. The following applies for private duty nursing/respiratory care and nursing services:

   a. Are licenses and registrations for RNs, LPNs and RTs from the State of Michigan current and available for viewing? (visually verify) Y_____ N_____
   b. Are LPNs supervised by RNs? Y_____ N_____
   c. Are there written procedures to govern administering of medications? Y_____ N_____
      If YES, describe these procedures _____

COMMENTS: _____

MI CHOICE PROVIDER MONITORING TOOL

8. The following applies to in-home workers (caregivers) including those delivering community living supports, respite, and chore services:

   a. Describe the typical tasks performed in the participant's home: _____

   b. Do any of the workers have certification? Y_____ N_____
      i. If YES, how many? _____
      ii. Are copies of the certification on file? Y_____ N_____

   c. Is in-service training provided to workers at least two times per year? Y_____ N_____
   d. Is there an annual in-service training plan? (review this plan) Y_____ N_____
   e. What types of training topics have been covered in the last 12 months? _____

   f. Is an aide training course provided as recommended by MDHHS? Y_____ N_____
   g. Does a qualified professional supervise workers? Y_____ N_____
      If YES, what are the credentials of the supervisor? _____

   h. Does the supervisor review the MI Choice work order with the in-home workers before the initial home visit? Y_____ N_____
   i. Is the supervisor available to workers at all times by telephone? Y_____ N_____
   j. Are supervisory in-home evaluations of workers conducted at least two times per calendar year? Y_____ N_____
   k. Do participant records reflect documentation of on-site supervisory visits including the following: Y_____ N_____
      i. Name and title of person doing the supervising? Y_____ N_____
      ii. Staff person being supervised? Y_____ N_____
      iii. Location of on-site supervision (participant ID number only, no names) Y_____ N_____
      (Note last monitoring date and findings)
   l. Is there a policy on dispensing of nonprescription medications? Y_____ N_____
   m. Is there a procedure to govern the dispensing or administering of prescription medications? Y_____ N_____

SERVICE COORDINATION

1. Describe how the agency coordinates with the waiver agency supports coordinators:
   a. What is the procedure for notifying the waiver agency supports coordinators of participant changes in condition or status? _____

   b. What is the agency's policy/procedure for notifying the supports coordinator of discontinued services due to participant not at home, death, institutionalization, hospitalization, personal choices, etc.? _____

COMMENTS: _____

c. What is the agency's policy/procedure for notifying the supports coordinator of upcoming appointments the participant may have that the agency becomes aware of? _____

d. What is the agency's policy/procedure for notifying the supports coordinator when paid staff fails to show up at the participant's home? _____

OTHER

1. Are the agency services available to the general public? Y_____ N_____
   If YES, how does the public rate compare to the unit rate waiver agency pays?
   Private pay rate: $_____ waiver agency rate: $_____
2. Does the provider have any need for technical assistance or training? Y_____ N_____
   If YES, in what areas? _____
3. How are the agency services publicized? _____
4. Were there any problems encountered during the last 12 months? Y_____ N_____
   If YES, please describe: _____
5. Is the agency an assisted living setting (i.e. licensed or non-licensed assisted living, AFC or HFA)? Y_____ N_____
6. If yes to #5, has this setting been evaluated regarding the Home and Community Based Settings requirements? Y_____ N_____
7. If yes to #6, does this setting meet the Federal Home and Community Based Settings requirements? Y_____ N_____
8. If no to #6, complete the Home and Community Based Settings assessment.
9. If no to #7, describe steps that need to be taken to become compliant. If the provider does not wish to become compliant, discuss a plan for transferring MI Choice participants to another setting as of 3/17/2018.

COMMENTS: _____

MI CHOICE PROVIDER MONITORING TOOL

BILLING AUDIT

NOTE: A complete audit of the participant case records is to be conducted for those cases being reviewed. The waiver agency must verify billing dates and units of service submitted by the provider agency and paid by the waiver agency with dates and units of service found in office participant case records.

