

SECTION 5:
APPENDICES & RESOURCES

FOR USE WITH
MEDICAID I/DD WAIVER STANDARDS
EFFECTIVE July 1, 2026

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TABLE OF CHANGES

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10	1	Definitions	Updated definitions
20	2	Acronyms & Abbreviations	Added Personal Care Assistance (PCA) and Residential Care Supports (RCS)
25	3	Assistance Directory	Added DOH-DDD EVV email address Updated address for DOH-DDD Case Management Branch Updated link to Hawaii Medicaid Application Updated link to DHS-MQD Medicaid eligibility verification Updated Address for Medicaid Fraud Control Unit Office of the Attorney General
39	4B	P&P #2.02 Restrictive Interventions	Updated P&P
57	4D	Nurse Delegation	Updated sample form and added Delegation Plan sample form
96	4F	Seizure Action Plans	Updated link to Seizure Action Plans
98	4H	Conflict of Interest Form	Added sample form
105	5B	Report Form for Suspected Abuse and Neglect of Vulnerable Adults	Updated link Added link

Page	Appendix	Document	Summary of Change
		Guidelines for mandated Reporters	
107	5C	Mandated Reporter Checklist for Suspected Child Abuse and Neglect	Updated link
107	5D	Guide for Mandated Reporters	Updated link
131	6	6A: Medicaid Application/Change Request	Updated link to DHS 1139
133	7	7A: Request for List of Employees Letter	Added sample form
134	7	7B: Validation List of Employees and Independent Contractors Form	Added sample form
135	7	7C: Selected List of Employees Letter	Added sample form
136	7	7D: Completed Verification Letter	Added sample form
137	7	7E: CAP for Validation	Added sample form
139	7	7F: CAP Status Letter for Satisfactory CAP	Added sample form
141	7	7G: CAP Status Letter (Unsatisfactory CAP)	Added sample form
134	7	7H: Partial Suspension Letter	Added sample form
145	7	7I: Full Suspension Letter	Added sample form
147	7	7J: Completed Validation List of Employees Form	Moved to 7J (formerly 7H)
148	7	7K: Attestation Form for High School Diploma and General Equivalency Degree	Updated title of form Moved to 7K (formerly 7I)
150	7	7L: Attestation Form for Service Supervisor	Added sample form
151	7	7M: Attestation Form for List of Excluded Individuals/Entities	Added sample form
152	7	7N: Attestation Form for Excluded Individuals	Added sample form

Page	Appendix	Document	Summary of Change
153	7	7O: Hyperlinks to Resources for Required Clearances	Updated link to HAR Title 11, Department of Health Chapter 164.2, Tuberculosis and link to TB Clearance Manual Moved to 7O (formerly 7J)
157	8	8A: QA Review Letter to Schedule	Added sample letter
159	8	8B: QA Review Results Letter	Added sample letter
160	8	8C: QA Review Results Letter (CAP Required)	Added sample letter
161	8	8D: QA/I Provider Monitoring Tool	Add sample score sheet and link to current version revised June 2026
162	8	8E: CAP Status Letter for Satisfactory CAP	Added sample letter
164	8	8F: CAP Status Letter (Unsatisfactory CAP)	Added sample letter
166	8	8G: CAP Status Letter (No CAP Received)	Added sample letter
168	8	8H: First Notice: Non-Compliance Sanction Letter	Added sample letter Moved to 8H (formerly 8I)
170	8	8I: Second Notice: Non-Compliance Sanction Letter	Added sample letter Moved to 8I (formerly 8J)
172	8	8J: Individual Plan (IP) and Quarterly Report Instruction Guide	Added link to instruction guide
173	8	8K: Attestation Form for Emergency Preparedness Plan	Added sample form
174	8	8L: Settings Evidence Template	Added sample template
175	8	8M: Attestation Form for Settings Evidence	Added sample form
176	8	8N: Attestation Form for Quality Management Plan	Added sample form

Page	Appendix	Document	Summary of Change
177	8	8O: On-Site Audit Notification Letter	Updated sample letter Moved to 8O (formerly 8K)
179	8	8P: Desk Audit Notification Letter	Updated sample letter Moved to 8P (formerly 8L)
181	8	8Q: Fiscal Audit Checklist	Updated sample letter Moved to 8Q (formerly 8M)
182	8	8R: Fiscal Audit Report	Updated sample letter Moved to 8R (formerly 8N)
183	8	8S: Notice of Fiscal Audit Results Letter	Updated sample letter Moved to 8S (formerly 8O)
185	8	8T: Review of Informal Appeal Letter	Updated sample letter Moved to 8T (formerly 8P)
188	8	8U: Recoupment Letter	Updated sample letter Moved to 8U (formerly 8Q)
191	9	9A: AFH Supplemental Payment Request Form	Added sample form
192	9	9B: CIE Attestation Form	Added sample form
195	10	10A: Interest Inventory	Moved to 10A (formerly 9A)
197	11	11A: Discovery & Career Planning Pathway	Updated sample and link. Moved to 11A (formerly 10A)
200	11	11B: Benefits Counseling Profile	Moved to 11B (formerly 10B)
201	11	11C: Discovery and Career Planning Profile 1	Moved to 11C (formerly 10C)
203	11	11D: Discovery and Career Planning Profile 2	Moved to 11D (formerly 10D)
216	11	11E: Discovery and Career Planning Profile 3	Moved to 11E (formerly 10E)
225	12	12A: State Medicaid Agency Responsibilities	Moved to 12A (formerly 11A)
227	12	12B: State Operating Agency Responsibilities	Moved to 12B (formerly 11B)

Page	Appendix	Document	Summary of Change
229	12	12C: Waiver Provider Responsibilities	Moved to 12C (formerly 11C)
230	13	13: I/DD Waiver Services and Schedule of Rates	Updated link to Medicaid Waiver Services I/DD Waiver Services Schedule of Rates Moved to 13 (formerly 12)
232	14	14: Hyperlinks to Hawaii Administrative Rules (HAR)	Updated chapter and link to Hawaii Administrative Rules (HAR) Title 11 Department of Health Chapter 148.1 “Certification of Adult Foster Homes”

APPENDIX 1: DEFINITIONS

DEFINITIONS

“Abuse” – means actual or imminent physical, psychological abuse or neglect, sexual abuse, financial exploitation, negligent treatment, or maltreatment, as further defined in Hawaii Revised Statutes (**HRS**) § 346-222.

“Activities of Daily Living” (ADLS) – means activities related to personal care including, but not limited to, bathing, dressing, toileting, transferring, and eating.

“Adjusted Claims” – means that for each adjusted claim, the new allowed amount is listed first with the previous amount paid to the provider subtracted from the new allowed amount. A new net paid amount is then calculated which may result in additional payment to or a recoupment from the provider.

“Adult Foster Home” (AFH) – shall have the same meaning as defined in HRS § 321-11.2.

“Adult Residential Care Home” (ARCH) – means any facility licensed under Title 11, Chapter 100.1, HAR that provides twenty-four (24) hour living accommodations, for a fee, to adults who are unrelated to the family and who require at least minimal assistance in the activities of daily living, but who do not need the services of an intermediate care facility. It does not include facilities operated by the federal government. There are two types of ARCHs:

Type I home for five or less residents; and

Type II home for six or more residents.

“Adverse Event” – means any incident or event that may have quality of care implications for participants, including, but not limited to:

- 1) changes in the participant's condition requiring medical treatment;
- 2) hospitalization of the participant;
- 3) death of the participant;
- 4) all bodily injuries sustained by the participant for which medical treatment (i.e., treatment rendered by a physician, nurse practitioner, ambulance or emergency medical personnel, or emergency room medical staff) and/or follow up is necessary, regardless of cause or severity;
- 5) all reports of abuse and neglect made to DHS-Adult Protective Services (APS) and/or DHS-Child Protective Services (CPS);
- 6) all medication errors and unexpected reactions to drugs or treatment;

- 7) situations where the participant's whereabouts are unknown; or
- 8) situations where participant's behavior requires plan of action or intervention.

“Aversive Procedures” – means procedures intended to inflict pain, discomfort and/or social humiliation in order to modify behavior. These include but are not limited to, electric skin shock, liquid spray to one's face and strong, non-preferred tastes applied in the mouth. Aversive Procedures are prohibited and shall not be used with DOH-DDD participants.

“Behavior Support Plan” (BSP) – is a written plan for the team members who are supporting the person who is engaging in behaviors perceived as challenging. The BSP outlines:

- 1) the steps that will be taken by the members of the person's team to modify the physical environment;
- 2) what replacement skills should be taught to the participant and how to do so;
- 3) the ways in which team members should respond to challenging behaviors, and;
- 4) ways in which team members can decrease the likelihood of challenging behaviors occurring.

BSP is developed based on the results of a Functional Behavior Assessment (FBA) – see definition of FBA.

“Behavioral Support Review Committee” (BSRC) – is the committee that will review BSPs that propose the use of restrictive interventions to address challenging behaviors that pose an imminent risk of harm to the participant or others.

“Benefit Counseling” – means a service that promotes work preparation by examining current disability benefits and assisting the individual and family to understand the impact of increased income on those benefits.

“Case Management Services” – means services defined in HRS § 333F-1 and HAR Title 17, Chapter 1738 including case assessment, case planning, and on-going monitoring and service coordination to persons with developmental and intellectual disabilities.

“Case Manager” (CM) – means DOH-DDD-CMB case manager who provides targeted case management services as defined in HAR Title 17, Chapter 1738.

“Circle of Supports” – means the participants' family, friends, and other persons identified by the participant as being important to the planning process. The Circle of Supports are defined in the Individualized Service Plan (ISP).

“Claim” – means a legal document submitted to Medicaid or its fiscal agent for payment.

“Case Management Branch” (CMB) – means the organizational entity under DOH-DDD that is responsible for provision of case management services.

“Centers for Medicare & Medicaid Services” (CMS) – means the federal entity authorized to administer and oversee Medicaid programs.

“Community Resources Branch” (CRB) – means the organizational entity under DOH-DDD that is responsible for identifying, directing and operating a statewide capacity of resource development, administration and management of services and supports for persons with intellectual and developmental disability (I/DD), and support to their families or guardians. CRB is responsible for monitoring all agency providers under the Medicaid I/DD Waiver Program.

“Denied Claims” – means claims that were not paid due to participant eligibility, benefit limitations or claim submission reasons. Denied claims are listed in the “Denied Claims” section of the Remittance Advice (RA) with the corresponding denial reason code(s). Denied claims will not be paid or returned to providers. The RA is the only notification of claim denial.

“Developmental Disabilities Domiciliary Home” (DD Dom) – shall have the same meaning as defined in HRS §321-15.9.

“Developmental Disabilities” – means a severe, chronic disability of a person which, as defined -in HRS §333F-1:is attributable to a mental or physical impairment or combination of mental and physical impairments;

- 1) is manifested before the person attains age twenty-two;
- 2) is likely to continue indefinitely;
- 3) results in substantial functional limitations in three or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic sufficiency; and
- 4) reflects the persons' need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services which are of lifelong or extended duration and are individually planned and coordinated.

An individual from birth to age nine who has substantial developmental delay or specific congenital or acquired condition may be considered to have a developmental disability

without meeting three or more of the criteria described above, if the individual without services and supports, has high probability of meeting those criteria later in life.

“Direct Support Worker” (DSW) – means a staff hired by the provider in accordance with the standards to provide services under the Medicaid I/DD Waiver as specified in the Individual Plan (IP).

“Department of Health, Developmental Disabilities Division” (DOH-DDD) – means the developmental disabilities division, department of health, State of Hawaii.

“Expanded Adult Residential Care Home” (E-ARCH) – means a category of an adult residential care home licensed under HAR Title 11, Chapter 100 that provides twenty-four (24) hour living accommodations, for a fee, to adults unrelated to the family, and that is qualified to serve nursing facility level residents. There are two types of extended care ARCHs:

- 1) Type I home that consists of five or less residents with no more than two nursing facility level residents; and
- 2) Type II home that consists of six or more residents with no more than ten percent of the home's licensed capacity as nursing facility level residents.

“Family Member” – means the biological, adoptive, step, in-law, or “hanai” father, mother, brother, sister, son or daughter, and grandfather or grandmother.

“Financial Literacy” – means a practical financial knowledge to access, save, budget, avoid debt, spend wisely, invest, donate, and manage other aspects of financial decision-making to enhance an individual’s quality of life.

“Functional Behavioral Assessment” or “FBA” – means the process of determining the functions, or understanding the origins of a challenging behavior.

“Hanai” – is a Hawaiian word which means that a child is permanently given to be reared, educated and loved by individual(s) other than the child’s natural parents at the time of the child’s birth or early childhood. The child is given outright, and the natural parents renounce all claims to the child.

“Individual Plan” (IP) – means a written plan that is developed and implemented by a provider within thirty (30) calendar days of the Individualized Service Plan (ISP) meeting and prior to implementation, which delineates the specific activities that the provider should do to meet the goals, objectives, and outcomes specified in the ISP.

“Individualized Service Plan” (ISP) – means the written plan that is required by HRS § 333F-6 and that is developed by the individual, with the input of family, friends, and other persons

identified by the individual as being important to the planning process. The ISP shall be a written description of what is important to the person, how any issue of health or safety shall be addressed, and what needs to happen to support the person in the person's desired life.

“Instrumental Activities of Daily Living” (IADLs) – means more complex life activities such as light housework, laundry, meal preparation, transportation, grocery shopping, using the telephone, managing one’s medication, and money management.

“Intellectual Disability” – means significantly subaverage general intellectual functioning resulting in or associated with concurrent moderate, severe, or profound impairments in adaptive behavior and manifested during the developmental period (HRS § 333F-1).

“Intermittent and Part-Time” – means occurring at irregular intervals, sporadic and not continuous.

“Legal Representative” – means the person that is legally allowed to act on behalf of the Participant if the Participant is unable to act on behalf of themselves.

“Licensed Practical Nurse” (LPN) – means a person licensed as a practical nurse by the State of Hawaii, pursuant to HRS Chapter 457.

“Licensed Behavior Analyst” (LBA) – is an individual licensed under HRS Chapter 465D.

“Measurable” – means to describe an objective or task in terms that delineate when the participant has accomplished the objective or task. It means it is quantifiable, material, quantitative, assessable, determinable, computable or gauge-able.

“Medication Administration Records” (MAR) - is a written legal document that provides for the specific documentation of all prescribed medications and supplements that are provided by the waiver worker to a participant during Medicaid Waiver service hours.

“Medicaid Waiver for Individuals with Intellectual and Developmental Disabilities” (Medicaid I/DD Waiver) – means the home and community-based services program authorized under section 1915(c) of the Social Security Act.

“Medicaid Waiver Services” – means the home and community-based services that are defined and approved in Hawaii’s Medicaid I/DD Waiver.

“Medical Treatment” – means treatment that is rendered by a physician, physician assistant, nurse practitioner, ambulance or emergency medical personnel, or emergency room medical staff.

“Med-QUEST Division” (MQD) – means a DHS organizational entity that is the state Medicaid agency for the State of Hawaii.

“Moratorium” – means the DDD’s prohibition against a provider providing services to a new Medicaid I/DD Waiver participant.

“Natural Supports” – means supports that are available to the participant within the family, circle of supports, and community and that are unpaid.

“Nursing Delegation Plan” – A plan that identifies the specific nursing tasks that are to be delegated by the Registered Nurse (RN) to the unlicensed direct support worker (DSW) and to provide a specific guideline and signed documentation that training of every DSW has occurred and for every delegable nursing task provided. It is developed for each Participant receiving nursing delegated tasks via Medicaid I/DD Waiver.

“Oversight and Monitoring” – is provided by a Service Supervisor:

- (1) at the site or location where services are rendered;
- (2) in the presence of the direct support worker (DSW) and the participant receiving services and
- (3) while the participant is receiving services as specified in the IP

“Outcomes and Compliance Branch” – is responsible for the DDD’s quality assurance and improvement program statewide, which include monitoring and evaluating program services, supports, and outcomes for individuals with intellectual disabilities and developmental disabilities (I/DD).

“Paid Claims” – are claims which Medicaid has made payment, and are listed in the “Paid Claims” section of the RA. The allowed amount for each paid claim is listed first followed by any deductions to calculate which may result in additional payment to or a recoupment from provider.

“Participant”– means a person with an intellectual and/or developmental disability who receives services from the DDD. .

“Person-Centered Planning” – means an on-going process directed by the participant that helps individuals in his or her circle learn how the participant wants to live and describe what supports are needed to help the participant move toward a life considered meaningful and productive.

“Physician” – means a person who is licensed to practice medicine or osteopathy in Hawaii under HRS Chapter 453 or 460.

“Positive Behavior Support” (PBS)– means a process for addressing challenging behaviors by understanding the relationships between a person’s behavior, communication and aspects of his or her environment. It offers strategies to modify the environment and interactions in order to prevent the occurrence of these behaviors; teaches skills to replace challenging behaviors;

outlines responses to challenging behaviors to reduce the likelihood that these behaviors will reoccur in the future; and offers proactive and functional strategies to promote a positive lifestyle change. Positive Behavior Support strategies are included in Behavior Support Plans (BSPs).

“Behavior Support Plan” (BSP) – means a written plan of action in response to situations involving challenging behavior. A behavior support plan (BSP) is also known as a behavioral intervention plan.

“Primary Caregiver” – means the caregiver living in the home with the participant who has primary responsibility for the participant’s care and well-being.

“Prior Authorization” (PA) – means a process by which health plans, program contractors, and the Med-QUEST Division determines in advance whether a medical service is appropriate and will be covered for payment. All approved Medicaid waiver services written into the ISP will be authorized by the DOH-DDD-CM. The provider shall receive a prior authorization (PA) notice before the delivery of service.

“Provider Agreement” – means the agreement detailing the conditions for participation in the Medicaid I/DD Waiver that is executed by the authorized representative of the provider and the authorized representative of DHS.

“Provider” – means an individual or agency delivering a service authorized through DDD inclusive of Consumer Directed services.

“Readily Available” – means the duration of the on-site monitoring visit or if a desk audit, by the due date.

“Registered Nurse” (RN) – means a person who is licensed as a registered nurse in the State of Hawaii pursuant to Chapter 457, HRS.

“Remittance Advice” (RA) – means a document that accompanies the weekly Medicaid payment to providers and reports all processed claims whether they are paid, denied, pending or in process, as well as all claim adjustments.

“Restraints” – means interventions (chemical, mechanical, or physical methods) used to limit an individual’s movement or level of consciousness. Refer to Policy #2.02 on Restrictive Interventions.

- 1) **“Chemical Restraint”** means any administration of a medication or chemical substance that restricts freedom of movement or alters the level of consciousness to a degree that is not in accordance with the prescribed and approved indications for treatment of the condition.

- 2) **“Mechanical Restraint”** means devices, materials, or equipment involuntarily applied to the participant’s body or immediate environment that immobilizes, restricts, or reduces bodily movement.
- 3) **“Physical Restraint”** or **“Personal Restraints”** means any intervention in which physical force is applied to the participant and involuntarily restricts their freedom of movement or normal access to portion or portions of their body.

“Restrictive Procedures” or “Restrictive Interventions” – means a practice that limits a person’s freedom of movement, access to other locations, property, individuals or rights. This includes, but is not limited to, Chemical, Mechanical, and Physical Restraints.

“Satisfactory Skills Verification” – means verification of skills determined by an appropriate Service Supervisor or delegating professional as defined in these standards and special tasks of nursing care, if applicable, to ensure competency in implementing the IP.

“Seclusion” – means the involuntarily confinement of an individual alone in a room or area from which The individual is physically prevented from leaving.

“Service Supervisor” – means an individual identified by the provider who has responsibility for programmatic, administrative, personnel, and contract compliance.

“Sharps Container” – means a rigid, puncture resistant, disposable container with a lid and a prominent biohazard label indicating needle container. The container shall be closable, leak-proof on sides and bottom, easily accessible, and maintained upright throughout use. The container shall be replaced routinely and not allowed to overfill.

“Sharps” or “Sharps Material” – means needles, scalpel blades, skin lancets, bleeding time devices, and any other material that can easily puncture the skin and should be handled with extreme caution.

“Special Task of Nursing Care” or “Special Tasks” – means a procedure that requires nursing education or that requires nursing education and training in order to be performed safely. Refer to HAR Title 16, Chapter 89, Sub chapter 15 (Delegation of Special Tasks of Nursing Care to Unlicensed Assistive Personnel).

“Stabilized in Place” – means the participant has had no further crisis situations, police contact or hospital visits between Crisis Mobile Outreach (CMO) and follow-up call.

“Voided Claims” – means the allowed amount listed as a negative amount and any previous deductions will be added to the allowed amount on the RA. As a result, the net paid amount is the amount to be recouped from the provider.

APPENDIX 2: ACRONYMS & ABBREVIATIONS

ACRONYMS & ABBREVIATIONS

Acronym / Abbreviation	Definition
§	Section
ACS	Administrator Certification Section
ADA	American Disabilities Act
ADH	Adult Day Health
ADL	Activity of Daily Living (one)
ADLs	Activities of Daily Living (two or more)
AER	Adverse Event Report
AFH	Adult Foster Home
APRN	Advanced Practice Registered Nurse
APS	Adult Protective Services
ARCH	Adult Residential Care Home
AT	Assistive Technology
AVRS	Automated Voice Response System
BPQY	Benefits Planning Query
BSP	Behavior Support Plan
BSRC	Behavioral Support Review Committee
CAN	Child Abuse Neglect
CAP	Corrective Action Plans
CESP	Certified Employment Support Professional
CFR	Code of Federal Regulations
CIT	Clinical Interdisciplinary Team
CLS	Community Learning Services
CM	Case Manager
CMB	Case Management Branch
CMO	Crisis Mobile Outreach
CMS	Centers for Medicare & Medicaid Services
CPA	Certified Public Accountant
CPI	Crisis Prevention Institute
CPR	Cardiopulmonary Resuscitation
CRB	Community Resources Branch
CTH	Crisis Telephone Hotline
CWS	Child Welfare Services
DCP	Discovery & Career Planning
DD	Developmental Disabilities
DD AFH	Developmental Disabilities Adult Foster Home
DD Dom	Developmental Disabilities Domiciliary Home

Acronym / Abbreviation	Definition
DDD	Developmental Disabilities Division within the Hawaii DOH
DHS	Hawaii Department of Human Services
DHS-MQD	Department of Human Services – Med-QUEST Division
DMO	DHS Medicaid Online
DOH	Hawaii Department of Health
DOH-DDD	Department of Health – Developmental Disabilities Division
DOH-DDD-CRB	Department of Health – Developmental Disabilities Division – Community Resources Branch
DOH-OHCA	Department of Health – Office of Health Care Assurance
DSW	Direct Support Worker
DSW-CD	Direct Support Worker – Consumer Directed
E-ARCH	Expanded Adult Residential Care Home
e-Crim	Hawaii’s Adult Criminal Information
EAA	Environmental Accessibility Adaptation
EFT	Electronic Fund Transfer
EPSDT	Early Periodic Screening Diagnosis and Treatment
EVV	Electronic Visit Verification
FBA	Functional Behavioral Assessment
FDA	Food Drug Administration
GT	Gastrostomy
HAR	Hawaii Administrative Rules
HCBS	Home and Community Based Services
HIePRO	State of Hawaii Procurement
HIPAA	Health Insurance Portability & Accountability Act
HRS	Hawaii Revised Statutes
IADL	Instrumental Activities of Daily Living
ICAP	Inventory for Client and Agency Planning
ICE	In Case of Emergency
ICF-IID	Intermediate Care Facility for Individuals with Intellectual Disabilities
ID	Intellectual Disabilities
I/DD	Intellectual and Developmental Disabilities
IEP	Individualized Educational Plan
IES	Individual Employment Supports
IP	Individual Plan

Acronym / Abbreviation	Definition
ISP	Individualized Service Plan
IV	Intravenous
LCSW	Licensed Clinical Social Worker
LMFT	Licensed Marriage and Family Therapist
LMHC	Licensed Mental Health Counselor
LOC	Level of Care
LP	Licensed Psychologist
LPN	Licensed Practical Nurse
LTC	Long Term Care
MAR	Medication Administration Record
MD	Medical Doctor
MQD	Med-QUEST Division within the Hawaii DHS
NG	Nasogastric
NOA	Notice of Action
OHCA	Office of Health Care Assurance
OHS	Out-of-Home Stabilization
OT	Occupational Therapy
OTC	Over-the-Counter
PA	Physician Assistant
PAB	Personal Assistance/Habilitation
P&P	Policies & Procedures
PBS	Positive Behavioral Supports
PCA	Personal Care Assistance
PERS	Personal Emergency Response System
PICC	Peripherally Inserted Central Catheter
PRN	Pro Re Nata (circumstances or as the circumstance arises)
PT	Physical Therapy
PUC	Public Utilities Commission
QA	Quality Assurance
QA/I	Quality Assurance/Improvement
QI	QUEST Integration
QAIP	Quality Assurance and Improvement Program
RBT	Registered Behavior Technician
RCA	Residential Care Supports
ResHab	Residential Habilitation
RN	Registered Nurse
SIS	Supports Intensity Scale

Acronym / Abbreviation	Definition
SMES	Specialized Medical Equipment & Supplies
SSDI	Social Security Disability Insurance
SSI	Supplemental Security Income
SSP	State Supplemental Payment
STF	Special Treatment Facility
TB	Tuberculosis
T&C	Training & Consultation
TLP	Therapeutic Living Program
TPN	Total Parenteral Nutrition
TST	Tuberculin Skin Test
U.S.C.	United States Code

APPENDIX 3: ASSISTANCE DIRECTORY

ASSISTANCE DIRECTORY

AGENCY	ADDRESS	PHONE/EMAIL
DOH-DDD Application Provider Address Changes	DOH-DDD-Community Resource Branch Diamond Head Health Center 3627 Kilauea Ave., Rm. 411 Honolulu, HI 96816	(808) 733-2135
DHS-MQD Hawaii Fiscal Agent - Conduent	Conduent P.O. Box 1220 Honolulu, HI 96807	(808) 952-5570 Oahu 1-800-235-4378 Neighbor Islands
DHS-MQD Medicaid Provider Enrollment	DHS Med-QUEST Division Health Care Services Branch Provider Enrollment 601 Kamokila Boulevard, Room 506A Kapolei, Hawaii 96707 Become a Medicaid Provider	(808) 692-8099 (808) 692-8087 (fax) HCSBInquiries@dhs.hawaii.gov
DHS-MQD Electronic Visit Verification (EVV)	DHS Med-QUEST Division Health Care Services Branch Electronic Visit Verification P.O. Box 700190 Kapolei, HI 96709 Electronic Visit Verification (EVV)	(808) 692-8087 (fax) EVV-MQD@dhs.hawaii.gov
DOH-DDD Electronic Visit Verification (EVV)		DDDEVV@doh.hawaii.gov
DOH-DDD Case Management Branch (CMB)	DOH-DDD CMB 2201 Waimano Home Road, Hale C Pearl City, HI 96782	(808) 733-9172
DOH-DDD Community Resource Branch (CRB)	DOH-DDD-CRB Diamond Head Health Center 3627 Kilauea Avenue, Rm. 411 Honolulu, HI 96816	(808) 733-2135

AGENCY	ADDRESS	PHONE/EMAIL
DOH-DDD Division	DOH-DDD Division Office 1250 Punchbowl Street, Rm. 463 Honolulu, HI 96813	(808) 586-5840
DHS-MQD Medicaid Eligibility or Enrollment Inquires	DHS Med-QUEST Division Customer Services P.O. Box 700190 Kapolei, HI 96709 Hawaii Medicaid Application	1-800-316-8005 1-877-628-5076
DHS-MQD Medicaid Eligibility Verification	Medicaid Online Providers must create an account using Medicaid ID#.	
Department of the Attorney General Criminal Justice Division Medicaid Fraud Control Unit Medicaid Provider, Care Facility, or Caregiver Fraud Reporting	Medicaid Fraud Control Unit Office of the Attorney General 707 Richards Street, Suite 402 Honolulu, HI 96813 Medicaid Fraud Control Unit	(808) 586-1058 (808) 586-1077 (fax)
Department of the Attorney General Criminal Justice Division Medicaid Fraud Control Unit Medicaid Beneficiary Fraud Reporting	Medicaid Fraud Control Unit	(808) 586-1160 FRAUD HOTLINES • Oahu: (808) 587-8444 • Big Island: (808) 933-8899 • Kauai: (808) 241-7106 • Maui: (808) 243-5840

QUEST INTEGRATION HEALTH PLAN

HEALTH CARE PLAN	PHONE	WEBSITE
AlohaCare	1-877-973-0712	Alohacare.org
HMSA	1-800-440-0640	Hmsa.com
Kaiser Permanente	1-800-651-2237	Kpinhawaii.org
Ohana Health Plan	1-888-846-4262	Ohanahealthplan.com
United Healthcare Community Plan	1-888-980-8728	Uhcommunityplan.com/hi

APPENDIX 4:

PARTICIPANT SAFEGUARDS

APPENDIX 4A: P&P #2.01 POSITIVE BEHAVIOR SUPPORTS



STATE OF HAWAII
DEPARTMENT OF HEALTH
P. O. BOX 3378
HONOLULU, HI 96801-3378

DEVELOPMENTAL DISABILITIES DIVISION

TITLE: Positive Behavior Supports

Policy #: 2.01

PURPOSE:

Historically interventions used for people with intellectual and developmental disabilities (I/DD) have been unacceptably intrusive, focused primarily on punitive consequences, inappropriate for integrated settings, and/or ineffective in producing meaningful changes. Positive Behavior Supports (PBS) are preferable because they are effective in improving behavior and quality of life for people with behavioral challenges. The Developmental Disabilities Division (DDD) is committed to using approaches that will increase the safety, independence and overall well-being of participants receiving services. While the goal of this policy is to safely support participants who may engage in challenging behaviors, it also strives to promote participants' engagement in integrated activities.

The fundamental features of this policy include a foundation built on person-centered values, a commitment to outcomes that are meaningful, and services individualized to each participants' unique interests and strengths. The primary purposes of this policy are to commit to approaches that embrace the unique strengths and challenges of each participant, and engage each participant's circle of support as partners in developing and implementing PBS using least restrictive interventions. When a participant presents behaviors that put them at imminent risk of hurting themselves or others, PBS shall be used, whenever possible, to decrease the behaviors that pose a risk. When PBS techniques have been used and are not effective in resolving the immediate risk of harm, restrictive interventions that involve temporary restrictions may be necessary (*refer to Policy 2.02, Restrictive Interventions*). Behavioral support plans (BSP) containing restrictive interventions are the least desirable approach to supporting participants and should only be utilized for the protection of the participant and others. Ultimately, this policy sets forth the core values of supporting participants to the best of their abilities by expanding opportunities and enhancing quality of life using PBS approaches.

DEFINITIONS:

"Behavior Support Plan" or "BSP" is a written plan for the team members who are supporting the person who is engaging in behaviors perceived as challenging. The BSP outlines:

1. Steps that will be taken by the members of the person's team to modify the physical environment;
2. What replacement skills should be taught to the participant as well as how to do so;

3. Ways in which team members should respond to challenging behaviors; and
 4. Ways in which team members can decrease the likelihood of challenging behaviors.
- The BSP is developed based on the results of a Functional Behavior Assessment (see definition below). As BSPs include Positive Behavior Support approaches (see definition below), a BSP may also be referred to as Positive Behavior Support Plan or PBS Plan.

“Functional Behavior Assessment” or “FBA” means the process of determining the functions, or reasons why a person is engaging in challenging behaviors, and to understand the conditions in which challenging behaviors occur. The FBA involves collecting data to identify patterns or trends and to develop a hypothesis of conditions that trigger and/or maintain these behaviors prior to developing a behavior support plan.

“Person-Centered Planning” means an ongoing process directed by the participant that helps individuals in his or her circle learn how the participant wants to live and describes what supports are needed to help the participant move toward a life considered meaningful and productive.

“Positive Behavior Supports” or “PBS” is a process for addressing challenging behaviors by understanding the relationships between a person’s behavior, communication, and aspects of his or her environment. It offers strategies to modify the environment and interactions in order to prevent the occurrence of these behaviors; teaches skills to replace challenging behaviors; outlines responses to challenging behaviors to reduce the likelihood that these behaviors will reoccur in the future; and offers proactive and functional strategies to promote a positive lifestyle change. Positive Behavior Supports strategies are included in Behavior Support Plans (BSPs).

“Trauma Informed Care” or “TIC” is a developmentally appropriate, strengths-based approach that creates opportunities for people who have experienced trauma to rebuild a sense of control and empowerment. TIC is grounded in an understanding of and responsiveness to the impact of trauma and emphasizes physical, psychological, and emotional safety for both providers and survivors. It involves vigilance in anticipating and avoiding institutional processes and individual practices that are likely to maintain and/or exacerbate the impact(s) of trauma and/or re-traumatize individuals who have histories of trauma. It upholds the importance of consumer participation and choice in the development, delivery, and evaluation of services. When appropriate for a participant, TIC recognizes trauma recovery as a primary goal of treatment which involves systems integration and a basic understanding of trauma, triggers, and the impact trauma may have had on a participant’s development and coping.

CORE PRINCIPLES:

PBS methods should be the primary interventions used to maintain the safety of participants and others, promote the independence of participants, and safely support participants who engage in challenging behavior(s). The following principles serve as the foundation for guiding and implementing PBS interventions with participants:

- A. **Respect:** All participants must be treated with respect and dignity. All interventions must be free from practices or interactions that are degrading, humiliating, painful, or harmful.

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- B. **Least Restricted Intervention:** Ensure that the most proactive, effective, and least intrusive methods are utilized.
 - C. **Person-Centered Services:** Specific needs of each participant are identified based on an individualized assessment that incorporates the preferences, values, lifestyles, strengths and abilities, and social circumstances of the participant.
 - D. **Most Integrated Setting:** A setting that enables participants with disabilities to interact with non-disabled persons to the fullest extent possible.
 - E. **Meaningful Activities:** Participation in meaningful and purposeful activities that are interesting and motivating as determined by the participant.
 - F. **Independence:** Participants learn functional skills, which are used in their daily routine and necessary to participate in the community in order to enhance their quality of life.
 - G. **Individualization:** Behavioral interventions are designed to meet the unique and individual needs of the participant.
 - H. **Choice:** Encourage individual choice in daily decision-making.
 - I. **Access to Services:** Participants should have timely access to quality services.
 - J. **Family Support:** It is essential for the circle of support members, particularly family and caregivers, to participate as partners in the design of behavioral interventions. Families and/or caregivers may often need continuous support when developing and/or implementing behavioral interventions.
 - K. **Cultural Competency:** Support of a participant should incorporate the priorities and needs of the individual as well as his/her cultural and ethnic backgrounds and values.
 - L. **Collaboration:** Effective change is achieved through the circle of support working together to understand the goals and recommended strategies. Collaboration ensures that members of the circle have adequate resources and support to consistently implement the recommendations.
 - M. **Consistency:** Ensure consistency and continuity between and within services. The behavioral supports must be compatible and sustainable with existing routines in the participant's natural environment.
 - N. **Communication:** Involve all members of the participant's circle of support, including but not limited to family members, caregivers, friends, service supervisors and direct support staff. Ensure clear communication of the interventions to those directly involved.
 - O. **Skill Development:** An absolute belief that every participant has the potential to learn new adaptive skills, with all members of the participant's circle of support working to determine how to teach such skills to meet the unique strengths and capabilities of the participant.
 - P. **Trauma Informed Care:** An organizational structure and framework that involves comprehensive understanding, recognizing, and responding to the effects of all forms of trauma, when warranted by the individualized needs of the participant.

POLICY:

DDD establishes that PBS practices and procedures - which serve to support a participant's engagement in positive behaviors and helps them to lead meaningful and productive lives - shall be the primary interventions used when supporting participants. This Policy applies to services authorized by the participant's Case Manager (CM).

- A. A BSP will be developed to support participants who engage in behaviors that threaten the health and safety of themselves or others, or that limits or prohibits the participant from engaging in an integrated activity. PBS approaches shall be the primary interventions proposed for use in a BSP to safely address challenging behaviors and increase a participant's independence and integration into community activities.
- B. A BSP will take into account an understanding of the participant's behavior by collecting and using data to make decisions. When appropriate, a trauma-informed care approach will be incorporated into a BSP to meet the individual needs of a participant with a history of trauma and/or abuse.
- C. A BSP will be developed and implemented for all participants receiving more than a 1:1 staff ratio with services in place to address health and safety goals, with regards to reducing challenging behaviors. The BSP must include recommendations and criteria on when to transition to a 1:1 staff ratio.
- D. The BSP must be overseen by a qualified DDD provider.

PROCEDURES:

- A. A BSP must be developed by a licensed professional in accordance with Hawaii state law.
- B. The Clinical Interdisciplinary Team (CIT) or designee may assist with assessing any medical, trauma, and/or mental health concerns that may impact the onset or exacerbation of challenging behaviors.
- C. The BSP is developed using the following set of criteria;
 - 1. Building a PBS team: The PBS team members are anyone who provides services or support to the participant. These members must coordinate their work at all times when developing, implementing, and/or monitoring the participant's BSP.
 - 2. Person-Centered: It is important to identify goals that are not only limited to addressing challenging behaviors, but goals that also enhance the participant's overall quality of life. The following questions shall be considered when developing goals:
 - a. How can participation and inclusion in the participant's home and community be increased?
 - b. How can we increase the meaningful activities that a participant engages in?
 - c. What would increase or strengthen the participant's social support?
 - d. How can we increase a participant's ability to make appropriate choices and control aspects of their life?
 - e. What barriers may interfere with the participant's progress?
 - 3. Defining the Target Behaviors: In order to monitor the outcomes of an intervention, specific behaviors of interest, also known as target behaviors, need to be defined in a concrete and observable manner. This definition should be written in clear, concise, and measurable objective terms (what the participant does or says). Target behaviors may be defined by answering the following questions:
 - a. What does the behavior look or sound like?
 - b. How often does the behavior occur (e.g., frequency, duration measure)?
 - c. How intense is the behavior (e.g., does the behavior result in bruising or breaking of skin)?

