Alabama Department of Senior Services Medicaid Waiver Programs

Case Management Home Visit Tool Cover Sheet: HCBS Requirements Guidance:

E&D, ACT and TA non-day program waiver services are generally provided only in the private homes of participants and are not owned, rented, leased or otherwise controlled by any provider of waiver services. The HCBS Final Settings Rule requires that, regardless of setting, waiver participants must have the opportunity to experience all the benefits of community living consistent with their preferences and desires. HCBS Case Managers monitor and document participants' experience in all settings, including private homes, to ensure it is consistent with the Rule requirements. Requirements specific to the Rule in the MW-1 are marked with an asterisk and require that, during the monthly home visit, the Case Manager will provide specific documentation in the Comments field that show how compliance was determined.

Block 1:

- Under Setting Type, you must select either Private Home (not provider owned or controlled) OR Non-Relative Foster Home. A private home (including a relative foster home) is located in a typical community neighborhood where others who do not use HCBS also reside **and** is not a private residence owned by an unrelated caregiver who is paid for providing HCBS services to the individual.
- If you select Non-Relative Foster Home, you must check that there is a current IEA in place that demonstrates compliance. If not, it must be completed at the current Home Visit.
- **If neither Setting Type is applicable (i.e., the settings appears to have characteristics that might indicate it is provider owned or controlled), notify your Lead Case Manager within 24 hours**.

If any of the HCBS indicators below are marked "No," notify your Lead Case Manager within 24 hours for appropriate remediation, or immediately if the client appears to be at risk of abuse, neglect, mistreatment or exploitation.

Block 2: Health and Welfare

Tool Question	Suggested Probes
Client shows no sign of/reports no abuse, restraint or coercion?*	• Does the individual report others in the home, including but not limited to the worker, prevent his/her freedom of movement? • Is there any indication that the individual's freedom of movement has been restricted, such as through blocking, manual holding, using non-vehicular seat belts or other restraining devices that are not medically prescribed, including holding or disabling a waiver participant's wheelchair or other mobility device; the use of medication to control behavior or restrict the person's freedom of movement; or enforcing any seclusion that is not for documented infection control purposes. (Exceptions: any method that is routinely used during a medical procedure or any brief blocking or holding to prevent immediate bodily injury.) • Does the individual know the person to contact or the process to make an anonymous complaint? • Is the individual comfortable discussing concerns? • Can the individual file an anonymous complaint? • Was the individual informed that they have the right to an environment free from coercion, restraint, or any restrictive intervention, and how to exercise those rights? • Except to prevent immediate bodily harm,
Client (or authorized representative when indicated) has control over personal resources?*	• Does the individual have a checking or savings account or other means to control his/her funds? • Does the individual have access to his/her funds?

Block 5: Provision of Services

Tool Question	Suggested Probes
Client/caregiver is satisfied with the services received?	• Does the individual express satisfaction with the services being received and the selected provider? • Does the individual know how and to whom to make a request for a new provider? • Do workers ask the individual about needs and preferences, and respect those choices?
Client is treated with dignity and respect?*	• Do workers and others in the home treat the individual with dignity and respect? • Do workers and others in the home converse with the individual in the setting while providing assistance and during the regular course of daily activities? • Do workers and others in the home address the individual in the manner in which the individual would like to be addressed as opposed to routinely addressing individuals as 'hon' or 'sweetie'? • If the individual needs assistance with grooming, is the grooming consistent with his/her preferences? • If the individual needs assistance with dressing, is the dress consistent with his/her