1. Do progress notes correspond with billing dates of service? Y_____ N_____

   Findings of visual review: _____

2. Did monitoring reveal any areas of participant needs not being addressed adequately through provider's provision of service? Y_____ N_____

   If YES, explain: _____

FINDINGS: _____

MI CHOICE IN-HOME PARTICIPANT VISIT
(CONDUCTED IN CONJUNCTION WITH PROVIDER MONITORING)

PROVIDER AGENCY MONITORED: _____

REVIEWER: _____ SIGNATURE: _____

PARTICIPANT'S NAME: _____ DATE: _____

SOCIAL SECURITY #: _____ D.O.B.: _____

CURRENT CLIENT TYPE: **WA** ☐ **CM** ☐ **OTHER (specify):** _____

CLIENT STATUS: **ACTIVE** ☐ **MAINTENANCE** ☐

OTHER (Check all that apply): Chose SD option ☐ NFT ☐ MFP ☐ SMOU ☐ MOU ☐

Dates of WA: _____ **Dates of CM/other program:** _____

Participant Meets NFLOC: Yes ☐ Door: _____ No ☐ Unable to Determine ☐

	PERSONAL GOALS, FUNCTIONAL ABILITY, DIAGNOSES, SOCIAL/OTHER CONCERNS	**COMMENTS**
Per Chart Review:		
Per Participant:		
Per Primary Caregiver:		

Current Services	Frequency	
	Per Person Centered Service Plan (PCSP) Authorizations	Per Participant
☐ ADULT DAY CARE		
☐ COMMUNITY LIVING SUPPORTS		
☐ RESPITE SERVICES		
☐ COUNSELING		
☐ HOME MODIFICATIONS		
☐ HOME DELIVERED MEALS		
☐ NURSING SERVICES		
☐ SUPPORTS COORDINATION		
☐ TRAINING		
☐ PERS		
☐ TRANSPORTATION		
☐ PRIVATE DUTY NURSINGRESPIRATORY CARE		
☐ CHORE		
☐ FISCAL INTERMEDIARY		
☐ GOODS AND SERVICES		
☐ COMMUNITY HEALTH WORKER		
☐ OTHER		

☐ **SPECIALIZED MEDICAL EQUIPMENT/SUPPLIES:**

☐ **HOSPITAL BED** ☐ **COMMODE** ☐ **WALKER** ☐ **WHEELCHAIR** ☐ **RAISED TOILET SEAT**
☐ **OXYGEN** ☐ **HUMIDIFIER** ☐ **DIAPERS** ☐ **BLUE PADS** ☐ **SYRINGES** ☐ **DRESSINGS**

☐ **OTHER:**_____

☐ **ADDITIONAL DME'S NEEDED:**_____

ISSUES	STANDARD MEASURES USED	Evident in FILE REVIEW (YES/NO)	Evident in HOME VISIT (YES/NO)	COMMENTS
Cultural sensitivity	***Direct service providers speak same language as participant.** ***Plan of service reflects specific cultural practices.**			
Timeliness of purchased services	***Time between service authorization and services in place in home.** ***Provider delivers services at times specified on plan of service or otherwise acceptable to participant.**			
Choice of service providers	***Participant approval of plan of service** ***Participant satisfied with provider and/or workers.**			
Responsiveness to changes in person centered service plan (PCSP)	***Provider implemented requested service change.** ***Provider responsive to participant requests and instruction.**			
Participant can contact provider with issues	***Participant able to name provider, locate phone number for provider, etc.**			
Participant has materials on complaint, appeals process	***Participant aware of right to complain and/or appeal.** ***Participant knows process.**			

ISSUES	STANDARD MEASURES USED	Evident in FILE REVIEW (YES/NO)	Evident in HOME VISIT (YES/NO)	COMMENTS
Evidence of PCP	***Participant satisfied with current service delivery.** ***Worker knows participant preferences.** ***Participants preferences honored during delivery of services.**			
Services are delivered as ordered	***Gaps in services are documented.** ***Agency notifies waiver agency if unable to provide services.**			
Emergency/ contingency plans	***Emergency plan in place.** ***Emergency plan followed when needed.** ***Services delivered according to ER plan during emergency or when unable to staff with regular worker.**			
PCSP sufficient to assure health and safety of participant	***Plan of service reflects assurance of health and safety and risk planning.** ***Provider/caregivers assure health & safety while in home.** ***Provider reports health/safety issues to supports coordinator.**			
Provider facilitates delivery of needed arranged services/supports	***Provider staff contact supports coordinator to notify of unmet need.** ***Provider staff assists with advocating for participant.**			

ISSUES	STANDARD MEASURES USED	Evident in FILE REVIEW (YES/NO)	Evident in HOME VISIT (YES/NO)	COMMENTS
Quality of care outcomes	***Participant satisfied with quality of service.** ***Provider completes all tasks as specified.**			
Evidence of effort to prevent excess disability	***Caregivers encourage participant to maintain and/or improve function.**			
Evidence of under-service to participant	***Provider consistently delivers services and supports according to plan of service and participant preferences.** ***Reasons for non-provision of service are documented and valid.**			