- d. Is the behavior harmful to the participant or others?
- e. Does the behavior result in property damage?
- f. Does the behavior prohibit or limit the participant's engagement in integrated activities?
- g. Is the progress of the participant or others being affected?
- 4. Functional Behavioral Assessment: The FBA must include the following components:
 - a. Review of relevant records, such as but not limited to, Adverse Event Reports, Individualized Service Plans (ISP), and/or provider quarterly reports.
 - b. Interviews with multiple people who interact with the participant regularly in different settings and activities.
 - c. Direct observations of the participant across multiple settings, activities and interactions with various people.
 - d. Individualized assessments to determine broader variables affecting the participant's behavior.
 - e. Collection and analysis of objective information regarding the following:
 - 1) Baseline data of the challenging behavior as well as signals that indicate more serious behavior is about to occur (e.g., threatening gestures, pacing, muttering).
 - 2) Antecedents (conditions that precede the occurrence of the participant's behavior) such as the time, setting, activity, and the people who are present or absent when challenging behaviors occur.
 - 3) Consequences (conditions that immediately follow the occurrence of the participant's behavior), such as if staff respond to the behavior by giving attention or removing undesirable activities.
 - 4) Setting events (ecological or motivational conditions) such as lack of sleep, skills deficits, change in routines, illness, or difficulties with crowded places.
 - f. One or more statements that summarize the patterns of behaviors, including the triggers and consequences, and offers an educated hypothesis for the function of the challenging behaviors and what may be maintaining it based on the objective data collected.
- 5. BSP Development: The FBA provides the basis for developing the BSP. The date(s) each of the FBA component activities (detailed in item 4 above) occurred must be documented in the BSP. This should include relevant details regarding the FBA activity completed (e.g., where an observation took place, the date, and who was present; who was interviewed, the date, and findings; what assessment was administered, the date, and results) as well as a list of the records that were reviewed by the author of the BSP, including the date indicated on the record and relevant information/findings.

The BSP facilitates the attainment of broad goals identified by the team and promotes the sustainability of the behavioral change. The BSP must include:

- a. Modifications to the social or physical environment that may prevent the challenging behavior and/or increase the likelihood of alternative appropriate behaviors.
 - b. Identification of specific behaviors or skills to teach and/or reinforce that will achieve the same function as the challenging behavior and that will allow the person to more effectively manage or respond to the environment.
 - c. Strategies for managing consequences so that positive reinforcement is provided for proactive behaviors.
 - d. Interventions that should be utilized during earlier stages of behavior escalation to prevent imminent risk of harm to the participant or others.
 - e. Detailed information on how data will be collected and analyzed by individuals implementing the BSP to evaluate the effectiveness of the plan for *each* objectively defined target behavior and goal.
 - f. An outline of crisis management procedures and the conditions in which they should be applied, should it be necessary to implement in order to ensure safety and rapid de-escalation of challenging behaviors.
 - g. Detailed information on how the author of the BSP will train all members in the participant's circle of support as well as documentation of how these individuals respond to the training (e.g., are they able to independently apply interventions appropriately). The service supervisor and caregiver(s) must be involved in the training of the BSP.
 - h. PBS strategies shall be the primary interventions used when supporting participants. If a restrictive intervention is proposed for use in a BSP, these interventions shall only be used on an emergency basis to prevent imminent risk of harm to the participant and/or others and applied only after less restrictive interventions were used and deemed ineffective, with appropriate documentation demonstrating their ineffectiveness. DDD's requirements regarding the documentation, data, training and supervision, interventions, and plans that must be included in BSPs involving restrictive interventions are detailed in *Policy 2.03, Behavior Support Review*.
6. Implementation and Monitoring: Specific procedures for implementing each intervention must be outlined in the BSP and progress toward the goals must be monitored as defined below:
- a. The PBS team must discuss and document the training(s), support(s), and/or other resources that may be needed to implement the BSP (e.g., supplementary aids or equipment).
 - b. The BSP must include specific objectives and activities, identify responsible persons, and set reasonable timelines.
 - c. Training on the BSP must be provided to all members of the PBS team and shall include, but not be limited to, a review of written materials, PBS approaches, and other interventions individualized for the participant, face-to-face behavioral modeling and coaching, feedback on the application of an intervention, instructions on data collection and review methods, and assistance in restructuring

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- routines, curriculum, instructional strategies, schedules and/or activities to minimize the likelihood of a challenging behavior.
- d. Plan implementation must be monitored through observation and data analysis to ensure intervention strategies are implemented appropriately and consistently across settings.
 - e. Objective data must be collected to evaluate the effectiveness of the BSP. Data should include decreases in challenging behavior, increases in replacement skills, achievement of broader goals, and staff implementation.
 - f. The PBS team must communicate regularly on a schedule defined by the team, to review progress and adjust the BSP as necessary.
 - g. The goals of the BSP shall be incorporated into the participant's Individualized Service Plan (ISP) by the participant's CM.
- D. An initial authorization of Training & Consultation (T&C) for Behavior Analysis may be authorized by the CMB Section Supervisor for a limited number of hours (up to five hours). The purpose of the initial T&C authorization is to enable a qualified provider to make a determination based on data of the need for a formal request to the CIT for additional hours of T&C to complete the FBA and BSP.
- E. The CIT shall make the decision whether or not to authorize T&C hours for a licensed professional in accordance with Hawaii state law to complete a FBA and BSP.
- F. The CMB Section Supervisor may authorize the author of the BSP to provide ongoing monitoring of the implementation of the BSP, retraining on the BSP, if necessary, and the collection and review of relevant data. This ongoing monitoring shall not exceed four (4) hours per month at a maximum of 6 months following completion of the initial training on the BSP. These hours shall not be used by the author of the BSP to complete tasks or other duties that are the responsibility of the DDD provider's service supervisor. A request for additional hours per month and/or an extension of the ongoing monthly supervision by the author of the BSP must be requested through the CIT. The CIT may authorize additional hours following a review of data and/or documentation which demonstrates the need for increased hours and provides detailed information regarding how previously authorized T&C hours were utilized. The author of the BSP or his/her designee shall also provide the CIT with a detailed description of how the additional hours will be used each month to improve the implementation of the BSP and/or collection of data.
- G. The CM must initiate contact with a T&C provider within five (5) working days of receiving written authorization from the CIT. The CM must report back to the Case Management Branch (CMB) Section Supervisor if a T&C provider has not been retained within 14 calendar days from the date the T&C approval was received. The Unit Supervisor may call the Section Supervisor of the Community Resource Management Section (CRMS) within the Community Resources Branch (CRB) for assistance in locating a provider.
- H. Once the FBA is completed, a BSP must be developed and written within 14 calendar days and shall include the date (month, day, and year) the BSP report was completed as well as the name of the author and his/her credentials. A final copy of the BSP report shall be forwarded by the author to the CM within 2 business days of the date of

completion indicated on the BSP report. Refer to *Policy 2.02, Restrictive Interventions*, for additional BSP requirements.

- I. Training must be initiated by the author of the BSP within 7 calendar days of the completion date indicated on the BSP and shall include a face-to-face training of, at minimum, all of the interventions and data collection methods included in the BSP by the author for all individuals in the participant's circle of support.
- J. Documentation of challenging behavior(s), including the effectiveness of the recommendations and/or interventions indicated in the BSP, shall be reported by the DDD provider to the CM every quarter or more frequently, as documented in the ISP.
- K. If a restrictive intervention is included in a BSP to address a challenging behavior, such interventions are permitted only when PBS strategies and less restrictive interventions have been applied first and deemed ineffective. Refer to *Policy 2.03, Behavior Support Review*, for the DDD's requirement specifications for BSPs that include restrictive interventions as well as when review by the Behavior Support Review Committee is required.
- L. The BSP must be reviewed at least annually by the participant's circle of support and updated as needed.
- M. A copy of the participant's current BSP must be accessible at the participant's home, and to all staff who work with the participant at the setting in which the DDD service is provided.
- N. Staff who work with the participant must implement the procedures as written in the BSP. If modifications are needed, staff must refer to a qualified professional.
- O. At minimum, the author of the BSP must remain on the participant's team until training and implementation of the plan is completed. The author should also be available to provide periodic monitoring of the BSP (not to exceed four hours per month) to ensure that it is being consistently and correctly implemented by all individuals in the participant's circle of support. If the author of the BSP is unable to provide ongoing monitoring of the BSP, he or she must appoint an appropriate designee who complies with Hawaii state law before transitioning off the team. It is at the discretion of the PBS team, with support from the CIT, to request another licensed professional in accordance with Hawaii state law to assume responsibility of the BSP.
- P. The DDD provider's service supervisor needs to demonstrate a level of competency on the BSP following training from the licensed professional in accordance with Hawaii state law who developed the plan.
- Q. All staff who implement the BSP must comply with Hawaii state law. A licensed professional in accordance with Hawaii state law shall train on the implementation of the BSP and provide periodic monitoring of BSP implementation.
- R. T&C services will not duplicate services provided through another source, including Applied Behavior Analysis (ABA) services covered by a participant's commercial insurance or, if the participant is under 21 years of age, through the Early Periodic Screening Diagnostic and Treatment (EPSDT) services under the Medicaid QUEST Integration Health Plan. When a participant has a BSP developed through another source (e.g., Department of Education, QUEST Integration, and private insurance), T&C may be authorized to develop a BSP to address behaviors that occur in settings where DDD

TITLE: Positive Behavior Supports

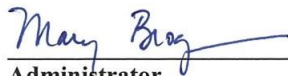
Policy #: 2.01

services are provided. The author of the BSP shall ensure consistency amongst and across the services the participant receives by consulting with the authors of the other BSPs and their treatment teams and utilizing similar interventions in settings where DDD services are provided, where appropriate. This T&C shall include training in implementing the BSP strategies and approaches during waiver service hours, as well as providing periodic monitoring of the BSP to ensure consistency.

AUTHORITATIVE & OTHER REFERENCES:

1. Koegel, L.K., Koegel, R.L., & Dunlap, G (1996). *Positive behavior support: Including people with difficult behavior in the community*. Baltimore: Paul H. Brookes Publishers.
2. O'Neill, R.E., Horner, R.H., Albin, R. W., Sprague, J.R., Storey, K., & Newton, J.S. (1997). *Functional assessment and program development for problem behavior: A practical handbook*. Pacific Grove, CA: Brooks/Cole.
3. Substance Abuse and Mental Health Services Administration. Trauma-Informed Care in Behavioral Health Services. Treatment Improvement Protocol (TIP) Series 57. HHS Publication No. (SMA) 13-4801. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014
4. Chapter 465D, HRS, "Behavior Analysts"¹
http://www.capitol.hawaii.gov/hrscurrent/Vol10_Ch0436-0474/HRS0465D/HRS_0465D-.htm
5. DD Policy 2.02, Restrictive Interventions
6. DD Policy 2.03, Behavior Support Review

Approved: _____



**Administrator
Developmental Disabilities Division**

Date: FEB 17 2017

¹This hyperlink connects to the most recent version of HRS through the Hawaii State Legislature website. Hyperlinks to HRS chapters show the first page of the chapter only, to see the rest of the contents of the chapter, click "Next" on the lower right hand side of the page on your screen.

APPENDIX 4B: P&P #2.02 RESTRICTIVE INTERVENTIONS



STATE OF HAWAII
DEPARTMENT OF HEALTH
P. O. BOX 3378
HONOLULU, HI 96801-3378

DEVELOPMENTAL DISABILITIES DIVISION

TITLE: Restrictive Interventions

Policy #2.02

BACKGROUND:

When a participant presents behaviors that places him/her at imminent risk of hurting themselves or others where steps must be taken to prevent harm, positive behavior supports (PBS) shall be used, whenever possible, to decrease the behaviors that pose risk to the person or others, and prevent the need for restrictive interventions (*refer to Policy 2.01, Positive Behavioral Supports*). When PBS techniques have been used and are not effective in resolving the immediate risk of harm, restrictive interventions that involve temporary restrictions may be necessary. Behavioral support plans (BSP) containing restrictive interventions are the least desirable approach to supporting participants and should only be utilized for the protection of the participant and others.

PURPOSE:

The purpose of this policy is to ensure that participants are supported in a caring and responsive manner that promotes dignity, respect, trust and free from abuse. Participants have all the same rights and personal freedoms granted to people without disabilities. This shall be accomplished by ensuring that:

- PBS methods are the primary interventions used to maintain the safety of participants and others, promote the independence of participants, and safely support participants who engage in challenging behavior;
- Services, supports, and/or BSPs are based on a thorough understanding of the participant and the reason why they are engaging in a challenging behavior (i.e., the function of the behavior);
- A pattern of behavior escalation has been identified and the BSP includes corresponding, least restrictive interventions to prevent or minimize the escalation of the challenging behavior at each phase to prevent imminent risk of harm;
- Restrictive measures are used only after PBS and/or less restrictive interventions were tried and documentation demonstrates that these interventions were ineffective at reducing the risk of imminent harm to the participant or others;
- Opportunities are provided for participants to exercise choice in matters affecting their everyday lives and are supported in choices that yield positive outcomes; and

DDD Policy Manual

Page 1

Effective Date: FEB 17 2017
Revised:

<https://health.hawaii.gov/ddd/files/2018/05/DD-Policy-2.02-Restrictive-Interventions.pdf>

- The Developmental Disabilities Division (DDD) system in Hawaii moves to a trauma-informed system, free from the use of restraints and restrictive interventions.

DEFINITIONS:

“Aversive Procedures” means procedures intended to inflict pain, discomfort and/or social humiliation in order to modify behavior. These include, but are not limited to, electric skin shock, liquid spray to one’s face, and strong, non-preferred tastes applied in the mouth.

Aversive Procedures are prohibited and shall not be used with participants.

“Behavior Support Plan” or “BSP” is a written plan for the team members who are supporting the person who is engaging in behaviors perceived as challenging. The BSP outlines:

1. Steps that will be taken by the members of the person’s team to modify the physical environment;
2. What replacement skills should be taught to the participant as well as how to do so;
3. Ways in which team members should respond to challenging behaviors; and
4. Ways in which team members can decrease the likelihood of challenging behaviors.

The BSP is developed based on the results of a Functional Behavior Assessment (see definition below). As BSPs include Positive Behavior Support approaches (see definition below), a BSP may also be referred to as Positive Behavior Support Plan or PBS Plan.

“Functional Behavior Assessment” or “FBA” means the process of determining the functions, or reasons why a person is engaging in challenging behaviors, and to understand the conditions in which challenging behaviors occur. The FBA involves collecting data to identify patterns or trends and to develop a hypothesis of conditions that trigger and/or maintain these behaviors prior to developing a behavior support plan.

“Overcorrection” is a behavioral intervention used to decrease an undesired behavior by having the individual either restore the environment to an improved state vastly better than it was prior to the undesired behavior (e.g., cleaning or fixing the environment) and/or repeatedly performing the appropriate way to do a behavior as a result of engaging in the undesirable behavior (e.g., repeatedly closing the door in an appropriate manner as opposed to slamming it closed or repeatedly requesting someone’s attention by saying their name in an appropriate manner as opposed to throwing an item at them). **Overcorrection is prohibited and shall not be utilized with participants.**

“Positive Behavior Supports” or “PBS” is a process for addressing challenging behaviors by understanding the relationships between a person’s behavior, communication, and aspects of his or her environment. It offers strategies to modify the environment and interactions in order to prevent the occurrence of these behaviors; teaches skills to replace challenging behaviors; outlines responses to challenging behaviors to reduce the likelihood that these behaviors will reoccur in the future; and offers proactive and functional strategies to promote a positive lifestyle change. Positive Behavior Supports strategies are included in Behavior Support Plans (BSPs).

“Provider” means any individual or agency delivering a service authorized through DDD inclusive of consumer directed services.

“Restraint” means a physical, chemical or mechanical intervention used as a last resort on an emergency basis to protect the participants from imminent harm to themselves and/or others using the least restrictive intervention possible and for the shortest duration necessary.

THE FOLLOWING ARE NOT CONSIDERED RESTRAINTS:

- Interventions used for the purpose of conducting routine physical or dental examination or diagnostic tests or completing a medical or dental treatment procedure;
 - A device used to protect the participant’s safety as indicated in the Individualized Service Plan (ISP) per a physician’s recommendation and reviewed by the Behavior Support Review Committee (BSRC); or
 - Vehicular passenger restraint systems required by state law (HRS §291-11.6).
1. **“Chemical Restraint”** means a psychotropic medication prescribed by a licensed health care professional with prescriptive authority:
 - a. On a routine basis without an appropriate Diagnostic and Statistical Manual (DSM) diagnosis for the purpose of behavioral control; or
 - b. Incidental use of medications, sometimes called PRN or as needed medication, to restrict the freedom of movement or temporarily sedate the individual.

THE FOLLOWING ARE NOT CONSIDERED CHEMICAL RESTRAINTS:

- Medications prescribed for the treatment of a diagnosed disorder found in the current version of the American Psychiatric Association's Diagnostic and Statistical Manual (DSM);
 - Adjusting the dose of a prescribed medication or prescribing a new medication to achieve better symptom control for the diagnostic disorder per the current DSM;
 - Medications prescribed to control seizures; and
 - Medications for medical or dental procedures.
2. **“Mechanical Restraint”** means an intervention involving a device, material or equipment that is involuntarily applied to the participant’s body or immediate environment (i.e., wheelchair, chair, bed, toilet, vehicle, etc.) that immobilizes, restricts, limits, or reduces any bodily movement in emergency situations to prevent the participant from harming themselves or others. See definition of “Restraints” for interventions that are not considered a Mechanical Restraint.
 3. **“Physical Restraint”** means an intervention in which physical force is applied to the participant and involuntarily restricts their freedom of movement or normal access to a

portion or portions of their body. See definition of “Restraints” for interventions that are not considered a Physical Restraint.

“Restrictive Intervention” or “Restrictive Procedure” means a practice that limits a participant’s freedom of movement, access to other locations, property, individuals, or rights. This includes, but is not limited to, Chemical, Mechanical, and Physical Restraints.

“Seclusion” means a restrictive intervention in which a person is involuntarily confined in a room or area from which they are prevented from having contact with others or leaving by closing a door or using another barrier. **Seclusion is prohibited and shall not be utilized with participants.**

POLICY:

This policy dictates that restrictive interventions are only to be used when a participant’s behavior(s) pose an imminent risk of harm to themselves and/or others and less restrictive interventions have been attempted with limited effectiveness at reducing and/or replacing the challenging behavior. The restrictive interventions utilized must be the least restrictive method to address the challenging behavior and shall be terminated when there is no longer an imminent risk of harm and/or a less restrictive intervention would achieve the same purpose. This policy also describes which restrictive interventions are allowed and which are prohibited when providing services to participants, the circumstances under which allowed restrictive interventions may be used, and the requirements that must be met. The fundamental features of this policy specifies that restrictive interventions are:

- Only meant to address situations of imminent risk of harm.
- Not to be used as threats or punishment to change behavior as participants have the right to be free from any restrictive intervention imposed for the purpose of discipline, retaliation and/or staff convenience.
- Not therapeutic in nature nor designed to alter behavior in a long-term manner so should not be utilized with this intent.

When behavioral data and the Individualized Service Plan (ISP) team confirms an imminent risk of harm to the participant and/or others, and it is documented that less restrictive interventions have been attempted and deemed ineffective at decreasing the risk of harm, a BSP with restrictive intervention(s) may be developed that contains the following features:

- PBS methods as the primary interventions to safely address challenging behaviors and increase a participant’s independence and integration into community activities.
- Restrictive interventions that are only used to protect the participant and/or others from imminent risk of harm after less restrictive interventions have been applied and deemed ineffective at addressing the challenging behavior, with appropriate documentation demonstrating their ineffectiveness.
- The specific conditions that warrant the use and removal of the restrictive intervention as well as procedures to restore the restricted right(s) of the participant following the use of a restrictive intervention.

- Strategies to prevent or minimize the challenging behaviors from occurring as well as identification of replacement skills that will be taught to the participant that serve the same function as the challenging behavior. Goals should also be identified in the BSP that enhance the participant's overall quality of life so that treatment objectives are not limited to addressing challenging behaviors only.
- Specific instructions on how documentation and/or data collection should be completed following the use of a restrictive intervention. The staff involved in the application of the restrictive intervention shall debrief the incident with the service supervisor overseeing the BSP within 24 hours of the initial application of the restrictive intervention (*refer to page 8 of this policy for specific provider requirements following the use of a restrictive intervention*). Adjustments to the BSP may be made by the author of the BSP or his/her designee if needed.
- A detailed plan for the eventual elimination of the restrictive intervention.

The procedures that are prohibited and shall not be used with participants include but are not limited to:

- Seclusions
- Aversive procedures involving:
 - Electric shock (excluding electroconvulsive therapy);
 - The non-accidental infliction of physical or bodily injury, pain, or impairment, including but not limited to hitting, slapping, causing burns or bruises, poisoning, or improper physical restraint;
 - Unpleasant tasting food or stimuli; and
 - Contingent application of any noxious substances which include but are not limited to noise, bad smells, or squirting a participant with any substance that is administered for the purpose of reducing the frequency or intensity of a behavior.
- The following types of restraints:
 - Restraints that cause pain or harm to participants. This includes restraint procedures such as arm twisting, finger bending, joint extensions or head locks;
 - Prone Restraints;
 - Supine Restraints;
 - Restraints that have the potential to inhibit or restrict a participant's ability to breathe; excessive pressure on the chest, lungs, sternum, and/or diaphragm of the participant; or any maneuver that puts weight or pressure on any artery, or otherwise obstructs or restricts circulation;
 - Restraint Chairs;
 - Restraint Boards;
 - Any maneuver that involves punching, hitting, poking, or shoving the participant;
 - Straddling or sitting on the torso;
 - Any technique that restrains a participant vertically, face first against a wall or post; and
 - Any maneuver where the head is used as a lever to control movement of other body parts.

- Interventions involving:
 - Verbal or demonstrative harm caused by oral, written language, or gestures with disparaging or derogatory implications;
 - Psychological, mental, or emotional harm caused by unreasonable confinement, intimidation, humiliation, harassment, threats of punishment, or deprivation;
 - Denial of food, beverage, shelter, bedding, sleep, physical comfort or access to a restroom as a consequence of behavior;
 - The restriction or disablement of a communication device;
 - Placing a participant in a room with no light;
 - Overcorrection; and
 - Removing, withholding or taking away money, incentives or activities previously earned.

PROCEDURES:

- A. A BSP must define the target behaviors being addressed by the plan and be developed by a licensed professional in accordance with Hawaii state law following the completion of a Functional Behavioral Assessment (FBA). For specific details regarding the developmental criteria of a BSP, refer to *Policy 2.01, Positive Behavioral Supports*.
- B. All staff who implement the BSP must comply with Hawaii state law. A licensed professional in accordance with Hawaii state law shall train on the implementation of the BSP and provide periodic monitoring of BSP implementation (*refer to Policy 2.01, Positive Behavioral Supports*). All provider staff who supervise the implementation of a BSP must demonstrate a level of competency on the BSP following training from the licensed professional who developed the plan in accordance with Hawaii state law.
- C. If a restrictive intervention is included in a BSP to address a challenging behavior, such interventions are permitted only when PBS strategies and less restrictive interventions have been applied and documentation demonstrates that these interventions were ineffective. Refer to *Policy 2.03, Behavior Support Review*, for the DDD's requirement specifications for BSPs that include restrictive interventions as well as when review by the Behavior Support Review Committee is required.
- D. The author of the BSP shall include a proposed training plan that should include: (1) when training of each individual in the participant's circle will occur (i.e., the projected date and timeframe), (2) what topics individuals will be trained on during a training session, (3) the individual's response to the training as well as any recommendations for follow-up trainings, and (4) how documentation of the training(s) will occur in the aforementioned areas. Documentation of the trainings received by the individual's circle, including how they responded to the training and any follow-up training recommendations, shall be maintained by the author of the BSP and available for review by the DDD. The initial review of and training on the BSP with all individuals in the participant's circle of support must be initiated by the author of the BSP within 7 calendar days of the completion date indicated on the BSP. If a review by the BSRC is required, a referral shall be made by the Case Manager to the

BSRC within 30 calendar days of the date of completion indicated on the BSP report (*refer to Policy 2.03, Behavior Support Review*).

- E. A BSP will be developed and implemented for all participants receiving more than a 1:1 staff ratio with services in place to address health and safety goals, with regards to reducing challenging behaviors. The BSP must include recommendations and specific measurable and objective criteria that indicates when a transition to a 1:1 staff ratio should commence and identify goals that are not only limited to address challenging behaviors but also goals that enhance the participant's overall quality of life.

When a restrictive intervention is proposed for use in a BSP by a licensed professional in accordance with Hawaii state law to address a challenging behavior, the BSP shall be written in accordance with the *Medicaid Waiver Standards Manual* which details the specific requirements for *each* restrictive intervention proposed for use.

F. Providers shall have:

1. Internal policies and procedures concerning restrictive interventions that are in accordance with state policies, and promote the use of positive behavior support approaches with the goal of eliminating the use of restrictive interventions;
2. A plan for recording and maintaining data on the use of restrictive interventions;
3. A plan for monitoring the outcomes of a restrictive intervention, its efficacy, and the continued need for its use in the BSP;
4. All staff who implement the BSP comply with Hawaii state law;
5. A licensed professional in accordance with Hawaii state law develop the BSP, train on the implementation of the BSP, and provide periodic monitoring of the implementation of the BSP (*refer to Policy 2.01, Positive Behavior Support*);
6. The staff administering the restrictive intervention be trained on the participant's BSP by the licensed professional who developed the plan. The initial training of all interventions proposed for use in the BSP shall occur in person with the author of the BSP and the individuals who will be implementing the BSP. Training should be received both prior to providing services to the participant and on an ongoing basis throughout the duration of services provided to the participant. Only specific restrictive interventions proposed for use in the BSP to address a specific behavior can be utilized. Documentation of the training received by the staff administering the restrictive intervention, including their response to the training(s) and recommendations for follow-up trainings, shall be maintained by the author of the BSP. Documentation of the supervision received by staff should be maintained in the provider agency's files. Both shall be available for review by the DDD;
7. Staff who provide services to participants whose treatment plans include restrictive intervention(s) trained in a nationally-recognized curricula approved by DDD. A component of these curricula includes de-escalation and re-direction techniques to be used prior to a restraint as well as crisis management and intervention techniques. In addition, staff must be trained on the participant's individualized BSP which focuses on utilizing non-aversive methods as a primary intervention;

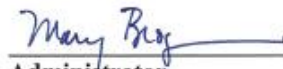
8. A copy of the BSP at the site where services for the participants are provided; and
 9. Written consent for the BSP from the participant, guardian and/or care team.
- G. During the use of a restrictive intervention, providers shall ensure that:
1. The participant is monitored for health and safety throughout the duration of the restrictive intervention with staff being continuously present and observing the participant's condition. This includes, but is not limited to, monitoring the participant's breathing, consciousness and pain;
 2. Mechanical and/or Physical Restraints are terminated immediately after the imminent risk of harm to self or others is no longer present;
 3. The start time and end time of the application and removal of a Mechanical and/or Physical Restraint are documented;
 4. Participants who are administered a chemical restraint must also be monitored for side effects or adverse effects of medication until effects of medications have ended; and
 5. For Chemical Restraints used to address imminent risk of harm as outlined in a BSP, the time the medication was administered must be documented and staff must monitor the health and safety of the participant. Chemical Restraints shall not be used as a preventative intervention and shall be used in accordance with the prescribing physician's orders.
- H. After a restrictive intervention is implemented, providers shall complete:
1. Documentation of:
 - a. The type of restrictive intervention used;
 - b. The location of the intervention;
 - c. The people involved in the intervention;
 - d. The time that the restrictive intervention was initiated and terminated; and
 - e. The events proceeding and following the restrictive intervention. This shall include but not be limited to:
 - 1) Antecedent(s) to the challenging behavior, including environmental and other contributing factors;
 - 2) Less restrictive interventions that were attempted and deemed ineffective at reducing the risk of harm, including the results of those interventions;
 - 3) Consequences of the restrictive intervention; and
 - 4) How the restricted rights of participant were restored.
 2. An Adverse Event Report (AER) and submit to DDD. Any use of restraints are considered an adverse event and submission of an AER is required in accordance with *Policy 3.07, Adverse Event Report for People Receiving Developmental Disabilities Division Services*. Seclusion is prohibited by the DDD. If Seclusion is utilized to address a challenging behavior, it is considered an adverse event and submission of an AER is required.
- I. Debriefing with all staff involved in the application of the restrictive intervention shall occur with the Service Supervisor overseeing the BSP within 24 hours of the initial application of the restrictive intervention. This purpose of this debriefing is to:

1. Provide specific instructions on how documentation and/or data collection will be completed following the use of a restrictive intervention;
 2. Assess what was effective and ineffective with regards to the interventions used throughout the escalation of the behavior;
 3. Determine what could have been done before, during, and/or after the restrictive intervention to minimize the likelihood of the challenging behavior and/or prevent the risk of harm;
 4. Assess how the safety and well-being of the participant was monitored throughout the application of the restrictive intervention;
 5. Determine antecedent-based interventions that should be utilized in the future to minimize the likelihood of the challenging behavior from occurring; and
- Adjustments to the BSP may be made by the author of the BSP or his/her designee, if needed, based on the findings of this debriefing.

AUTHORITATIVE & OTHER REFERENCES:

1. Chapter 465D, HRS "Behavior Analysts":
http://www.capitol.hawaii.gov/hrscurrent/Vol10_Ch0436-0474/HRS0465D/HRS_0465D-.htm.¹
2. Cooper, J.O., Heron, T.E., & Heward, W.L. (2007). *Applied Behavior Analysis, 2nd Edition*. Saddle River, NJ: Pearson Publishing.
3. DD Policy 2.01, Positive Behavioral Supports
4. DD Policy 2.03, Behavior Support Review
5. DD Policy 3.07, Adverse Event Report for People Receiving Developmental Disabilities Division Services

Approved: _____

Administrator
Developmental Disabilities Division

Date: _____

FEB 17 2017

¹ This hyperlink connects to the most recent version of HRS through the Hawaii State Legislature website. Hyperlinks to HRS chapters show the first page of the chapter only, to see the rest of the contents of the chapter, click "Next" on the lower right hand side of the page on your screen.

APPENDIX 4C: P&P #2.03 BEHAVIOR SUPPORT REVIEW



STATE OF HAWAII
DEPARTMENT OF HEALTH
P. O. BOX 3378
HONOLULU, HI 96801-3378

DEVELOPMENTAL DISABILITIES DIVISION

TITLE: Behavior Support Review

Policy #: 2.03

BACKGROUND:

The purpose of therapeutic interventions when working with individuals with Intellectual and Developmental Disabilities (I/DD) is to provide individuals with support strategies and therapeutic approaches that are tailored to their specific needs. This allows individuals to strengthen their ability to live productive and satisfying lives in the community and ensures that the rights of individuals with I/DD are not violated. When participants of the Developmental Disabilities Division (DDD) present behaviors that put them at imminent risk of hurting themselves or others, steps must be taken to prevent harm. Positive behavior supports (PBS) (*refer to Policy 2.01, Positive Behavioral Supports*) shall be used, whenever possible, to decrease behaviors that pose a risk of harm to self or others, and prevent the need for restrictive practices.

The DDD policy on PBS ensures that behavioral interventions are implemented by trained and supervised staff and documented appropriately to assist and support participants receiving services, and those providing support to them. When PBS techniques have been attempted and are not effective at reducing risks of harm, restrictive interventions that involve safe and temporary restrictions may be necessary (*refer to Policy 2.02, Restrictive Interventions*). Restrictive interventions should only be used in the context of a comprehensive, functional approach to behavior support that is designed to teach, nurture, and encourage positive behaviors. Safeguards for restrictive interventions are required to ensure that a participant's rights are protected, and that interventions do not violate these rights. To minimize the use of interventions that are intrusive, focused exclusively on punitive consequences, and/or are ineffective in producing meaningful outcomes, Behavioral Support Plans (BSPs) containing restrictive interventions are the least desirable approach to supporting participants and such interventions shall be reviewed by the Behavior Support Review Committee (BSRC) to ensure the safety of participants and others.

PURPOSE:

The purpose of Behavior Support Review is to ensure that PBS methods are used when working with participants and that appropriate safeguards are in place when restrictive interventions are proposed for use in a Behavior Support Plan (BSP). The BSRC may review BSPs for which there is a restrictive intervention that meets specific DDD thresholds to address a challenging

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Effective Date: FEB 17 2017
Revised:

<https://health.hawaii.gov/ddd/files/2018/06/DD-Policy-2.03-Behavior-Support-Review.pdf>

behavior (see *Procedures* section, item A) and may provide recommendations to ensure appropriate, effective, and safe application of an intervention by service providers.

DEFINITIONS:

“Aversive Procedures” means procedures intended to inflict pain, discomfort and/or social humiliation in order to modify behavior. These include, but are not limited to, electric skin shock, liquid spray to one’s face, and strong, non-preferred tastes applied in the mouth.

Aversive Procedures are prohibited and shall not be used with participants.

“Behavior Support Plan” or “BSP” is a written plan for the team members who are supporting the person who is engaging in behaviors perceived as challenging. The BSP outlines:

1. Steps that will be taken by the members of the person’s team to modify the physical environment;
2. What replacement skills should be taught to the participant as well as how to do so;
3. Ways in which team members should respond to challenging behaviors; and
4. Ways in which team members can decrease the likelihood of challenging behaviors.

The BSP is developed based on the results of a Functional Behavior Assessment (see definition below). As BSPs include Positive Behavior Support approaches (see definition below), a BSP may also be referred to as Positive Behavior Support Plan or PBS Plan.

“Functional Behavior Assessment” or “FBA” means the process of determining the functions, or reasons why a person is engaging in challenging behaviors, and to understand the conditions in which challenging behaviors occur. The FBA involves collecting data to identify patterns or trends and to develop a hypothesis of conditions that trigger and/or maintain these behaviors prior to developing a behavior support plan.

“Licensed Behavior Analyst” or “LBA” is an individual licensed under HRS Chapter 465D.

“Positive Behavior Supports” or “PBS” is a process for addressing challenging behaviors by understanding the relationships between a person’s behavior, communication, and aspects of his or her environment. It offers strategies to modify the environment and interactions in order to prevent the occurrence of these behaviors; teaches skills to replace challenging behaviors; outlines responses to challenging behaviors to reduce the likelihood that these behaviors will reoccur in the future; and offers proactive and functional strategies to promote a positive lifestyle change. Positive Behavior Supports strategies are included in Behavior Support Plans (BSPs).

“Provider” means any individual or agency delivering a service authorized through DDD inclusive of consumer directed services.

“Restraint” means a physical, chemical or mechanical intervention used as a last resort on an emergency basis to protect the participants from imminent harm to themselves and/or others using the least restrictive intervention possible and for the shortest duration necessary.

THE FOLLOWING ARE NOT CONSIDERED RESTRAINTS:

- Interventions used for the purpose of conducting routine physical or dental examination or diagnostic tests or completing a medical or dental treatment procedure;
 - A device used to protect the participant's safety as indicated in the Individualized Service Plan (ISP) per a physician's recommendation and reviewed by the Behavior Support Review Committee (BSRC); or
 - Vehicular passenger restraint systems required by state law (HRS §291-11.6).
1. **"Chemical Restraint"** means a psychotropic medication prescribed by a licensed health care professional with prescriptive authority:
 - a. On a routine basis without an appropriate Diagnostic and Statistical Manual (DSM) diagnosis for the purpose of behavioral control; or
 - b. Incidental use of medications, sometimes called PRN or as needed medication, to restrict the freedom of movement or temporarily sedate the individual.

THE FOLLOWING ARE NOT CONSIDERED CHEMICAL RESTRAINTS:

- Medications prescribed for the treatment of a diagnosed disorder found in the current version of the American Psychiatric Association's Diagnostic and Statistical Manual (DSM);
 - Adjusting the dose of a prescribed medication or prescribing a new medication to achieve better symptom control for the diagnostic disorder per the current DSM;
 - Medications prescribed to control seizures; and
 - Medications for medical or dental procedures.
2. **"Mechanical Restraint"** means an intervention involving a device, material or equipment that is involuntarily applied to the participant's body or immediate environment (i.e., wheelchair, chair, bed, toilet, vehicle, etc.) that immobilizes, restricts, limits, or reduces any bodily movement in emergency situations to prevent the participant from harming themselves or others. See definition of "Restraints" for interventions that are not considered a Mechanical Restraint.
 3. **"Physical Restraint"** means an intervention in which physical force is applied to the participant and involuntarily restricts their freedom of movement or normal access to a portion or portions of their body. See definition of "Restraints" for interventions that are not considered a Physical Restraint.

"Restrictive Intervention" or "Restrictive Procedure" means a practice that limits a participant's freedom of movement, access to other locations, property, individuals, or rights. This includes, but is not limited to, Chemical, Mechanical, and Physical Restraints.

“Authorized Restricted Intervention” means a restricted intervention proposed for use in a BSP by a licensed professional in accordance with Hawaii state law following the completion of a Functional Behavior Assessment.