Tool Question	Suggested Probes
	preferences?
Client's maximum level of autonomy and independence are fully supported by provider?*	• Are the individual's needs and interests identified through their input and individual needs assessments? • Are there opportunities for the individual to participate in activities that will assist with increasing maximum mental and physical potential in areas of daily living and self- care? • Does the individual have a choice about with whom to interact? • Does the individual have full access to the home? • Does the setting have characteristics or obstructions that limit the individual's mobility in the setting or if they are present, are there environmental adaptations to ameliorate the obstruction?
Client is afforded privacy for personal care?*	• Is the individual provided privacy for and assisted in self-care and personal hygiene activities? • As appropriate to the individual's needs, is the individual provided privacy for and assisted in other social support services activities? • Does the individual have their own bedroom?
Client has full access to the community as desired?*	• Are the individual's needs and interests for community access identified through their input and individual needs assessments? • As desired, does the individual participate regularly in meaningful non-work activities in integrated community settings? • Does the individual come and go at any time? • Is the individual provided a variety of opportunities for access to and integration in the community, including, but not limited to opportunities to shop, bank, pay bills, participate in community social events, participate in community educational events and engage in interaction with other members of the community not receiving HCBS waiver services? • Does the individual have access to public transportation? Are there bus stops nearby or are taxis available in the area? • Where public transportation is limited, are other resources provided for the individual to access the broader community? • If school-aged, does the individual attend school in the community?
Amount and type of service(s) provided is/are appropriate to meet client needs?*	• Is the individual aware of how to make a service request? • Are requests for services and supports appropriately considered and accommodated (i.e., not ignored or denied without due consideration)?
Client has support to engage in employment if desired?*	• If desired, does the individual work in an integrated community setting? • If the individual would like to work, but does not have a job, is there activity that ensures employment opportunities are pursued?

For additional probes, please review the Exploratory Questions for Residential Settings: https://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/home-and-community-based-services/downloads/exploratory-questions-re-settings-characteristics.pdf

Alabama Department of Senior Services Medicaid Waiver Programs

Case Management Home Visit Tool

(Client Assessment)

○ **Successful Visit** CM successfully conducted a Face-to-Face visit with client

○ **Attempted Visit** CM attempted a Face-to-Face visit but is unable to connect with client

○ **Missed Visit** CM was unable to complete a scheduled Face-to-Face visit on this date

Name of Client	Medicaid Number	Name of Case Manager	Date
Setting Type	☐ Private Home (as defined in cover sheet)	☐ Non- Relative Foster Home (IEA is current) Date_____	
Present During Home Visit:	☐ Primary Caregiver ☐ Service Provider/HA ☐ Family/Friend ☐ Certified CM If so, who? ☐ Other ☐ None		
Caregiver System is:	☐ Supportive ☐ Strained ☐ Adequate ☐ Inadequate ☐ Other If other, describe:		
Type of Visit	☐ Monthly ☐ Recertification/Redetermination ☐ Reinstatement ☐ Other If other, describe:		
Is this form being completed telephonically (via telephone)?	○ Yes ○ No If yes, select reason: ○ AMA Approved ○ Client refused due to COVID-19 concerns If AMA Approved, what is the approval date:		

Health and Safety (client)

	Yes	No	N/A	
Client's physical status is acceptable (no bruises)?				Comments:
Client shows no sign of/reports no abuse, restraint or coercion?*				
Client (or authorized representative when indicated) has control over personal resources?*				
Client is clean?				
Client is free of odor?				
Client is properly groomed?				
Client is dressed appropriately?				
Client reports receiving proper nutrition?				
Is the mental status observed appear normal for the client?				Comments:
Client is alert?				
Client is oriented?				
Client is confused?				
Client exhibits memory impairment?				
Client is hallucinating?				
Client's Gait is:				
Steady without help?				Comments:

	Yes	No	N/A	
Steady with use of assistive device?				
Client reports falling since last visit?				
Critical Incident report filed?				
Additional comments on client condition (i.e. what client is wearing, doing & who is present, probes used to determine status of HCBS indicators marked with asterisk, etc.)				

Medical Equipment

	Yes	No	N/A	
Client needs device/does not have?				Comments:
Client has device/does not use?				
Client's assistive devices are in good working order? (walker, wheelchair, cane, trapeze bar, etc.)				
Client's adaptive devices are in good working order? (ramps, grab bars, etc.)				
Client/caregiver uses specialized equipment (oxygen, blood glucose monitor, nebulizer, etc.) and it is functional?				
Client/caregiver knows how to use the specialized equipment and uses it properly?				
Additional comments on medical equipment... List adaptive devices:				

Health and Safety (home)

Home Environment is:	Yes	No	N/A	
Clean?				Comments:
Safe? (trip/fall/fire hazards)				
Uncluttered?				
Odor free?				
Structurally sound?				
Home has working utilities?				
Refrigerator/freezer is free of expired food?				
Premises are free of infestation?				
Premises provide for privacy based on the client's needs and preferences?				

Alabama Department of Senior Services Medicaid Waiver Programs

Case Management Home Visit Tool

(Client Assessment)

Home Environment is:	Yes	No	N/A	
Additional comments on home condition...i.e. condition of home, rooms inspected, hazards noticed?				