ISSUES	STANDARD MEASURES USED	Evident in FILE REVIEW (YES/NO)	Evident in HOME VISIT (YES/NO)	COMMENTS
Consumer satisfaction	**1. Service and support needs met by direct care workers.** **2. Providers arrive as scheduled.** **3. Providers complete all tasks specified in PCSP.** **4. Providers treat participant with respect and dignity.** **5. Participant is pleased with services and supports.** **6. Other services needed.**	**File review N/A for these questions**		**1. ☐ Always ☐ Usually ☐ Sometimes ☐ Rarely ☐ Never ☐ N/A** **2. ☐ Always ☐ Usually ☐ Sometimes ☐ Rarely ☐ Never ☐ N/A** **3. ☐ Always ☐ Usually ☐ Sometimes ☐ Rarely ☐ Never ☐ N/A** **4. ☐ Always ☐ Usually ☐ Sometimes ☐ Rarely ☐ Never ☐ N/A** **5. ☐ Always ☐ Usually ☐ Sometimes ☐ Rarely ☐ Never ☐ N/A** **6. List other services:**

OTHER COMMENTS:

For participants who reside in a provider-owned setting, please also complete the following:

Question	Yes	No	Comments (Explain all "NO" answers)
1. Can you close and lock your bedroom door?			
2. Do individuals have keys to your bedroom door?			
3. Does your bedroom door have doorknobs that may be unlocked from the inside with one motion (automatically unlocks with one turn of the knob)?			
4. Can you close and lock your bathroom door			
5. Does your bathroom door have doorknobs that may be unlocked from inside with one motion (automatically unlocks with one turn of the knob)?			
6. Do staff members have a key or keypad access to your bedroom doors?			
7. Do staff members have a key or keypad access to your bathroom doors?			
8. Do staff members respect your privacy when entering your personal space?			
9. Are you allowed to have meals/snacks at the time and place you choose?			
10. Can you choose what you eat, as appropriate?			
11. Can you choose to eat alone or with other housemates?			
12. Can you choose what clothes to wear?			
13. Can you receive assistance with dressing if necessary?			
14. If you have access to a personal communications device (e.g., cell phone, landline phone, personal			

Question	Yes	No	Comments (Explain all "NO" answers)
computer, tablet), can you use this device in private at any time?			
15. If you have access to a **shared** communication device (e.g., cell phone, landline phone, personal computer, tablet), can you use the device in a location that allows for private communication?			
16. Does your bedroom offer a telephone jack, wireless internet, or an Ethernet jack?			
17. If there are cameras and visual/audio monitors present in the individual's bedroom or bathroom, was the equipment installed to meet an assessed or documented need for the individual?			
18. Do you have privacy when receiving support with your personal care needs?			
19. Did you have a choice of roommate(s)?			
20. Can you furnish or decorate your bedroom?			
21. Do you arrange and control your personal schedule of daily appointments and activities?			
22. Do you have full access to the following common areas?			
a. Kitchen			
b. Dining Area			
c. Laundry Room			
d. Comfortable Seating Area			
e. Bathroom			
23. Is there space for you to meet with visitors to have private conversations?			
24. Are you free to come and go from the home setting?			

Question	Yes	No	Comments (Explain all "NO" answers)
25. Can you freely move about the inside space of the home setting?			
26. Can you freely move about the outside space of the home setting?			
27. Is the residence physically accessible to you?			
28. Are there environmental adaptions (grab bars, shower chairs, wheelchair ramps) within the setting to enhance the physical accessibility of the setting?			
29. Are the household appliances within the setting physically accessible to you?			
30. Is the furniture at a height and location that is accessible and comfortable to you?			
31. Does the home have gates, locked doors, or other barriers preventing entrance or exit from common areas of the home (i.e. kitchen, dining area, laundry, comfortable seating area, and bathroom)?			
32. If available, do you have the same access to features of the housing community (e.g. pool, gym) as other housemates?			
33. Is accessible transportation available for you to make trips within the community?			
34. Do you have access to nearby public transportation?			
35. If public transit is available, do you receive training or assistance with using public transit?			

Question	Yes	No	Comments (Explain all "NO" answers)
36. If public transit is limited or unavailable, do you have other resources to access the broader community?			
Additional Information:			

In addition to explaining all "No" answers provided by the participant, the waiver agency should also follow up with the provider for their explanation to assure the setting is compliant with home and community based services setting requirements.

Residential Survey for MI Choice Waiver

Expected Respondent: MI Choice Waiver Agency

Provide the respondent's contact information for further questions:

Name: Click here to enter text.
Position: Click here to enter text.
Waiver Agency: Click here to enter text.
Contact Phone Number: Click here to enter text.
Contact Email Address: Click here to enter text.