“Seclusion” means a restrictive intervention in which a person is involuntarily confined in a room or area from which they are prevented from having contact with others or leaving by closing a door or using another barrier. **Seclusion is prohibited and shall not be utilized with participants.**

POLICY:

This policy describes how the Behavior Support Review Committee (BSRC) will review BSPs that propose the use of restrictive interventions to address challenging behaviors that pose an imminent risk of harm to the participant or others. This policy establishes that the BSRC will:

- Review specific interventions proposed in a BSP to ensure that PBS methods which promote the growth, development, and independence of participants, individual choice in daily decision-making, and self-management are the primary interventions used;
- Review and monitor BSPs that include restrictive interventions to ensure that appropriate safeguards and oversight of restricted interventions (planned or in time of crisis) are used, with planning for the eventual elimination of the restrictive intervention(s);
- Ensure that restrictive interventions are the least restrictive method available to address a challenging behavior and are utilized in combination with positive procedures designed to teach appropriate replacement behaviors that serve the same function (as opposed to suppression or elimination of undesirable behaviors); and
- Ensure that appropriate preventative strategies are in place to prevent or minimize the challenging behaviors from occurring.

When a restrictive intervention - including Chemical, Mechanical, and/or Physical Restraint - is used as a last resort intervention to prevent imminent risk of harm to self or others, a BSP must be written for *each* challenging behavior in which a restrictive intervention is proposed for use. The BSP shall be developed by a licensed professional in accordance with Hawaii state law and be in accordance with the *Medicaid Waiver Standards Manual* which details the specific requirements for *each* restrictive intervention proposed for use in a BSP. Prior to the application of a restrictive intervention, other less intrusive interventions must be attempted with appropriate documentation demonstrating their ineffectiveness at reducing and/or replacing a challenging behavior. Baseline data of the challenging behavior shall also be documented.

The Behavior Support Review Committee (BSRC) will review BSPs and supporting documents as described in the procedures below to ensure that appropriate safeguards are in place when restrictive interventions are used. This involves a systematic review to:

- Establish that a restrictive intervention will be utilized as a last resort intervention to maintain the safety of the participant and/or others at imminent risk of harm only after less restrictive

interventions have been attempted, appropriately documented, and deemed unsuccessful at addressing the unsafe behavior;

- Ensure that a pattern of behavior escalation has been identified and the BSP includes corresponding, less restrictive interventions to prevent or minimize the escalation of the challenging behavior at each phase;
- Ensure that suggested interventions in the BSP are applied by trained and supervised providers who are overseen by a qualified DDD Service Supervisor, not a Consumer Directed Personal Assistant or family member; and
- Ensure that the rights of participants are not violated. Procedures that will restore the restricted right(s) of the participant following the use of a restrictive intervention will be reviewed by the BSRC as well as interventions that will provide the participant with functional skills allowing for the eventual elimination of the Restricted Intervention.

PROCEDURES:

A. Referrals to BSRC

1. A referral by the DDD Case Manager (CM), Outcomes and Compliance Branch (OCB) staff monitoring adverse events, or Community Resources Branch (CRB) staff monitoring providers shall be made to the BSRC in the following situations:
 - a. PRN medication(s) is used to manage unsafe or challenging behavior without an appropriate DSM diagnosis;
 - b. Any restrictive intervention is proposed for use or currently being utilized with a participant less than 18 years of age;
 - c. An injury has occurred to the participant and/or others as a result of the application of a restrictive intervention;
 - d. The use of a restrictive intervention on three (3) or more instances during a one (1) month period, including but not limited to PRN medication for challenging behavior, Mechanical, and/or Physical Restraint. This includes both authorized restrictive interventions that are proposed for use in a BSP by a licensed professional in accordance with Hawaii state law as well as interventions that are not included in a BSP. This threshold may be adjusted following the BSRC's review of appropriate documentation and data;
 - e. A participant is receiving more than a 1:1 staff ratio to manage challenging behavior(s);
 - f. Challenging behavior results in psychiatric or medical hospitalization or results in the need for medical care;
 - g. An intervention prohibited by DDD was utilized including but not limited to Seclusion or any Aversive Procedure intended to inflict pain, discomfort and/or social humiliation in order to modify behavior (*refer to Policy 2.02, Restrictive Interventions*); and/or
 - h. More than two (2) restrictive interventions are proposed for use in a BSP to address challenging behavior(s).
2. The BSRC may receive referrals from other reporting sources, including but not limited to the Clinical Interdisciplinary Team (CIT) or the LBA who developed the BSP. The

CM and/or their Unit Supervisor will be contacted by the BSRC or designee to request the necessary documents for review by the BSRC.

3. The BSRC may select a participant and review all CMB and service provider records as well as interview the participant's circle of support to provide recommendations to ensure that appropriate safeguards are in place.

B. Required Documentation for Referral to the BSRC

1. All referrals to the BSRC shall be made utilizing the BSRC Referral Form.
2. When making a referral to the BSRC, the CM shall provide the following information within five (5) working days of the scheduled BSRC review for each challenging behavior for which a restrictive intervention is being utilized or proposed for implementation:
 - a. Proposed Behavior Support Plan (BSP) or current BSP if restrictive interventions have been employed prior to the approval of this Policy. The BSP shall include strategies on how to effectively address the challenging behavior and decrease the likelihood of its occurrence as well as identify alternative, functional behaviors that can be taught to the participant that serve the same purpose (see item 4 below for detailed description);
 - b. Current Functional Behavioral Assessment (FBA). The FBA shall include baseline data of the challenging behavior and a functional analysis of the purpose of the behavior as well as what may be maintaining it based on objective data collected (*refer to Policy 2.01, Positive Behavior Support*, for the required components of a FBA);
 - c. Current Individualized Service Plan (ISP) with current list of ALL medications, including diagnoses, dosage, strength, and purpose;
 - d. As documentation is required each time a restrictive intervention is utilized (*refer to Policy 3.07, Adverse Event Report for People Receiving Developmental Disabilities Division Services*) applicable Quarterly Reports should be submitted for review as well as Adverse Event Reports (AERs) from the last 12 months, at minimum;
 - e. Information about any hospitalizations including the reason for the hospitalization and the duration of the stay from the last 12 months, at minimum;
 - f. Documentation of alternative, less restrictive interventions that were attempted as a primary intervention to address a challenging behavior, including data demonstrating their limited effectiveness at reducing and/or replacing the challenging behavior (see item 3 below);
 - g. Physician Orders for PRN medications;
 - h. Physician Orders for restrictive intervention(s) used to protect the participant or others from imminent harm; and
 - i. Other information that may be applicable to the BSRC such as the Authorization for the use or Disclosure of Protected Health Information (PHI).
3. Individuals providing behavioral intervention services to the participant will be contacted by the BSRC support staff to provide the following documentation; such documentation shall be provided to the BSRC at least five (5) working days prior to the scheduled review by the BSRC:

- a. Data or information indicating the proposed antecedents and consequences to the challenging behavior;
 - b. Data or information detailing the alternative, less restrictive behavioral interventions that were attempted as a primary intervention throughout the escalation phases of the behavior and the results of those interventions;
 - c. Data or information regarding the frequency, intensity, and duration of the challenging behavior;
 - d. Data or information regarding the replacement skills that have been identified and will be taught to the participant that serve the same function as the challenging behavior; and
 - e. Information on how the participant's health and safety was monitored during the application of the restrictive intervention as well as how the restricted rights of the participant were restored following the removal of the restrictive intervention.
4. The individual referring the case to the BSRC, the CM, the LBA who developed the BSP, the provider(s) currently providing behavioral intervention services to the participant, and the provider's Service Supervisor shall be available to the BSRC, as scheduled, to address questions, provide explanation and data, clarify the participant's situation, and/or discuss alternative behavioral strategies attempted and the success/failure of those strategies.

C. Recommendations and Decisions of the BSRC

1. The BSRC shall review all available documentation and provide recommendations to (1) ensure that the rights of participants are not violated, (2) establish that PBS methods are the primary interventions used, and (3) establish that appropriate safeguards are in place when working with participants.
2. The BSRC may provide recommendations to address the following areas:
 - a. The appropriateness of the BSP and/or proposed interventions to address challenging behavior and teach appropriate replacement skills. If multiple restrictive interventions are proposed to address a challenging behavior, the BSRC will review the appropriateness of *each* restrictive intervention and may provide recommendations;
 - b. The need for medical and/or dental exams to minimize the occurrence and/or exacerbation of a challenging behavior;
 - c. The appropriateness of the participant's current list of medications as well as the method and/or schedule of administration;
 - d. Mental Health or psychiatric issues that may be impacting the challenging behavior;
 - e. Environmental and other situational factors that may be impacting the challenging behavior; and/or
 - f. Support systems and other interpersonal factors that may be impacting the challenging behavior.
3. All requests for additional information must be supported by the majority of the BSRC. The date of the next BSRC review will be established and the required documentation

must be submitted within 5 working days of the scheduled review by the appropriate source.

4. All requests for changes to the participant's BSP, ISP, Individual Plan (IP), data collection methods, and/or other documentation, methods, or, interventions - whether involving behavioral, medical, psychiatric, or other supports - must be supported by the majority of the committee for each challenging behavior. Such recommendations may include but are not limited to:
 - a. Modifications to the BSP. Any recommendations made by the BSRC shall be made by the author of the BSP and addressed *prior to* implementation of the restrictive intervention(s). The modified BSP must be submitted to the BSRC within 7 calendar days of the CM's receipt of the revised BSP from the LBA;
 - b. Additional training and/or supports needed by the participant's circle, in addition to those required by the BSP or ISP, to assist in maximizing the participant's growth and skill development as well as maintain their safety and meet their specific needs. Recommended trainings and/or supports will address the specific training needs of individuals supporting the participant so that the use of restrictive intervention(s) can be reduced or eliminated;
 - c. Additional medical, psychiatric, psychological, behavioral, and/or dental evaluation(s) to determine if challenging behaviors are caused and/or exacerbated by physical and/or medical conditions;
 - d. Additional safeguards that may be required for the safe and effective use of a restrictive intervention;
 - e. Obtaining authorization for a formal request of Training and Consultation services from the CIT (*refer to Policy 2.01, Positive Behavior Support*); and
 - f. Visitation by members of the BSRC to observe the participant in any necessary setting(s), including but not limited to the home, community, workplace, or service provider setting.
5. Any revisions recommended by the BSRC must be supported by the majority of the BSRC. The date of the next BSRC review will be established and the required documentation must be submitted by the appropriate source within 5 working days of the scheduled review.
6. The BSP shall be reviewed annually by the BSRC as long as any criteria in Item 1 of the Procedure section, *Referrals to BSRC (p. 5)*, are met. The date of annual review shall be determined by the initial review by the BSRC.
7. If there is preceding BSRC data BSRC shall analyze this data to identify trends and patterns on a quarterly basis, and develop recommendations for programmatic and/or systemic improvement through the Safety and Well-Being Committee. This shall include, but not be limited to:
 - a. How the rights of participants were violated as a result of a restrictive intervention(s) and, how the participants' rights were restored, including practices to better maintain the rights of the participant;
 - b. Restrictive interventions that require more individualized training and supervision to maintain the safety of the participant;

- c. Any medical, dental, trauma, mental health or other conditions that require a more thorough assessment to identify confounding issues that may be maintaining and/or exacerbating these conditions; and
 - d. Conditions, diagnoses, and/or challenging behaviors that require additional, individualized training to safely support a participant and ensure that PBS methods are the primary interventions used.
8. For immediate situations where there is imminent danger to the person or others, the CIT can review the proposed restrictive intervention(s) and render a temporary recommendation until the next scheduled BSRC meeting. Between BSRC scheduled meetings, CMs may also consult with the CIT to receive temporary recommendations for behavior supports and/or if they are unclear on how to meet the requests of the BSRC.

D. Composition and Responsibilities of the BSRC

1. BSRC Membership:
 - a. The Chairperson of the BSRC shall be from the DDD and appointed by the DDD Administrator;
 - b. One member from the DDD who is a psychologist or behavior analyst;
 - c. One Registered Nurse (RN) from DDD;
 - d. One Case Management Unit Supervisor (or designee);
 - e. OCB Chief (or designee);
 - f. One CRB member;
 - g. A volunteer of the BSRC, who may include:
 - 1) Family member or parent of a participant receiving services from the DDD;
 - 2) DDD provider agency representative;
 - 3) Community member with no direct involvement with a DDD provider agency; or
 - 4) Consumer receiving services from the DDD.
 - h. A Vice-Chair shall be appointed by the Chair of BSRC to conduct business in the absence of the chair; and
 - i. No professional whose prospective BSP is the subject of review may review and/or provide recommendations on a proposed BSP. No member may review and/or provide recommendations if there is professional, financial, or familial conflict(s) of interest.
2. Before participation in the BSRC, Non-State Government Employee Volunteers must:
 - a. Complete requirements of the Department of Human Resources & Development's Intra-Departmental Directive 13.01 "Utilization of Volunteer Services;" and
 - b. Complete HIPAA training
3. All BSRC Members are required to protect the confidentiality of all records and information disclosed in carrying out the duties and activities of the BSRC, and must sign a confidentiality agreement and receive training in HIPAA, unless they are State employees of a HIPAA covered entity.
4. BSRC Meetings
 - a. The BSRC shall meet monthly. The Chair, or designee, shall be responsible for informing all members of meeting dates and times and cancellation of meetings.
 - b. DDD support staff shall maintain a record that includes:

TITLE: Behavior Support Review

Policy #: 2.03

- 1) A summary of the BSRC recommendations for each BSP reviewed;
 - 2) A record of attendance; and
 - 3) The date of the meeting.
5. Notification of BSRC Decision
- a. The BSRC will consult with and send a written copy of the BSRC recommendations to the assigned CM, or person referring the case to the BSRC, including a subsequent review date.

AUTHORITATIVE & OTHER REFERENCES:

1. State of Hawaii, Department of Health, Developmental Disabilities Division, "Medicaid Waiver Provider Standards Manual."
2. §333F-8, HRS, "Rights of persons with developmental or intellectual disabilities."
3. Chapter 465D, HRS "Behavior Analysts":
http://www.capitol.hawaii.gov/hrscurrent/Vol10_Ch0436-0474/HRS0465D/HRS_0465D-.htm.¹
4. Department of Human Services & Development's Intra-Departmental Directive 13.01 "Utilization of Volunteer Services";
5. DD Policy 2.01, Positive Behavioral Supports
6. DD Policy 2.02, Restrictive Interventions
7. DD Policy 3.07, Adverse Event Report for People Receiving Developmental Disabilities Division Services

NOTE:

Forms related to this P&P are posted with the P&P on SharePoint for your reference & use.

Approved: _____

Mary Bogar

Administrator
Developmental Disabilities Division

Date: FEB 17 2017

¹ This hyperlink connects to the most recent version of HRS through the Hawaii State Legislature website. Hyperlinks to HRS chapters show the first page of the chapter only, to see the rest of the contents of the chapter, click "Next" on the lower right hand side of the page on your screen.

APPENDIX 4D: NURSE DELEGATION

JOINT STATEMENT ON DELEGATION. AMERICAN NURSES ASSOCIATION (ANA) AND THE NATIONAL COUNCIL OF STATE BOARDS OF NURSING (NCSBN)

I. Introduction

There is more nursing to do than there are nurses to do it. Many nurses are stretched to the limit in the current chaotic healthcare environment. Increasing numbers of people needing healthcare combined with increasing complexity of therapies create a tremendous demand for nursing care. More than ever, nurses need to work effectively with assistive personnel. The abilities to delegate, assign, and supervise are critical competencies for the 21st century nurse.

In 2005, both the American Nurses Association and the National Council of State Boards of Nursing adopted papers on delegation.¹ Both papers presented the same message: delegation is an essential nursing skill. This joint statement was developed to support the practicing nurse in using delegation safely and effectively.

II. Terminology

Although there is considerable variation in the language used to talk about delegation, ANA and NCSBN both defined delegation as the process for a nurse to direct another person to perform nursing tasks and activities. NCSBN describes this as the nurse transferring authority while ANA calls this a transfer of responsibility. Both mean that a registered nurse (RN) can direct another individual to do something that that person would not normally be allowed to do. Both papers stress that the nurse retains accountability for the delegation.

Both papers define assignment as *the distribution of work that each staff member is responsible for during a given work period*. The NCSBN uses the verb “assign” to describe those situations when a nurse directs an individual to do something the individual is already authorized to do, e.g., when an RN directs another RN to assess a patient, the second RN is already authorized to assess patients in the RN scope of practice.

Both papers consider supervision² to be the provision of guidance and oversight of a delegated nursing task. ANA refers to on-site supervision and NCSBN refers to direct supervision, but both have to do with the physical presence and immediate availability of the supervising nurse. The ANA refers to off-site supervision, and NCSBN refers to

indirect supervision. Both have to do with availability of the supervising nurse through various means of written and verbal communication.

III. Policy Considerations

State nurse practice acts define the legal parameters for nursing practice. Most states authorize RNs to delegate.

- There is a need and a place for competent, appropriately supervised nursing assistive personnel in the delivery of affordable, quality health care.
- The RN assigns or delegates tasks based on the needs and condition of the patient, potential for harm, stability of the patient's condition, complexity of the task, predictability of the outcomes, abilities of the staff to whom the task is delegated, and the context of other patient needs.
- All decisions related to delegation and assignment are based on the fundamental principles of protection of the health, safety and welfare of the public.

IV. Principles of Delegation

- The RN takes responsibility and accountability for the provision of nursing practice.
- The RN directs care and determines the appropriate utilization of any assistant involved in providing direct patient care.
- The RN may delegate components of care but does not delegate the nursing process itself. The practice pervasive functions of assessment, planning, evaluation and nursing judgment cannot be delegated.
- The decision of whether or not to delegate or assign is based upon the RN's judgment concerning the condition of the patient, the competence of all members of the nursing team and the degree of supervision that will be required of the RN if a task is delegated.
- The RN delegates only those tasks for which she or he believes the other health care worker has the knowledge and skill to perform, taking into consideration training, cultural competence, experience and facility/agency policies and procedures.
- The RN individualizes communication regarding the delegation to the nursing assistive personnel and client situation and the communication should be clear, concise, correct and complete. The RN verifies comprehension with the nursing assistive personnel and that the assistant accepts the delegation and the responsibility that accompanies it.
- Communication must be a two-way process. Nursing assistive personnel should have the opportunity to ask questions and/or for clarification of expectations.
- The RN uses critical thinking and professional judgment when following the Five Rights of Delegation, to be sure that the delegation or assignment is:
 1. The right task
 2. Under the right circumstances
 3. To the right person
 4. With the right directions and communication; and
 5. Under the right supervision and evaluation.
- Chief Nursing Officers are accountable for establishing systems to assess, monitor, verify and communicate ongoing competence requirements in areas related to delegation.

- There is both individual accountability and organizational accountability for delegation. Organizational accountability for delegation relates to providing sufficient resources, including:
 - Sufficient staffing with an appropriate staff mix
 - Documenting competencies for all staff providing direct patient care and for ensuring that the RN has access to competence information for the staff to whom the RN is delegating care of.
- Organizational policies on delegation are developed with the active participation of all nurses and acknowledge that delegation is a professional right and responsibility.

V. Delegation Resources

Both the ANA and NCSBN have developed resources to support the nurse in making decisions related to delegation. Appendix A of this paper provides the ANA Principles of Delegation. Appendix B presents the NCSBN decision tree on delegation that reflects the four phases of the delegation process articulated by the NCSBN.

VI. Delegation in Nursing Education

Both the ANA and the NCSBN acknowledge that delegation is a skill that must be taught and practiced for nurses to be proficient in using it in the delivery of nursing care. Nursing schools should provide students with both didactic content and the opportunity to apply theory in a simulated and realistic context. Nursing curricula must include competencies related to delegation. RNs are educated and mentored on how to delegate and supervise others. The effective use of delegation requires a nurse to have a body of practice experience and the authority to implement the delegation.

A. Delegation in NCLEX®

The *NCLEX-RN® Examination Test Plan* includes competencies related to delegation.

Delegation in the Provision of Nursing Care

The ANA paper outlines some basic elements for the nurse that is essential to form the foundation for delegation, including:

1. Emphasis on professional nursing practice;
2. Definition of delegation, based on the nurse practice act and rules/regulations;
3. Review of specific sections of the law and regulations regarding delegation;
4. Emphasis on tasks/functions that cannot be delegated or cannot be routinely delegated;
5. Focus on RN judgment for task analysis and the decision whether or not to delegate.
6. Determination of the degree of supervision required for delegation;
7. Identification of guidelines for lowering risk related to delegation;

8. Development of feedback mechanisms to ensure that a delegated task is completed and to receive updated data to evaluate the outcome.

The NCSBN paper discusses these elements as part of the preparation to delegate. The NCSBN paper also articulates the following steps of the delegation process:

- Assess and plan the delegation, based on the patient needs and available resources.
- Communicate directions to the delegate including any unique patient requirements and characteristics as well as clear expectations regarding what to do, what to report, and when to ask for assistance.
- Surveillance and supervision of the delegation, including the level of supervision needed for the particular situation and the implementation of that supervision, including follow-up to problems or a changing situation.
- Evaluation and feedback to consider the effectiveness of the delegation, including any need to adjust the plan of care.

Delegation skills are developed over time. Nursing employers need to recognize that a newly licensed nurse is a novice who is still acquiring foundational knowledge and skills. In addition, many nurses lack the knowledge, the skill and the confidence to delegate effectively, so ongoing opportunities to enforce the theory and apply the principles of delegation is an essential part of employment orientation and staff development.

Many nurses are reluctant to delegate. This is reflected in NCSBN research findings and a review of the literature as well as anecdotal accounts from nursing students and practicing nurses. There are many contributing factors, ranging from not having had educational opportunities to learn how to work with others effectively to not knowing the skill level and abilities of nursing assistive personnel to simply the work pace and turnover of patients. At the same time, NCSBN research shows an increase in the complexity of the nursing tasks performed by assistive personnel. With the demographic changes and resultant increase in the need for nursing services, plus the nursing shortage, nurses need the support of nursing assistive personnel.

VII. Conclusions

The topic of delegation has never been timelier. Delegation is a process that, used appropriately, can result in safe and effective nursing care. Delegation can free the nurse for attending more complex patient care needs, develop the skills of nursing assistive personnel and promote cost containment for the healthcare organization. The RN determines appropriate nursing practice by using nursing knowledge, professional judgment and the legal authority to practice nursing. RNs must know the context of their practice, including the state nurse practice act and professional standards as well as the facility/organization's policies and procedures related to delegation. Facing a shortage of epic proportions, the nursing community needs to plan how we can continue to

accomplish nursing care while assuring the public access to safe, competent nursing care. RNs are urged to seek guidance and appropriate direction from supervisors or mentors when considering decisions about delegation. Mastering the skill and art of delegation is a critical step on the pathway to nursing excellence.

Attachments:

Attachment A: *ANA Principles of Delegation*

Attachment B: *NCSBN Decision Tree – Delegation to Nursing Assistive Personnel*

ATTACHMENT A: AMERICAN NURSES ASSOCIATION PRINCIPLES FOR DELEGATION

The following principles have remained constant since the early 1950s.

Overarching Principles:

- The nursing profession determines the scope of nursing practice.
- The nursing profession defines and supervises the education, training and utilization for any assistant roles involved in providing direct patient care.
- The RN takes responsibility and accountability for the provision of nursing practice.
- The RN directs care and determines the appropriate utilization of any assistant involved in providing direct patient care.
- The RN accepts aid from nursing assistive personnel in providing direct patient care.

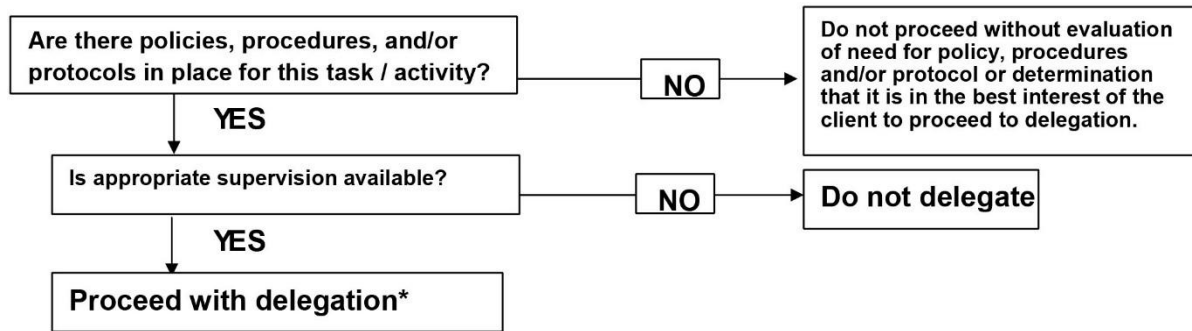
Nurse-related Principles:

- The RN may delegate elements of care but does not delegate the nursing process itself.
- The RN has the duty to answer for personal actions relating to the nursing process.
- The RN takes into account the knowledge and skills of any individual to whom the RN may delegate elements of care.
- The decision of whether or not to delegate or assign is based upon the RN's judgment concerning the condition of the patient, the competence of all members of the nursing team and the degree of supervision that will be required of the RN if a task is delegated.
- The RN delegates only those tasks for which she or he believes the other health care worker has the knowledge and skill to perform, taking into consideration training, cultural competence experience and facility/agency policies and procedures.
- The RN uses critical thinking and professional judgment when following The Five Rights of Delegation:
 1. Right task
 2. Right circumstances
 3. Right person
 4. Right directions and communication
 5. Right supervision and evaluation (NCSBN 1995)
- The RN acknowledges that there is a relational aspect to delegation and that communication is culturally appropriate and the person receiving the communication is treated respectfully.
- Chief nursing officers are accountable for establishing systems to assess, monitor, verify and communicate ongoing competence requirements in areas related to delegation, both for RNs and delegates.
- RNs monitor organizational policies, procedures and position descriptions to ensure there is no violation of the nurse practice act, working with the state board of nursing if necessary.

Organization-related Principles:

- The organization is accountable for delegation through the allocation of resources to ensure sufficient staffing so that the RN can delegate appropriately.
- The organization is accountable for documenting competencies for all staff providing direct patient care and for ensuring that the RN has access to competency information for staff to whom the RN is delegating patient care.
- Organizational policies on delegation are developed with the active participation of all nurses (staff, managers and administrators).
- The organization ensures that the education needs of nursing assistive personnel are met through the implementation of a system that allows for nurse input.
- Organizations have policies in place that allow input from nurses indicating that delegation is a professional right and responsibility.

Step One – Assessment and Planning



Step Two – Communication

Communication must be a two-way process

The nurse: • Assesses the assistant's understanding ○ How the task is to be accomplished ○ When and what information is to be reported, including • Expected observations to report and record • Specific client concerns that would require prompt reporting. • Individualizes for the nursing assistive personnel and client situation • Addresses any unique client requirements and characteristics, and clear expectations of: • Assesses the assistant's understanding of expectations, providing clarification if needed. • Communicates his or her willingness and availability to guide and support assistant. • Assures appropriate accountability by verifying that the receiving person accepts the delegation and accompanying responsibility	The nursing assistive personnel: • Ask questions regarding the delegation and seek clarification of expectations if needed • Inform the nurse if the assistant has not done a task/function/activity before, or has only done infrequently • Ask for additional training or supervision • Affirm understanding of expectations • Determine the communication method between the nurse and the assistive personnel • Determine the communication and plan of action in emergency situations. •	Documentation: <i>Timely, complete and accurate documentation of provided care</i> • Facilitates communication with other members of the healthcare team • Records the nursing care provided.
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Step Three – Surveillance and Supervision

The purpose of surveillance and monitoring is related to nurse's responsibility for client care within the context of a client population. The nurse supervises the delegation by monitoring the performance of the task or function and assures compliance with standards of practice, policies and procedures. Frequency, level and nature of monitoring vary with needs of client and experience of assistant.

The nurse considers the: • Client's health care status and stability of condition • Predictability of responses and risks • Setting where care occurs • Availability of resources and support infrastructure. • Complexity of the task being performed.	The nurse determines the frequency of on-site supervision and assessment based on: • Needs of the client • Complexity of the delegated • function/task/activity • Proximity of nurse's location.	The nurse is responsible for: • Timely intervening and follow-up on problems and concerns. Examples of the need for intervening include: • Alertness to subtle signs and symptoms (which allows nurse and assistant to be proactive before a client's condition deteriorates significantly). • Awareness of assistant's difficulties in completing delegated activities. • Providing adequate follow-up to problems and/or changing situations is a critical aspect of delegation.
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Step Four – Evaluation and Feedback

Evaluation is often the forgotten step in delegation.

- In considering the effectiveness of delegation, the nurse addresses the following questions:
- Was the delegation successful?
- Was the task/function/activity performed correctly?
- Was the client's desired and/or expected outcome achieved?
- Was the outcome optimal, satisfactory or unsatisfactory?
- Was communication timely and effective?
- What went well; what was challenging?
- Were there any problems or concerns; if so, how were they addressed?
- Is there a better way to meet the client need?
- Is there a need to adjust the overall plan of care, or should this approach be continued?
- Were there any "learning moments" for the assistant and/or the nurse?
- Was appropriate feedback provided to the assistant regarding the performance of the delegation?
- Was the assistant acknowledged for accomplishing the task/activity/function?

Reference: American Nurses Association & National Council of State Boards of Nursing. (2010). Joint Statement on Delegation.

ATTACHMENT B: NATIONAL GUIDELINES FOR NURSING DELEGATION

I. Purpose

Delegation is an essential nursing skill. Building on previous work of NCSBN and the American Nurses Association (ANA), this joint statement reflects an effort to standardize the nursing delegation process based on research findings and evidence in the literature and is applicable to all levels of nursing licensure (advanced practice registered nurse [APRN], registered nurse [RN]).

These guidelines can be applied to:

- APRNs when delegating to RNs, LPN/VNs and assistive personnel (AP)
- RNs when delegating to LPN/VNs and AP

Note: These guidelines do not apply to the transfer of responsibility for care of a patient between licensed health care providers (e.g., RN to another RN or LPN/VN to another LPN/VN), which is considered a handoff (Agency for Healthcare Research and Quality, 2015).

Introduction

Health care is continuously changing and necessitates adjustment for evolving roles and responsibilities of licensed health care providers and assistive personnel. The abilities to delegate, assign and supervise are critical competencies for every RN. It is important to note that states/jurisdictions have different laws and rules/regulations about delegation, and it is the responsibility of all licensed nurses to know what is permitted in their jurisdiction. When certain nursing care needs to be delegated, it is imperative that the delegation process and the jurisdiction NPA be clearly understood so that it is safely, ethically and effectively carried out.

The decision of whether or not to delegate or assign is based upon the RN's judgment concerning the condition of the patient, the competence of all members of the nursing team and the degree of supervision that will be required of the RN if a task is delegated. The difference between delegation and assignment has been a source of debate for years.

Definitions

- **Accountability:** “To be answerable to oneself and others for one’s own choices, decisions and actions as measured against a standard...” (American Nurses Association, 2015, p. 41).
- **Delegated Responsibility:** A nursing activity, skill or procedure that is transferred from a licensed nurse to a delegatee.
- **Delegatee:** One who is delegated a nursing responsibility by either an APRN, RN or LPN/VN (where jurisdiction NPA allows), is competent to perform it and verbally accepts the responsibility. A delegatee may be an RN, LPN/VN or AP.
- **Delegator:** One who delegates a nursing responsibility. A delegator may be APRN, RN, or LPN/VN (where jurisdiction NPA allows).
- **Assignment:** The routine care, activities and procedures that are within the authorized scope of practice of the RN or LPN/VN or part of the routine functions of the AP.
- **Licensed Nurse:** A licensed nurse includes APRNs, RNs and LPN/VNs. In some states/jurisdictions, LPN/VNs may be allowed to delegate.
- **Assistive Personnel (AP):** Any assistive personnel trained to function in a supportive role, regardless of title, to whom a nursing responsibility may be delegated. This includes but is not limited to certified nursing assistants or aides (CNAs), patient care technicians, CMAs, certified medication aids, and home health aides (formerly referred to as “unlicensed” assistive personnel [UAP]).

When performing a fundamental skill on the job, the delegatee is considered to be carrying out an assignment. The routine care, activities and procedures assigned are those which would have been included in the delegatee’s basic educational program. A licensed nurse is still responsible for ensuring an assignment is carried out completely and correctly. Delegation is allowing a delegatee to perform a specific nursing activity, skill, or procedure that is beyond the delegatee’s traditional role and not routinely performed. This applies to licensed nurses as well as AP. Regardless of the current role of the delegatee (RN, LPN/ VN or AP), delegation can be summarized as follows:

- A delegatee is allowed to perform a specific nursing activity, skill or procedure that is outside the traditional role and basic responsibilities of the delegatee’s current job.
- The delegatee has obtained the additional education and training, and validated competence to perform the care/delegated responsibility. The context and processes associated with competency validation will be different for each activity, skill or procedure being delegated. Competency validation should be specific to the knowledge and skill needed to safely perform the delegated responsibility as well as to the level of practitioner (i.e., RN, LPN/VN, AP) to whom the activity, skill or procedure has been delegated. The licensed nurse who delegates the “responsibility” maintains overall accountability for the patient. However, the delegatee bears the responsibility for the delegated activity, skill or procedure.

- The licensed nurse cannot delegate nursing judgment or any activity that will involve nursing judgment or critical decision making.
- Nursing responsibilities are delegated by someone who has the authority to delegate.
- The delegated responsibility is within the delegator's scope of practice.
- When delegating to a licensed nurse, the delegated responsibility must be within the parameters of the delegatee's authorized scope of practice under the NPA. Regardless of how the state/jurisdiction defines delegation, as compared to assignment, appropriate delegation allows for transition of a responsibility in a safe and consistent manner. Clinical reasoning, nursing judgment and critical decision making cannot be delegated.

The delegation process is multifaceted. It begins with the administrative level of the organization including: determining nursing responsibilities that can be delegated, to whom, and what circumstances; developing delegation policies and procedures; periodically evaluating delegation processes; and promoting positive culture/work environment. The licensed nurse must be responsible for determining patient needs and when to delegate, ensure availability to delegate, evaluate outcomes of and maintain accountability for delegated responsibility. Finally, the delegatee must accept activities based on their competency level, maintain competence for delegated responsibility and maintain accountability for delegated activity



Five Rights of Delegation

- **Right task:** The activity falls within the delegatee's job description or is included as part of the established written policies and procedures of the nursing practice setting. The facility needs to ensure the policies and procedures describe the expectations and limits of the activity and provide any necessary competency training.
- **Right circumstance:** The health condition of the patient must be stable. If the patient's condition changes, the delegatee must communicate this to the licensed nurse, and the licensed nurse must reassess the situation and the appropriateness of the delegation.
- **Right person:** The licensed nurse along with the employer and the delegatee is responsible for ensuring that the delegatee possesses the appropriate skills and knowledge to perform the activity.
- **Right directions and communication:** Each delegation situation should be specific to the patient, the licensed nurse and the delegatee. The licensed nurse is expected to

communicate specific instructions for the delegated activity to the delegatee; the delegatee, as part of two-way communication, should ask any clarifying questions. This communication includes any data that need to be collected, the method for collecting the data, the time frame for reporting the results to the licensed nurse, and additional information pertinent to the situation. The delegatee must understand the terms of the delegation and must agree to accept the delegated activity. The licensed nurse should ensure that the delegate understands that she or he cannot make any decisions or modifications in carrying out the activity without first consulting the licensed nurse.

- **Right supervision and evaluation:** The licensed nurse is responsible for monitoring the delegated activity, following up with the delegatee at the completion of the activity, and evaluating patient outcomes. The delegatee is responsible for communicating patient information to the licensed nurse during the delegation situation. The licensed nurse should be ready and available to intervene as necessary. The licensed nurse should ensure appropriate documentation of the activity is completed.

Source: NCSBN. (1995, 1996)

Guidelines for Delegation

Employer/Nurse Leader Responsibilities

1. **The employer must identify a nurse leader responsible for oversight of delegated responsibilities for the facility.** If there is only one licensed nurse within the practice setting, that licensed nurse must be responsible for oversight of delegated responsibilities for the facility

Rationale: The nurse leader has the ability to assess the needs of the facility, understand the type of knowledge and skill needed to perform a specific nursing responsibility, and be accountable for maintaining a safe environment for patients. He or she is also aware of the knowledge, skill level and limitations of the licensed nurses and AP. Additionally, the nurse leader is positioned to develop appropriate staffing models that take into consideration the need for delegation. Therefore, the decision to delegate begins with a thorough assessment by a nurse leader designated by the institution to oversee the process.

2. **The designated nurse leader responsible for delegation, ideally with a committee (consisting of other nurse leaders) formed for the purposes of addressing delegation, must determine which nursing responsibilities may be delegated, to whom and under what circumstances.** The nurse leader must be aware of the state/jurisdiction's NPA and the laws/rules and regulations that affect the delegation process and ensure all institution policies are in accordance with the law.

Rationale: A systematic approach to the delegation process fosters communication and consistency of the process throughout the facility

3. **Policies and procedures for delegation must be developed.** The employer/nurse leader must outline specific responsibilities that can be delegated and to whom these responsibilities can be delegated. The policies and procedures should also indicate what may not be delegated. The employer must periodically review the policies and procedures for delegation to ensure they remain consistent with current nursing practice trends and that they are consistent with the state/jurisdiction's NPA (institution/employer policies can be more restrictive, but not less restrictive).

Rationale: Policies and procedures standardize the appropriate method of care and ensure safe practices. Having a policy and procedure specific to delegation and delegated responsibilities eliminates questions from licensed nurses and AP about what can be delegated and how they should be performed.

