Attachment to ISP
HCBS Rights Modification Plan
Residential Setting

PART 1: DEMOGRAPHICS AND DESCRIPTION OF NEED
To be completed by the DDD case manager within 14 calendar days from agreement by the ISP team that a modification is warranted.

There may be situations when a participant has health and/or safety needs that may require a modification to their rights and freedoms in a HCBS setting. Modifications should only be considered when no other less restrictive alternatives are available.

Residential settings include Adult Residential Care Homes/Expanded Adult Residential Care Homes, Developmental Disabilities Adult Foster Homes, Developmental Disabilities Domiciliary Homes, Special Treatment Facilities/Therapeutic Living Programs, and provider-owned or controlled residential settings (e.g., a private residence in which the opportunity to participate in a lease or residential agreement requires that the participant receive HCBS from a particular Waiver Provider).

SECTION A:

Participant Last, First Name:		Birthdate:	
Case Manager:		Case Management Unit:	
Modification Period: Provide the start and end dates for the modification (cannot extend one (1) year).			
Modification Start Date:		Modification End Date:	
Check the frequency for periodic reviews.			
☐ Monthly	☐ Quarterly	☐ Semi-Annually	☐ Other: specify (minimum requirement is at the end of the Modification Period)

SECTION B:

1. Check the specific participant right and freedom that may be subject to a modification (check only one). If more than one participant right and freedom requires a modification, a separate Attachment to ISP, HCBS Rights Modification Plan must be developed. The modification must be absolutely necessary based on a specific assessed need, and to ensure the health, safety, and well-being of the participant.	
☐	B1. Right to privacy in the participant's living unit or bedroom including lockable doors and only the participant and appropriate staff have keys to the door(s).
☐	B2. Right to choose a roommate if sharing a living unit or bedroom.
☐	B3. Right to furnish and decorate the living unit or bedroom.
☐	B4. Right to have individualized activities and schedule selected by the participant.

☐	B5. Right to have access to food at any time.
☐	B6. Right to have visitors at any time when visits occur.

2. Describe the specific assessed need that supports the modification to the participant right and freedom. There must be a current health and/or safety need, identified in a formal assessment, and an active need for support to mitigate the risk for a modification to be valid.

- **Describe the current condition or situation.**
- **Describe the specific health and/or safety need.**
- **Describe what makes this a current need (what recent event occurred to drive the need for a modification).**

Note: Historical references, including identification of past events or practices applied are not sufficient to justify a need for a modification. However, a past event (or series of events) coupled with an identification of current, active supports to address or avoid future events, may be used to make a case to support the need for a modification.

3. List the formal assessment, including the name of the assessment, the person who completed and the date completed. This may be an initial assessment or reassessment.

4. Identify setting where modification will be used.

Type of Residential Setting:			
Address of Setting:			
Caregiver Primary Contact (Last, First Name):			
Contact email:		Contact Phone Number:	
Waiver Agency:		Waiver Service:	
Waiver Provider Primary Contact (Last, First Name):			
Contact email:		Contact Phone Number:	

PART 2: IMPLEMENTATION OF MODIFICATIONS
To be completed by the Waiver Provider and returned to the DDD case manager within 30 calendar days of receipt from the DDD case manager.

The Waiver Provider must ensure the modification is implemented in the least restrictive manner necessary to protect the participant, provide support to reduce or eliminate the need for the modification as soon as feasible and provide updates on the implementation and effectiveness of this plan to the participant and DDD case manager when requested.

1. Describe the modification. The description needs to answer the following questions: • **What is the modification?** • **How is the modification proportionate to the health/safety need, including how the modification balances the health/safety needs with the participant's rights to privacy, dignity, respect, autonomy, independence, choice, and community integration and participation?** • **How often will the modification be implemented and by whom?**
2. Describe what has already been tried and other possible options that were ruled out. Include documentation of positive interventions and less intrusive methods that were previously implemented and determined to be ineffective in meeting the health/safety need.
3. Describe the strategies that will be implemented to reduce or eliminate the need for the modification, including development of participant skills and knowledge, additional accommodations, changes in supports, environmental adaptations, assistive technologies, or other approaches.
4. Describe how the effectiveness of the modification will be measured, including the plan and timeframe to collect and review data to measure the ongoing effectiveness of the modification, and to determine if the modification is still necessary or can be terminated. Periodic review must occur at a minimum, at the frequency determined by the ISP team and as identified in Part 1, Section A. ***For example, documentation to review may include observational data, incident reports, progress reports, and other supplemental provider documentation that demonstrates whether the modification should be maintained, reduced, eliminated or replaced.)***
5. Describe the plan for monitoring the safety of the participant and the effectiveness and continued need for the modification. This monitoring can align with other monitoring activities such as service and onsite monitoring. • **Who is responsible for monitoring?** • **How often will monitoring occur (monthly, quarterly, bi-annual, annually)?** • **How will a determination be made that there continues to be a need for the modification?**

☐ **I assure that any intervention and support utilized as part of the modification will cause no harm to the participant.**

Waiver Provider Staff Name:	
Waiver Provider Staff Signature:	Date:

PART 3: APPROVAL

To be completed by the DDD case manager within 7 calendar days from transmittal by the Waiver Provider unless there is additional information that is requested, or the proposed modification is denied.

The case manager must approve the proposed modification by the Waiver Provider and ensure that it is aligned with the participant's assessed needs, modification policy and other applicable policies, and does not reduce the participant's likelihood of goal attainment.

Case Manager Signature:	Date:

PART 4: CONSENT

To be completed by the participant and legal representative, if applicable

Participant Informed Consent and Signature(s):

The reason for a modification of my rights has been explained to me in a way that I understand.
I understand how the modification will happen to ensure my health, safety, and well-being.
I can ask my case manager for a review discussion on a modification at any time.

☐ **I consent to the modification(s) of my rights as identified and described in this plan, which is part of my Individualized Service Plan (ISP).** I understand that I may withdraw my consent at any time. If I withdraw my consent, I understand that my rights must be immediately and fully restored.

☐ **I refuse to allow my rights to be modified.** I understand that my health, safety, and well-being may be at risk. My case manager and my team, including my Waiver Provider(s), will need to determine if my health, safety, and well-being can be supported in this setting without the listed modification(s).

Participant Signature:	Date:
Legal Representative Signature:	Date:
Legal Representative Name:	