Instructions: Provide a response to each question, taking into consideration all individuals who live at the address. If responses vary based on individual needs, provide your response if it impacts or is present for at least one individual who is living in the setting. Most of the questions asked for "additional information" to support the response provided. At the end of sections, indicate additional information to support your responses. Do not submit any additional documentation separate from the completed survey; simply give a written description of the additional information within the survey. Responses to this survey and supporting information may be verified at a later date with an on-site visit.

a. Name of the Setting: Click here to enter text.
b. Residential Support Provider Address: Click here to enter text.
c. City, State, and Zip Code: Click here to enter text.
d. If setting is licensed by the Michigan Department of Health & Human Services, Bureau of Children and Adult Licensing (BCAL), license number (if not licensed, leave blank): Click here to enter text.
e. NPI (if no NPI, enter EIN): Click here to enter text.
f. Contact Name: Click here to enter text.
g. Contact Phone Number: Click here to enter text.
h. Contact Email Address (where compliance letter will be sent after MDHHS review): Click here to enter text.

Note: If you have questions about completing the survey, please contact the Michigan Department of Community Health at HCBSTransition@michigan.gov.

Section 1: Provider Background of Residential Living Supports

1. Type of residence or setting
   a. ☐Specialized residential home
   b. ☐Nursing Care Facility
   c. ☐Assisted Living Facility
   d. ☐Adult Foster Care
   e. ☐Home for the Aged
   f. ☐Other: If marked, why? Click here to enter text.

2. Does this setting accept residents who are receiving services through a Medicaid HCBS waiver program such as MI Choice, MI Health Link HCBS, or Habilitation Supports Waiver?

   ☐Yes: If marked, how many participants are currently enrolled in a Medicaid HCBS program? Click here to enter text.
   ☐No

3. Licensing and characteristics:
   a. If this is a licensed living arrangement under BCAL, what is the maximum number of individuals the home is licensed to serve? Click here to enter text.
   b. What is the total number of people living at the home? Click here to enter text.
   c. Complete the table below to indicate the population characteristics of participants within your setting. **Each person should be listed only once in the most appropriate category.**

Type of health need	Number of people with this type of health need who participate in this setting
Alzheimer's or Dementia	Click here to enter text.
Developmental Disabilities	Click here to enter text.
Mental Illness	Click here to enter text.
Physical Disabilities	Click here to enter text.
Traumatic Brain Injury	Click here to enter text.

Section 2: Physical Location and Operations of Residential Living Supports

1. Is the residence located in the same building or on the same campus as an institutional treatment option (as defined in the glossary on the last page of this survey)?
   ☐Yes: If marked, explain. Click here to enter text.
   ☐No

2. Does the provider operate or manage multiple home settings which are (1) on the same campus, (2) located close together, or (3) offer a continuum of care?
   ☐Yes: If marked, explain. Click here to enter text.
   ☐No

3. Is the residence intended for people with the same diagnoses or disabilities?
   ☐Yes: If marked, explain. Click here to enter text.
   ☐No

Provide additional information to support responses in Section 2: Physical Location and Operations of Residential Setting: Click here to enter text.

Section 3: Community Integration of Residential Setting

1. Are there options for using services and supports outside of the residence instead of onsite services?
   ☐Yes
   ☐No: If marked, why? Click here to enter text.

2. Have individuals receiving Medicaid funded HCBS been provided with the opportunity to receive services and supports or participate in social and/or recreational activities in the same manner as individuals who are not receiving Medicaid funded HCBS?
   ☐Yes
   ☐No: If marked, why? Click here to enter text.

3. Do individuals receiving Medicaid funded HCBS participate in any of the following activities of their choosing in the community (check all that apply)?
   ☐Individual shopping
   ☐Religious or spiritual services
   ☐Scheduled appointments (personal or medical)
   ☐Meals with friends or family
   ☐Recreation activities
   ☐Community events
   ☐Volunteer community services
   ☐Community employment
   ☐School or Education
   ☐Other: Click here to enter text.

4. Visitors to the residence:
   a. Does the residence have restrictions on visitors (hours or schedules)?
      ☐Yes: If marked, why? Click here to enter text.
      ☐No

   b. Does the residence allow for exceptions to the visiting hours to address special circumstances?
      ☐Yes
      ☐No: If marked, why? Click here to enter text.

5. Can the MI Choice supports coordinator visit at any time without permission?
   ☐Yes
   ☐No: If marked, why? Click here to enter text.

Provide additional information to support responses in Section 3: Community Integration of Residential Setting: Click here to enter text.

Section 4: Individual Rights within Residential Setting

1. Does each individual have a lease or residential agreement for the residential setting?
   ☐Yes
   ☐No: If marked, why? Click here to enter text.