4. **The employer/nurse leader must communicate information about delegation to the licensed nurses and AP and educate them about what responsibilities can be delegated.** This information should include the competencies of delegates who can safely perform a specific nursing responsibility.

Rationale: Licensed nurses must be aware of the competence level of staff and expectations for delegation (as described within the policies and procedures) in order to make informed decisions on whether or not delegation is appropriate for the given situation. Licensed nurses maintain accountability for the patient. However, the delegatee has responsibility for the delegated activity, skill or procedure.

5. **All delegates must demonstrate knowledge and competency on how to perform a delegated responsibility.** Therefore, the employer/nurse leader is responsible for providing access to training and education specific to the delegated responsibilities. This applies to all RNs, LPN/VNs and AP who will be delegates. Competency validation should follow education and competency testing should be kept on file. Competency must be periodically evaluated to ensure continued competency. The context and processes associated with competency validation will be different for each activity, skill or procedure being delegated. Competency validation should be specific to the knowledge and skill needed to safely perform the delegated responsibility as well as to the level of practitioner (i.e., RN, LPN/VN, AP) to whom the activity, skill, or procedure has been delegated.

Rationale: This ensures that competency of the delegatee is determined not only at the beginning of the delegation process, but on an ongoing basis, as well.

- 6. The nurse leader responsible for delegation, along with other nurse leaders and administrators within the facility, must periodically evaluate the delegation process.** The licensed nurse and/or his or her manager (if applicable) must report any incidences to the nurse leader responsible for delegation. A decision should be made about corrective action, including if further education and training are needed, or if that individual should not be allowed to perform a specific delegated responsibility.

Rationale: Patient safety should always be the priority for a health care setting. If any compromises in care are noted, immediate action must be taken. Gravlin and Bittner (2010) identified that evaluation of the effectiveness of the delegation process and resolution of any issues is critical to delegation.

- 7. The employer/nurse leader must promote a positive culture and work environment for delegation.**

Rationale: A positive culture nurtures effective communication and collaboration in order to create an environment supportive of patient directed care.

Licensed Nurse Responsibilities

Any decision to delegate a nursing responsibility must be based on the needs of the patient or population, the stability and predictability of the patient's condition, the documented training and competence of the delegatee, and the ability of the licensed nurse to supervise the delegated responsibility and its outcome, with special consideration to the available staff mix and patient acuity. Additionally, the licensed nurse must consider the state/jurisdiction's provisions for delegation and the employer's policies and procedures prior to making a final decision to delegate. Licensed nurses must be aware that delegation is at the nurse's discretion, with consideration of the particular situation. The licensed nurse maintains accountability for the patient, while the delegatee is responsible for the delegated activity, skill or procedure. If, under the circumstances, a nurse does not feel it is appropriate to delegate a certain responsibility to a delegatee, the delegating nurse should perform the activity him/herself.

- 1. The licensed nurse must determine when and what to delegate based on the practice setting, the patients' needs and condition, the state/jurisdiction's provisions for delegation, and the employer policies and procedures regarding delegating a specific responsibility.** The licensed nurse must determine the needs of the patient and whether those needs are matched by the knowledge, skills and abilities of the delegatee and can be performed safely by the delegatee. The licensed nurse cannot delegate any activity that requires clinical

reasoning, nursing judgment or critical decision making. The licensed nurse must ultimately make the final decision whether an activity is appropriate to delegate to the delegatee based on the Five Rights of Delegation (NCSBN, 1995, 1996).

Rationale: The licensed nurse, who is present at the point of care, is in the best position to assess the needs of the patient and what can or cannot be delegated in specific situations.

- 2. The licensed nurse must communicate with the delegatee who will be assisting in providing patient care.** This should include reviewing the delegatee's assignment and discussing delegated responsibilities, including information on the patient's condition/stability, any specific information pertaining to a certain patient (e.g., no blood draws in the right arm), and any specific information about the patient's condition that should be communicated back to the licensed nurse by the delegatee.

Rationale: Communication must be a two-way process involving both the licensed nurse delegating the activity and the delegatee being delegated the responsibility. Evidence shows that the better the communication between the nurse and the delegatee, the more optimal the outcome (Corazzini, Anderson, Mueller, Hunt-McKinney et al., 2013). The licensed nurse must provide information about the patient and care requirements. This includes any specific issues related to any delegated responsibilities. These instructions should include any unique patient requirements. The licensed nurse must instruct the delegatee to regularly communicate the status of the patient.

- 3. The licensed nurse must be available to the delegatee for guidance and questions, including assisting with the delegated responsibility, if necessary, or performing it him/herself if the patient's condition or other circumstances warrant doing so.**

Rationale: Delegation calls for nursing judgment throughout the process. The final decision to delegate rests in the hands of the licensed nurse as he or she has overall accountability for the patient.

- 4. The licensed nurse must follow up with the delegatee and the patient after the delegated responsibility has been completed.**

Rationale: The licensed nurse who delegates the "responsibility" maintains overall accountability for the patient, while the delegatee is responsible for the delegated activity, skill or procedure.

- 5. The licensed nurse must provide feedback information about the delegation process and any issues regarding delegatee competence level to the nurse**

leader. Licensed nurses in the facility need to communicate, to the nurse leader responsible for delegation, any issues arising related to delegation and any individual that they identify as not being competent in a specific responsibility or unable to use good judgment and decision making.

Rationale: This will allow the nurse leader responsible for delegation to develop a plan to address the situation.

Delegatee Responsibilities

Everyone is responsible for the well-being of patients. While the nurse is ultimately accountable for the overall care provided to a patient, the delegatee shares the responsibility for the patient and is fully responsible for the delegated activity, skill or procedure.

- 1. The delegatee must accept only the delegated responsibilities that he or she is appropriately trained and educated to perform and feels comfortable doing given the specific circumstances in the health care setting and patient's condition.** The delegatee should confirm acceptance of the responsibility to carry out the delegated activity. If the delegatee does not believe he or she has the appropriate competency to complete the delegated responsibility, then the delegatee should not accept the delegated responsibility. This includes informing the nursing leadership if he or she does not feel he or she has received adequate training to perform the delegated responsibility, is not performing the procedure frequently enough to do it safely, or his or her knowledge and skills need updating.

Rationale: The delegatee shares the responsibility to keep patients safe and this includes only performing activities, skills or procedures in which he or she is competent and comfortable doing.

- 2. The delegatee must maintain competency for the delegated responsibility.**

Rationale: Competency is an ongoing process. Even if properly taught, the delegatee may become less competent if he or she does not frequently perform the procedure. Given that the delegatee shares the responsibility for the patient, the delegatee also has a responsibility to maintain competency.

- 3. The delegatee must communicate with the licensed nurse in charge of the patient.** This includes any questions related to the delegated responsibility and follow-up on any unusual incidents that may have occurred while the delegatee was performing the delegated responsibility, any concerns about a patient's condition, and any other information important to the patient's care.

Rationale: The delegatee is a partner in providing patient care. He or she is interacting with the patient/family and caring for the patient. This information and two-way communication is important for successful delegation and optimal outcomes for the patient.

4. **Once the delegatee verifies acceptance of the delegated responsibility, the delegatee is accountable for carrying out the delegated responsibility correctly and completing timely and accurate documentation per facility policy.** The delegatee cannot delegate to another individual. If the delegatee is unable to complete the responsibility or feels as though he or she needs assistance, the delegatee should inform the licensed nurse immediately so the licensed nurse can assess the situation and provide support. Only the licensed nurse can determine if it is appropriate to delegate the activity to another individual. If at any time the licensed nurse determines he or she needs to perform the delegated responsibility, the delegatee must relinquish responsibility upon request of the licensed nurse.

Rationale: Only a licensed nurse can delegate. In addition, because they are responsible, they need to provide direction, determine who is going to carry out the delegated responsibility, and assist or perform the responsibility him/herself, if he or she deems that appropriate under the given circumstances.

Reference: American Nurses Association & National Council of State Boards of Nursing. (2019, April 29.) [National Guidelines for Nursing Delegation](#).

APPENDIX 4E: DDD PROVIDER NURSE DELEGATION PACKET

DDD Provider Nursing Assessment

Participants whose health and safety needs include nursing tasks, performed during waiver service hours, must receive a Nursing Assessment by a Provider Registered Nurse (RN) to help inform the person-centered planning process. The Nursing Assessment must be completed by a Registered Nurse who is licensed in the State of Hawai'i, in accordance with Chapter 89 of the HAR and HRS §457.

TO BE COMPLETED:

- UPON THE IMPLEMENTATION OF A NEW T&C-RN* AND/OR NURSING SERVICES
- ANNUALLY BY AGENCY RN PROVIDING OVERSIGHT

**THIS INCLUDES T&C-RN SERVICES THAT ARE AUTHORIZED AS A SEPARATE SERVICE AND/OR ARE BUILT BACK INTO EXISTING SERVICES.*

Training and Consultation-Registered Nurse (T&C RN) & PDN may be authorized for the following types of activities (refer to Waiver Standards (07/01/2026), Section 1.7D: Nursing Assessment and Delegation, for details):

- Completion of the Provider Nursing Assessment;
- Development of Nurse Delegation Plan(s) and/or protocols to address identified needs;
- Training and/or teaching - initial or ongoing;
- Oversight and monitoring of Nurse Delegation; and/or
- Revisions to Nurse Delegation plan(s) and/or protocols, as needed.

T&C RN may be authorized per Provider as nursing tasks may occur during multiple services the participant receives, and Providers are not obligated to delegate to workers outside of their agency.

T&C RN for Nursing Assessment:

- May authorize up to two (2) hours for the Provider RN to complete the DDD Provider Nursing Assessment and Delegation Plan (if applicable) for:
 - Consumer-Directed
 - PAB
 - CLS-Ind;
 - Respite;
 - Community Navigator;
 - Discovery and Career Planning (DCP); and
 - Individual Employment Supports (IES).

T&C RN for Nurse Delegation:

- For CD (PAB, CLS-I, Respite), Community Navigator, Discovery & Career Planning, and Individual Employment Supports the Provider RN will include their recommendation for the number of hours needed to complete the nurse delegation requirements (e.g. Nurse Delegation Plan(s), training, skills verification, supervision/monitoring).
- For ADH, PAB, CLS-I, CLS-G, ResHab, PCA, RCA and Respite the Provider RN does not need to include a recommendation for the number of hours needed to complete the nurse delegation requirements, as it is not a separate authorization. Review by DDD for approved hours does not need to occur for these services.

Nurse Delegation Plan(s), training, skills verification, supervision/monitoring) because the T&C RN has been built back into these services effective 11/01/2023 (Waiver Amendment #7).

- The Provider Nursing Assessment includes an Authorization Guide, based on the participant's identified risk category, for those services with a separate T&C RN authorization.
- If T&C RN will be a separate authorization, the recommended hours will be reviewed and considered for authorization by the DOH-DDD.
- If any nursing tasks will be delegated, a separate delegation plan must be attached to the RN Assessment, and be reviewed each time there is a change to the RN Assessment and updated annually or as needed.

Instructions:

Provider RN must complete the DDD Provider Nursing Assessment and DDD Delegation Plan (if applicable) and submit to the Developmental Disabilities Division (DDD) Case Manager (CM). The DDD Provider Nursing Assessment includes the following:

- 1) Provider Nursing Assessment;
- 2) Worksheet A: Nurse Delegation T&C RN Worksheet;
- 3) Worksheet B: Assessment of Risk Guidelines (pg. 2 Risk Guideline Category will pertain when T&C-RN is authorized as a separate service, per the guidelines in the Waiver Standards);
- 4) Delegation Plan (Separate form - Complete if applicable and tasks are delegated).

Timelines/Requirements

- The DDD Provider Nursing Assessment is due to CM:
 - New participant or new services:
 - Within 15 days of the ISP meeting (when nursing services were determined to be needed) and prior to the start of services.
 - Ongoing services:
 - Prior to the annual ISP meeting and before the start of services.
- All agency staff performing delegated tasks must be trained upon completion of the DDD Provider Nursing Assessment and Delegation Plan (if applicable) and prior to performing the delegated tasks.
- The Nurse Delegation form, which documents the delegated tasks and training of staff, is due to the CM within 15 calendar days of completion of the RN assessment and prior to services starting.
- All services delivered must be in accordance with the current version of the Waiver Provider Standards Manual.

Provider Agency RN Shall:

- Complete a face-to-face visit with participant as per the request of the CM and within the time frame requested of the CM upon discharge from hospital/medical facility to review and update the DDD Provider Nursing Assessment and Delegation Plan as applicable.
- Review and update the DDD Provider Nursing Assessment and Delegation Plan, if applicable, immediately upon changes to participant's health
- Be present at participant's hospital discharge, upon request of DDD Case Manager.

DDD PROVIDER NURSING ASSESSMENT

1. Background Information

Date:		RN Provider Agency:	
Participant Name:		Provider RN conducting the nurse assessment:	
Date of Birth:		CMB Unit & CM:	
Health Plan Name:		Health Plan Service Coordinator:	
Guardian (if applicable):		Residential Setting:	

Medical History:

Medical Stability: *(include all risk factors, precautions, hospitalizations, and AERs in the past year)*

Diet/Nutrition:

Durable Medical Equipment/Medical Supplies:

Medications/Allergies (please include medication name, indication, dosage and route, and ordering physician):

2. Identification of Nursing Tasks

Nursing Task(s) (See Worksheet A)	List the delegatee each task is being delegated to & the service(s) setting the task is delegated in (if applicable)	If not delegated, reason and who will be completing the task:	RN authorization of task delegation (If "No" provide reason why task cannot be delegated) <i>*Delegation plan must be completed and attached</i>	Associated risks (Please list any potential negative outcomes associated with the task)
Task #1:	Person(s) and Service(s):		☐ Yes – task will be delegated. ☐ No – Reason:	
Task #2:	Person(s) and Service(s):		☐ Yes – task will be delegated. ☐ No – Reason:	
Task #3:	Person(s) and Service(s):		☐ Yes – task will be delegated. ☐ No – Reason:	
Task #4:	Person(s) and Service(s):		☐ Yes – task will be delegated. ☐ No – Reason:	
Task #5:	Person(s) and Service(s):		☐ Yes – task will be delegated. ☐ No – Reason:	

Identification of Nursing Tasks (continued)				
Nursing Task(s) (See Worksheet A)	List the delegatee each task is being delegated to & the service(s) setting the task is delegated in (if applicable)	If not delegated, reason and who will be completing the task:	RN authorization of task delegation (If "No" provide reason why task cannot be delegated) *Delegation plan must be completed and attached	Associated risks (Please list any potential negative outcomes associated with the task)
Task #6:	Person(s) and Service(s):		☐ Yes – task will be delegated. ☐ No – Reason:	
Task #7:	Person(s) and Service(s):		☐ Yes – task will be delegated. ☐ No – Reason:	
Task #8:	Person(s) and Service(s):		☐ Yes – task will be delegated. ☐ No – Reason:	
Task #9:	Person(s) and Service(s):		☐ Yes – task will be delegated. ☐ No – Reason:	
Task #10:	Person(s) and Service(s):		☐ Yes – task will be delegated. ☐ No – Reason:	

3. Supervision/Monitoring Requirements *Mandatory for all nursing tasks.

The RN must conduct, at a minimum, quarterly face-to-face visits with the participant and person being delegated to and other supervision/monitoring activities needed, based on the Nursing Assessment. RN may assess if more frequent supervision/monitoring requirements are needed based on RN assessment. (See Waiver Provider Standards Manual, Section 4.18 – Training & Consultation for more details.)

Supervision/Monitoring Requirements (based on Provider Nursing Assessment)	☐ Quarterly face-to-face visits ☐ Other frequency supervision/monitoring recommendation. Please enter your recommended frequency for supervision/monitoring here:
RN Rationale/Comments	

4. Provider RN Additional Comments/Notes

Comments/Notes (If applicable, RN may provide any additional relevant information)	☐ Check here if additional information is attached
---	---

5. Assessment of Participant's Circumstance *For T&C-RN services authorized separately for IES, DCP, Community Navigator, CD (PAB, CLS-I, Respite) ONLY

RN may consider the participant's medical stability, condition, and the situation, etc. when assessing the participant's circumstance.

Category Risk Determination (Apply Criteria in Worksheet B)	Recommended Hours for T&C for Nurse Delegation (Recommended hours will be reviewed and considered for authorization by the DOH-DDD. Please enter the recommended hours.)	
	Authorization Guide (Per plan year)	Enter Provider RN's recommendation for hours needed to complete the nurse delegation requirements (Nurse Delegation Plan(s), training, skills verification, supervision/monitoring).
☐ Category 1 (Low Risk)	Up to 4 hours annually	
☐ Category 2 (Moderate Risk)	Up to 6 hours annually	
☐ Category 3 (High Risk)	Up to 12 hours annually	
☐ Category 4 (Highest Risk)	Up to 24 hours annually	

RN Comments:

===== FOR DDD INTERNAL USE ONLY =====		
DDD RN REVIEWER		
AUTHORIZATION	☐ Yes	Approved Hours:
	☐ No	Recommended Hours:
Comments:		

Worksheet A: Nurse Delegation, Training & Consultation – Registered Nurse (T&C – RN) Worksheet

Participant Name: _____

Date: _____

Instructions for Worksheet:

1. Use the table below to identify which services are being provided to the participant that require RN delegation and oversight.
2. Under each service the participant receives, indicate the agency provider authorized to provide the service.
3. Check off whether the RN delegation activity is provided under that specific service.

Note: Many of the activities are broken down into specific tasks and/or amounts in order to consistently identify factors considered in determining participant's risk category.

RN Delegated Activities	Services provided by:	Service(s) under which RN Delegated activities are being performed.				
		PAB	ResHab	CLS-I	Respite	Other
	Provider:					
Medication Assistance - PRN only		☐	☐	☐	☐	☐
Medication Assistance - ongoing		☐	☐	☐	☐	☐
Medication Administration - PRN only		☐	☐	☐	☐	☐
Medication Administration - via oral administration (1-5 meds)		☐	☐	☐	☐	☐
Medication Administration - via oral administration (6-10 meds)		☐	☐	☐	☐	☐
Medication Administration - via oral administration (11 or more meds)		☐	☐	☐	☐	☐
Medication Administration - via topical administration		☐	☐	☐	☐	☐
Medication Administration - via rectal administration		☐	☐	☐	☐	☐
Medication Administration - via G/J-Tube (1-5 meds)		☐	☐	☐	☐	☐
Medication Administration - via G/J-Tube (6 or more meds)		☐	☐	☐	☐	☐
Medication Administration - via pre-drawn subcutaneous injections (e.g. insulin)		☐	☐	☐	☐	☐

RN Delegated Activities	Services provided by:	Service(s) under which RN Delegated activities are being performed.				
		PAB	ResHab	CLS-I	Respite	Other
	Provider:					
Medication Administration - via pre-drawn intramuscular injection (e.g. epi-pen given as first aid)		☐	☐	☐	☐	☐
Medication Administration - via Nebulizer (inhalation therapy)		☐	☐	☐	☐	☐
Cough Assist w/ Suctioning		☐	☐	☐	☐	☐
Chest Physiotherapy		☐	☐	☐	☐	☐
Suctioning – Oropharyngeal (when done separately from cough assist)		☐	☐	☐	☐	☐
G/J Tube – Bolus feeds		☐	☐	☐	☐	☐
G/J Tube – Continuous		☐	☐	☐	☐	☐
G/J Tube – site care		☐	☐	☐	☐	☐
Glucose Monitoring		☐	☐	☐	☐	☐
Oxygen Monitoring - Pulse Oximeter spot checks		☐	☐	☐	☐	☐
Oxygen Monitoring - Pulse Oximeter continuous monitoring		☐	☐	☐	☐	☐
Oxygen Therapy - Oxygen mask/cannula application		☐	☐	☐	☐	☐
Indwelling Foley Catheter Care		☐	☐	☐	☐	☐
Straight Urinary Catheterization or		☐	☐	☐	☐	☐
Suprapubic Catheter Care		☐	☐	☐	☐	☐
Apnea Care and Monitoring – BIPAP/CPAP >12 hours/day		☐	☐	☐	☐	☐

RN Delegated Activities	Services provided by:	Service(s) under which RN Delegated activities are being performed.				
		PAB	ResHab	CLS-I	Respite	Other
	Provider:					
Apnea Care and Monitoring – BIPAP/CPAP <12 hours/day		☐	☐	☐	☐	☐
Ileostomy/Colostomy care		☐	☐	☐	☐	☐
Tracheostomy Care		☐	☐	☐	☐	☐
Wound Care - Simple (for wounds, burns, ulcers using dry gauze and tape)		☐	☐	☐	☐	☐
Other (specify):		☐	☐	☐	☐	☐
Other (specify):		☐	☐	☐	☐	☐
Other (specify):		☐	☐	☐	☐	☐

For Reference: The following tasks do not require T&C RN since it can only be performed by a RN or LPN under supervision of a RN.

Skilled Nursing Activities (Activities cannot be delegated)	SN Care Currently Being Provided
Medication Administration - via non-prepared subcutaneous injection (drawing up of medications may NOT be delegated)	☐
Medication Administration - via non-prepared intramuscular injection (drawing up of medications may NOT be delegated)	☐
Oxygen Therapy requiring assessment and intervention by a nurse due to instability	☐
Suctioning – Tracheostomy	☐
Suctioning – Nasotracheal	☐
Suctioning – Endotracheal	☐
Tracheostomy Tube Change (stable trach)	☐
Wound Care - Complex (requiring sterile dressing changes and RN wound assessment)	☐
Other (specify):	☐
Other (specify):	☐
Other (specify):	☐

Worksheet B: Assessment of Risk Guidelines

Participants should be assigned to a risk category based on information from the Nursing Assessment, if applicable, and factors such as the participant's medical stability, complexity of care, and behavioral or other needs. Examples provided for each category below are intended to assist providers, CMs, unit RNs and unit supervisors, if applicable, with determining which category is most appropriate.

Participants do NOT have to meet all criteria in any given category and participants may fall into different categories depending on their assessed need(s) in different circumstances.

Indicators of Medical Instability (Used to support risk category determination)	Check all that apply
Frequent reassessment by medical professionals	☐
Frequent medication changes or adjustments requiring regular MD and RN review	☐
Inconsistent lab results (waxing/waning) requiring frequent medical follow up	☐
Medical treatment for issue(s) requiring specific precautions	☐
Administration of narcotic analgesic or psychotropic medication(s)	☐
Unstable blood sugars requiring sliding scale insulin or titration of medication	☐
Complicating factors negatively impacting health status	☐
Challenging behaviors impacting medical stability	☐
Frequent visits to urgent care or emergency room	☐
Multiple hospitalizations (2 or more hospital admissions within past year)	☐
Multiple AERs related to changes in health condition	☐
Other (specify):	☐
Other (specify):	☐
Other (specify):	☐
Other (specify):	☐

Risk Category Guidance	
Category 1 (Low Risk)	<u>Participant has maintained medical stability and has non-complex care needs.</u> <i>Examples:</i> • No changes to health condition reported over past year (excluding common cold, flu, or other seasonal illness) • Receives only annual medical check-ups with primary physician • May receive care from other medical specialists (e.g. neurologist, cardiologist, nephrologist, etc.) • Medications are well managed and require sporadic RN assessment if at all (e.g. daily vitamins) • Medications are taken on PRN basis and require sporadic RN assessment (e.g. Acetaminophen, Ibuprofen)
Category 2 (Moderate Risk)	<u>Participant has maintained medical stability but has complex care needs:</u> <i>Examples:</i> • Requires quarterly medical check-ups with primary physician • May require regular check-ups with other medical specialists (e.g. neurologist, cardiologist, nephrologist, etc.) • Medications include PRN psychotropic or narcotic analgesic orders which require verbal RN consult • Has therapeutic plans for care due to complexity of need requiring implementation of specific precautions (e.g. aspiration, falls) • Presence of complicating factors (e.g. dementia or Alzheimer's disease) but medical stability not compromised
Category 3 (High Risk)	<u>Participant is medically unstable and has complex care needs:</u> <i>Examples:</i> • Requires ongoing medical check-ups with primary physician or other medical specialists for reassessment (e.g. neurologist, cardiologist, nephrologist, pulmonologist, etc.) • Has required medical treatment for medical issue within the past six months (e.g. fall, pneumonia, bowel obstruction, sepsis, decubitus) requiring implementation of specific precautions • Has PRN order(s) for narcotic analgesic or psychotropic medication AND required administration of the medication within the past six months • Has unstable blood sugars requiring sliding scale insulin or titration of medication • Frequent medication changes or adjustments; medications require regular MD and RN review (i.e. medications require MD assessment or adjustment quarterly at minimum) • Presence of complicating factors affecting medical stability or complexity of care (e.g. MRSA, VRSA, dysphagia resulting in severe weight loss, age related conditions such as dementia or Alzheimer's) • Presence of challenging behaviors impacting medical stability (e.g. medication refusal, refusal to eat, pulling out tube, inability to follow fall risk protocols) • Multiple hospitalizations (2 or more hospital admissions within past year)
Category 4 (Highest Risk)	<u>Participant is medically unstable, has high acuity complex care needs, and is under review for transition of care:</u> <i>Examples:</i> • Requires frequent medical check-ups with other medical specialists for reassessment (e.g. neurologist, cardiologist, nephrologist, pulmonologist, etc.) • Has high risk care requiring ongoing, highly involved RN assessment • Progressive, degenerative, or terminal illness • Experienced organ failure (including renal failure requiring dialysis) • Acuity level of support needs requires involvement of multiple systems for delivery of services and care coordination Note: Participants in this level may be transitioning off PDN to address long term support or will be in transition to health plan.
Worksheet B: Risk Category Guidance 07/01/2026 Page 2	

DDD RN Delegation Plan

To accompany RN Assessment

Demographic Information:

Participant: _____
(Name)

RN Delegating Tasks: _____
(Name)

Setting: _____
(for delegating tasks)

Physician's Orders Attached: ☐ Yes ☐ No

ISP Plan Year: _____

All Current DDD Waiver Services: (Please list)

Service	Agency Provider	RN Delegated Task	Service	Agency Provider	RN Delegated Task
		☐ Yes ☐ No			☐ Yes ☐ No
		☐ Yes ☐ No			☐ Yes ☐ No
		☐ Yes ☐ No			☐ Yes ☐ No
		☐ Yes ☐ No			☐ Yes ☐ No
		☐ Yes ☐ No			☐ Yes ☐ No
		☐ Yes ☐ No			☐ Yes ☐ No

Rationale: (Please describe the reason and intent of the RN delegation.)

Clinical Notes: (Please include what the order is, the medical provider, and clear parameters if needed for each delegated task.)

Order and Parameters	Potential Risks and Safety Plan

Skill: (Please describe clearly and concisely each task the delegatee will need to complete – broken down step-by-step, if applicable.)

No.	Skill (Describe task, broken down step-by-step)	Rationale (What tasks will be delegated & why)	Equipment & Supplies	Competency Validation:	
				Delegatee (Initials)	Delegator (Initials)
1					
2					
3					
4					
5					
6					

No.	Skill (Describe task, broken down step-by-step)	Rationale (What tasks will be delegated & why)	Equipment & Supplies	Competency Validation:	
				Delgatee (Initials)	Delegator (Initials)
7					
8					
9					
10					
11					
12					

Acknowledgement of Understanding of Nursing Delegation Protocol:

Disclaimer:

This Nurse Delegation Form is intended to authorize a qualified delegatee to perform specific nursing tasks under the delegation and supervision of a licensed nurse, in accordance with applicable laws and regulations.

By signing this form, all parties acknowledge and agree to the following:

1. **Scope of Delegation:** The tasks delegated are appropriate to the *delegatee's* level of training and competence and have been assessed and approved by the delegating nurse.
2. **Limitations:** Delegated tasks do not include those that require nursing judgment, assessment, or clinical decision-making and may not be re-delegated to another individual.
3. **Responsibility:** The delegating nurse retains accountability for the decision to delegate and the overall outcomes, but the *delegatee* is responsible for performing the delegated tasks safely and correctly, as instructed.
4. **Training and Supervision:** The *delegatee* has received appropriate training and demonstrated competence in the delegated task(s) and understands the conditions under which the delegation may be withdrawn or modified.
5. **Revocation:** This delegation may be revoked at any time by the delegating nurse if the caregiver fails to perform the task safely, the patient's condition changes, or any concerns arise that affect the safety or appropriateness of the delegated task.
6. **Legal Compliance:** This form and the delegation of tasks comply with all applicable local, state, and federal laws and professional practice standards.

This form does not replace medical advice, treatment plans, or clinical supervision. It is the responsibility of the parties involved to ensure they understand their roles and limitations under this agreement.

Delegatee: _____
(Print / Signature)

Date: _____

Provider RN: _____
(Signature)

Date: _____

Service Supervisor: _____
(Signature)

Date: _____

Follow-Up Recommendations:

Retraining Log:

Date	Task	Reason	Initials

APPENDIX 4F: SEIZURE ACTION PLANS

NOTE

For a copy of the *Seizure Action Plan* form, please go to the weblink provided below:

<https://www.epilepsy.com/preparedness-safety/action-plans>

APPENDIX 4G: MEDICATION ADMINISTRATION RECORD

NOTE

For a copy of the *Medication Administration Record* form, please go to the weblink provided below:

<https://health.hawaii.gov/ddd/files/2018/06/4F-Medication-Administration-Record.pdf>

APPENDIX 4H: CONFLICT OF INTEREST DISCLOSURE FORM

STATE OF HAWAII
Department of Health

DEVELOPMENTAL DISABILITIES DIVISION
Community Resources Branch

DDD CONFLICT OF INTEREST DISCLOSURE FORM

Provider agencies must comply with the Conflict of Interest provisions set forth in DDD's Waiver Provider Standards Manual, effective July 1, 2026. Pursuant to Section 3.3 of the Waiver Standards, Provider agencies shall not furnish Waiver services to a participant where a conflict of interest exists, unless such conflict is fully disclosed and appropriately mitigated. A conflict of interest exists if the agency, or any owner, officer, director, member, or partner of the agency: (1) is related to the participant by blood, marriage or adoption; (2) is financially or legally responsible for the participant; (3) has legal authority to make financial or health care decisions on behalf of the participant; or (4) holds a direct or indirect financial or controlling interest in any entity that is compensated to provide services to the same participant.

Provider agencies are required to disclose any potential conflicts of interest to DDD prior to the start of service delivery, and if appropriate, request a time-limited exception. Disclosure shall be made to DDD on the following Form. Should any information on this Form change during service delivery, the Provider must update DDD within 10 business days.

Section 1: Identifying Information
Legal Name (Provider Agency):
DBA Name (if different from Legal Name):
Name of Person Completing the Form:
Title:
Phone Number:
Email:
Street Address:
City, State, Zip Code:
Name of Participant Receiving Services:

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<https://health.hawaii.gov/ddd/files/2026/06/DDD-Conflict-of-Interest-Disclosure-Form.pdf>

Section 2: Conflict Disclosure

Answer the following questions by checking "Yes" or "No." If any of the questions are answered "Yes," provide additional information in the space provided below each question.

1. Are any owners, officers, directors, members, or partners of your agency related to the participant by blood, marriage, or adoption?

☐ Yes ☐ No

If Yes, provide the name of the owner, officer, director, member, or partner, their role in the agency, and their relationship to the participant.

2. Are any owners, officers, directors, members, or partners of your agency financially or legally responsible for the participant?

☐ Yes ☐ No

If Yes, provide the name of the owner, officer, director, member, or partner, their role in the agency, and the scope of their financial or legal responsibility for the participant.

3. Do any owners, officers, directors, members, or partners of your agency have legal authority to make financial or healthcare decisions on behalf of the participant (such as through a power of attorney)?

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☐ Yes ☐ No

If Yes, provide the name of the owner, officer, director, member, or partner, their role in the agency, and the scope of their authority to make decisions on behalf of the participant.

4. Does the agency or any owner, officer, director, member, or partner of your agency hold a direct or indirect financial or controlling interest in any entity that is compensated to provide services to the same participant?

☐ Yes ☐ No

If Yes, provide the name of the owner, officer, director, member, or partner, their role in the agency, and their interest in the other entity providing services to the participant.

Section 3: Exception Request

If DDD determines that a conflict of interest exists, would you like to request a time-limited exception?

☐ Yes ☐ No

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If Yes, provide the reason you are requesting an exception.

Section 4: Signature

I hereby certify that all information provided in this Form is true, correct, and complete to the best of my knowledge. I understand that any false information or omissions may result in non-compliance with the Waiver Standards.

Name (Print or Type):

Title:

Signature:

Date:

July 2026

APPENDIX 5: ADVERSE EVENT REPORT

APPENDIX 5A: P&P 2.05 MANDATORY REPORTING OF ABUSE AND NEGLECT



STATE OF HAWAII
DEPARTMENT OF HEALTH
P. O. BOX 3378
HONOLULU, HI 96801-3378

DEVELOPMENTAL DISABILITIES DIVISION

TITLE: Mandatory Reporting of Abuse and Neglect

Policy #2.05

PURPOSE To protect, to the extent possible, the health, safety, and well-being of the people that the Developmental Disabilities Division (DDD) serves, and be compliant with state laws on reporting abuse and neglect of vulnerable adults and children by reporting abuse, exploitation, financial exploitation, neglect and self-neglect to proper authorities according to state law.

SCOPE This policy (#2.05) applies to suspected victims of abuse and neglect who are not receiving waiver services. Suspected cases of abuse and neglect for participants receiving Medicaid Waiver Home and Community Based Services (HCBS) should follow DD Policy 3.07 "Adverse Events Reports for DDD Participants."

DEFINITIONS

Definitions can be found at the following links:

1. Adult abuse or neglect statutory definitions:
http://www.capitol.hawaii.gov/hrscurrent/Vol07_Ch0346-0398/HRS0346/HRS_0346-0222.htm
2. Child abuse or neglect statutory definitions:
http://www.capitol.hawaii.gov/hrscurrent/Vol07_Ch0346-0398/HRS0350/HRS_0350-0001.htm

POLICY DDD employees who in the performance of their professional or official duties, know or have reason to believe that a child or vulnerable adult has been abused or is in danger of abuse if immediate action is not taken promptly, shall report this matter promptly and appropriately to the Department of Human Services (DHS) Child Welfare Services (CWS) or Adult Protective Services (APS). The mandate to report abuse and neglect applies to all DDD employees who are licensed or registered in a health or health-related occupation and who examines, attends,

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Effective Date: **MAR -8 2016**
Revised Date(s):

<https://health.hawaii.gov/ddd/files/2018/05/DD-Policy-2.05-Mandatory-Reporting-of-Abuse-and-Neglect.pdf>

treats, or provides other professional or specialized services to a vulnerable adult. This includes social workers who are licensed by the State of Hawaii and non-licensed persons employed in social worker positions. State statutes does not prohibit any person from reporting an incident of abuse and neglect that is brought to a DDD employees' attention in a private or non-professional capacity.

PROCEDURES

- A. Suspected abuse of a vulnerable adult.** When a DDD employee, who in his/her professional or official capacity has reason to believe a vulnerable adult has been the victim of abuse or neglect or has a substantial risk of this occurring in the reasonably near future:
1. Shall inform employee's immediate supervisor or DDD designee to ensure DDD policies and procedures are followed;
 2. Shall immediately orally report instances of suspected abuse, or at risk of abuse if immediate action is not taken, to the Department of Human Services (DHS), Adult Protective Services (APS) and/or the Honolulu Police Department, as appropriate. (APS contact information can be found on: <http://humanservices.hawaii.gov/ssd/home/adult-services/>).
 3. Shall document his/her oral report of abuse to APS, in writing, by completing the attached APS "Report Form for Adult Abuse and Neglect" on the day of or at the latest the next business day of suspected abuse and neglect. Follow the directions on the APS report form to fax or mail the form to the appropriate APS office where the verbal report was made. A copy of the completed report form should then be submitted to his/her immediate supervisor for filing.
 4. As a courtesy and upon the discretion of the DDD employee/supervisor, if the vulnerable adult was living in a residence licensed by the Office of Health Care Assurance (OHCA), the employee may report the matter to OHCA.
- B. Suspected abuse of a child under age 18 years old.** The DDD employee, who in the employee's professional or official capacity has reason to believe that child abuse or neglect has occurred or that there exists a substantial risk that child abuse or neglect may occur in the foreseeable future:
1. Shall inform the employee's immediate supervisor or DDD designee of disclosure and ensure DDD policies and procedures are followed;
 2. Shall immediately orally report the case to DHS, Child Welfare Services (CWS) or the Honolulu Police Department. (CWS contact information can be found on: <http://humanservices.hawaii.gov/ssd/home/child-welfare-services/>);
 3. Shall document his/her oral report of abuse to CWS, in writing, by completing the attached CWS "Mandated Reporter Checklist for Suspected Child Abuse & Neglect" on the day of or on the latest the next business day of suspected abuse and neglect. Follow directions on the CWS report form to fax or mail the report form to the appropriate CWS office. A copy of the completed report form should then be submitted to his/her immediate supervisor for filing.