Provision of Services

	Yes	No	N/A	
Client/caregiver is satisfied with the services received?*				Comments:
Client is treated with dignity and respect?				
Client's maximum level of autonomy and independence are fully supported by provider?*				
Client is afforded privacy for personal care?*				
Client has full access to the community as desired?*				
Amount and type of service(s) provided is/are appropriate to meet client needs?*				
Client has support to engage in employment if desired?*				
Have all of the client's needs been addressed? (If no, explain in comments.)				
Client/caregiver was afforded "Freedom of Choice"?				
Client/caregiver is comfortable with the service provider and does not want to make a change?				
Is there a backup plan if the service or meal provider cannot provide services? (If yes, describe plan in comments.)				
How many home delivered meals in freezer?				
Excess home delivered meals? (15+ meals)				
Home delivered meals are utilized properly?				
Are there any issues with the home delivered meals?				
Have the issues been reported?				
Does client have hospice?				
How is hospice paid for? (Medicare, Medicaid, Both, Neither)				
There is an accessible file in the home with the following (current & signed as required) forms:				
1. Service Provider Authorization				Comments:
2. Care Plan				
3. Appeal & Fair Hearing Instructions				
4. Client Rights & Responsibilities				

	Yes	No	N/A	
5. Complaint/Grievance Policy & Procedures				
6. Contact info for CM, DSP, ADSS, AMA, and ASN in folder?				
Additional comments on service provision...i.e. list all waiver & non-waiver services & their frequency, probes used to determine status of HBSC indicators marked with asterisk, etc.)				

Health Update

	Yes	No	N/A	
Client/caregiver has received new (un-reported to the case manager) special dietary instructions?				Comments:
Client was hospitalized since last visit?				
Where?				
How many times has client visited the Emergency Room/Emergency Department since last visit?				
Client saw the physician since last CM visit?				
Physician :	Date Seen :			
Physician :	Date Seen :			
Physician :	Date Seen :			
Physician :	Date Seen :			
Physician :	Date Seen :			
Any changes to client's medications?				
Additional comments on health education...i.e. list most recent medical appointments & specific changes to meds:				

Medicaid Eligibility

	Yes	No	N/A	
Client reports receiving letters/phone calls from AMA about their eligibility?				Comments:
Client reports receiving letters/phone calls from Social Security about losing benefits?				

	Yes	No	N/A	
Additional comments on Medicaid eligibility...i.e. note any/all other correspondence reported by client:				

Case Manager Information

	Yes	No	N/A	
Client/caregiver knows to discuss with\call the CM if there is a concern/problem with services?				Comments:
The CM provided the client with his/her telephone number & with Medicaid's toll free telephone number?				
Client/client's representative knows how to report allegations of abuse, neglect and exploitation?				
The CM provided the client/client's representative with the toll-free number (800-458-7214) to report allegations of abuse, neglect and exploitation?				
The CM discussed "Benefits & Outcomes" of each service with the Client/caregiver?				
The CM informed the Client/caregiver of other available sources of support as needed? (travel vouchers, other agencies/services...etc.)				
The CM discussed the NET Program with Client/caregiver?				
The CM provided the client/client's representative with a copy of :	ICN Brochure ICN Flyer P3 / CARE Plus Materials Resource Directory			
Additional comments:				

(The below may be used in place of the *MW-11 Case Management Verification* form)

Case Management Verification

This is to certify that the below information is true, accurate and complete. I understand that by signing this form, I am certifying to the Alabama Medicaid Agency that I received Case Management services on the date reflected below.

Client/Caregiver Signature

Date Signed

E&D Waiver **ACT Waiver** **TA Waiver**

Form Version: 11

MW-1 **3/2022**

Alabama Department of Rehabilitation Services Medicaid Waiver Programs

Case Management Home Visit Tool Addendum: HCBS Requirements Guidance

SAIL program waiver services are generally provided only in the private homes of participants that are not owned, rented, leased or otherwise controlled by any provider of waiver services. The HCBS Final Settings Rule requires that, regardless of setting, waiver participants must have the opportunity to experience all the benefits of community living. HCBS Case Managers monitor and document participants' experience in all settings, including private homes, to ensure it is consistent with the Rule requirements. Requirements specific to the Rule below require that, during the monthly home visit, the Case Manager will provide specific documentation in the Comments field that show how compliance was determined for all determinations. All questions must be answered Y (Yes) or "N" (No), following the Guidance.