2. Does the lease or residential agreement provide each individual who is receiving Medicaid funded HCBS with information on the eviction process and a means to appeal an eviction?
   ☐Yes
   ☐No: If marked, why? Click here to enter text.

3. Are provider policies outlining individual rights, protections, and expectations of services and supports provided to individuals in an understandable format?
   ☐Yes
   ☐No: If marked, why? Click here to enter text.

4. Is information about filing a complaint posted in an obvious location in an understandable format?
   ☐Yes
   ☐No: If marked, why? Click here to enter text.

5. Are individuals informed about how to discuss their concerns with residence staff?
   ☐Yes
   ☐No: If marked, why? Click here to enter text.

6. Do individuals know the person to contact for completing an anonymous complaint?
   ☐Yes
   ☐No: If marked, why? Click here to enter text.

7. Does the setting protect the privacy of an individual's health and personal information?
   ☐Yes
   ☐No: If marked, why? Click here to enter text.

8. Does staff discuss individual resident issues in public spaces?
   ☐Yes: If marked, why? Click here to enter text.
   ☐No

9. Does staff address individuals in the manner in which the individual would prefer to be addressed?
   ☐Yes
   ☐No: If marked, why? Click here to enter text.

10. Do individuals have access to their personal funds as appropriate?
    ☐Yes
    ☐No: If marked, why? Click here to enter text.

11. Do individuals have control over their personal funds as appropriate?
    ☐Yes
    ☐No: If marked, why? Click here to enter text.

12. Do individuals have a secure place (e.g. locker or lockbox) to store their personal belongings?
    ☐Yes
    ☐No: If marked, why? Click here to enter text.

13. Do individuals have options within the setting to choose who provides their services and supports?
    ☐Yes
    ☐No: If marked, why? Click here to enter text.

14. Are individuals able to update or change their services and supports that they receive based on their preferences and needs?
    ☐Yes
    ☐No: If marked, why? Click here to enter text.

15. Does the setting allow individuals to participate in legal activities as appropriate? (e.g. voting in public elections when 18 years of age or older)?
    ☐Yes
    ☐No: If marked, why? Click here to enter text.

16. Does staff receive training and continuing education on individual rights and protections?
    ☐Yes
    ☐No: If marked, why? Click here to enter text.

17. Does the setting prohibit the use of physical restraints and/or restrictive intervention (unless documented and agreed upon in the person-centered plan)?
    ☐Yes
    ☐No: If marked, why? Click here to enter text.

Provide additional information to support responses in Section 4: Individuals Rights of Residential Settings: Click here to enter text.

Section 5: Individual Experience within Residential Setting

Individual Preferences with Home Setting

1. Individual Privacy and Doors
   a. Can individuals close and lock their bedroom door?
      ☐Yes
      ☐No: If marked, why? Click here to enter text.

   b. Do individuals have keys to their bedroom doors?
      ☐Yes
      ☐No: If marked, why? Click here to enter text.

   c. Do bedroom doors have doorknobs that may be unlocked from inside with one motion (automatically unlocks with one turn of the knob)?
      ☐Yes
      ☐No: If marked, why? Click here to enter text.

   d. Can individuals close and lock their bathroom door?
      ☐Yes
      ☐No: If marked, why? Click here to enter text.

   e. Do bathroom doors have doorknobs that may be unlocked from inside with one motion (automatically unlocks with one turn of the knob)?
      ☐Yes
      ☐No: If marked, why? Click here to enter text.

   f. Do staff members have a key or keypad access to individual bedroom doors?
      ☐Yes: If marked, why? Click here to enter text.
      ☐No

g. Do staff members have a key or keypad access to individual bathroom doors?
☐Yes: If marked, why? Click here to enter text.
☐No

h. Do staff members respect individual privacy when entering an individual's personal space?
☐Yes
☐No: If marked, why? Click here to enter text.

2. Meals and Food
   a. Does the setting allow for individuals to have meals/snacks at the time and place of their choosing?
   ☐Yes
   ☐No: If marked, why? Click here to enter text.

   b. Can individuals choose what they eat, as appropriate?
   ☐Yes
   ☐No: If marked, why? Click here to enter text.

   c. Can individuals choose to eat alone or with other housemates?
   ☐Yes
   ☐No: If marked, why? Click here to enter text.

3. Clothes and Apparel
   a. Can individuals choose what clothes to wear?
   ☐Yes
   ☐No: If marked, why? Click here to enter text.

   b. Can individuals receive assistance with dressing if necessary?
   ☐Yes
   ☐No: If marked, why? Click here to enter text.