- C. DDD employees shall refer to DOH Health Insurance Portability & Accountability Act (HIPAA) Policy 3.03 on "Uses and disclosures of Protected Health Information (PHI) about victims of abuse, neglect or domestic violence," and DDD Policies & Procedures 3.03 on "Uses and disclosures of PHI for Victims of Abuse, Neglect or Domestic Violence" for guidance on disclosures of information on alleged incidences of abuse and neglect.**

AUTHORITATIVE & OTHER REFERENCES:

1. §346-222, HRS (Definitions of Vulnerable Adult Abuse)
http://www.capitol.hawaii.gov/hrscurrent/Vol07_Ch0346-0398/HRS0346/HRS_0346-0222.htm;
2. §346-224, HRS, (Mandatory reporting of vulnerable adult abuse and neglect)
http://www.capitol.hawaii.gov/hrscurrent/Vol07_Ch0346-0398/HRS0346/HRS_0346-0224.htm;
3. §350-1, HRS, (Definitions of Child Abuse)
http://www.capitol.hawaii.gov/hrscurrent/Vol07_Ch0346-0398/HRS0350/HRS_0350-0001.htm;
4. §350-1.1, HRS (Mandatory reporting of child abuse and neglect)
http://www.capitol.hawaii.gov/hrscurrent/Vol07_Ch0346-0398/HRS0350/HRS_0350-0001_0001.htm;
5. Department of Human Services, CWS "A Guide for Mandated Reporters"
<http://humanservices.hawaii.gov/ssd/files/2013/01/MANDATED-REPORTER-HANDBOOK.pdf>;
6. Department of Health & Human Services, APS and Executive Office on Aging "Guidelines for Mandated Reporters Vulnerable Adult Abuse & Neglect"
<http://humanservices.hawaii.gov/ssd/files/2013/01/APS-Guidelines.pdf>;
7. Director of Health's "DDD Directive to Report Adult Abuse" dated 08-29-11;
8. HIPAA "Uses and disclosures of PHI about victims of abuse, neglect or domestic violence", "DOH Policy 03.03, March 17, 2008;
9. DDD Policies & Procedures 3.03 on "Uses and disclosures of PHI for Victims of Abuse, Neglect or Domestic Violence."

ATTACHMENTS:

1. APS "Report Form for Adult Abuse and Neglect;"
2. CWS "Mandated Reporter Checklist for Suspected Child Abuse and Neglect."

Approved: _____



Administrator,
Developmental Disabilities Division

Date: March 8, 2016

**APPENDIX 5B: REPORT FORM FOR SUSPECTED ABUSE AND
NEGLECT OF VULNERABLE ADULTS AND GUIDELINES FOR
MANDATED REPORTERS**

NOTE

For a copy of the *Report Form for Suspected Abuse and Neglect of Vulnerable Adults*, please go to the weblink provided below:

<https://apsreport.hawaii.gov/>

NOTE

For a copy of the *Guideline for Mandated Reporters for Vulnerable Adult Abuse and Neglect*, please go to the weblink provided below:

<https://humanservices.hawaii.gov/ssd/files/2015/10/Guidelines-for-Mandated-Reporters.pdf>

**APPENDIX 5C: MANDATED REPORTER CHECKLIST FOR
SUSPECTED CHILD ABUSE AND NEGLECT**

NOTE

For a copy of the *Mandated Reporter Checklist for Suspected **Child** Abuse and Neglect* form, please go to the weblink provided below:

<https://humanservices.hawaii.gov/ssd/files/2021/04/Mandated-Reporter-Checklist-fillable.pdf>

APPENDIX 5D: GUIDE FOR MANDATED REPORTERS

NOTE

For a copy of the Child Welfare Services, *Guide for Mandated Reporters*, please go to the weblink provided below:

<https://humanservices.hawaii.gov/ssd/files/2021/03/GUIDE-FOR-MANDATED-REPORTERS-Rev.-12-2-2020-new-logo-final0021.pdf>

APPENDIX 5E: P&P #3.07 ADVERSE EVENT REPORT FOR PEOPLE RECEIVING CASE MANAGEMENT SERVICES



STATE OF HAWAII
DEPARTMENT OF HEALTH
P. O. BOX 3378
HONOLULU, HI 96801-3378

DEVELOPMENTAL DISABILITIES DIVISION

TITLE: Adverse Event Report for People
Receiving Case Management
Services with the Developmental
Disabilities Division

Policy # 3.07

PURPOSE:

To provide a uniform process and procedures for documenting, reporting and follow-up of adverse events, involving participants of the Developmental Disabilities Division (DDD) receiving case management services.

DEFINITIONS & ACRONYMS:

“Suspected abuse and neglect” as defined in state statute for

- Adults - Section 346-222, Hawaii Revised Statutes (HRS),
http://www.capitol.hawaii.gov/hrscurrent/Vol07_Ch0346-0398/HRS0346/HRS_0346-0222.htm; and
- Children - Section 350-1, HRS,
http://www.capitol.hawaii.gov/hrscurrent/Vol07_Ch0346-0398/HRS0350/HRS_0350-0001.htm;

“Expected death” means:

- Death resulting from a documented medical diagnosis or terminal illness;
- Death resulting from an irreversible deterioration of health; or
- Death resulting from certain congenital conditions;

“Financial exploitation” as defined in State Statute Section 346-222, HRS (above);

“Medication errors” means medication administration involving one or more of the following and/or an unexpected reaction to the medication or treatment:

- Wrong medication – participant receives and takes medication which is intended for another person, discontinued, or inappropriately labeled;
- Wrong dose – participant receives the incorrect amount of medication;
- Wrong time – participant receives medication dose at an incorrect time interval;
- Missed dose – participant does not receive a prescribed dose of medication or when a participant refuses to take medication;

DDD Policy Manual

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Effective Date: JUL 5, 2017

Revised: JAN 29 2018

<https://health.hawaii.gov/ddd/files/2018/05/DD-Policy-3.07-AER-for-DDD-Participants.pdf>

- Wrong route/method – participant does not receive the medication by the route prescribed (i.e., by mouth, injection, under the tongue (sublingually), rectally); or
- Failure to document or incorrect documentation – failure to initial the Medication Administration Record (MAR) by the person assisting with the medication (i.e., failure to initial the MAR each time a medication is given) or failure to transcribe the prescription onto the MAR correctly (i.e., failure to transfer information such as the drug name, dose, route, or frequency from an order or prescription to the MAR).

“Medical or dental treatment” means treatment rendered by ambulance or emergency medical personnel, urgent care or emergency room medical or dental staff, or results in hospitalization;

“Restraint” means a physical, chemical or mechanical intervention used as a last resort on an emergency basis to protect the participants from imminent harm to themselves and/or others using the least restrictive intervention possible and for the shortest duration necessary.

THE FOLLOWING ARE NOT CONSIDERED RESTRAINTS:

- Interventions used for the purpose of conducting routine physical or dental examination or diagnostic tests or completing a medical or dental treatment procedure;
 - A device used to protect the participant’s safety as indicated in the Individualized Service Plan (ISP) per a physician’s recommendation and reviewed by the Behavior Support Review Committee (BSRC); or
 - Vehicular passenger restraint systems required by state law (HRS §291-11.6).
1. **“Chemical Restraint”** means a psychotropic medication prescribed by a licensed health care professional with prescriptive authority:
- a. On a routine basis without an appropriate Diagnostic and Statistical Manual (DSM) diagnosis for the purpose of behavioral control; or
 - b. Incidental use of medications, sometimes called PRN or as needed medication, to restrict the freedom of movement or temporarily sedate the individual.

THE FOLLOWING ARE NOT CONSIDERED CHEMICAL RESTRAINTS:

- Medications prescribed for the treatment of a diagnosed disorder found in the current version of the American Psychiatric Association's Diagnostic and Statistical Manual (DSM);
- Adjusting the dose of a prescribed medication or prescribing a new medication to achieve better symptom control for the diagnostic disorder per the current DSM;
- Medications prescribed to control seizures; and
- Medications for medical or dental procedures.

2. **“Mechanical Restraint”** means an intervention involving a device, material or equipment that is involuntarily applied to the participant’s body or immediate environment (i.e., wheelchair, chair, bed, toilet, vehicle, etc.) that immobilizes, restricts, limits, or reduces any bodily movement in emergency situations to prevent the participant from harming themselves or others. See definition of “Restraints” for interventions that are not considered a Mechanical Restraint.
3. **“Physical Restraint”** means an intervention in which physical force is applied to the participant and involuntarily restricts their freedom of movement or normal access to a portion or portions of their body. See definition of “Restraints” for interventions that are not considered a Physical Restraint.

“Seclusion” means a restrictive intervention in which a person is involuntarily confined in a room or area from which they are prevented from having contact with others or leaving by closing a door or using another barrier. **Seclusion is prohibited and shall not be utilized with participants.**

“Restrictive Intervention” or “Restrictive Procedure” means a practice that limits a participant’s freedom of movement, access to other locations, property, individuals, or rights. This includes, but is not limited to, Chemical, Mechanical, and Physical Restraints.

“Unexpected death” means:

- Death that was not expected or anticipated according to any previously known terminal medical diagnosis;
- The result of an accident (car, fall, choking, etc.), even if the person had a known terminal condition;
- Due to suspected/alleged homicide or suicide; or
- Due to suspected/alleged abuse or neglect.

Adult Foster Home (AFH)
Adult Protective Services (APS)
Adverse Event Report (AER)
Behavior Support Review Committee (BSRC)
Case Manager (CM)
Case Management Branch (CMB)
Child Protective Services (CPS)
Child Welfare Services (CWS)
Clinical Interdisciplinary Team (CIT)
Community Resources Branch (CRB)
Consumer Complaints Resolution Unit (CCRU)
Consumer-directed (CD)

TITLE: Adverse Events
Reports for DDD
Participants

Policy # 3.07

Consumer Directed Personal Assistant (CDPA)
Department of Human Services (DHS)
Developmental Disabilities Division (DDD)
Diagnostic and Statistical Manual (DSM)
Hawaii Revised Statutes (HRS)
Health Insurance Portability and Accountability Act of 1996 (HIPAA)
Hospital and Community Dental Services Branch (HCDSB)
Individualized Service Plan (ISP)
Long Term Adult Supports and Resources (LASR)
Medication Administration Record (MAR)
Office of Healthcare Assurance (OHCA)
Outcomes and Compliance Branch (OCB)
Outcomes Section (OS)
Program Services Evaluation Unit (PSEU)
Registered Nurse (RN)

POLICY:

Adverse events include incidents listed below and shall be reported:

- Suspected abuse and neglect;
- Financial exploitation;
- Injuries of a known or unknown cause sustained by the participant requiring medical or dental treatment or hospitalization;
- Medication errors;
- Changes in the DDD participant's behavior, including but not limited to aggression, self-injurious behaviors, property destruction, or sexualized behaviors that may require a new or updated behavior support plan as a result of the intensity and/or severity of the behavior;
- Changes in the DDD participant's health condition requiring medical or dental treatment or hospitalization;
- Expected death of a DDD participant;
- Unexpected death of a DDD participant;
- Whereabouts unknown regardless of the amount of time the participant is missing or unaccounted for;
- Any use of restraints, which includes chemical, mechanical and physical restraints;
- Any use of seclusion is prohibited and shall not be utilized with participants; and
- Any use of prohibited restrictive intervention or restrictive procedure.

Waiver providers, LASR providers, DDD CMs, HCDSB staff, CD Employers, AFH Certified Caregivers, individuals involved with the participant (e.g. families, guardians, if applicable), and workers shall report occurrences of adverse events on the AER form and in accordance with timelines specified in this policy.

For disclosures for reporting of abuse of adults, refer to *DDD Policy 03.03, Health Insurance Portability and Accountability Act of 1996 (HIPAA)*. For statutory mandatory requirements for reporting of non-waiver adult and child abuse and neglect, refer to *DD policy 2.05 entitled "Mandatory Reporting of Abuse and Neglect."*

Participants may self-report abuse to their CMs or to the CCRU in DDD's OCB. The CM or CCRU staff shall then submit an adverse event report.

PROCEDURES:

A. DUTIES AND RESPONSIBILITIES OF THE REPORTER

1. Verbally notify the DDD Case Manager (CM) within 24 hours or the next business day of an adverse event or when notified that an adverse event occurred.
2. Complete and submit the Adverse Event Report (AER) Form to the DDD CM within 72 hours of an event or when notified that an adverse event occurred.
3. Submit the AER form directly to the Outcomes and Compliance Branch, Outcomes Section within 72 hours for the following adverse events:
 - a. Suspected abuse, neglect, financial exploitation;
 - b. Death;
 - c. Participant's whereabouts are unknown and efforts to locate the participant have been unsuccessful;
 - d. Any use of restraint;
 - e. Any use of seclusion; and
 - f. Any use of prohibited restrictive intervention or procedure.
4. Notify OCB when there is media involvement including, but not limited to press inquiries, broadcast, and media coverage related to any adverse event.
5. Fax AER to the Outcomes Section at (808) 453-6585.

B. DUTIES AND RESPONSIBILITIES OF THE DDD CASE MANAGER

1. Receive verbal notification of an adverse event **within 24 hours or the next business day** by a waiver provider, LASR provider, HCDSB staff, CD employer, or AFH certified caregiver. A verbal report can also be made by a DDD participant, family member, guardian, DDD employee, and other persons who witness or become aware of a reportable event. The CM shall:
 - a. Verify that immediate action was taken to safeguard the participant;
 - b. Assess if there is potential for further injury or harm to the participant and/or others in the home or program setting, and notify supervisor immediately;
 - c. Determine if additional supports or actions are necessary to safeguard the participant; and
 - d. Coordinate services as necessary.
2. For events involving suspected abuse, neglect, or exploitation, the CM shall:
 - a. Gather the following information **within 24 hours** of receiving the verbal report or the next working day for events involving suspected abuse, neglect, or exploitation:

- 1) Date, time, and location of the event;
- 2) Person(s) present and/or involved when the event occurred;
- 3) Alleged perpetrator, if applicable, and the relationship to the participant;
- 4) Extent of injury or harm;
- 5) Actions taken for the participant's immediate safety; and
- 6) Confirm if a report was made to CWS or APS. If a report was not made, verbally report incident immediately to CWS or APS as referenced in the *DD Policy 2.05 on Mandatory Reporting of Abuse and Neglect*;
- b. Complete the written report to CWS or APS following the initial verbal report.
 - 1) For APS, fax or mail Form DHS 1640 entitled "Report Form for Adult Abuse and Neglect" to the APS office where the verbal report was made.
 - 2) For CPS, fax or mail Form DHS 1516 entitled "Mandated Reporter Checklist for Suspected Child Abuse and Neglect" to the CWS office where the verbal report was made.
- c. Inform supervisor immediately to determine follow-up actions.
- d. Conduct a face-to-face interview with the participant **within 24 hours** of receipt of the verbal report for events involving suspected abuse, neglect, or exploitation.
- e. If applicable, inform the participant's legal guardian of the situation (if the legal guardian is not involved in the situation) and discuss the recommended course of action;
- f. Work in collaboration with the CWS or APS representative;
- g. Verbally inform the respective licensing and certifying agency if the person resides in a licensed or certified home.
3. Receive and review the written AER form **within 72 hours** of the adverse event by a waiver provider, LASR provider, HCDSB staff, CD employer, or AFH certified caregiver.
 - a. Review page 1 "18. What Was Done?" to ensure immediate appropriate actions were taken to safeguard the participant's health and safety;
 - b. Review description of the event in Section B: Discovery, including potential causes and/or factors contributing to the adverse event;
 - c. Verify that the type of adverse event checked in Section C: Nature/Type of Adverse Event Being Reported is consistent with the description in Section B;
 - d. Determine if the appropriate persons/agencies were notified based on the type of adverse event, residential setting, and guardianship status of the participant. If the appropriate persons/agencies were not notified, the CM shall notify the respective persons/agencies; and
 - e. Request an updated/revised AER form from the reporter/supervisor if the form contains incomplete and/or incorrect information. The CM shall retain the original form. The updated/revised form shall be returned to the CM within 24 hours of the request.

4. Complete the following sections of the AER form **within two (2) working days** from receipt of the AER (if the form required updates/revisions, it would be two (2) working days from the date the revised form was received):
 - a. Summary of Action Taken by the CM;
 - b. CM Assessment;
 - c. CM Plan of Action:
 - 1) Complete if additional actions are warranted. Describe actions taken or to be taken with timelines, including referrals to CIT or BSRC; and
 - 2) Update the ISP with risk factors that need to be addressed, including supports to minimize the assessed risks; and any change in needs/condition, requiring an ISP update.
 - d. Consult with the unit RN or RN designee at a minimum, for all AERs involving medication errors, change in health condition, and when an adverse event results in hospitalization. The RN shall review and assist the CM in identifying appropriate follow-up actions, including, but not limited to updating the ISP when there is a change in condition/diagnoses, medication, risk factors, and when a referral to the CIT may be warranted;
 - e. Document in the participant's contact notes follow-up actions taken including face-to-face contacts, home visits, etc.; and
 - f. Submit AER to immediate supervisor.
 5. Complete the AER form if no AER was generated or when a report is made by a participant, family member, guardian, DDD employee, or any person who witnesses or becomes aware of an event that requires reporting.
 - a. For events involving suspected abuse, neglect, or exploitation, a written report shall be completed **within 24 hours** of verbal notification; or
 - b. For events other than suspected abuse, neglect, or exploitation, a written report shall be completed **within 72 hours** of verbal notification.
 6. The CM shall assess the effectiveness of the remediation plan of action and activities in preventing future recurrences. If the remediation actions and activities are not effective in preventing the recurrences of the adverse event(s), the CM shall make recommendations, including additional actions to be taken by the waiver provider, LASR provider, CD employer, and/or caregivers of licensed or certified homes.
- C. DUTIES AND RESPONSIBILITIES OF THE CM SUPERVISOR
1. Determine if there is potential for further harm or injury to the participant and/or others based on the CM's report of the adverse event.
 2. Consult with immediate supervisor who will then notify the CMB Chief, DDD Administrator, and Medical Director, as appropriate who will determine if an initial onsite assessment is warranted and identify the DDD staff who will be conducting the assessment.
 3. Ensure mandatory reporting requirements are met for events involving suspected abuse, neglect, or exploitation of a participant.

4. Evaluate to determine the appropriateness of the CM's assessment and actions and complete the Supervisor Review and Comments Section **within two (2) working days** from receipt of the AER from the CM.
 - a. Review the CM's summary of action taken and determine if actions were appropriate given the nature of the event. Determine if CM met timelines for review.
 - b. Determine if the CM's assessment was appropriate in Section 1.
 - c. Determine if the CM's plan of action was appropriate in Section 2.
 - d. Determine if additional follow-up is required by the CM beyond what was documented in the CM's plan of action.
 - e. Verify that the ISP was updated if the 'ISP Updated' box is checked.
 5. Notify immediate supervisor of adverse events that may warrant follow-up by the CRB, OCB, or HCDSB. Given the critical nature of the adverse event, CMB Chief may consult with the respective branch chief(s) and the DDD Administrator to determine appropriate follow-up actions.
 6. Distribute copies of the completed AER form **within five (5) working days** from receipt of the written report to the:
 - a. Agency, CD employer, or AFH certified caregiver who reported the event;
 - b. OCB - PSEU; and
 - c. OCB - Certification Unit or OHCA if the event involves a caregiver of a licensed or certified home.
 7. Ensure a tracking system in the Unit is continuously implemented and monitored to meet deadlines, including documentation of dates that AERs are received, reviewed, and distributed.
 8. Ensure ongoing monitoring of services by the CM.
- D. DUTIES AND RESPONSIBILITIES OF OCB
1. Receive, log, and evaluate all AERs to determine whether appropriate actions were taken to prevent the recurrence of the event and to ensure the participant's immediate safety.
 2. Notify the DDD Administrator, CMB Chief, and CRB Chief immediately of events that may require an investigation, pose a present or imminent risk to the safety and well-being of the participant and/or others in the home or program setting due to the severity and seriousness of the event, and result or have the potential for media coverage due to the circumstances surrounding the event.
 3. Notify the CM supervisor when the adverse event has been reported to the DDD Administrator and Branch Chiefs.
 4. Ensure mandatory reporting requirements are met for events involving suspected abuse, neglect, or exploitation of a participant.
 5. Review all available information and assess the appropriateness of reporter's remediation actions, CM's follow-up actions, and CM's plan of action, if applicable, to prevent the recurrence of the event.
 - a. If PSEU determines based on PSEU's assessment that additional information is needed from the CM (i.e., form is incomplete, information is inconsistent, or critical

- information is missing), PSEU supervisor will request through the CM supervisor the additional information with specified deadline to submit.
- b. If PSEU determines based on PSEU's assessment that no additional follow-up is required, the AER is closed.
 - c. If the adverse event involves an AFH and PSEU determines that additional follow-up with the Certification Unit is warranted:
 - 1) PSEU supervisor will provide the OS supervisor with a written description of the certification issues; and
 - 2) OS supervisor will submit the request to the Compliance Section Supervisor if the request is appropriate.
 - d. If the adverse event involves a waiver provider or LASR provider and PSEU determines that additional follow-up is warranted, the OCB Chief will provide the CRB Chief with a written description of the issues.
 - e. If the adverse event involves a CD Employer and PSEU determines that additional follow-up is warranted, the OCB Chief will provide the CMB Chief with a written description of the issues.
 - f. If the adverse event involves HCDSB staff and PSEU determines that additional follow-up is warranted, the OCB Chief will provide the HCDSB Chief with a written description of the issues.
6. Conduct an investigation if the adverse event falls within any of the following circumstances:
- a. Any death as a result of:
 - i. serious injury that required treatment in the emergency room or urgent care or resulted in a hospitalization;
 - ii. medication error;
 - iii. elopement;
 - iv. unknown circumstances; or
 - v. the use of restraints, seclusion, or prohibited restrictive intervention.
 - b. Any report of serious issues, including serious violations of standards; and
 - c. Any and all other situations identified by the DDD Administrator or OCB Chief as requiring an investigation.
- Note: Any adverse events involving suspected abuse/neglect will be investigated by the respective protective services agency.
7. Conduct investigation **within 72 hours** of receiving the written AER form and in accordance with internal guidelines and report findings and recommendations to the DDD Administrator, CRB Chief, CMB Chief, and OCB Chief. For death investigations, findings and recommendations will be forwarded to the Mortality Review Committee.
 8. Track and analyze the AER data to identify trends/patterns and make recommendations for quality improvement through the Safety and Well-Being Subcommittee of the Quality Assurance and Improvement Program.
 9. Complete and submit quarterly reports to the BSRC, CIT and DHS.

E. DUTIES AND RESPONSIBILITIES OF THE DDD ADMINISTRATOR AND BRANCH CHIEFS

1. Determine if an initial onsite assessment is warranted and identify the DDD staff who will be conducting the assessment.
2. Determine what immediate actions should be taken, including timelines.
3. Determine when to implement investigations based on reports of serious issues or serious violations of standards.
4. Coordinate follow-up actions with respective branch chiefs, as necessary.
5. Ensure branch staff responds to requests for information in a timely manner.

AUTHORITATIVE & OTHER REFERENCES:

1. Adult Protective Services (APS) Definitions: Section 346-222, HRS, http://www.capitol.hawaii.gov/hrscurrent/Vol07_Ch0346-0398/HRS0346/HRS_0346-0222.htm;
2. Mandatory Reporting of Abuse/Neglect: Section 346-224, HRS, http://www.capitol.hawaii.gov/hrscurrent/Vol07_Ch0346-0398/HRS0346/HRS_0346-0224.htm;
3. Child Abuse: Section 350-1, HRS, Section 350-1, HRS, http://www.capitol.hawaii.gov/hrscurrent/Vol07_Ch0346-0398/HRS0350/HRS_0350-0001.htm;
4. Medicaid Waiver Provider Standards <http://health.hawaii.gov/ddd/provider/pm/>;
5. Application for a §1915(c) Home and Community Based Services Waiver, Appendix G: Participant Safeguards, approved by Center for Medicaid and Medicare Services (CMS) 7-1-2011;
6. Chapter 323B, HRS, Health Care Privacy Harmonization Act¹ http://www.capitol.hawaii.gov/hrscurrent/Vol06_Ch0321-0344/HRS0323B/HRS_0323B-.htm;
7. Chapter 587A, HRS, Child Protective Act² http://www.capitol.hawaii.gov/hrscurrent/Vol12_Ch0501-0588/HRS0587A/HRS_0587A-.htm.
8. DD Policy 2.03, Behavior Support Review
9. DD Policy 2.05, Mandatory Reporting of Abuse and Neglect
10. DDD Policy 03.03, Health Insurance Portability and Accountability Act of 1996 (HIPAA)

^{1,2} These hyperlinks connect to the most recent version of HRS through the Hawaii State Legislature website. Hyperlinks to HRS chapters show the first page of the chapter only, to see the rest of the contents of the chapter, click "Next" on the lower right-hand side of the page on your screen.

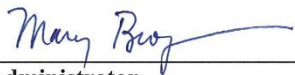
TITLE: Adverse Events
Reports for DDD
Participants

Policy # 3.07

NOTE:

The form related to this P&P is posted with the P&P on SharePoint for your reference and use.

Approved: _____



Administrator,
Developmental Disabilities Division

Date: JAN 29 2018

APPENDIX 5F: ADVERSE EVENT REPORT (AER FORM)

NOTE

For a copy of the *Adverse Event Report (AER)* form,
please go to the weblink provided below:

<http://health.hawaii.gov/ddd/files/2018/03/AER-Form.docx>

APPENDIX 5G: AER INSTRUCTIONS

Department of Health
Developmental Disabilities Division

Adverse Event Report

Instructions for Completing Form 28-3 (Rev. 01/18)

This form must be completed within 72 hours of the adverse event. Please type or write legibly.

Top of Form: DDD USE ONLY

Verbal Date: DOH-DDD Case Manager (CM) or designee to write the date the verbal report was received from the reporter. Write “NA” if the person completing the form is the case manager.

Verbal Time: The CM or designee to write the time the verbal report was received from the reporter. Write “NA” if the person reporting the event is the case manager.

Verbal Met: The CM or designee to write “Yes” if the waiver provider, LASR provider, CD provider, or caregiver of a licensed or certified home notified the CM within 24 hours or the next business day of the event occurrence or of being informed of the event. If not, enter “No”. Write “NA” if the person reporting the event is the case manager.

Written Date: The CM or designee to write the date the written report was received from the reporter. Write “NA” if the person reporting the event is the case manager.

Written Time: The CM or designee to write the time the written report was received from the reporter. Write “NA” if the person reporting the event is the case manager.

Written Met: The CM or designee to write “Yes” if the waiver provider, LASR provider, CD provider, or caregiver of a licensed or certified home submitted the written report to the CM within 72 hours or the next business day of the event occurrence or of being informed of the event. If not, enter “No”. Write “NA” if the person reporting the event is the case manager.

Waiver Participant: Select “waiver participant” if the participant is currently in the I/DD Waiver Program.

Non-Waiver Participant: Select “non-waiver participant” if the participant is not currently in the I/DD Waiver Program (i.e. receiving only state funded services such as LASR).

Event Occurred During Billable Services: Select “Yes” if the event occurred during a billable service (i.e. waiver provider service delivery hours, LASR program hours, CD service time). Select “No” if the event occurred when services were not being provided.

- 1. Event Date:** Write or enter the date the adverse event occurred in MM/DD/YYYY. For example, September 1, 2017 shall be entered as 09/01/2017.

2. **Event Time:** Write or enter the time the adverse event occurred. The time shall be entered as the time followed by a.m. or p.m. Do not use military time or 24-hour clock format. For example, four o'clock in the afternoon shall be written as 4:00 p.m.
3. **Participant Name:** Write or enter the participant's name – Last name, First name, M.I. Be sure to use given name and not nicknames.
4. **Birthdate:** Write or enter the birthdate of the participant in MM/DD/YYYY. For example, August 30, 2006 shall be entered as 08/30/2006.
5. **Sex:** Write or enter the sex of the participant – male or female.
6. **Medicaid ID #:** Write or enter the participant's 10-digit Medicaid ID #. If participant is not in the I/DD Waiver Program, write or enter "NA".
7. **CM Unit No.:** Write or enter the case management unit to which the participant is assigned.
8. **Reporter's Name:** Write or enter the name of the person completing the form.
9. **Relationship:** Write or enter the reporter's relationship to the participant (e.g. direct support worker, foster parent, mother).
10. **Island:** Write or enter the name of the island where the participant receives services.
11. **Telephone No.:** Write or enter the phone number of the reporter.
12. **Fax No.:** Write or enter the fax number of the reporter.
13. **Name of the Reporter's Agency (if applicable):** Write or enter the name of the agency. If the reporter is a consumer-directed provider, write or enter "CD Services".

SECTION A: GENERAL INFORMATION

14. **Event location:** Check the location where the adverse event occurred. Community includes places such as grocery store, park, or workplace. Program site includes such places as an Adult Day Health, or other center-based settings where the participant attends or meets for activities. If the adverse event occurred in the participant's residence, indicate the type of residence. If the residence is a licensed or certified home, include the name of the home as documented on the home's license or certificate. If "Other" is checked, specify the location.
15. **Person(s) Present:** Check to indicate who was present when the event occurred. If the event was not observed and the participant cannot identify who was present, check "unknown". If "other" is checked, specify the person(s). Examples include, but are not limited to, friend, bus driver, restaurant employee, sister, or father.
16. **Who Was Notified? (Check all that apply):** Check to indicate the persons or agencies notified in response to the type of event that occurred. Write or enter the name of the person notified, date, and time of the notification. If "other" is selected, specify the person contacted. For any notification to the Police Department, Adult Protective Services, and/or Child Welfare Services, enter the report number assigned by the corresponding agency.
17. **What Was Done?** Check to indicate what was done (immediate action taken) to safeguard the participant following the adverse event. Include date and time of treatment and where the treatment occurred, including name of facility, if applicable (e.g. Queen's Emergency Room, Straub Hospital).

SECTION B: DISCOVERY

18. Provide a full description of the adverse event, including potential causes and/or contributory factors. The description shall address WHO was involved, HOW, WHERE, AND WHEN the event occurred, and WHAT actions were taken in response to the event.

For events that occurred outside of billable services:

- Indicate date/time that the reporter was informed of the event
- Describe the circumstances under which the information was received

For events involving medication error(s) related to wrong medication:

- Indicate the medication that **was** given and the medication that **was not** given.

For events involving a death, this section must also include:

- Description of the circumstances surrounding the death
- Any medical resources involved at the time of death (i.e. hospice care)

For events involving any use of restraint, seclusion, or prohibited restrictive intervention or procedure, this section must also include:

- Description of the restrictive intervention or procedure
- Description of what happened before the behavior that caused the use of the restrictive intervention or procedure, including environmental and other contributing factors
- Other interventions that were attempted and the results of those interventions
- Consequences of the use of the restrictive intervention or procedure
- Description of any injuries the participant sustained
- How the rights of the participant were restored
- Note: For chemical restraints, documentation must also include description of behaviors after medication was given, including any side effects.

The reporter may attach diagrams, charts, and/or additional pages of description. If additional pages are attached, number pages B-1, B-2, etc.

SECTION C: NATURE/TYPE OF ADVERSE EVENT BEING REPORTED

19. Check the box (**select only one**) that best describes the adverse event and complete the information in that section.

When multiple events are involved, the reporter should use their best judgment to select the most appropriate category based on significance of the event (i.e. which event caused the most harm or most negatively impacted the participant).

Suspected Abuse/Neglect/Financial Exploitation

Chapter 346, Part X, Hawaii Revised Statutes, Adult Protective Services, mandates reporting when there is reason to believe abuse has occurred or the vulnerable adult is in danger of abuse if immediate action is not taken.

Chapter 350, Hawaii Revised Statutes mandates reporting to Child Welfare Services or the Police Department when there is reason to believe that child abuse or neglect will occur in the reasonably foreseeable future.

Mandated reporters include professionals and personnel in health care, social services, law enforcement, employees or officers of any public or private agency providing social, medical, hospital, or mental health services, including financial assistance, employees or officers of adult residential care homes, adult day care centers, foster care, or similar institutions, employees or officers of any public or private school.

Persons who are not mandated reporters are also encouraged to report suspected abuse or neglect to Adult Protective Services, Child Welfare Services, and the Police Department.

Check all that apply for type of suspected abuse, neglect, or financial exploitation. List person(s) and their relationship to the participant who were present when suspected abuse/neglect occurred.

- **Physical:** Non-accidental injury, pain, or impairment such as from hitting, slapping, improper physical restraint or poisoning.
- **Psychological/Verbal:** Threats, insults, harassment, humiliation, intimidation, or other means that profoundly confuse or frighten the participant.
- **Sexual:** Sexual contact or conduct including pornographic photographing without consent.
- **Neglect:** 1) Caregiver: failure to provide adequate food, shelter, clothing, timely health care, personal hygiene, supervision, protection from abandonment or failure to care out responsibilities that a reasonable person would exercise as an assumed legal, or contractual caregiver; and 2) Self: failure to care for one's self thereby exposing one's self to a condition that poses an immediate risk or death or serious physical harm.
- **Financial Exploitation:** Wrongful taking, withholding, appropriation or use of the participant's money, real property, or personal property.

Injury from a Known or Unknown Cause Requiring Medical or Dental Treatment

All bodily injuries sustained by the participant for which medical treatment (i.e. treatment rendered by ambulance or emergency medical personnel, urgent care or emergency room medical or dental staff, or results in hospitalization).

Check all that apply for type of injury, location of injury, and cause of injury. Using the diagram in this section, circle the body parts that describe the location of the injury.

Medication Errors and/or Unexpected Reaction to Medication or Treatment

Medication Errors means medication administration involving one or more of the following: wrong medication, wrong dose, wrong time, missed dose, wrong route/method, or failure to document or incorrect documentation.

Check all that apply for medication error. For medication errors involving wrong medication, Section B: Discovery must include the medication that **was** given and the medication that **was not** given.

Check the type of medication involved: Over the Counter or Prescription and Drug Name

Unexpected Reaction to Medication or Treatment means any unexpected reaction to medication or treatment that may or may not require medical treatment.

Check the box that describes if the event was an unexpected reaction to medication or treatment.

Change in the Participant's Behavior that may Require a New or Updated Behavior Support Plan

Check the box to indicate if the event involves a new behavior or a change in behavior.

- **New Behavior:** No history of the behavior(s) exhibited in this event and a positive behavior support plan may be necessary to address the challenging behavior(s).
- **Change in Behavior:** There is a current positive behavior support plan, but the behavior(s) exhibited in this adverse event is/are not addressed in the plan OR behavior(s) is/are addressed in the plan, but have increased in severity, intensity, and/or duration.

Check all behaviors exhibited in this event.

Check the appropriate box to indicate whether the participant has a current behavior support plan.

Change in the Participant's Health Condition Requiring Medical or Dental Treatment

Check all that apply for change in health condition. These are significant changes or deterioration in the participant's health status for which medical or dental treatment was necessary.

Death

All deaths, regardless of the cause must be reported. Section B: Discovery must include a description of the circumstances surrounding the death and documentation of any medical resources involved at the time of death (i.e. hospice care).

Participant's Whereabouts Unknown

Check to indicate if the participant's whereabouts are still unknown or if the participant was found. If the participant was found, indicate the length of time the participant was missing and if any injuries were noted.

Any Use of Restraints

Check type of restraint used. Indicate if the participant sustained any injuries as a result of being restrained.

Use the definitions below to determine if the intervention applied meets the definition of a restraint. If the intervention is **not** considered a restraint, an AER is **not** required.

*The following are **not** considered restraints:*

- Interventions used for the purpose of conducting routine physical or dental examination or diagnostic tests or completing a medical or dental treatment procedure;
- A device used to protect the participant's safety as indicated in the Individualized Service Plan (ISP) per a physician's recommendation and reviewed by the Behavior Support Review Committee; or
- Vehicular passenger restraint systems required by state law (HRS §291-11.6)

*The following are **not** considered chemical restraints:*

- Medications prescribed for the treatment of a diagnosed disorder found in the current version of the DSM;
- Adjusting the dose of a prescribed medication or prescribing a new medication to achieve better symptom control for the diagnostic disorder per the current DSM;
- Medications prescribed to control seizures; and
- Medications for medical or dental procedures.

The following are considered restraints:

- **Chemical restraint** means a psychotropic medication prescribed by a licensed health care professional with prescriptive authority:
 - On a routine basis **without** an appropriate diagnosis found in the current version of the Diagnostic and Statistical Manual (DSM) for the purpose of behavioral control; or
 - Incidental use of medications, sometimes called PRN or as needed medication, to restrict the freedom of movement or temporarily sedate the participant.
- **Mechanical restraint** means an intervention involving a device, material, or equipment involuntarily applied to the participant's body or immediate environment (i.e. wheelchair, chair, bed, toilet, vehicle) that immobilizes, restricts or reduces any bodily movement in emergency situations to protect the participant from harming themselves or others.
- **Physical restraint** means an intervention in which physical force is applied to the participant and involuntarily restricts the participant's freedom of movement or normal access to a portion or portions of the participant's body.

Any Use of Seclusion

Seclusion is prohibited and shall not be utilized with participants.

This box shall be checked for any incident involving the involuntarily confinement of a participant in a room or area from which the participant was prevented from having contact with others or leaving by closing the door or using another barrier. Indicate if the participant sustained any injuries as a result of the use of seclusion. Refer to Policy #3.07.

Any Use of Prohibited Restrictive Intervention or Procedure (Other than Restraints and Seclusion)

This box shall be checked for any use of prohibited restrictive intervention or procedure that restricts the participant's freedom of movement, access to other locations, property, individuals, or rights. Refer to Policy #3.07.

Section D: Remediation Plan of Action to Prevent Recurrence of the Event

- 20.** Provide a description of what was done or what will be done to prevent the recurrence of the adverse event. This section should identify actions that will be implemented to prevent the event from recurring. Include timelines for completion and implementation. If additional pages are attached, number the additional pages as D-1, D-2, etc.

Agency/Representative Signature: The person attesting to the information on the form shall sign and print full name and date.