Note: if any of the HCBS indicators are marked "N," notify the SAIL State Office Specialist or Director within 24 hours for appropriate remediation, or immediately if the client appears to be at risk of abuse, neglect, mistreatment or exploitation.

Tool Question	Y/N	Guidance
Confirm the residence is a private home and not provider owned or controlled.		• Is the home is located in a typical community neighborhood where others who do not use HCBS also reside? • If the home is operated or controlled by a provider of waiver services, or is a private residence that owned by an unrelated caregiver who is paid for providing HCBS services to the individual, it is considered provider owned or controlled, and this indicator must be marked "N."
Client shows no sign of/reports no abuse, restraint or coercion?		• Does the individual report others in the home, including but not limited to the worker, prevent his/her freedom of movement? • Is there any indication that: the individual's freedom of movement has been restricted, such as through blocking, manual holding, using non-vehicular seat belts or other restraining devices that are not medically prescribed, including holding or disabling a waiver participant's wheelchair or other mobility device; medication to control behavior or restrict the person's freedom of movement has been implemented; seclusion has been used that is not for documented infection control purposes. (Exceptions: any method that is routinely used during a medical procedure or any brief blocking or holding to prevent immediate bodily injury.) • Does the individual know the person to contact or the process to use to make an anonymous complaint? • Is the individual comfortable discussing concerns? • Can the individual file an anonymous complaint? • Was the individual informed that they have the right to an environment free from coercion, restraint, or any restrictive intervention, and instructed how to exercise those rights?
Client (or authorized representative when indicated) has control over personal resources?		• Does the individual have a checking or savings account or other means to control his/her funds? • Does the individual have access to his/her funds?
Client/caregiver is satisfied with the services received?		• Does the individual express satisfaction with the services being received and the selected provider? Does the individual know how and to whom to make a request for a new provider? • Do workers ask the individual about needs and preferences and respect those choices?
Client is treated with dignity and respect?		• Do workers treat the individual with dignity and respect? • Do workers converse with individuals in the setting while providing assistance and during the regular course of daily activities? • Do workers address individuals in the manner in which the individual would like to be addressed as opposed to routinely addressing individuals as "hon" or "sweetie"? • Do individuals who need assistance with grooming receive grooming consistent with their preferences? • Do individuals who need assistance with dressing receive assistance to dress consistent with their preferences?
Client's maximum level of autonomy and independence are fully supported by provider?		• Are the individual's needs and interests identified through their input and individual needs assessments? • Are there opportunities for the individual to participate in activities that will assist with increasing maximum mental and physical potential in areas of daily living and self-care? • Does the individual have a choice about with whom to interact? • Does the individual have full access to their home (not to include another person's

Tool Question	Y/N	Guidance
		private room)? • Does the setting have characteristics or obstructions that limit the individual's mobility in the setting or if they are present, are there environmental adaptations to ameliorate the obstruction?
Client is afforded privacy for personal care?		• Is the individual provided privacy for and assistance with self-care and personal hygiene activities? • As appropriate to the individual's needs, is the individual provided privacy for and assistance in other social support services activities? • Does the individual have their own bedroom?
Client has full access to the community as desired?		• Are the individual's needs and interests for community access identified through their input and individual needs assessments? • As desired, does the individual participate regularly in meaningful non-work activities in integrated community settings? • Does the individual come and go at any time? • Is the individual provided a variety of opportunities for access to and integration in the community, including, but not limited to opportunities to shop, bank, pay bills, participate in community social events, participate in community educational events and engage in interaction with other members of the community not receiving HCBS waiver services? • Does the individual have access to public transportation? Are there bus stops nearby or are taxis available in the area? • Where public transportation is limited, are other resources provided for the individual to access the broader community? • If school-aged, does the individual attend school in the community?
Amount and type of service(s) provided is/are appropriate to meet client needs?		• Are individuals aware of how to make a service request? • Are requests for services and supports appropriately considered and accommodated (i.e., not ignored or denied without due consideration)?
Comments (Must be provided for all questions):		

For additional probes, please review the Exploratory Questions for Residential Settings: https://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/home-and-community-based-services/downloads/exploratory-questions-re-settings-characteristics.pdf