4. If an individual has access to a personal communications device (e.g., cell phone, landline phone, personal computer, tablet), can he or she use this device in private at any time?
   ☐Yes
   ☐No: If marked, why? Click here to enter text.

5. If an individual has access to a **shared** communication device (e.g., cell phone, landline phone, personal computer, tablet), can the device be used in a location that allows for private communication?
   ☐Yes
   ☐No: If marked, why? Click here to enter text.

6. Do individual bedrooms offer a telephone jack, wireless internet, or an Ethernet jack?
   ☐Yes
   ☐No: If marked, why? Click here to enter text.

7. If there are cameras and visual/audio monitors present in the individual's bedroom or bathroom, was the equipment installed to meet an assessed or documented need for the individual?
   ☐Yes
   ☐No: If marked, why? Click here to enter text.
   ☐Not applicable

8. If an individual needs assistance with personal care, does he or she have privacy when receiving this support?
   ☐Yes
   ☐No: If marked, why? Click here to enter text.
   ☐Not applicable

9. Do individuals who share a personal space/bedroom have a choice of roommate(s)?
   ☐Yes
   ☐No: If marked, why? Click here to enter text.

10. Do individuals have the freedom to furnish or decorate their own bedrooms?
    ☐Yes
    ☐No: If marked, why? Click here to enter text.

11. Do individuals arrange and control their personal schedule of daily appointments and activities?
    ☐Yes
    ☐No: If marked, why? Click here to enter text.

Freedom of Access in the Home Setting

12. Do individuals have full access to the home's common areas? Complete the table below.

Home's Common Areas	*Do individuals have full access?*	*Can individuals access these common areas at any time?*
Kitchen	☐Yes ☐No	☐Yes ☐No
Dining Area	☐Yes ☐No	☐Yes ☐No
Laundry Room	☐Yes ☐No	☐Yes ☒No
Comfortable Seating Area	☐Yes ☐No	☐Yes ☐No
Bathroom	☐Yes ☐No	☐Yes ☐No

If the setting does not provide full access to the home's common areas, please explain why there are restrictions: Click here to enter text.

13. Is there space within the home where individuals may meet with visitors to have private conversations?
☐Yes
☐No: If marked, why? Click here to enter text.

14. Does the setting place restrictions on an individual's ability to come and go from the home setting?
☐Yes: If marked, why? Click here to enter text.
☐No

15. Does the setting place restrictions on an individual's ability to freely move about the inside space of the home setting?
☐Yes: If marked, why? Click here to enter text.
☐No

16. Does the setting place restrictions on an individual's ability to freely move about the outside space of the home setting?
☐Yes: If marked, why? Click here to enter text.
☐No

Physical Accessibility of the Home Setting

17. Is the residence physically accessible to all individuals?
    ☐Yes
    ☐No: If marked, why? Click here to enter text.

18. Are there environmental adaptions (grab bars, shower chairs, wheelchair ramps) within the setting to enhance the physical accessibility of the setting?
    ☐Yes
    ☐No: If marked, why? Click here to enter text.

19. Are the household appliances within the setting physically accessible to all individuals?
    ☐Yes
    ☐No: If marked, why? Click here to enter text.

20. Is the furniture at a height and location that is accessible and comfortable to all individuals?
    ☐Yes
    ☐No: If marked, why? Click here to enter text.

21. Does the home have gates, locked doors, or other barriers preventing entrance or exit from common areas of the home (i.e. kitchen, dining area, laundry, comfortable seating area, and bathroom)?
    ☐Yes: If marked, where and why? Click here to enter text.
    ☐No

22. If available, do individuals who are receiving Medicaid funded HCBS have the same access to features of the housing community (e.g. pool, gym) the same as individuals who are not receiving Medicaid funded HCBS?
    ☐Yes
    ☐No: If marked, why? Click here to enter text.

Accessibility within the Community

23. Is accessible transportation available for individuals to make trips within the community?
    ☐Yes
    ☐No: If marked, why? Click here to enter text.

24. Do individuals have access to nearby public transportation?
    ☐Yes
    ☐No: If marked, why? Click here to enter text.

25. If public transit is available, do individuals receive training or assistance with using public transit?
    ☐Yes
    ☐No: If marked, why? Click here to enter text.

26. If public transit is limited or unavailable, do individuals have other resources to access the broader community?
    ☐Yes: What other resources? Click here to enter text.
    ☐No: If marked, why? Click here to enter text.

Provide additional information to support responses in Section 5: Individual Experience within Residential Setting: Click here to enter text.

Section 6: Waiver Administration and Policy Enforcement of Residential Settings

These questions should be completed by the waiver entity.