FOR DDD USE ONLY

- 21. Summary of Action Taken by Case Manager:** The CM must document follow-up actions taken in response to the adverse event. Follow-up actions must include dates of face-to-face contacts, home and site visits, and telephone calls

22. Case Manager Assessment:

- **Re: immediate action taken:** The CM must check whether appropriate or inappropriate immediate action was taken by the waiver provider/CD employer/caregiver of licensed or certified home to safeguard the participant as indicated in Section A – “What Was Done”. If immediate action was inappropriate, the case manager must complete the next section (Case Manager Plan of Action). Leave this section blank if the person reporting the event is the case manager.
- **Re: plan of action:** The CM must check whether the plan of action to prevent the recurrence of the adverse event is appropriate or inappropriate. If the plan of action is inappropriate, the case manager must complete the next section (Case Manager Plan of Action). Leave this section blank if the person reporting the event is the case manager.

- 23. Case Manager’s Plan of Action:** The CM must describe additional actions taken or to be taken to minimize the risk and prevent the recurrence of this event. Examples include, but are not limited to, revising the service plan to authorize additional services, reassessment of needs, or obtaining alternative residential placement.

If the ISP requires updates as a result of the adverse event, the CM must check the box to confirm whether the ISP has been updated.

- 24. Case Manager Signature:** The CM signs and prints his/her name and date.

- 25. Supervisor’s Review and Comments:** The supervisor must determine whether the CM’s action(s) and assessment were completed within the required timeframe. If so, the supervisor checks the box for timeline met. If not, write comment on reason and corrective action for the future.

The supervisor will check the appropriate box for CM assessment in Section 1. The supervisor will check the appropriate box for CM Plan of Action in Section 2, if applicable. If the CM updates the ISP with health and safety concerns and interventions, the supervisor must verify that this has been completed.

If the supervisor does not concur with the assessment and/or plan of action, the supervisor writes his/her comments, returns the form to the case manager and discusses the required changes. The CM changes the assessment or plan of action as appropriate. If the changes meet the supervisor’s satisfaction, the supervisor signs and dates the form.

If the supervisor determines that additional follow-up date is required, the supervisor will indicate a follow-up date.

26. Supervisor Signature: Supervisor shall sign and print his/her name and date.

27. Distribution: Check the appropriate box and the date it was sent. CM Unit to retain original.

- **Provider/CD Employer/Caregiver:** The CM Follow-Up Report must be sent to the reporting Waiver Provider/CD Employer/Caregiver within five (5) working days of receiving the written report with the final report, if applicable submitted within 2 weeks.
- **DDD-OCB Outcomes Section:** All adverse event reports must be sent to DDD-OCB Outcomes Section.
- **DDD-OCB Certification Unit:** Send for appropriate follow-up by the DDD-OCB Certification Unit if the adverse event involves an adult foster parent.
- **Office of Health Care Assurance (OHCA):** Send for appropriate follow-up by OHCA if adverse event involves an adult residential care home operator or DD Domiciliary home caregiver.
- **Other:** Specify persons or agencies adverse event report was sent to.

APPENDIX 6: PARTICIPATION AS A MEDICAID PROVIDER

APPENDIX 6A: MEDICAID APPLICATION/CHANGE REQUEST

Important Reminder

- [DHS 1139](#) (Link updated)
- [HOKU Provider Enrollment System](#)
- [More enrollment information including FAQs, training, and resources](#)

Providers requesting changes to current information, must also notify DOH-DDD by email to doh.dddcrb@doh.hawaii.gov and update information on the Provider Portal.

APPENDIX 7: GENERAL STAFF QUALIFICATION REQUIREMENTS

APPENDIX 7A: REQUEST FOR LIST OF EMPLOYEES LETTER

JOHN GREEN, M.D. GOVERNOR OF HAWAII KE KULING O KA MOHUKA O HAWAII	 STATE OF HAWAII DEPARTMENT OF HEALTH KA 'OIHANA OLAKINO DEVELOPMENTAL DISABILITIES DIVISION COMMUNITY RESOURCES BRANCH 3627 KILAUEA AVENUE, ROOM 411 HONOLULU, HAWAII 96816	KENNETH S. FINK, MD, MGA, MPH DIRECTOR OF HEALTH KE KULING O KA MOHUKA
Telephone: 808-733-2136 Fax: 808-733-9841		In reply, please refer to: File:

[Date]

[Title, First Name Last Name, Position Title]
[Agency Name]
[Address]
[City], Hawaii [Zip]

Re: Request for List of Employees

Dear [Title, Last Name]:

The Department of Health, Developmental Disabilities Division (DDD) is conducting quality assurance reviews for providers during the [year-year] fiscal year. As part of this review, all providers must comply with the current Medicaid Waiver Provider Standards prior to providing waiver services.

Once we receive your completed Validation List of Employees and Independent Contractors, the DDD will review it and notify you of a randomly selected sample of your total workforce. This sample will consist of at least twenty (20) individuals or ten percent (10%) of current workers, whichever is greater, for 100% document verification. For new workers (those hired within the last 12 months), service supervisors, and licensed or certified workers, the sample size will be 100%.

Please complete the attached Validation List of Employees and Independent Contractors by **[two weeks from the date of this letter]** and email the completed list to doh.dddcrb@doh.hawaii.gov. If your agency has multiple locations, kindly consolidate all information into a single list before submitting it.

Should you have any questions, please call our Community Resource Management Section staff at (808) 733-2133.

Sincerely,

[Name], Supervisor
Community Resources Management

Attached: Validation List of Employees and Independent Contractors Form

Request for List of Employees Letter ver. 06/2026

APPENDIX 7B: VALIDATION LIST OF EMPLOYEES AND INDEPENDENT CONTRACTORS FORM

[illegible]

APPENDIX 7C: **SELECTED LIST OF EMPLOYEES LETTER**

JOSH GREEN, M.D. GOVERNOR OF HAWAII KE KULING O KA MOHOLE O HAWAII	 STATE OF HAWAII DEPARTMENT OF HEALTH KA 'OIHANA OLAKINO DEVELOPMENTAL DISABILITIES DIVISION COMMUNITY RESOURCES BRANCH 3627 KILAUEA AVENUE, ROOM 411 HONOLULU, HAWAII 96816	KENNETH S. FINK, MD, MGA, MPH DIRECTOR OF HEALTH KE ULUKE MO OHELE
Telephone: 808-733-2136 Fax: 808-733-0841		In reply, please refer to: File:
[Date]		
[Title, First Name Last Name, Position Title] [Agency Name] [Address] [City], Hawaii [Zip]		
Re: Selected List of Employees for QA Review		
Dear [Title, Last Name]:		
The Home and Community-Based Services Medicaid Waiver program requires the Developmental Disabilities Division (DDD) to conduct an annual validation review for each provider agency. To start this review, we have selected the following sample from your list of employees and independent contractors (see attached):		
• All licensed or certified workers, such as Registered Nurses, Registered Behavior Technicians, etc. (100% sample) • All Service Supervisors (100% sample); and • Minimally, 20 randomly selected employees/Independent Contractors or 10% (if over 200 employees/Independent Contractors).		
Provider qualification requirements are specified in Section 3.5 General Staff Qualification Requirements and service-specific qualifications are described in Section 4. Providers must maintain and update staff records in the Provider Portal.		
Please have documents uploaded for review in the Provider Portal by [Date of Audit].		
We appreciate your cooperation in this matter. If you have any questions, please contact our Community Resource Management Section at (808) 733-2133.		
Sincerely, [Name], Supervisor Community Resources Management Section		
Selected List of Employees Letter ver. 06/2026		

APPENDIX 7D: COMPLETED VERIFICATION LETTER

JOSH GREEN, III, D. GOVERNOR OF HAWAII HE KULANA O KA MOLO KALI, O HAWAII	 STATE OF HAWAII DEPARTMENT OF HEALTH KA 'OIHANA OLAKINO DEVELOPMENTAL DISABILITIES DIVISION COMMUNITY RESOURCES BRANCH 3827 KILAUEA AVENUE, ROOM 411 HONOLULU, HAWAII 96816	KENNETH S. FINK, III, MGA, MPH DIRECTOR OF HEALTH KA LUNG KO OKELE
Telephone: 808-733-2135 Fax: 808-733-9841		In reply, please refer to: File:

[Date]

[Title, First Name Last Name, Position Title]
[Agency Name]
[Address]
[City], Hawaii [Zip]

Re: Completed 100% Verification of Staff Validation

Dear [Title, Last Name]:

This letter is to inform you that the Department of Health, Developmental Disabilities Division has completed our verification of your agency's staff documentation.

Please find the results enclosed. It has been determined that your agency meets 100% of the qualification requirements for fiscal year [Year]. Your next QA Review audit is for the Fiscal Year [Year].

Should you have any questions, please call our Community Resource Management Section staff at (808) 733-2133.

Sincerely,

[Name], Supervisor
Community Resources Management Section

~~~~~  
Enclosed: Completed Validation List of Employees and Independent Contractors Form  
cc: [Name], DHS, MQD, HCBS  
[Name], DHS, MQD, HCBS  
[Name], DHS, MQD, HCBS

Completed Verification Letter ver. 6/2026

## APPENDIX 7E: CAP FOR VALIDATION

|                                                                                            |                                                                                                                                                                                                                                                                                                        |                                                                                                         |
|--------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|
| <p><b>JOSH GREEN, M.D.</b><br/>GOVERNOR OF HAWAII<br/>KE KULING O NE IHOULANA O HAWAII</p> |  <p><b>STATE OF HAWAII</b><br/>DEPARTMENT OF HEALTH<br/>KA 'OIHANA OLAKINO<br/>DEVELOPMENTAL DISABILITIES DIVISION<br/>COMMUNITY RESOURCES BRANCH</p> <p>3627 KILAUEA AVENUE, ROOM 411<br/>HONOLULU, HAWAII 96816</p> | <p><b>KENNETH S. FINK, MD, MGA, MPH</b><br/>DIRECTOR OF HEALTH<br/>KA KULING O NE IHOULANA O HAWAII</p> |
|--------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|

|                                                      |                                             |
|------------------------------------------------------|---------------------------------------------|
| <p>Telephone: 808-733-2135<br/>Fax: 808-733-9841</p> | <p>In reply, please refer to:<br/>File:</p> |
|------------------------------------------------------|---------------------------------------------|

[Date]

[Title, First Name Last Name, Position Title]  
[Agency Name]  
[Address]  
[City], Hawaii [Zip]

Re: Correction Action Plan for Staff Validation

Dear [Title, Last Name]:

This letter is to inform you that the Department of Health, Developmental Disabilities Division, has started the process of validating the qualifications of your agency's staff. To complete our review, we need clarification on the validation documents for the staff listed below in the Provider Portal. Please respond to the columns under *Corrective Action Plan (CAP)* by **2 weeks from the letter date** and email your response to [doh.dddcrb@doh.hawaii.gov](mailto:doh.dddcrb@doh.hawaii.gov).

| Name of Employee/Independent Contractor | Issues and Concerns | Corrective Action Plan                          |                            |
|-----------------------------------------|---------------------|-------------------------------------------------|----------------------------|
|                                         |                     | Reasons for not meeting Validation Requirements | Quality Improvement Action |
|                                         |                     |                                                 |                            |
|                                         |                     |                                                 |                            |
|                                         |                     |                                                 |                            |
|                                         |                     |                                                 |                            |

Please notify the CRMS if an employee has been terminated, and they will be removed from the audit review. The CAP must specify the action(s) to be taken, identify the responsible staff to implement these actions, and establish a timeline for remediation. Failure by the Provider to submit a CAP that DDD accepts within timelines may result in sanctions imposed by DDD and the Med-QUEST Division (MQD).

Correction Action Plan for Staff Validation ver. 06/2026

[Title. First Name Last Name, Position Title]  
[Agency Name]  
[Date]  
Page 2

Thank you for your immediate attention to this letter. If you have any questions, please call our Community Resource Management Section staff at (808) 733-2133.

Sincerely,

[Name], Supervisor  
Community Resources Management Section

SAMPLE

Partial Suspension Verification Letter ver. 06/2026

## APPENDIX 7F: CAP STATUS LETTER FOR SATISFACTORY CAP

**JOSH GREEN, M.D.**  
GOVERNOR OF HAWAII  
KE KULUINGI O NA MOHUKU O HAWAII



**STATE OF HAWAII**  
DEPARTMENT OF HEALTH  
KA'OIHANA OLAKINO  
DEVELOPMENTAL DISABILITIES DIVISION  
COMMUNITY RESOURCES BRANCH  
3627 KILAUEA AVENUE, ROOM 411  
HONOLULU, HAWAII 96816

**KENNETH S. FINK, MD, MSA, MPH**  
DIRECTOR OF HEALTH  
KA LUALUHO O KEIA

Telephone: 808-733-2135  
Fax: 808-733-9841

In reply, please refer to:  
File:

[Date]

[Title, First Name Last Name, Position Title]  
[Agency Name]  
[Address]  
[City], Hawaii [Zip]

RE: Corrective Action Plan (CAP) Status for Staff Validation

Dear [Title, Last Name]:

This letter is to inform you of the status of your **staff validation** Corrective Action Plan (CAP) in response to the Department of Health, Developmental Disabilities Division's (DOH/DDD), Quality Assurance Review audit dated on [date of report sent] for the review period of [Month/Year – Month/Year].

Please review the following checkboxes regarding your CAP status:

☒ **Satisfactory CAP**  
We have received and reviewed your Corrective Action Plan on [date of CAP received]. Your CAP for Fiscal Year [Year] is now satisfactory. Your next QA Review audit is for the Fiscal Year [Year].

☐ **Unsatisfactory CAP**  
We received your Corrective Action Plan on [date CAP received] and need further information/clarification. Please respond in writing to the Issues/Concerns below by **[2 weeks from the date of this letter]**. Upload your CAP to the Provider Portal, and notify the Community Resources Management Section (CRMS) by emailing [doh.dddcrb@doh.hawaii.gov](mailto:doh.dddcrb@doh.hawaii.gov) that the CAP has been submitted.

Issues/Concerns:

☐ **No CAP Received**  
Your Corrective Action Plan (CAP) was due on [due date of CAP]. As of today, we have not received your CAP. Another copy of the Partial Suspension letter is attached, if applicable. Please complete and upload to the Provider Portal by **[2 weeks from the date of this letter]**. Failure to submit your CAP in response to this Second Notice may result in an Accountability Plan (see most recent Medicaid Waiver Standards Manual, Accountability and Sanctions Section).

[Title, First Name Last Name, Position Title]  
[Agency Name]  
[Date]  
Page 2

Should you have any questions, please contact the Community Resources Management Section at (808) 733-2133. Thank you very much for your assistance in this process.

Sincerely,

[Name], Supervisor  
Community Resources Management Section

~~~~~  
cc: [Name], DHS, MQD, HCBS
[Name], DHS, MQD, HCBS

CAP Status Letter rev. 06/2026

APPENDIX 7G: CAP STATUS LETTER (UNSATISFACTORY CAP)

JOHN GREEN, M.D. GOVERNOR OF HAWAII HE KULUING O KA MOHUKU O HAWAII	 STATE OF HAWAII DEPARTMENT OF HEALTH KA 'OIHANA OLAKINO DEVELOPMENTAL DISABILITIES DIVISION COMMUNITY RESOURCES BRANCH 3627 KILAUEA AVENUE, ROOM 411 HONOLULU, HAWAII 96816	KENNETH S. FINK, MD, MGA, MPH DIRECTOR OF HEALTH KA LUNA HO'OMILO
Telephone: 808-733-2135 Fax: 808-733-9841		In reply, please refer to: File:

[Date]

[Title, First Name Last Name, Position Title]
[Agency Name]
[Address]
[City], Hawaii [Zip]

RE: Corrective Action Plan (CAP) Status for Staff Validation

Dear [Title, Last Name]:

This letter is to inform you of the status of your **staff validation** Corrective Action Plan (CAP) in response to the Department of Health, Developmental Disabilities Division's (DOH/DDD), Quality Assurance Review audit dated on [date of report sent] for the review period of [Month/Year – Month/Year].

Please review the following checkboxes regarding your CAP status:

☐ Satisfactory CAP
We have received and reviewed your Corrective Action Plan on [date of CAP received]. Your CAP for Fiscal Year [Year] is now satisfactory. Your next QA Review audit is for the Fiscal Year [Year].

☒ Unsatisfactory CAP
We received your Corrective Action Plan on [date CAP received] and need further information/clarification. Please respond in writing to the Issues/Concerns below by **2 weeks from the date of this letter**. Upload your CAP to the Provider Portal, and notify the Community Resources Management Section (CRMS) by emailing doh.dddcrb@doh.hawaii.gov that the CAP has been submitted.

Issues/Concerns:

☐ No CAP Received
Your Corrective Action Plan (CAP) was due on [due date of CAP]. As of today, we have not received your CAP. Another copy of the Partial Suspension letter is attached, if applicable. Please complete and upload to the Provider Portal by **2 weeks from the date of this letter**. Failure to submit your CAP in response to this Second Notice may result in an Accountability Plan (*see most recent Medicaid Waiver Standards Manual, Accountability and Sanctions Section*).

[Title, First Name Last Name, Position Title]
[Agency Name]
[Date]
Page 2

Should you have any questions, please contact the Community Resources Management Section at (808) 733-2133. Thank you very much for your assistance in this process.

Sincerely,

[Name], Supervisor
Community Resources Management Section

~~~~~  
cc: [Name], DHS, MQD, HCBS  
[Name], DHS, MQD, HCBS

CAP Status Letter rev. 06/2026

# APPENDIX 7H: PARTIAL SUSPENSION LETTER

**JOSEPH GREEN, M.D.**  
GOVERNOR OF HAWAII  
KA KULANA O KA MOHAKA O KA HAWAII



**STATE OF HAWAII**  
DEPARTMENT OF HEALTH  
KA 'OIHANA OLAKINO  
DEVELOPMENTAL DISABILITIES DIVISION  
COMMUNITY RESOURCES BRANCH

3627 KILAUEA AVENUE, ROOM 411  
HONOLULU, HAWAII 96816

**KENNETH S. FINK, MD, MGA, MPH**  
DIRECTOR OF HEALTH  
KA LUNA HO OHOLE

Telephone: 808-733-2136  
Fax: 808-733-9841

In reply, please refer to:  
File:

[Date]

[Title, First Name Last Name, Position Title]  
[Agency Name]  
[Address]  
[City], Hawaii [Zip]

Re: Partial Suspension Verification of Employees and Correction Action Plan

Dear [Title, Last Name]:

This letter is to inform you that the Department of Health, Developmental Disabilities Division, has started the process of validating the qualifications of your agency's staff. To complete our review, we require providers to upload copies of all necessary validation documents into the Provider Portal. Your agency has failed to submit the requirements for the staff listed below. Upload the listed documents and respond to the columns under *Corrective Action Plan (CAP)* by **[2 weeks from the letter date]**. Please notify the Community Resources Management Section (CRMS) that the documents and letter have been uploaded by emailing [doh.dddcrb@doh.hawaii.gov](mailto:doh.dddcrb@doh.hawaii.gov).

| Name of Employee/Independent Contractor | Needed Document(s) | Corrective Action Plan                          |                            |
|-----------------------------------------|--------------------|-------------------------------------------------|----------------------------|
|                                         |                    | Reasons for not meeting Validation Requirements | Quality Improvement Action |
|                                         |                    |                                                 |                            |
|                                         |                    |                                                 |                            |
|                                         |                    |                                                 |                            |
|                                         |                    |                                                 |                            |

The CAP must specify the action(s) to be taken, identify the responsible staff to implement these actions, and establish a timeline for remediation. Failure by the Provider to submit a CAP that DDD accepts within timelines may result in sanctions imposed by DDD and the Med-QUEST Division (MQD).

Partial Suspension Verification Letter ver. 06/2026

[Title, First Name Last Name, Position Title]  
[Agency Name]  
[Date]  
Page 2

If we cannot verify the qualifications of the employee(s) or independent contractor(s) mentioned above, they will be unable to provide services to DDD participants until all necessary qualification requirements are fulfilled. If these requirements are not met, they will not be allowed to continue providing waiver services, even under supervision, until full compliance is achieved. Please notify the CRMS if the employee has been terminated and they will be removed from the audit review.

Thank you for your immediate attention to this letter. If you have any questions, please call our Community Resource Management Section staff at (808) 733-2133.

Sincerely,

[Name], Supervisor  
Community Resources Management Section

Partial Suspension Verification Letter ver. 06/2026

## APPENDIX 7I: FULL SUSPENSION LETTER

|                                                                                              |                                                                                                                                                                                                                                                                                                        |                                                                                                  |
|----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|
| <p><b>JOSH GREEN, M.D.</b><br/>GOVERNOR OF HAWAII<br/>HE KULUING O KE MONI'EALE O HAWAII</p> |  <p><b>STATE OF HAWAII</b><br/>DEPARTMENT OF HEALTH<br/>KA 'OIHANA OLAKINO<br/>DEVELOPMENTAL DISABILITIES DIVISION<br/>COMMUNITY RESOURCES BRANCH</p> <p>3627 KILAUEA AVENUE, ROOM 411<br/>HONOLULU, HAWAII 96816</p> | <p><b>KENNETH B. FINK, MD, MBA, MPH</b><br/>DIRECTOR OF HEALTH<br/>HE KULUING O KE MONI'EALE</p> |
| Telephone: 808-733-2136<br>Fax: 808-733-9541                                                 |                                                                                                                                                                                                                                                                                                        | In reply, please refer to:<br>File:                                                              |

[Date]

[Title, First Name Last Name, Position Title]  
[Agency Name]  
[Address]  
[City], Hawaii [Zip]

Re: Full Suspension Verification of Non-Compliant Employees

Dear [Title, Last Name]:

This letter is to inform you that the Department of Health, Developmental Disabilities Division, has completed the validation process for your agency's staff. Enclosed are the results. ***Effective immediately, the staff members listed below are not permitted to provide services to DDD participants until all qualification requirements are fulfilled.***

| Name of Agency Staff | Position | Reason(s) Why Agency Staff are Unable to Provide Services | Date Agency Staff Cleared to Provide Services<br>(to be completed by DDD) |
|----------------------|----------|-----------------------------------------------------------|---------------------------------------------------------------------------|
| 1.                   |          |                                                           |                                                                           |
| 2.                   |          |                                                           |                                                                           |
| 3.                   |          |                                                           |                                                                           |
| 4.                   |          |                                                           |                                                                           |
| 5.                   |          |                                                           |                                                                           |

Submit the qualification requirements for the staff listed above by uploading them to the Provider Portal. Please notify the Community Resources Management Section (CRMS) that the documents have been uploaded by emailing [doh.dddcrb@doh.hawaii.gov](mailto:doh.dddcrb@doh.hawaii.gov). In addition, if an employee has been terminated, please inform the CRMS so that they can be removed from the audit review.

Suspension Verification Letter ver. 02/2022

[Title, First Name Last Name, Position Title]  
[Agency Name]  
[Date]  
Page 2

Thank you for your prompt attention to this matter. If you have any questions, feel free to call our Community Resource Management Section at (808) 733-2133.

Sincerely,

[Name], Supervisor  
Community Resources Management Section

Enclosed: Completed Validation List of Employees and Independent Contractors Form

cc: [Name], DDD Administrator  
[Name], DDD, CMB  
[Name], DDD, Fiscal  
[Name], DHS, MQD, HCBS  
[Name], DHS, MQD, HCBS  
[Name], DHS, MQD, HCBS

Full Suspension Verification Letter ver. 06/2026

## APPENDIX 7J: COMPLETED VALIDATION LIST OF EMPLOYEES FORM

State of Hawaii  
Department of Health

Developmental Disabilities Division  
Community Resources Branch

### COMPLETED VALIDATION LIST OF EMPLOYEES AND INDEPENDENT CONTRACTORS

Name of Provider Agency: \_\_\_\_\_

The DOH-DDD has completed the validation for your agency's staff. Listed below are the employees and Independent Contractors who were reviewed for your Quality Assurance Audit. Employees/Independent Contractors who do NOT meet the qualification requirements in accordance with the Medicaid Waiver Provider Standards, is suspended to provide services to DDD participants until all requirements are met and cleared by DDD. The employee/Independent Contractor may not continue to provide waiver services, even under supervision, until full compliance is complete.

| No. | Name of Employee/Independent Contractor | Meets 100% | Does NOT Meet 100% | Reason(s) Why Agency Staff are Unable to Provide Services |
|-----|-----------------------------------------|------------|--------------------|-----------------------------------------------------------|
| 1   |                                         |            |                    |                                                           |
| 2   |                                         |            |                    |                                                           |
| 3   |                                         |            |                    |                                                           |
| 4   |                                         |            |                    |                                                           |
| 5   |                                         |            |                    |                                                           |
| 6   |                                         |            |                    |                                                           |
| 7   |                                         |            |                    |                                                           |
| 8   |                                         |            |                    |                                                           |
| 9   |                                         |            |                    |                                                           |
| 10  |                                         |            |                    |                                                           |
| 11  |                                         |            |                    |                                                           |
| 12  |                                         |            |                    |                                                           |
| 13  |                                         |            |                    |                                                           |
| 14  |                                         |            |                    |                                                           |
| 15  |                                         |            |                    |                                                           |
| 16  |                                         |            |                    |                                                           |
| 17  |                                         |            |                    |                                                           |
| 18  |                                         |            |                    |                                                           |
| 19  |                                         |            |                    |                                                           |
| 20  |                                         |            |                    |                                                           |
| 21  |                                         |            |                    |                                                           |

DDD Staff Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Ver. 06/2026



APPENDIX 7K: ATTESTATION FORM FOR HIGH SCHOOL DIPLOMA AND  
GENERAL EQUIVALENCY DEGREE

|                                                                      |                                                              |
|----------------------------------------------------------------------|--------------------------------------------------------------|
| <b>STATE OF HAWAII</b><br>DIVISION<br>Department of Health<br>Branch | <b>DEVELOPMENTAL DISABILITIES</b><br><br>Community Resources |
|----------------------------------------------------------------------|--------------------------------------------------------------|

**ATTESTATION FORM**  
(Use for Employees who do not have a  
High School Diploma or a General  
Equivalency Diploma)

The agency must retain the original signed form in the employee's personnel file for the duration of their employment.

**Provider Agency Name:** \_\_\_\_\_

**Employee Name:** \_\_\_\_\_

**Position Title of Employee:** \_\_\_\_\_

☐ I attest that the employee does not have documentation of a High School (HS) Diploma or General Equivalency Diploma (GED).

☐ I attest that the employee meets the minimum requirements for the position to provide services to participants in the Home and Community Based Waiver for Individuals with Intellectual and Developmental Disabilities (I/DD Waiver). The minimum requirements include the following:

- 1) Understand and follow written instructions
- 2) Understand and follow verbal instructions
- 3) Complete required documentation for the position
- 4) Demonstrate the ability to perform the duties and tasks required in the position description

☐ I understand this form only pertains to the HS diploma or GED requirement and does not waive any other General Staff Qualification Requirements as set forth in the Waiver Provider Standards Manual.

Note: The provider agency may have additional requirements for the position.

---

By signing, I attest I am authorized to sign on the provider agency's behalf and the information in this document is true and accurate.

|                                      |       |
|--------------------------------------|-------|
| Print Name of Person Completing Form | Title |
| Signature                            | Date  |

*This form can be signed electronically ("E-sign") or printed and signed. An E-sign is accepted as an original signature.*

I/DD Waiver: Attestation in place of HS Diploma/GEDJuly 2019

<https://health.hawaii.gov/ddd/files/2019/07/CRB-FY2020-01-7-9-19-Attestation-Form-HS-GED.pdf>

## APPENDIX 7L: ATTESTATION FORM FOR SERVICE SUPERVISOR

STATE OF HAWAII  
Department of Health

DEVELOPMENTAL DISABILITIES DIVISION  
Community Resources Branch

### ATTESTATION FORM (Use for verifying Service Supervisor qualifications)

Source: HI Waiver Provider Standards Manual (July 2026): 3.5.D - Additional Qualifications for Service Supervisors (pp. 87-88).

The agency must retain the original signed form in the employee's personnel file for the duration of their employment. Complete and submit this attestation form to [DOH.dddcrb@doh.hawaii.gov](mailto:DOH.dddcrb@doh.hawaii.gov) and upload it to the Provider Portal.

Provider Agency Name: \_\_\_\_\_

Employee Name: \_\_\_\_\_

I attest that the employee listed above possesses one of the minimum requirements checked below for the Service Supervisor position, to provide services to participants in the Home and Community Based Waiver for Individuals with Intellectual and Developmental Disabilities (I/DD Waiver).

- ☐ Bachelor's degree from an accredited college or university in a field other than social sciences or education with one (1) year verifiable experience working directly with individuals with disabilities or the elderly.
- ☐ Registered Nurse license in the State of Hawaii.
- ☐ High school diploma or equivalent (GED) and a minimum of two (2) years of experience providing direct assistance to individuals with intellectual and/or developmental disabilities and has met all requirements listed below:
  - ☐ Has been employed by the agency for a minimum of six (6) months;
  - ☐ Will be under the supervision/oversight of a qualified staff who will co-sign for the first six (6) months; and
  - ☐ Possesses people skills, advocacy skills, ability to build relationships and verbal and written communication skills.
- ☐ Qualifications from an accredited foreign college or university with one of the requirements listed below:
  - ☐ Document verification that the degree is equivalent or higher than a bachelor's degree in the United States; or
  - ☐ Document verification of acceptance of admission to a graduate program at the University of Hawaii, Hawaii Pacific University, or Chaminade College.

By signing, I attest I am authorized to sign on the provider agency's behalf and the information in this document is true and accurate.

\_\_\_\_\_  
Print Name of Person Completing Form

\_\_\_\_\_  
Title

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

*This form can be signed electronically ("E-sign") or printed and signed. An E-sign is accepted as an original signature.*

<https://health.hawaii.gov/ddd/files/2026/06/DDD-Attestation-Form-for-Service-Supervisor.pdf>

## APPENDIX 7M: ATTESTATION FORM FOR LIST OF EXCLUDED INDIVIDUALS/ENTITIES

STATE OF HAWAII  
Department of Health

DEVELOPMENTAL DISABILITIES DIVISION  
Community Resources Branch

### ATTESTATION FORM (Use for verifying completed checks of the List of Excluded Individuals and Entities (LEIE))

Source: HI Provider Waiver Standards Manual (July 2026) 3.5.E(1)(b) List of Excluded Individuals/Families (p.91).

Complete and submit this attestation form and upload it to the Provider Portal.

**Provider Agency Name:** \_\_\_\_\_

- ☐ I attest that my agency, as a Medicaid-funded provider, has searched the Office of the Inspector General's (OIG) List of Excluded Individuals (LEIE) to determine if any existing employee or contractor has been excluded from participating in the Medicaid program, **prior to hire and annually**.

By signing, I attest I am authorized to sign on the provider agency's behalf and the information in this document is true and accurate.

\_\_\_\_\_  
Print Name of Person Completing Form

\_\_\_\_\_  
Title

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

*This form can be signed electronically ("E-sign") or printed and signed. An E-sign is accepted as an original signature.*

<https://health.hawaii.gov/ddd/files/2026/06/DDD-Attestation-Form-for-List-of-Excluded-Individuals-and-Entities.pdf>

## APPENDIX 7N: ATTESTATION FORM FOR EXCLUDED INDIVIDUALS

STATE OF HAWAII  
Department of Health

DEVELOPMENTAL DISABILITIES DIVISION  
Community Resources Branch

### ATTESTATION FORM

(Use for verifying completed checks of Med-  
QUEST Excluded Individuals list)

Source: HI Waiver Provider Standards Manual (July 2026) 3.5.E(2) Med-QUEST Exclusion List Requirement (p.91).

Complete and submit this attestation form and upload it to the Provider Portal.

Provider Agency Name: \_\_\_\_\_

☐ I attest that my agency, as a Medicaid-funded provider, has searched Hawaii's excluded provider list to determine if any existing employee or contractor has been excluded from participating in the Medicaid program, prior to hire and monthly.

By signing, I attest I am authorized to sign on the provider agency's behalf and the information in this document is true and accurate.

\_\_\_\_\_  
Print Name of Person Completing Form

\_\_\_\_\_  
Title

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

*This form can be signed electronically ("E-sign") or printed and signed. An E-sign is accepted as an original signature.*

I/DD Waiver: Attestation for LEIE and Med-QUEST Excluded Individuals Checks

July 2026

<https://health.hawaii.gov/ddd/files/2026/06/DDD-Attestation-Form-for-Excluded-Individuals.pdf>

## APPENDIX 70: HYPERLINKS TO RESOURCES FOR REQUIRED CLEARANCES

| Clearance                                     | Forms, Instructions, Administrative Rules, Standards                                                                           | Hyperlink Reference                                                                                                                                                                                                                                                                                                                        |
|-----------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Tuberculosis (TB)                             | <a href="#"><u>Hawaii Administrative Rules (HAR), Title 11, Department of Health, Chapter 164.2, Tuberculosis</u></a>          | <a href="https://health.hawaii.gov/tb/files/2025/07/Hawaii-TB-Clearance-Manual_5-19-2025.pdf"><u>https://health.hawaii.gov/tb/files/2025/07/Hawaii-TB-Clearance-Manual_5-19-2025.pdf</u></a>                                                                                                                                               |
| Criminal History Record and Background Checks | <a href="#"><u>Department of Human Services Med-QUEST Division, Criminal History Record and Background Check Standards</u></a> | <a href="https://medquest.hawaii.gov/content/dam/formsanddocuments/resources/Provider-Resources/criminal-history-record/Criminal-History-Record-Check-Standards.pdf"><u>https://medquest.hawaii.gov/content/dam/formsanddocuments/resources/Provider-Resources/criminal-history-record/Criminal-History-Record-Check-Standards.pdf</u></a> |
| Criminal History Record and Background Checks | MQD                                                                                                                            | <a href="https://medquest.hawaii.gov/en/plans-providers/criminal-history-background-check.html"><u>https://medquest.hawaii.gov/en/plans-providers/criminal-history-background-check.html</u></a>                                                                                                                                           |
| Criminal History Record and Background Checks | <a href="#"><u>Request for Exemption from Criminal History Record and Background Check Standards (DHS Form 1200)</u></a>       | <a href="https://medquest.hawaii.gov/content/dam/formsanddocuments/resources/Provider-Resources/criminal-history-record/DHS1200_Exemption_Request_form-Rev1015.pdf"><u>https://medquest.hawaii.gov/content/dam/formsanddocuments/resources/Provider-Resources/criminal-history-record/DHS1200_Exemption_Request_form-Rev1015.pdf</u></a>   |

| Clearance                                     | Forms, Instructions, Administrative Rules, Standards                                                                                                                                | Hyperlink Reference                                                                                                                                                                                                                                                                                            |
|-----------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Criminal History Record and Background Checks | <a href="#"><u>Request for Exemption from Criminal History Record and Background Check Standards Instructions (DHS Form 1200A)</u></a>                                              | <a href="https://medquest.hawaii.gov/content/dam/formsanddocuments/client-forms/1200-request-for-exemption/DHS1200-Instr-Rev0616.pdf"><u>https://medquest.hawaii.gov/content/dam/formsanddocuments/client-forms/1200-request-for-exemption/DHS1200-Instr-Rev0616.pdf</u></a>                                   |
| Criminal History Record and Background Checks | <a href="#"><u>Department of Human Services Med-QUEST Division Procedures for Processing Exemption Requests from the Criminal History Record and Background Check Standards</u></a> | <a href="https://medquest.hawaii.gov/content/dam/formsanddocuments/resources/Provider-Resources/criminal-history-record/Exemption-Procedures-1012.pdf"><u>https://medquest.hawaii.gov/content/dam/formsanddocuments/resources/Provider-Resources/criminal-history-record/Exemption-Procedures-1012.pdf</u></a> |
| Criminal History Record and Background Checks | <a href="#"><u>Statement of Authenticity</u></a>                                                                                                                                    | <a href="https://medquest.hawaii.gov/content/dam/formsanddocuments/resources/Provider-Resources/criminal-history-record/StatementOfAuthenticity.pdf"><u>https://medquest.hawaii.gov/content/dam/formsanddocuments/resources/Provider-Resources/criminal-history-record/StatementOfAuthenticity.pdf</u></a>     |

| <b>Clearance</b>                                                                     | <b>Forms, Instructions, Administrative Rules, Standards</b>                                                                                                                                              | <b>Hyperlink Reference</b>                                                                                                                                                                               |
|--------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Adult Protective Services (APS)                                                      | APS                                                                                                                                                                                                      | <a href="#"><u>Protective Services Central Registry Check Standards</u></a>                                                                                                                              |
| Child Abuse and Neglect Registry (CAN)                                               | CAN                                                                                                                                                                                                      | <a href="#"><u>Protective Services Central Registry Check Standards</u></a>                                                                                                                              |
| Federal Office of Inspector General List of Excluded Entities and Individuals (LEIE) | <a href="https://oig.hhs.gov/exclusions/index.asp"><u>https://oig.hhs.gov/exclusions/index.asp</u></a>                                                                                                   | <a href="https://oig.hhs.gov/exclusions/exclusions_list.asp"><u>https://oig.hhs.gov/exclusions/exclusions_list.asp</u></a>                                                                               |
| DHS-MQD Excluded Individuals List                                                    | <a href="https://medquest.hawaii.gov/en/plans-providers/provider-exclusion-reinstatement-list.html"><u>https://medquest.hawaii.gov/en/plans-providers/provider-exclusion-reinstatement-list.html</u></a> | <a href="https://medquest.hawaii.gov/en/plans-providers/provider-exclusion-reinstatement-list.html"><u>https://medquest.hawaii.gov/en/plans-providers/provider-exclusion-reinstatement-list.html</u></a> |

# **APPENDIX 8: MONITORING PROVIDER AGENCIES**



## APPENDIX 8A: QA REVIEW LETTER TO SCHEDULE

|                                                                                                                                                                                                                                                  |                                                                                   |                                                                                             |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|
| <p><b>JOHN GREEN, M.D.</b><br/>GOVERNOR OF HAWAII<br/>HE KULANA O NA MOLOKUNI O HAWAII</p>                                                                                                                                                       |  | <p><b>KENNETH S. FINK, MD, MSA, MPH</b><br/>DIRECTOR OF HEALTH<br/>KULANA O NA MOLOKUNI</p> |
| <p><b>STATE OF HAWAII</b><br/><b>DEPARTMENT OF HEALTH</b><br/><b>KA 'OIHANA OLAKINO</b><br/><b>DEVELOPMENTAL DISABILITIES DIVISION</b><br/><b>COMMUNITY RESOURCES BRANCH</b></p> <p>3627 KILAUEA AVENUE, ROOM 411<br/>HONOLULU, HAWAII 96816</p> |                                                                                   |                                                                                             |
| Telephone: 808-733-2135<br>Fax: 808-733-6841                                                                                                                                                                                                     |                                                                                   | In reply, please refer to:<br>File:                                                         |

[Date]

[Title, First Name Last Name, Position Title]  
[Agency Name]  
[Address]  
[City], Hawaii [Zip]

Dear [Title, Last Name]:

This letter is to inform you that the Developmental Disabilities Division (DDD) will be conducting a Quality Assurance (QA) review of your agency, pursuant to the Hawaii Section 1915(c) Home and Community-Based Services for People with Intellectual and Developmental Disabilities (I/DD) Waiver (Medicaid Waiver) and the Waiver Provider Standards Manual.

This QA review will continue to take place as a desk audit. Please upload all documents to the provider portal by **[AUDIT DATE]**.

The DDD is required, by federal and state law, to maintain the privacy of all information and will be responsible for reporting any incidents to the Office of Civil Rights (OCR). Documents, records, and files disclosed to the DDD for the waiver provider monitoring are DDD records and will be securely managed and stored, pursuant to the DOH HIPAA Policies & Procedures and the DOH Guidelines for Protecting Confidential Information (July 2016).

After the waiver provider monitoring is completed, records and/or validation documents will be archived for up to twelve (12) months from date of audit completion.  
For this QA review, DDD will be evaluating:

- Program Records for [MONTH/YEAR] – [MONTH/YEAR]
- Validation Records for [MONTH/YEAR] – [MONTH/YEAR]

DDD will contact your agency fourteen (14) business days before the due date and provide the list of participant names to be reviewed. The number of participant records in the sample to be reviewed will depend on the number of participants served by your agency.

Specifically, DDD will be reviewing the documents listed below.

**Program Records:**

Please organize documents by participant and label with the participant's number provided by CRB (e.g., "P1", "P2", etc.).

- Individualized Service Plans (ISP) (for Program audit period)

QA Review Results Letter rev. 06/2026

- Individualized Plans (IPs) including detailed strategies for a 24-month period that ends one (1) month prior to the monitoring date,
- Behavior Support Plans (if applicable),
- Evidence of staff training,
- Nursing Assessment and Nurse Delegation Plan (if applicable),
- Reports (or more frequent),
- Documentation of face-to-face observations/reviews of service delivery,
- Adverse Event Reporting and internal quality assurance activities,
- Emergency Preparedness Plan and/or attestation form (see Appendix 8K),
- Quality Management Plan and/or attestation form (see Appendix 8N),
- A copy of your agency's current general liability insurance certificate and automobile insurance certificate covering the organization
- Additional documents required for the following services:
  - For Adult Day Health
    - Interest Inventory
    - Settings Rule Evidence Template,
    - Additional evidence (if applicable,) and
    - Attestation form (if applicable) (see Appendix 8M).
  - For Residential Habilitation:
    - Setting Rule Evidence Template,
    - Additional evidence (if applicable), and
    - Attestation form (if applicable) (see Appendix 8M).
  - For Discovery and Career Planning:
    - Discovery Profiles I, II, III (if applicable),
    - Documentation of Discovery Action Meeting (if applicable), and
    - Customized Employment Plan (if applicable),
  - For Individual Employment Supports:
    - Customized Employment Plan (if applicable) and
    - Job Coaching Fade Plan (if applicable).

Please note that other documentation may be required to be submitted upon request by the DDD.

**Staff Validation Records:**

- The request for employee list will continue to be sent to your agency in a separate letter. Notification of the **Fiscal Audit** will be sent separately by the DDD Fiscal Section. Should you have any questions, please call our Community Resource Management Section staff at (808) 733-2133. Thank you very much for your assistance in this process.

Sincerely,

[Name], Supervisor  
Community Resources Management Section

Enclosed: FINAL QA Review Results Tool  
c: [Name], DHS, MQD, HCSB

QA Review Results Letter rev. 06/2026

## APPENDIX 8B: QA REVIEW RESULTS LETTER

|                                                                                                                                                                                  |                                                                                   |                                                                                         |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|
| <p><b>JOHN GREEN, M.D.</b><br/>GOVERNOR OF HAWAII<br/>KE KULANU O KA MONI'AKA O HAWAII</p>                                                                                       |  | <p><b>KENNETH S. FINK, MD, MGA, MPH</b><br/>DIRECTOR OF HEALTH<br/>KU LUAL HO OKELE</p> |
| <p><b>STATE OF HAWAII</b><br/><b>DEPARTMENT OF HEALTH</b><br/><b>KA 'OIHANA OLAKINO</b><br/><b>DEVELOPMENTAL DISABILITIES DIVISION</b><br/><b>COMMUNITY RESOURCES BRANCH</b></p> |                                                                                   |                                                                                         |
| <p>Telephone: 808-733-2135<br/>Fax: 808-733-9841</p>                                                                                                                             | <p>3627 KILAUEA AVENUE, ROOM 411<br/>HONOLULU, HAWAII 96816</p>                   | <p>In reply, please refer to:<br/>File:</p>                                             |

[Date]

[Title, First Name Last Name, Position Title]  
[Agency Name]  
[Address]  
[City], Hawaii [Zip]

Re: Quality Assurance Review Results

Dear [Title, Last Name]:

The Department of Health, Developmental Disabilities Division (DOH/DDD), has completed our Quality Assurance Review report for the audit conducted on [date of site visit].

Please review the following checkboxes regarding your QA Program Review Audit results.

☒ **Compliant**  
We are very pleased to inform you that no citations were found, and no corrective action is needed. Your next QA Review Audit is FY [Year].

☐ **Corrective Action Plan Required**  
Please send us your Corrective Action Plan for each of the cited areas attached, including timelines of when you will complete each item by **[CAP date 30 days from date of letter]**. Upload your CAP to the Provider Portal. Please send notification to the Community Resources Management Section (CRMS) that the documents have been uploaded by emailing [doh.dddcrb@doh.hawaii.gov](mailto:doh.dddcrb@doh.hawaii.gov).

If you have any questions, please call the Community Resource Management Section at (808) 733-2133. Thank you for your time and attention.

Sincerely,

[Name], Supervisor  
Community Resources Management Section

Enclosed: FINAL QA Review Results Tool  
c: [Name], DHS, MQD, HCSB

QA Review Results Letter rev. 06/2026

## APPENDIX 8C: QA REVIEW RESULTS LETTER (CAP REQUIRED)

|                                                                                                                                                                                  |                                                                                   |                                                                                         |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|
| <p><b>JOSH GREEN, M.D.</b><br/>GOVERNOR OF HAWAII<br/>HE KULANA O NA MOLO/MAIL O HAWAII</p>                                                                                      |  | <p><b>KENNETH S. FINK, MD, MGA, MPH</b><br/>DIRECTOR OF HEALTH<br/>KA LUALA OI OIAE</p> |
| <p><b>STATE OF HAWAII</b><br/><b>DEPARTMENT OF HEALTH</b><br/><b>KA 'OIHANA OLAKINO</b><br/><b>DEVELOPMENTAL DISABILITIES DIVISION</b><br/><b>COMMUNITY RESOURCES BRANCH</b></p> |                                                                                   |                                                                                         |
| <p>Telephone: 808-733-2135<br/>Fax: 808-733-9841</p>                                                                                                                             | <p>3527 KILAUEA AVENUE, ROOM 411<br/>HONOLULU, HAWAII 96816</p>                   | <p>In reply, please refer to:<br/>File:</p>                                             |

[Date]

[Title, First Name Last Name, Position Title]  
[Agency Name]  
[Address]  
[City], Hawaii [Zip]

Re: Quality Assurance Review Results

Dear [Title, Last Name]:

The Department of Health, Developmental Disabilities Division (DOH/DDD), has completed our Quality Assurance Review report for the audit conducted on [date of site visit].

Please review the following checkboxes regarding your QA Program Review Audit results.

☐ Compliant  
We are very pleased to inform you that no citations were found, and no corrective action is needed. Your next QA Review Audit is FY [Year].

☒ Corrective Action Plan Required  
Please send us your Corrective Action Plan for each of the cited areas attached, including timelines of when you will complete each item by [CAP date 30 days from date of letter]. Upload your CAP to the Provider Portal. Please send notification to the Community Resources Management Section (CRMS) that the documents have been uploaded by emailing [doh.dddcrb@doh.hawaii.gov](mailto:doh.dddcrb@doh.hawaii.gov).

If you have any questions, please call the Community Resource Management Section at (808) 733-2133. Thank you for your time and attention.

Sincerely,

[Name], Supervisor  
Community Resources Management Section

Enclosed: FINAL QA Review Results Tool  
c: [Name], DHS, MQD, HCSB

QA Review Results Letter rev. 06/2026

## APPENDIX 8D: QA/I PROVIDER MONITORING TOOL

| SCORE SHEET                                                                                                                                                                                             |                    | June 17, 2026 - Good Morning |                   |               |         |           |               |       |       |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------|------------------------------|-------------------|---------------|---------|-----------|---------------|-------|-------|
| [Agency In Review]                                                                                                                                                                                      |                    | [Monitor Name]               |                   |               |         |           |               |       |       |
| Provider Agency In Review:                                                                                                                                                                              | [Agency In Review] |                              |                   |               |         |           |               |       |       |
| Monitor Name:                                                                                                                                                                                           | [Monitor Name]     |                              |                   |               |         |           |               |       |       |
| COMPLIANCE STATUS                                                                                                                                                                                       |                    |                              |                   |               |         |           |               |       |       |
| OVERALL                                                                                                                                                                                                 | 0.00%              | Non-Compliant                |                   |               |         |           |               |       |       |
| <table border="1"> <thead> <tr> <th colspan="2">Scoring Key</th> </tr> <tr> <th>Compliant</th> <th>Non-Compliant</th> </tr> </thead> <tbody> <tr> <td>≥ 86%</td> <td>≤ 85%</td> </tr> </tbody> </table> |                    |                              |                   | Scoring Key   |         | Compliant | Non-Compliant | ≥ 86% | ≤ 85% |
| Scoring Key                                                                                                                                                                                             |                    |                              |                   |               |         |           |               |       |       |
| Compliant                                                                                                                                                                                               | Non-Compliant      |                              |                   |               |         |           |               |       |       |
| ≥ 86%                                                                                                                                                                                                   | ≤ 85%              |                              |                   |               |         |           |               |       |       |
| Non-Developmental Only                                                                                                                                                                                  | Compliant          | Transitionally Compliant     | Compliant         | Non-Compliant | BLANK   |           |               |       |       |
| Total Possible                                                                                                                                                                                          | 22                 | 22                           | 22                | 22            | 22      |           |               |       |       |
| P1                                                                                                                                                                                                      | 0                  | 0                            | 0                 | 0             | 22      |           |               |       |       |
| P2                                                                                                                                                                                                      | 0                  | 0                            | 0                 | 0             | 22      |           |               |       |       |
| P3                                                                                                                                                                                                      | 0                  | 0                            | 0                 | 0             | 22      |           |               |       |       |
| P4                                                                                                                                                                                                      | 0                  | 0                            | 0                 | 0             | 22      |           |               |       |       |
| P5                                                                                                                                                                                                      | 0                  | 0                            | 0                 | 0             | 22      |           |               |       |       |
| Org                                                                                                                                                                                                     | 0                  | 0                            | 0                 | 0             | 2       |           |               |       |       |
| TOTAL INDICATORS                                                                                                                                                                                        | 0.00%              | 0.00%                        | 0.00%             | 0.00%         | 100.00% |           |               |       |       |
| Total Percentages                                                                                                                                                                                       | Compliant          | Non-Compliant                | COMPLIANCE STATUS |               |         |           |               |       |       |
| P1                                                                                                                                                                                                      | 0.00%              | 0.00%                        | Non-Compliant     |               |         |           |               |       |       |
| P2                                                                                                                                                                                                      | 0.00%              | 0.00%                        | Non-Compliant     |               |         |           |               |       |       |
| P3                                                                                                                                                                                                      | 0.00%              | 0.00%                        | Non-Compliant     |               |         |           |               |       |       |
| P4                                                                                                                                                                                                      | 0.00%              | 0.00%                        | Non-Compliant     |               |         |           |               |       |       |
| P5                                                                                                                                                                                                      | 0.00%              | 0.00%                        | Non-Compliant     |               |         |           |               |       |       |
| TOTAL PERCENTAGES of INDICATORS                                                                                                                                                                         | 0.00%              | 0.00%                        | Non-Compliant     |               |         |           |               |       |       |

<https://health.hawaii.gov/ddd/files/2026/06/DDD-QA-Provider-Monitoring-Tool.xlsx>

## APPENDIX 8E: CAP STATUS LETTER FOR SATISFACTORY CAP

|                                                                                           |                                                                                                                                                                                                                                                                                                        |                                                                                         |
|-------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|
| <p><b>JOSEH GREEN, M.D.</b><br/>GOVERNOR OF HAWAII<br/>HE KULANA O NA MOHUKA O HAWAII</p> |  <p><b>STATE OF HAWAII</b><br/>DEPARTMENT OF HEALTH<br/>KA 'OIHANA OLAKINO<br/>DEVELOPMENTAL DISABILITIES DIVISION<br/>COMMUNITY RESOURCES BRANCH</p> <p>3627 KILAUEA AVENUE, ROOM 411<br/>HONOLULU, HAWAII 96816</p> | <p><b>KENNETH S. FINK, MD, MBA, MPH</b><br/>DIRECTOR OF HEALTH<br/>KA LANA HO OHELE</p> |
| Telephone: 808-733-2135<br>Fax: 808-733-9841                                              |                                                                                                                                                                                                                                                                                                        | In reply, please refer to:<br>File:                                                     |

[Date]

[Title, First Name Last Name, Position Title]  
[Agency Name]  
[Address]  
[City], Hawaii [Zip]

Re: Corrective Action Plan Status for Program Monitoring

Dear [Title, Last Name]:

This letter is to inform you of the status of your **QA Programs Review Audit** Corrective Action Plan (CAP) in response to the Department of Health, Developmental Disabilities Division's (DOH/DDD), Quality Assurance Review report dated [date of report sent] for the review period [Month/Year – Month/Year].

Please review the following checkboxes regarding your CAP Status.

☒ **Satisfactory CAP**  
We have received and reviewed your Corrective Action Plan on [date of CAP received]. Your CAP for Fiscal Year [Year] is now satisfactory. Your next QA Review Audit will be in FY [Year].

☐ **Unsatisfactory CAP**  
We received your Corrective Action Plan on [date CAP received] and need further information/clarification. Please respond in writing to the issues/concerns below by 12 weeks from the date of this letter. Upload your CAP to the Provider Portal and notify the Community Resources Management Section (CRMS) by emailing [doh.dddcrb@doh.hawaii.gov](mailto:doh.dddcrb@doh.hawaii.gov) that the CAP has been submitted.

Issues/Concerns: [monitor's notes]

☐ **CAP Not Received**  
Your Corrective Action Plan was due on [due date of CAP]. A reminder email was sent to you on [date of reminder email] by CRMS regarding the submission of your CAP. As of today, we have not received your CAP. Another copy of the Quality Assurance Review report is attached. Please complete and upload to the Provider Portal by 12 weeks from the date of this letter, and notify the Community Resources Management

CAP Status Letter rev. 06/2026

Section (CRMS) by emailing [doh.dddcrb@doh.hawaii.gov](mailto:doh.dddcrb@doh.hawaii.gov) that the CAP has been submitted. Failure to submit your CAP in response to this notice may result in an Accountability Plan (see most recent Medicaid Waiver Standards Manual, Accountability and Sanctions Section).

Should you have any questions, please contact the Community Resources Management Section at (808) 733-2133. Thank you very much for your assistance in this process.

Sincerely,

[Name], Supervisor  
Community Resources Branch

c: [Name], DHS, MQD, HCBS

CAP Status Letter rev. 08/2026

## APPENDIX 8F: CAP STATUS LETTER (UNSATISFACTORY CAP)

|                                                                                                                                                                                                                      |                                                                                   |                                                                                  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|----------------------------------------------------------------------------------|
| <p>JOSH GREEN, M.D.<br/>GOVERNOR OF HAWAII<br/>KS KILINO O KILU MOU'EAU O HAWAII</p>                                                                                                                                 |  | <p>KENNETH S. FINK, MD, MGA, MPH<br/>DIRECTOR OF HEALTH<br/>KULU'UAE MOU'EAU</p> |
| <p><b>STATE OF HAWAII</b><br/>DEPARTMENT OF HEALTH<br/>KA 'OIHANA OLAKINO<br/>DEVELOPMENTAL DISABILITIES DIVISION<br/>COMMUNITY RESOURCES BRANCH</p> <p>3627 KILAUEA AVENUE, ROOM 411<br/>HONOLULU, HAWAII 96816</p> |                                                                                   |                                                                                  |
| <p>Telephone: 808-733-2135<br/>Fax: 808-733-9841</p>                                                                                                                                                                 |                                                                                   | <p>In reply, please refer to:<br/>File:</p>                                      |

[Date]

[Title, First Name Last Name, Position Title]  
[Agency Name]  
[Address]  
[City], Hawaii [Zip]

Re: Corrective Action Plan Status for Program Monitoring

Dear [Title, Last Name]:

This letter is to inform you of the status of your **QA Programs Review Audit Corrective Action Plan (CAP)** in response to the Department of Health, Developmental Disabilities Division's (DOH/DDD), Quality Assurance Review report dated [date of report sent] for the review period [Month/Year – Month/Year].

Please review the following checkboxes regarding your CAP Status.

☐ Satisfactory CAP  
We have received and reviewed your Corrective Action Plan on [date of CAP received]. Your CAP for Fiscal Year [Year] is now satisfactory. Your next QA Review Audit will be in FY [Year].

☒ Unsatisfactory CAP  
We received your Corrective Action Plan on [date CAP received] and need further information/clarification. Please respond in writing to the issues/concerns below by 2 weeks from the date of this letter. Upload your CAP to the Provider Portal and notify the Community Resources Management Section (CRMS) by emailing [doh.dddcrb@doh.hawaii.gov](mailto:doh.dddcrb@doh.hawaii.gov) that the CAP has been submitted.

Issues/Concerns: [monitor's notes]

☐ CAP Not Received  
Your Corrective Action Plan was due on [due date of CAP]. A reminder email was sent to you on [date of reminder email] by CRMS regarding the submission of your CAP. As of today, we have not received your CAP. Another copy of the Quality Assurance Review report is attached. Please complete and upload to the Provider Portal by 2 weeks from the date of this letter, and notify the Community Resources Management

CAP Status Letter rev. 08/2026



Section (CRMS) by emailing [doh.dddcrb@doh.hawaii.gov](mailto:doh.dddcrb@doh.hawaii.gov) that the CAP has been submitted. Failure to submit your CAP in response to this notice may result in an Accountability Plan (see most recent Medicaid Waiver Standards Manual, Accountability and Sanctions Section).

Should you have any questions, please contact the Community Resources Management Section at (808) 733-2133. Thank you very much for your assistance in this process.

Sincerely,

[Name], Supervisor  
Community Resources Branch