1. Did individuals have the opportunity to choose a residential setting from a variety of options?
   ☐Yes
   ☐No: If marked, why? Click here to enter text.

2. Did individuals have an option of choosing a residential setting with a private bedroom?
   ☐Yes
   ☐No: If marked, why? Click here to enter text.

3. Have individuals been provided with information on how to request new housing?
   ☐Yes
   ☐No: If marked, why? Click here to enter text.

4. Do all individuals in the setting have a documented person centered service plan?
   ☐Yes
   ☐No: If marked, why? Click here to enter text.

Provide additional information to support responses in Section 6: Waiver Administration and Policy Enforcement of Residential Settings: Click here to enter text.

Non-Residential Survey for the MI Choice Waiver

Expected Respondent: MI Choice Waiver Agency

Provide the respondent's contact information for further questions:

Name: Click here to enter text.
Title: Click here to enter text.
Waiver Agency: Click here to enter text.
Contact Phone Number: Click here to enter text.
Contact Email Address: Click here to enter text.

Instructions: The waiver agency shall complete this survey tool through discussion of the questions with the setting staff and observation of the setting. Provide a response to each question, taking into consideration all individuals who participate at this setting. If responses vary based on individual needs, provide your response if it impacts or is present for at least one individual who participates in the setting. Most of the questions asked for "additional information" to support the response provided. At the end of sections, indicate additional information to support your responses. Do not submit any additional documentation separate from the completed survey; simply give a written description of the additional information within the survey. Responses to this survey and supporting information may be verified at a later date with an on-site visit.

a. Name of the Setting: Click here to enter text.
b. Non-Residential Support Provider Address: Click here to enter text.
c. City, State, Zip Code: Click here to enter text.
d. Contact Phone Number: Click here to enter text.
e. NPI (if no NPI, enter EIN): Click here to enter text.
f. Contact Name: Click here to enter text.
g. Contact Phone Number: Click here to enter text.
h. Contact Email Address (where compliance letter will be sent after MDHHS review): Click here to enter text.

Note: If you have questions about completing the assessment for the MI Choice waiver, please contact the Michigan Department of Community Health at HCBSTransition@michigan.gov.

Section 1: Individual Experience for Non-Residential Settings

1. What is the total number of people participating in this day program? Click here to enter text.

2. Does this setting accept participants who are receiving day program services through a Medicaid program such as the MI Choice or the MI Health Link HCBS waiver programs?
   ☐Yes: If marked, how many participants are currently enrolled in a Medicaid HCBS program? Click here to enter text.
   ☐No

3. Complete the table below to indicate the population characteristics of participants within your setting. **Each person should be listed only once in the most appropriate category.**

Type of health need	Number of people with this type of health need who are receiving Medicaid funded services in this setting
Alzheimer's or Dementia	Click here to enter text.
Developmental Disabilities	Click here to enter text.
Mental Illness	Click here to enter text.
Physical Disabilities	Click here to enter text.
Traumatic Brain Injury	Click here to enter text.

4. Is the setting located in the same building or on the same campus as an institutional treatment option (as defined in the glossary on the last page of this survey)?
   ☐Yes
   ☐No

5. Does the setting afford opportunities for individual schedules that focus on the needs and desires of an individual?
   ☐Yes
   ☐No: If marked, why? Click here to enter text.

6. Do individuals participate in any of the following activities of his/her choosing in the community (check all that apply)?
   ☐Individual shopping
   ☐Religious or spiritual services
   ☐Scheduled appointments (personal or medical)
   ☐Meals with friends or family
   ☐Recreation activities
   ☐Community events
   ☐Volunteer community services
   ☐Community employment
   ☐ School or Education
   ☐ Other: Click here to enter text.

7. Does the setting allow individuals the freedom to move about inside and outside of the setting as opposed to one restricted room or area within the setting?
   ☐Yes
   ☐No: If marked, why? Click here to enter text.

8. Does the setting prohibit individuals who are participating in the day program through a Medicaid program (e.g. MI Choice waiver, MI Health Link HCBS waiver) from participating in activities with other day program participants who are not receiving services through a Medicaid program?
   ☐Yes: If marked, why? Click here to enter text.
   ☐No

9. Is the setting located among other residential buildings, private businesses, retail businesses, restaurants, doctor's offices, etc. that facilitates integration with the greater community?
   ☐Yes
   ☐No: If marked, why? Click here to enter text.

10. Does the setting encourage visitors or other people from the greater community (aside from paid staff) to be present, and is there evidence that visitors have been present at regular frequencies?
    ☐Yes
    ☐No: If marked, why? Click here to enter text.

11. Does the setting provide individuals with contact information, access to, and training on the use of public transportation, such as buses, taxis, etc., and are these public transportation schedules and telephone numbers available in a convenient location?
    ☐Yes
    ☐No: If marked, why? Click here to enter text.

12. If public transportation is limited, does the setting provide information about resources for the individual to access the broader community, including accessible transportation for individuals who use wheelchairs?
    ☐Yes
    ☐No: If marked, why? Click here to enter text.
    ☐Not applicable

13. Does the setting assure that tasks and activities for individuals who receive Medicaid funded HCBS are comparable to tasks and activities for people of similar ages who do not receive Medicaid funded HCBS?
    ☐Yes
    ☐No: If marked, why? Click here to enter text.

14. Is the setting physically accessible including access to bathrooms and break rooms?
    ☐Yes
    ☐No: If marked, why? Click here to enter text.

15. Are appliances, equipment, and tables/desks and chairs at a convenient height and location?
    ☐Yes
    ☐No: If marked, why? Click here to enter text.

16. Does the setting have obstructions such as steps, lips in a doorway, narrow hallways, etc. that limit individuals' mobility in the setting?
    ☐Yes: If marked, why? Click here to enter text.
    ☐No

17. If obstructions are present, are there environmental adaptations such as a stair lift or elevator to get around the obstructions?
    ☐Yes
    ☐No: If marked, why? Click here to enter text.

18. Are the setting's policies explained to each participant in such a way that is understandable to the individual?
    ☐Yes
    ☐No: If marked, why? Click here to enter text.

19. Does the setting only provide services to individuals with a specific type of diagnosis/disability?
    ☐Yes: If marked, why? Click here to enter text.
    ☐No

20. Does the setting protect the privacy of an individual's health and personal information?
    ☐Yes
    ☐No: If marked, why? Click here to enter text.

21. If an individual needs assistance with personal care, does he or she have privacy when receiving this support?
    ☐Yes
    ☐No: If marked, why? Click here to enter text.

22. Does staff address individuals in the manner with which the individual would prefer to be addressed?
    ☐Yes
    ☐No: If marked, why? Click here to enter text.

23. Does staff discuss individual resident issues in public spaces?
☐Yes: If marked, why? Click here to enter text.
☐No

24. Does the setting prohibit the use of physical restraints and/or restrictive intervention (unless documented and agreed upon in the person-centered plan)?
☐Yes
☐No: If marked, why? Click here to enter text.

25. Does the setting offer a secure place (locker or lock box) for the individual to store personal belongings?
☐Yes
☐No: If marked, why? Click here to enter text.

26. Are there gates, Velcro strips, locked doors, fences or other barriers preventing individuals' entrance to or exit from certain areas of the setting?
☐Yes: If marked, why? Click here to enter text.
☐No

27. Does the setting allow individuals to choose with whom they participate in social or recreational activities?
☐Yes
☐No: If marked, why? Click here to enter text.

28. Does the setting allow for individuals to have meals or snacks at the time and place of their choosing?
☐Yes
☐No: If marked, why? Click here to enter text.

29. Does the setting post or provide information on individual rights?
☐Yes
☐No: If marked, why? Click here to enter text.

30. Does the setting afford the opportunity for tasks and activities matched to individuals' skills, abilities, and desires?
☐Yes
☐No: If marked, why? Click here to enter text.

31. Does the setting afford individuals the opportunity to regularly and periodically update or change their preferences?
☐Yes
☐No: If marked, why? Click here to enter text.

32. Does staff receive training and continuing education on individual rights and protections?
    ☐Yes
    ☐No: If marked, why? Click here to enter text.

33. Are provider policies outlining the individual's rights, protections, and expectations of services and supports provided to individuals in an understandable format?
    ☐Yes
    ☐No: If marked, why? Click here to enter text.

Provide additional information to support responses in Section 1: Individual Experience for Non-Residential Settings: Click here to enter text.

Section 2: Waiver Administration and Policy Enforcement for Non-Residential Settings

These questions should be completed by the waiver entity.

1. Did individuals have the opportunity to choose a non-residential setting from a variety of options?
   ☐Yes
   ☐No: If marked, why? Click here to enter text.

2. Have individuals been provided with information on how to request a new setting?
   ☐Yes
   ☐No: If marked, why? Click here to enter text.

3. Do all individuals in the setting have a person centered service plan?
   ☐Yes
   ☐No: If marked, why? Click here to enter text.

Provide additional information to support responses in Section 2: Waiver Administration and Policy Enforcement for Non-Residential Settings: Click here to enter text.