~~~~~  
c: [Name], DHS, MQD, HCBS

CAP Status Letter rev. 08/2026

APPENDIX 8G: CAP STATUS LETTER (NO CAP RECEIVED)

JOSH GREEN, M.D. GOVERNOR OF HAWAII HE KULUING O KA MOHUKU O HAWAII	 STATE OF HAWAII DEPARTMENT OF HEALTH KA 'OIHANA OLAKINO DEVELOPMENTAL DISABILITIES DIVISION COMMUNITY RESOURCES BRANCH 3827 KILAUEA AVENUE, ROOM 411 HONOLULU, HAWAII 96816	KENNETH S. FINK, MD, MGA, MPH DIRECTOR OF HEALTH HE KULUING O KA MOHUKU
Telephone: 808-733-2136 Fax: 808-733-9841		In reply, please refer to: File:

[Date]

[Title, First Name Last Name, Position Title]
[Agency Name]
[Address]
[City], Hawaii [Zip]

Re: Corrective Action Plan Status for Program Monitoring

Dear [Title, Last Name]:

This letter is to inform you of the status of your **QA Programs Review Audit Corrective Action Plan (CAP)** in response to the Department of Health, Developmental Disabilities Division's (DOH/DDD), Quality Assurance Review report dated [date of report sent] for the review period [Month/Year – Month/Year].

Please review the following checkboxes regarding your CAP Status.

☐ **Satisfactory CAP**
We have received and reviewed your Corrective Action Plan on [date of CAP received]. Your CAP for Fiscal Year [Year] is now satisfactory. Your next QA Review Audit will be in FY [Year].

☐ **Unsatisfactory CAP**
We received your Corrective Action Plan on [date CAP received] and need further information/clarification. Please respond in writing to the issues/concerns below by **2 weeks from the date of this letter**. Upload your CAP to the Provider Portal and notify the Community Resources Management Section (CRMS) by emailing doh.dddcrb@doh.hawaii.gov that the CAP has been submitted.

Issues/Concerns: [monitor's notes]

☒ **CAP Not Received**
Your Corrective Action Plan was due on [due date of CAP]. A reminder email was sent to you on [date of reminder email] by CRMS regarding the submission of your CAP. As of today, we have not received your CAP. Another copy of the Quality Assurance Review report is attached. Please complete and upload to the Provider Portal by **2 weeks from the date of this letter**, and notify the Community Resources Management

CAP Status Letter rev. 08/2026

Section (CRMS) by emailing doh.dddcrb@doh.hawaii.gov that the CAP has been submitted. Failure to submit your CAP in response to this notice may result in an Accountability Plan (see most recent Medicaid Waiver Standards Manual, Accountability and Sanctions Section).

Should you have any questions, please contact the Community Resources Management Section at (808) 733-2133. Thank you very much for your assistance in this process.

Sincerely,

[Name], Supervisor
Community Resources Branch

c: [Name], DHS, MQD, HCBS

CAP Status Letter rev. 08/2026

APPENDIX 8H: FIRST NOTICE: NON-COMPLIANCE SANCTION LETTER

JOSH GREEN, M.D. GOVERNOR OF HAWAII HE KULANA O NA MOHAKA O HAWAII	 STATE OF HAWAII DEPARTMENT OF HEALTH KA 'OIHANA OLAKINO DEVELOPMENTAL DISABILITIES DIVISION COMMUNITY RESOURCES BRANCH 3627 KILAUEA AVENUE, ROOM 411 HONOLULU, HAWAII 96816	KENNETH S. FINK, MD, MGA, MPH DIRECTOR OF HEALTH HE KULANA O NA MOHAKA
Telephone: 808-733-2135 Fax: 808-733-9841		In reply, please refer to: File:

[Date]

[Title, First Name Last Name, Position Title]
[Agency Name]
[Address]
[City], Hawaii [Zip]

Re: Notice of Non-Compliance

Dear [Title, Last Name]:

Please review the following checkboxes regarding notice of Non-Compliance.

☒ **FIRST NOTICE:** of Non-Compliance with the Medicaid Waiver Provider Standards Manual

☐ **SECOND NOTICE:** Non-Compliance with the Medicaid Waiver Provider Standards Manual

The Department of Health (DOH), Developmental Disabilities Division (DDD), is issuing this notice of non-compliance to your agency due to the following outstanding issues/concerns:

Subject: [FY Year CAP]
Date of Correspondence: [date of original Results Letter]
Days Overdue: [of days]
Date Notified: [date of letter]
Final Due Date: [2 weeks from this letter]

Please find attached documents regarding these issues. Your agency must come into compliance by the final due date listed above. If you cannot come into compliance by the final due date listed above, please contact the Community Resource Management Section by [1 week from this letter].

Please review the Medicaid Waiver Provider Standards Manual, which states:

3.12 *Accountability and Sanctions*

B. *Sanctions*

The Provider may be subject to sanctions based on a determination by DOH-DDD in consultation with DHS-MQD. DOH-DDD will assess the

[Title, First Name Last Name, Position Title]
[Agency Name]
[Date]
Page 2

safety and well-being of the participants and the Provider's ability to provide services per the ISP and IP. Sanctions may include, but not limited to:

1. *DOH-DDD will initiate action to ensure the health, safety and well-being of the participants.*
2. *Heightened monitoring by DOH-DDD including a larger sample and/or more frequent scheduled or unannounced monitoring visits.*
3. *Suspension to admit new participants for services.*
4. *Termination of the Medicaid Provider Agreement. This sanction must be approved in advance by DHS-MQD and the letter of termination will be issued by DHS-MQD.*

Should you have any questions, please call the Community Resource Management Section at (808) 733-2133. Thank you for your immediate attention to this notice.

Sincerely,

[Name], Supervisor
Community Resources Management Section

~~~~~  
Enclosed: FINAL QA Review Results Tool  
c: [Name], DDD Administrator  
[Name], DHS, MQD, HCBS

Notice of Non-Compliance Letter ver. 6/2026

## APPENDIX 8I: SECOND NOTICE: NON-COMPLIANCE SANCTION LETTER

|                                                                                      |                                                                                                                                                                                                                                                                                                        |                                                                                    |
|--------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------|
| <p>JOHN GREEN, M.D.<br/>GOVERNOR OF HAWAII<br/>KE KULANA O KA MONI/KAHI O HAWAII</p> |  <p><b>STATE OF HAWAII</b><br/>DEPARTMENT OF HEALTH<br/>KA 'OIHANA OLAKINO<br/>DEVELOPMENTAL DISABILITIES DIVISION<br/>COMMUNITY RESOURCES BRANCH</p> <p>3627 KILAUEA AVENUE, ROOM 411<br/>HONOLULU, HAWAII 96816</p> | <p>KENNETH S. FINK, MD, MGA, MPH<br/>DIRECTOR OF HEALTH<br/>KE KULANA HO'OMILO</p> |
| <p>Telephone: 808-733-2135<br/>Fax: 808-733-9841</p>                                 |                                                                                                                                                                                                                                                                                                        | <p>In reply, please refer to:<br/>File:</p>                                        |

[Date]

[Title, First Name Last Name, Position Title]  
[Agency Name]  
[Address]  
[City], Hawaii [Zip]

Re: Notice of Non-Compliance

Dear [Title, Last Name]:

Please review the following checkboxes regarding notice of Non-Compliance.

☐ FIRST NOTICE: of Non-Compliance with the Medicaid Waiver Provider Standards Manual

☒ SECOND NOTICE: Non-Compliance with the Medicaid Waiver Provider Standards Manual

The Department of Health (DOH), Developmental Disabilities Division (DDD), is issuing this notice of non-compliance to your agency due to the following outstanding issues/concerns:

Subject: [FY Year CAP]  
Date of Correspondence: [date of original Results Letter]  
Days Overdue: [of days]  
Date Notified: [date of letter]  
Final Due Date: [2 weeks from this letter]

Please find attached documents regarding these issues. Your agency must come into compliance by the final due date listed above. If you cannot come into compliance by the final due date listed above, please contact the Community Resource Management Section by 1 week from this letter.

Please review the Medicaid Waiver Provider Standards Manual, which states:

3.12 Accountability and Sanctions

B. Sanctions

*The Provider may be subject to sanctions based on a determination by DOH-DDD in consultation with DHS-MQD. DOH-DDD will assess the*

[Title, First Name Last Name, Position Title]  
[Agency Name]  
[Date]  
Page 2

*safety and well-being of the participants and the Provider's ability to provide services per the ISP and IP. Sanctions may include, but not limited to:*

1. *DOH-DDD will initiate action to ensure the health, safety and well-being of the participants.*
2. *Heightened monitoring by DOH-DDD including a larger sample and/or more frequent scheduled or unannounced monitoring visits.*
3. *Suspension to admit new participants for services.*
4. *Termination of the Medicaid Provider Agreement. This sanction must be approved in advance by DHS-MQD and the letter of termination will be issued by DHS-MQD.*

Should you have any questions, please call the Community Resource Management Section at (808) 733-2133. Thank you for your immediate attention to this notice.

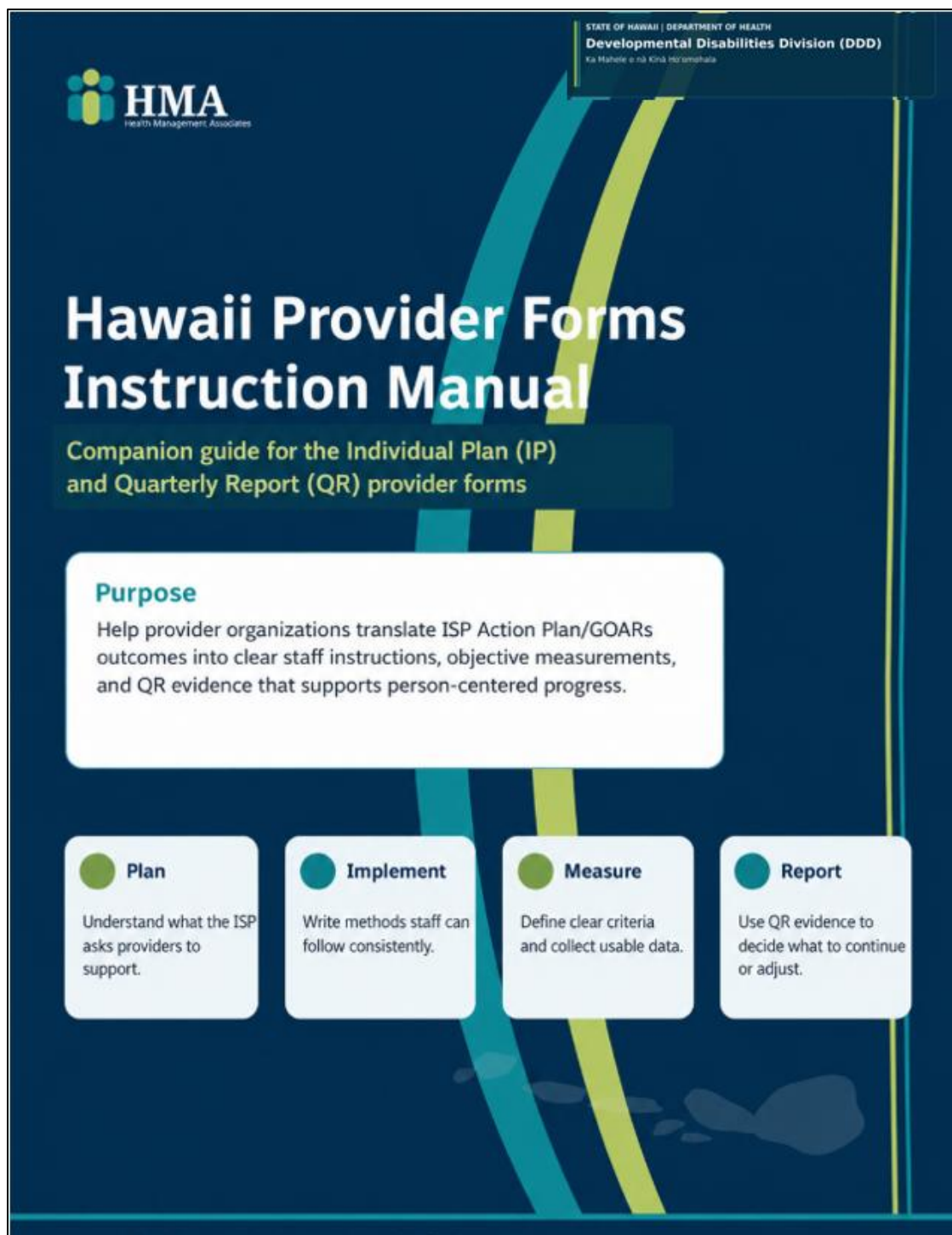
Sincerely,

[Name], Supervisor  
Community Resources Management Section

~~~~~  
Enclosed: FINAL QA Review Results Tool
c: [Name], DDD Administrator
[Name], DHS, MQD, HCBS

Notice of Non-Compliance Letter ver. 6/2026

APPENDIX 8J: INDIVIDUAL PLAN AND QUARTERLY REPORT INSTRUCTION MANUAL



<https://health.hawaii.gov/ddd/files/2026/06/DDD-Individual-Plan-and-Quarterly-Report-Instruction-Manual.pdf>

APPENDIX 8K: ATTESTATION FORM FOR EMERGENCY PREPAREDNESS PLAN

STATE OF HAWAII
Department of Health

DEVELOPMENTAL DISABILITIES DIVISION
Community Resources Branch

ATTESTATION FORM (Use for verifying Emergency Preparedness Plan Requirement)

Source: HI Waiver Provider Standards Manual (July 2026) 3.2.G Emergency Preparedness (p.76).

Complete and submit this attestation form and upload it to the Provider Portal. Use one (1) form per agency. If there are locations on other islands, ensure all addresses where services are provided are listed.

Provider Agency Name: _____

Provider Agency Address/s: _____

- ☐ I attest that my agency has developed and maintains a current written Emergency Preparedness Plan (EPP) in compliance with Hawai'i Department of Health, Developmental Disabilities Division (DOH-DDD) requirements. This plan addresses our protocols for responding to natural disasters, man-made emergencies, technological/infrastructure failures, disease outbreaks, and other types of emergencies that could impact the individuals we serve. If requested by DOH-DDD, the agency will respond to any requests for updates on the status of participants who may need additional supports due to an emergency. The agency understands that DOH-DDD may request information through agency self-assessments, policies or other documentation that demonstrate health and safety of participants are fully addressed.
- ☐ I attest that this plan is current and that any deficiencies previously identified in our emergency preparations (for example, during provider monitoring or certification reviews) have been rectified.
- ☐ I attest that all staff (including Residential Habilitation caregivers, if applicable) have been informed and trained on the procedures in the EPP and are prepared to implement them in the event of an emergency. In addition, the EPP is readily available for staff review. We understand the critical importance of emergency preparedness in protecting the health and safety of participants and remain committed to continuous readiness.

By signing, I attest I am authorized to sign on the provider agency's behalf and the information in this document is true and accurate.

Print Name of Person Completing Form

Title

Signature

Date

This form can be signed electronically ("E-sign") or printed and signed. An E-sign is accepted as an original signature.

<https://health.hawaii.gov/ddd/files/2026/06/DDD-Attestation-Form-for-Emergency-Preparedness-Plan.pdf>

APPENDIX 8L: SETTINGS RULE EVIDENCE TEMPLATES

Settings Rule Evidence Template for Non-Residential Settings

<https://health.hawaii.gov/ddd/files/2026/06/DDD-Non-Residential-Single-Setting-Evidence-Tool.xlsx>

Settings Rule Evidence Template for Single Residential Setting

<https://health.hawaii.gov/ddd/files/2026/06/DDD-Residential-Single-Setting-Evidence-Tool.xlsx>

Settings Rule Evidence Template for Multiple Residential Settings

<https://health.hawaii.gov/ddd/files/2026/06/DDD-ResHab-Agency-Multiple-Setting-Evidence-Tool.xlsx>

APPENDIX 8M: ATTESTATION FORM FOR SETTINGS RULE

STATE OF HAWAII
Department of Health

DEVELOPMENTAL DISABILITIES DIVISION
Community Resources Branch

ATTESTATION FORM (Use for verifying Settings Rule Compliance and Plan of Correction Completion for Adult Day Health (ADH) and Residential Habilitation (ResHab) Settings)

Source: HI Waiver Provider Standards Manual (July 2026) 3.2.D - HCBS Settings Rule Compliance (p.74).

Complete and submit this attestation form and upload it to the Provider Portal, **annually**.

Use one (1) form per agency. Ensure all locations where services are provided are listed. If there are locations on other islands, ensure all addresses where services are provided are listed and indicate if the address is an Adult Day Health (ADH) or Residential Habilitation (ResHab) Setting.

Provider Agency Name: _____

Setting Name, Type, and Address/s: _____

- ☐ I attest that I understand my agency, as a Medicaid-funded Adult Day Health/Residential Habilitation provider, is responsible for ensuring that each setting where I/DD waiver services are provided and as listed above meets the requirements of the Home and Community-Based Services (HCBS) Settings rule (42 CFR §441.301).
- ☐ Our agency currently has one or more settings under a Plan of Correction (POC). The deficiencies identified under the POC will be addressed within 30 days. I will submit a new attestation form once all Plan of Corrections have been remediated. **(If this box is checked, skip the next box.)**
- ☐ I attest to the Department of Health, Developmental Disabilities Division (DOH-DDD) that there are currently no deficiencies or compliance issues related to the HCBS settings rule (42 CFR §441.301) for this setting, and therefore, no Plan of Correction (POC) or remediation is required at this time.
- ☐ I further confirm there have been no updates to the policies and procedures previously submitted, and there have been no changes to the setting's location or operations compared to the information on file from the Settings Rule Evidence templates.

By signing, I attest I am authorized to sign on the provider agency's behalf and the information in this document is true and accurate.

Print Name of Person Completing Form

Title

Signature

Date

This form can be signed electronically ("E-sign") or printed and signed. An E-sign is accepted as an original signature.

APPENDIX 8N: ATTESTATION FORM FOR QUALITY MANAGEMENT PLAN

STATE OF HAWAII
Department of Health

DEVELOPMENTAL DISABILITIES DIVISION
Community Resources Branch

ATTESTATION FORM (Use for verifying implementation of an internal Quality Management (QM) Program)

Source: HI Waiver Provider Standards Manual (July 2026) 2.3.A Provider Quality Management Program Requirement (p.62).

Complete and submit this attestation form and upload it to the Provider Portal.

Provider Agency Name: _____

- ☐ I attest that my agency's QM Plan has been formally reviewed and approved within the past three (3) years by the established quality group.
- ☐ I attest that on an ongoing basis: the agency completes activities to measure and evaluate the impacts of the QM actions and sustainability of QM practices which demonstrate organizational oversight and accountability for QM activities.

By signing, I attest I am authorized to sign on the provider agency's behalf and the information in this document is true and accurate.

Print Name of Person Completing Form

Title

Signature

Date

This form can be signed electronically ("E-sign") or printed and signed. An E-sign is accepted as an original signature.

<https://health.hawaii.gov/ddd/files/2026/06/DDD-Attestation-Form-for-Quality-Management-Plan.pdf>

APPENDIX 8 **O: ON-SITE NOTIFICATION LETTER**

JOSH GREEN, M.D. GOVERNOR OF HAWAII KE KULU O KA HONU IMA O HAWAII		KENNETH S. FINK, MD, MSA, MPH DIRECTOR OF HEALTH KE KULU HO OHOLE
STATE OF HAWAII DEPARTMENT OF HEALTH KA 'OIHANA OLAKINO DEVELOPMENTAL DISABILITIES DIVISION P. O. BOX 3378 HONOLULU, HI 96801-3378 TELEPHONE: (808) 586-5840 FAX NUMBER: (808) 733-9182		
In reply, please refer to: File #		
[Date of Letter]		
[Title, First Name Last Name], [Position Title] [Company Name] [Street Address] [City, State Zip Code]		
RE: Notification of Fiscal Audit – Initial Fiscal Audit		
Dear [Title, Last Name]:		
This letter is to inform you that the Developmental Disabilities Division (DDD) will be conducting a fiscal audit of your agency in accordance with the DDD Waiver Provider Standards Manual. This fiscal audit will be conducted as an on-site audit. The Auditor will be at your agency on [Audit Date] by 10:00 AM.		
Please have all documents photocopied and submitted by 3:00 PM on [Audit Date] to the Auditor.		
For this fiscal audit, we will be evaluating <u>Fiscal Records</u> for the following dates:		
• [Month/Year – Month/Year]		
Specifically, DDD will be reviewing the following documents:		
• Individualized Service Plan (ISP) – The Provider must have an approved ISP which covers the entire fiscal audit period. More than one ISP may be needed. • Service Records – The Provider must have a service record to substantiate the billed claims. At a minimum, service records must contain the following: 1. Participant full name 2. Date(s) of service (day, month, and year) 3. Time of service (begin time and end time, using either AM and PM or military time)		
01. On-site Audit Notification Letter rev 06/2026		

[Title, First Name Last Name]

[Company Name]

[Date of Letter]

Page 2

4. Type of service (list service name or service code and modifier (ex: CLS-I or H2021-U4)
5. Staff to participant ratio
6. Name, title, and signature of direct support worker delivering the service (Electronic/digital signature, or unique electronic identifier with audit train permissible.)
7. Name, title, and signature of service supervisor verifying the service and information above. (Electronic/digital signature, or unique electronic identifier with audit train permissible.)

Please refer to the Waiver Standards Manual, Section 3.10, for more information on the required documentation. The fiscal audit checklist included may be utilized to prepare the required documentation.

Please provide the name, telephone number, and email address of a designated contact person for the audit to DOH.DDDFiscalAudit@doh.hawaii.gov prior to the audit date.

The Auditor will send a Fiscal Audit List to the Provider's designated contact person via encrypted email or secured portal on the day of the audit. Notify the Auditor by 8:00 AM on the day of the audit if the designated contact person is unavailable and provide an alternative designated contact.

Should you have any questions, please email DOH.DDDFiscalAudit@doh.hawaii.gov. Thank you very much for your assistance in this process.

Sincerely,

, Administrator
Developmental Disabilities Division

Attachments: Waiver Provider Standards Manual, Section 3.10
Fiscal Audit Checklist

c: Jon Fujii, DHS, MQD, HCBS

01. On-site Audit Notification Letter rev 06/2026

APPENDIX 8P: DESK AUDIT NOTIFICATION LETTER

JOHN GREEN, M.D.
GOVERNOR OF HAWAII
KA KIU OIAU O KA HONOU KAU O HAWAII



KENNETH S. FINK, MD, MGA, MPH
DIRECTOR OF HEALTH
KA LUNA HO OHOLE

STATE OF HAWAII
DEPARTMENT OF HEALTH
KA 'OIHANA OLAKINO
DEVELOPMENTAL DISABILITIES DIVISION
P. O. BOX 3378
HONOLULU, HI 96801-3378
TELEPHONE: (808) 586-5640
FAX NUMBER: (808) 733-9182

In reply, please refer to:
File:

[Date of Letter]

[Title, First Name Last Name], [Position Title]
[Company Name]
[Street Address]
[City, State Zip Code]

RE: Notification of Fiscal Audit – Initial Fiscal Audit

Dear [Title, Last Name]:

This letter is to inform you that the Developmental Disabilities Division (DDD) will be conducting a fiscal audit of your agency in accordance with the DDD Waiver Provider Standards Manual. This fiscal audit will be conducted as a desk audit.

Please have all documents photocopied and submitted by 3:00 PM on [Audit Date], via encrypted email, secured portal, mail, or fax. If a copy of the required documents is mailed, it must be postmarked on [Audit Date].

Hawaii State Department of Health
Developmental Disabilities Division – Fiscal Section
3627 Kilauea Avenue, Room 104
Honolulu, HI 96816
Fax: (808) 733-9182
Email: DOH.DDDFiscalAudit@doh.hawaii.gov

For this fiscal audit, we will be evaluating Fiscal Records for the following dates:

- [Month/Year – Month/Year]

Specifically, DDD will be reviewing the following documents:

- Individualized Service Plan (ISP) – The Provider must have an approved ISP which covers the entire fiscal audit period. More than one ISP may be needed.

02. Desk Audit Notification Letter rev 06/2026

[Title, First Name Last Name]
[Company Name]
[Date of Letter]
Page 2

- Service Records – The Provider must have a service record to substantiate the billed claims. At a minimum, service records must contain the following:
 1. Participant full name
 2. Date(s) of service (day, month, and year)
 3. Time of service (begin time and end time, using either AM and PM or military time)
 4. Type of service (list service name or service code and modifier (ex: CLS-I or H2021-U4)
 5. Staff to participant ratio
 6. Name, title, and signature of direct support worker delivering the service (Electronic/digital signature, or unique electronic identifier with audit train permissible.)
 7. Name, title, and signature of service supervisor verifying the service and information above. (Electronic/digital signature, or unique electronic identifier with audit train permissible.)

Please refer to the Waiver Standards Manual, Section 3.10, for more information on the required documentation. The fiscal audit checklist included may be utilized to prepare the required documentation.

Please provide the name, telephone number, and email address of a designated contact person for the audit to DOH.DDDFiscalAudit@doh.hawaii.gov prior to the audit date.

The Auditor will then send a Fiscal Audit List to the Provider's designated contact person via encrypted email or secured portal on the day of the audit. Notify the Auditor by 8:00 AM on the day of the audit if the designated contact person is unavailable and provide an alternative designated contact.

Should you have any questions, please email DOH.DDDFiscalAudit@doh.hawaii.gov. Thank you very much for your assistance in this process.

Sincerely,

, Administrator
Developmental Disabilities Division

Attachments: Waiver Provider Standards Manual, Section 3.10
Fiscal Audit Checklist

c: Jon Fujii, DHS, MQD, HCBS

02. Desk Audit Notification Letter rev 06/2026

APPENDIX 8Q: FISCAL AUDIT CHECKLIST

Department of Health Developmental Disabilities Division Fiscal Audit Checklist

Provider Name: _____ Participant Name: _____

Fiscal Audit Date: _____ Fiscal Audit Period: _____

Waiver Service: _____ Direct Support Worker: _____

Please use the checklist below to ensure all required documentation is complete and ready for review by the Auditor. Refer to the Waiver Standards Manual, Section 3.10, Fiscal Accountability – Post-Payment Reviews, for detailed documentation requirements. Please note that the fiscal audit checklist is not intended to replace service record(s) or satisfy required data elements, nor is it required to be submitted with your service record(s).

Individualized Service Plan (ISP)		
1.	☐	Service authorized by the CM identified and documented in the ISP and Consent for Services form is signed.
Service Record(s) At a minimum, service records must include the following information when a service is provided:		
1.	☐	Participant's full name
2.	☐	Date(s) of service (day, month, and year)
3.	☐	Time of service (begin time and end time, using either AM and PM or military time)
4.	☐	Type of service (list service name, such as ADH 1:3, PAB 1:1, etc. or list the service code and modifier such as H2021-U4)
5.	☐	Staff-to-participant ratio for applicable services. (Refer to Section 4 of the Waiver Standards Manual for details on staff to participant ratio regarding each DD waiver service.)
6.	☐	Name, title, and signature of Direct Support Worker (Electronic/digital signature, or unique electronic identifier with audit trail report permissible). If an audit trail cannot verify a digital signature, Providers must submit alternative documentation to confirm validity.
7.	☐	Name, title, and signature of Service Supervisor (Electronic/digital signature, or unique electronic identifier with audit trail report permissible). If an audit trail cannot verify a digital signature, Providers must submit alternative documentation to confirm validity.

Reminder: Missing any of the data elements above in the service record(s) provided will be subject to recoupment.

The Auditor may request additional documents that are not listed above and/or beyond the fiscal audit period to complete the fiscal audit.

2. Fiscal Audit Checklist rev. 06/2026

APPENDIX 8R: FISCAL AUDIT REPORT

State of Hawaii
Department of Health
Developmental Disabilities Division

FISCAL MONITORING REVIEW OF HAWAII'S DD/ID WAIVER PROVIDERS AUDIT REPORT

Provider/Agency:	Provider ID:	Date of Review:
Fiscal Review Period:		
PARTICIPANT INFORMATION		
Participant Name: _____	CMU: _____	
Participant Name: _____	CMU: _____	
Participant Name: _____	CMU: _____	
Participant Name: _____	CMU: _____	
Participant Name: _____	CMU: _____	
Participant Name: _____	CMU: _____	
Participant Name: _____	CMU: _____	
Participant Name: _____	CMU: _____	
Participant Name: _____	CMU: _____	
Participant Name: _____	CMU: _____	
Participant Name: _____	CMU: _____	
Participant Name: _____	CMU: _____	
Participant Name: _____	CMU: _____	
Participant Name: _____	CMU: _____	
Participant Name: _____	CMU: _____	
PROVIDER SCORE AND RATING		
Provider Score: _____	Provider Rating: _____	

APPENDIX 8S: NOTICE OF FISCAL AUDIT RESULTS LETTER

JOSH GREEN, M.D.
GOVERNOR OF HAWAII
HE KOU OULA O NA HONOU EING O HAWAII



KENNETH S. FINK, MD, MGA, MPH
DIRECTOR OF HEALTH
HE LUNA HO OHELE

STATE OF HAWAII
DEPARTMENT OF HEALTH
KA 'OIHANA OLAKINO
DEVELOPMENTAL DISABILITIES DIVISION
P. O. BOX 3378
HONOLULU, HI 96801-3378
TELEPHONE: (808) 586-5840
FAX NUMBER: (808) 733-9182

In reply, please refer to:
File:

[Date of Letter]

[Title, First Name Last Name], [Position Title]
[Company Name]
[Street Address]
[City, State Zip Code]

RE: Notice of Fiscal Audit Results

☐ Initial Audit ☐ Follow-Up Audit

Dear [Title, Last Name]:

Attached are the findings of the Department of Health, Developmental Disabilities Division (DDD) initial fiscal audit for the §1915(c) Home and Community-Based Services (HCBS) Waiver for Individuals with Intellectual and Developmental Disabilities (I/DD). The initial audit was conducted on [Date of audit].

Fiscal Audit Results:

Audit Score	Compliance Rating		Recoupment	
[Enter score here]	☐	Fully Compliant	☐	No
	☐	Substantially Compliant	☐	Yes. Please see attached Recoupment Letter.
	☐	Not Compliant		

Providers scoring below 86% are required to review the "DDD Fiscal Audit – Provider Training" posted on the DOH/DDD website and must submit a Corrective Action Plan (CAP) within fourteen (14) calendar days from the date of this letter to DDD Fiscal

4. Fiscal Audit Results Letter rev. 06/2026

[Title, First Name Last Name]
Notice of Fiscal Audit Results
[Date of Letter]
Page 2

Section. There will be one (1) follow-up audit to be conducted approximately six (6) months after the initial audit date to ensure that a CAP is implemented, and issues identified in the CAP are corrected. Please refer to the Waiver Standards Manual 3.10.B.7-9 for information.

Please send CAP by mail, fax, or email to:

Department of Health
Development Disabilities Division
Fiscal Section
3627 Kilauea Avenue, Room104
Honolulu, HI 96816
Fax: (808) 733-9182
Email: DOH.DDDFiscalAudit@doh.hawaii.gov

Thank you for your cooperation and assistance in complying with the §1915(c) HCBS Waiver for I/DD financial accountability requirements.

Should you have any questions, please email DOH.DDDFiscalAudit@doh.hawaii.gov.

Sincerely,

Deborah Shay
Acting Administrative Officer

DS:
Enclosures

c: , Acting Administrator, DDD
Fiscal Section Supervisor, DDD
Jon Fujii, DHS, Med Quest Division

04. Initial Audit Results Letter rev. 06/2026

APPENDIX 8T: REVIEW OF INFORMAL APPEAL LETTER

JOSH GREEN, M.D.
GOVERNOR OF HAWAII
HE KAHANA O KA MOHUKA, TO HAWAII



KENNETH S. FINK, MD, MGA, MPH
DIRECTOR OF HEALTH
KA LUHA HO'OLELE

STATE OF HAWAII
DEPARTMENT OF HEALTH
KA 'OIHANA OLAKINO
DEVELOPMENTAL DISABILITIES DIVISION
P. O. BOX 3378
HONOLULU, HI 96801-3378
TELEPHONE: (808) 586-5840
FAX NUMBER: (808) 733-9182

In reply, please refer to:
File:

[Date of Letter]

[Title, First Name Last Name], [Position Title]
[Company Name]
[Street Address]
[City, State Zip Code]

RE: Review of Informal Appeal Request

☐ 1st Request ☐ 2nd Request

Dear [Title, Last Name]:

This letter is to inform you that we have received and reviewed the documents submitted with your informal appeal request in response to the Department of Health, Developmental Disabilities Division (DDD) Fiscal Audit results letter dated [letter dated] for the review period [review period].

- ☐ The additional supporting documents submitted **met** the service documentation requirements. Recoupment amount has been adjusted.
- ☐ The additional supporting documents submitted **did not meet** the service documentation requirements. Recoupment amount remains the same.

Thank you for your cooperation and assistance in complying with the §1915(c) HCBS Waiver for I/DD financial accountability requirements.

Should you have any questions, please email DOH.DDDFiscalAudit@doh.hawaii.gov.

Sincerely,

5. Review of Informal Appeal Letter rev. 06/2026

[Title, First Name Last Name]
Review of Informal Appeal Request
[Date of Letter]
Page 2

Deborah Shay
Acting Administrative Officer

SS:
Enclosures

c: Tracey Comeaux, Acting Administrator, DDD
Wendie Lino, Branch Chief, Community Resources Branch, DDD
Fiscal Section Supervisor, DDD
Jon Fujii, DHS, Med Quest Division

APPENDIX 8U: RECOUPMENT LETTER

JOSH GREEN, M.D.
GOVERNOR OF HAWAII
KO KA AHA O KA MOLOA'ANA O HAWAII



STATE OF HAWAII
DEPARTMENT OF HEALTH
KA 'OIHANA OLAKINO
DEVELOPMENTAL DISABILITIES DIVISION
P. O. BOX 3378
HONOLULU, HI 96801-3378
TELEPHONE: (808) 586-5840
FAX NUMBER: (808) 733-9182

KENNETH S. FINK, MD, MGA, MPH
DIRECTOR OF HEALTH
KA LUNA HO'OMILE

In reply, please refer to:
File:

[Date of Letter]

[Title, First Name Last Name], [Position Title]
[Company Name]
[Street Address]
[City, State Zip Code]

RE: Notice of Recoupment

☐ Initial Audit ☐ Informal Appeal ☐ Follow-Up Audit

Dear [Title, Last Name]:

The results of the Department of Health, Developmental Disabilities Division (DDD) fiscal audit for the §1915(c) Home and Community-Based Services (HCBS) Waiver for Individuals with Intellectual and Developmental Disabilities (I/DD), originally conducted on [Date of audit] for the fiscal audit period [review period], identified the following overpayment for your agency:

Name	Provider PIN	Medicaid ID	Dates	HCPC/CPT Code and Modifiers	Rate	Units Paid to Provider	Units Approved after Audit	Overpayment
Total								

6. Recoupment Letter rev. 06/2026

[Title, First Name Last Name]
Notice of Recoupment
[Date of Letter]
Page 2

The overpayment will be recovered through Conduent, the Fiscal Agent for Hawaii's Medicaid Program from your future claim(s) payment.

If you believe the overpayment findings are in error, you may appeal the decision. Please refer to the Waiver Standards Manual 3.10.B.5 and 6 for instructions to file an appeal.

Thank you for your cooperation and assistance in complying with the §1915(c) HCBS Waiver for I/DD financial accountability requirements.

Should you have any questions, please email DOH.DDDFiscalAudit@doh.hawaii.gov.

Sincerely,

Deborah Shay
Acting Administrative Officer

DS:

Enclosures

c: , Acting Administrator, DDD
Fiscal Section Supervisor, DDD
Jon Fujii, DHS, Med Quest Division
Brittany Diggs, Provider Field Representative, Conduent

APPENDIX 9:

SUPPLEMENTAL PAYMENT FORMS

APPENDIX 9A: AFH SUPPLEMENTAL PAYMENT REQUEST FORM

STATE OF HAWAII
Department of Health

DEVELOPMENTAL DISABILITIES DIVISION
Community Resources Branch

Adult Foster Home (AFH) Supplemental Payment Request FORM (Residential Habilitation (ResHab) providers use this form for requesting supplemental payments for neighbor island placements)

There are two (2) supplemental payments available for ResHab providers who successfully place participants into a newly certified AFH on the neighbor islands. Review the reimbursable activities and limits listed below to ensure eligibility for receiving supplemental payment is met. Refer to Waiver Standards 4.2.1 for all eligibility requirements. Retain a copy of the AFH Certificate of Approval to verify DDD certification and the certification period.

Complete and email this form to the DDD Outcomes and Compliance Branch, Compliance Section at doh.dddafh@doh.hawaii.gov. Additional information may be requested to authorize the supplemental payment.

ResHab Agency:	Case Manager:
AFH Address:	Certification Period:
Participant Name:	Placement Date:

☐ **Supplemental Payment for First Participant Placement:**

- This is a newly certified home and has not been certified as an AFH by DDD within the past six (6) months.
- Participant has remained in the AFH for a minimum of 120 days.

☐ **Supplemental Payment for Second Participant Placement (AFH must be certified for up to two (2) participants):**

- The first participant is still living in the AFH at the time a second participant is placed;
- The second participant remains in the AFH for a minimum of 120 days;
- The second placement occurs within one (1) year of the start of the AFH certification period.

Note: The second supplemental payment is not contingent on the first participant remaining in the home after the second participant has been placed.

By signing, I attest I am authorized to sign on the provider agency's behalf and the information in this document is true and accurate.

Print Name of Person Completing Form

Title

Signature

Date

This form can be signed electronically ("E-sign") or printed and signed. An E-sign is accepted as an original signature.

I/DD Waiver: AFH Supplemental Payment Request Form

July 2026

<https://health.hawaii.gov/ddd/files/2026/06/AFH-Request-for-Supplemental-Payment-Form.pdf>

For OCB Compliance Section Use Only

- ☐ As of today, this AFH is in compliance with current Hawaii Administrative Rules (HAR) requirements for DDD AFH.
- ☐ As of today, this AFH is not in compliance with current HAR requirements for DDD AFH. See attached Plan of Correction.

Print Name of OCB Compliance Section Supervisor or Designee

Signature

Date

APPENDIX 9B: COMPETITIVE INTEGRATED EMPLOYMENT ATTESTATION FORM

STATE OF HAWAII
Department of Health

DEVELOPMENTAL DISABILITIES DIVISION
Community Resources Branch

ATTESTATION FORM

(Use to request Competitive Integrated Employment (CIE) Supplemental Payment)

The provider agency must retain the original signed form. Complete and submit this attestation form to DOH.DDDEmploymentServices@doh.hawaii.gov.

Participant:	Provider Agency:
Employer:	Start Date:
Position Description:	

Typical Work Schedule:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

I attest the following requirements have been met to receive the supplemental payment:

- 1) The participant has been placed in a new job (that matches their employment goals, interests, and abilities) in an integrated community setting that aligns with Medicaid HCBS Settings Rule:
 - a. A location where the participant interacts with other persons who are not individuals with disabilities (co-workers, supervisors, customers, general public) to the same extent as employees who are not individuals with disabilities and who are in comparable positions.
 - b. Interaction must extend beyond job coaches or others who are associated with the provision of supports.
- 2) The participant is not employed by a business owned by, managed by, or financially related to the provider agency.
- 3) No more than two supplemental payments have been received within the participant's ISP plan year.
- 4) The participant is earning minimum wage or higher. Participant's hourly wage is: _____.
- 5) The participant has maintained employment for 90 days and has worked at least one hundred (100) hours (accounting for sick and vacation time).
- 6) On-the-job accommodations (if needed) have been identified and implemented with the participant and employer. Describe the following:
 - a. Type of accommodation(s):
 - b. When and how the accommodation is applied:

<https://health.hawaii.gov/ddd/files/2026/06/DDD-Attestation-Form-CIE-Supplemental-Payment.pdf>

- 7) Natural support at the worksite has been identified and developed for the participant to achieve maximum independence.
- a. Identify the position of the person providing natural support to the participant at the worksite:
- b. If the natural support is not available, how will the employer support the participant:
- 8) The participant has been scheduled to work a minimum of ten (10) hours per week for at least 10 weeks. (Complete table below.)

Week	Dates	Hours Worked
Week 1		
Week 2		
Week 3		
Week 4		
Week 5		
Week 6		
Week 7		
Week 8		
Week 9		
Week 10		
Week 11		
Week 12		
TOTAL		0

Demonstrate the 10-hours for 10 weeks requirement was met by listing only dates/hours the participant actually worked. Do not include dates for sick and/or vacation leave taken by the participant.

***NOTE:** DOH-DDD may verify a participant's employment status with their employer.

By signing, I attest I am authorized to sign on the provider agency's behalf and the information in this document is true and accurate.

Print Name of Person Completing Form

Title

Signature

Date

This form can be signed electronically ("E-sign") or printed and signed. An E-sign is accepted as an original signature.

I/DD Waiver: Attestation for CIE Supplemental Payment

July 2026

APPENDIX 10:

ADULT DAY HEALTH RESOURCES

APPENDIX 10A: INTEREST INVENTORY

NOTE

For a copy of the *Interest Inventory* form, please go to the weblink provided below:

<http://health.hawaii.gov/ddd/files/2017/11/Interest-Checklist.pdf>

APPENDIX 11:
DISCOVERY & CAREER PLANNING
RESOURCES

APPENDIX 11A: DISCOVERY & CAREER PLANNING PATHWAY

Operational Guidelines: *The outcome of Discovery & Career Planning (DCP) services is to: 1) complete or revise a Customized Employment Plan to guide job development; and 2) develop the knowledge and skills needed to get a job in competitive, integrated employment or be self-employed. Maximize DCP service delivery outcomes by implementing these strategic steps:*

Step 1 – Initial Meeting: ISP meeting with CM to write a Discovery and Career Planning goals.

- **Provide Social Security Information:** Provide the [Benefits Planning Query information](#) to the job seeker and support if applicable and encourage them to contact Social Security, and request their BPQY as soon as possible.
- **Select a Provider and make an Appointment:** Provide the job seeker with a list of Benefits Counseling Providers and ask who they would like to complete their Benefits and Work Incentives Counseling Session with.
- **Provide an outline of Discovery Process and Career Planning:** Explain Discovery and Career Planning and how it will be delivered by your agency. (Include any additional Agency Specific information at this time.)
- **Schedule Next Steps:** Schedule initial home and neighborhood visit.

Step 2 – Begin Documentation: Complete identification information on the *Profile I Interview/Intake General Information form* before home visit.

Step 3 – Confirm Correct Information: During the home visit confirm that the information on the *Profile I Interview/Intake General Information form* is accurate.

- **Home Visit:** The goal of the home visit is to learn as much about the job seeker as possible in the place he/she is most comfortable. Spending time with the job seeker is the best way to get the information you need to assist the job seeker with creating a career plan that encompasses a pathway to successful employment.
- **Home Interview:** In addition to observing the job seeker in his/her home, begin interviewing family members and natural supports to complete Profile I and begin working on Profile II
- **Who:** Ask the job seeker and supports to Identify three to five people who know the job seeker well that would agree to being interviewed. (Coaches, past teachers, neighbors, club members)

Note: This meeting is not to judge how someone lives, but to discover clues about the strengths and preferences of the job seeker. This meeting may last up to 2 hours.

Step 4 - *Get to know the job seeker:* to create a complete picture of the job seeker, interview people who know the job seeker well to help gather information on the following categories.

- Background, Routines, Home life, Education, Employment history, Daily skills/chores,
- Transportation, Leisure activities at home and community, Acquired skills, Social Collateral
- Hobbies, Barriers, Self-Assessment

Step 5 - *Neighborhood Observation:* Complete a neighborhood observation documenting local businesses and resources.

Step 6 - *Mobility Training:* Begin Mobility Training to use a fixed route and/or paratransit public transportation as independently as possible. (Incorporate personal safety using transportation)

Step 7 - *Financial Information:* Review the results of the job seeker's benefits counseling report and have him/her identify how many hours per week they would like to work and how much money per hour they would like to earn.

Step 8 - *Community Observation:* Observe the job seeker in community activities and identify community members he/she interacts with. For example, Special Olympics, Religious Activities, or volunteering.

Step 9 - *Identify Conditions for Success:* Based on the job seekers **interest**, identify a few unfamiliar activity which they haven't tried before or visit places they haven't gone before and participate in this activity with them. Observe the job seeker to obtain more information about support needs, reactions, attention to natural cues etc.

Step 10 – *Task Analysis:* Identify and complete assessments that will define the job seekers skill level in the interests that this process has identified. For example, if the previous interviews and observations identify that the job seeker is interested in clerical work, assist him/her by conducting assessments in that area. Can he/she type, answer multi-line phone system, use computer programs, file information correctly, do they pay attention to detail?
Document all assessment outcomes in Profile III

Step 11 – *Home Visit:* Return to the job seeker's home for additional information, unstructured conversations, observations and further interviews if needed.

Step 12 – *Complete Profile III:* Share the completed Profile II and III with the job seeker and family and ask for any corrections or clarifications.

Step 13 – *Vocational Themes:* After reviewing the three profiles from the discovery and career planning process identify three emerging themes that meld the tasks, interests, talents and skills of the individual.(These are not job descriptions or business ideas.)

Example:

Theme 1: Music Theme 2: Sports Them 3: Crafts

Step 14 – *Discovery Community/Family Meeting*

- Ask the job seeker to invite family members, neighbors and friends that know him/her well to their meeting at the venue of their choice.
- Explain to the attendees what has been “Discovered” while the job seeker has been going through this process. Be sure to include, “Activities that have been completed (where you went and what you learned, Tasks preferred, Interests, Skills, Personal Attributes and desired Conditions and Work Culture.)
- Ask members of the audience to help fill in the boxes with information they know from their personal experience knowing the job seeker. Keep the poster up to refer back to from time to time.

Step 15 – Vocational Theme Application: While at the meeting ask the members to help identify twenty (20) places for each theme where people with similar themes work in their desired commute area.

Example:

Theme 1: Music

1. Easy Music Center
2. The Republik
3. The Blaisdell Center

Theme 2: Sports

1. Bike Factory Sports Shop
2. Hustle Basketball Club
3. Kidz Art Hawaii

Theme 3: Crafts

1. Ben Franklin Crafts
2. Clay Café Hawaii
3. Kidz Art Hawaii

For example, someone who has a vocational theme of Sports will have a mixture of the following: local sporting goods stores, sports education facilities, bowling alley, sports performance locations, local gym, place where sports equipment is manufactured etc.

NOTE: It is best if the list doesn't contain the same kind of businesses, for example 20 retail shops that sell sportswear.

Step 16 – Community Connections

Document the names of the attendees, their contact information and where they work. This is the beginning of a network that may be beneficial throughout this process.

APPENDIX 11B: BENEFIT COUNSELING PROFILE

NOTE

For a copy of *Benefit Counseling Profile*, please go to the weblink provided below:

<https://health.hawaii.gov/ddd/files/2018/06/10B-Benefit-Counseling-Profile.pdf>

APPENDIX 11C: DISCOVERY AND CAREER PLANNING PROFILE 1

Profile Part 1 **SAMPLE**

Participant's Name: John Dawson

Facilitator: Jane Jones

1. Participant's Identification

- a. Date of birth: 01/13/1990
- b. Address: 3 Brown Bear Rd. Eagle River, AK
- c. Phone: 907-555-1212 Cell: none Other:
- d. Marital status: X Single Married
- e. Current status with Local/State funding entity: Enrolled in AK DD Services; Enrolled in AKIDVR
- f. Additional agencies involved with the participant: Eagle River School District
- g. Additional agencies involved with the family: None

2. Residential/Domestic

a. Family

Spouse/significant other: None
 Length of relationship: N/A
 Current Employment: None

b. Extended family in local area:

John has no extended family in Alaska. All his grandparents, aunts/uncles and cousins live in the lower forty-eight.

c. Names, ages, relationships and employment of persons living in same home/residence:

- | | | | |
|------------------|---------|------------------|-------------------------|
| 1. Doris Dawson | Age: 43 | Relation: Mother | Employment: dental tech |
| 2. Bart Dawson | Age: 45 | Relation: Father | Employment: Air Force |
| 3. Amber Dawson | Age: 16 | Relation: sister | Employment: N/A |
| 4. Alicia Dawson | Age: 12 | Relation: sister | Employment: N/A |
| 5. Sarah Dawson | Age: 10 | Relation: sister | Employment: N/A |

Team Member / Title	Method of Observation	Section	Date Observed	Time/ Duration
Jessica Worster, Emp. Spec	Face to face home interview	1 a - g 1 a - c	10/15/2016	5:00 pm- 6:00 pm/1hr.

d. Residential history:

The family has lived in their current residence for a period of three years. They lived outside Alaska from the time John was four until he was in the sixth grade, when they returned to Alaska. Prior to this move, they had lived on Elmendorf Air Force Base, where John's dad was a tech sergeant. They don't know their neighbors well. John knows that one neighbor is named Sully and they made a lot of noise last summer building a garage.

e. Description of neighborhood:

John lives in a very rural neighborhood, in a small community suburb of Anchorage located approximately 25 miles up the Parks Highway. Once off the main highway, his house sits off a series of winding and one-lane roads. The roads, although rustic, do appear to be plowed. The houses are on large lots, and neighbors are not within close proximity.

f. Location of neighborhood in community:

Their neighborhood sits about five miles off of the highway, behind the Eagle River Lumber Company. Their house is not located in the actual community of Eagle River, which is about five miles away on local roads.

g. Identify the transportation used by the participant and family (or staff):

John's father Bart drives to work at Elmendorf Air Force Base or in Palmer at the NOAA facility in his truck, leaving at approximately 7:30 in the morning and returning at 5:30 in the afternoon, Monday through Friday. Doris, John's mom, drives her SUV into Anchorage four days per week to her job as a dental technician leaving at 8:00 AM and returning by 1:00 PM. There is no local bus service that extends out as far as their home, however there is a bus stop approximately two miles away that goes into Eagle River and connects with busses to Anchorage. John's parents would be willing to transport one way, if it coincides with their work schedule. Mom and John have this arrangement now if John needs to meet with his Access Alaska counselor. At this point, John does not have a driver's license but he does have a bicycle that he rides into Eagle River, approximately 5 miles from home or to the bus stop, 2 miles away.

h. List the general commercial (shopping, industry, or services) areas near home:

There is the North Star Store nearby, which provides basic items, similar to a general store. The Knotty Shop, which offers souvenirs and items crafted from knots of wood, as well as ice cream, is about a half a mile from the family household. Eagle River Lumber is on the road into town and about a quarter of a mile from them.

Team Member / Title	Method of Observation	Section	Date Observed	Time/ Duration
Jessica Worster, Emp. Spec	Face to face home interview	2. d, g	10/15/2016	7:00 pm- 7:30 pm/.5 hr.
Ryan Barlow, Emp. Associate	Neighborhood Mapping with participant	2. e, f, h	10/18/2016	9:30 am – 12:30 pm / 3 hr.

APPENDIX 11D: DISCOVERY AND CAREER PLANNING PROFILE 2

Discovery Profile Profile Part II Sample

Participant's Name: John Dawson
Facilitator: Jane Jones

Date: June 15, 20xx

1. Participant and Family

a. Brief summary based on Intake Interview:

John Dawson is an eighteen year old young man who lives with his family in Eagle River, Alaska. Eagle River is a small suburb of Anchorage, approximately 25 miles northeast of central Anchorage. John is a recent graduate from Eagle River High School. He and his family, including his three sisters, have lived in Eagle River for three years following his family's return to Alaska from Pennsylvania. John and his family wanted a job to be developed for him prior to his departure from high school but since that did not occur they are very interested in John getting a job as soon as possible. John's father, Bart, works for NOAA on the north side of Anchorage and his mother, Doris is a dental technician in Anchorage. John's sisters are all younger than he is and in their teen and pre-teen years.

b. Description of typical routines:

When John does not have an appointment with his caseworkers at Access Alaska, he gets up at eleven or twelve o'clock noon. After he gets up, he fixes himself something to eat. He often cooks himself eggs or an omelet, but sometimes just pours milk on cereal. After breakfast, he usually spends time on the computer, emailing friends and acquaintances and looking up information. He also spends time playing video games. He has several television shows that he enjoys and he also likes to watch videos. Sometimes his mother leaves him chores to do – mostly taking out the trash and working in the yard. When his sisters get home from school, they typically fix him something to eat. They say they like to take care of him. He watches TV and plays games late into the evening, often going to bed around 2:00 AM to 3:00 AM. His mother said that she sees this schedule as a bad habit and when John was in school he woke up with his family at around 6:30 AM and he went to bed at about 11:00 PM.

c. Family (or staff, as appropriate) supports:

John's Mom drives him to town and to the nearest bus stop for recreational activities if John lets her know a day in advance. She cooks most of John's meals, cleans the house and often does his laundry. John's dad occasionally drives him to planned events in Eagle River and Anchorage. Bart also mentors John on most of the events, chores and recreational activities that occur outside the home. He has taught John to operate the machinery used around the house such as the snow blower; the snow machine, the four-wheeler and the family's chain saw. Bart has also taught John to fish including how to cast, set up a rod, setting the hook and fighting a fish, removing the fish from the hook and skinning the fish and preparing it to be cooked. His younger sister, Amber, has her driver's license and, according to John, reluctantly gives him a ride into town about once a month. Amber also has taught John to use Facebook and other social media on the Internet.

d. Family (Staff) and Personal Responsibilities:

Bart, John's dad, has a federal job that involves him working a typical five day week, from 8:00 AM until 5:00 PM, Monday through Friday. Bart spends one to two days per week at Elmendorf Air Force Base, approximately, 15 miles from Eagle River and the remainder of his time in Palmer, about 40 miles from Eagle River. He drives this truck to work leaving the house at about 7:30 AM and returning at 5:30 PM. Doris works mornings, four days per week -- Tuesday - Friday -- in Anchorage, about 25 miles away. Doris leaves at 8:00 AM, after the kids get on their bus for school, and she returns by 1:00 PM, in order to be at home when the children return around 3:00 PM. John does not have set formal responsibilities at home other than the expectation that he complete his homework before watching television or movies.

e. Physical and health related issues:

John has had a recent physical examination by his family physician and was found to be in excellent health. He says he is allergic to dust and that he had asthma as a child. His mom says that work environments that are dusty should be avoided.

Team Member / Title	Method of Observation	Section	Date Observed	Time/ Duration
Jessica Worster, Emp. Spec	Face to face home interview	1 a,b,c 4 e,f 5 a, e, f	11/15/2016	6:30pm-8:30pm/ 2hr.
Julie Kaloha, DSP	Assisted phone call	1 e	11/28/2016	2:30pm-3:00pm/ .5hr

2. Educational Experiences

a. Overall Educational Experiences:

Throughout his school experiences, John was served primarily in a self-contained classroom at Eagle River High School. When he attended classes with non-disabled peers, materials were modified and aide support was available. John's school records indicate that he is strong in the area of nonverbal performance. He is described as having excellent adaptive behavior skills. In terms of his reading, he sounds words out and identifies a number of functional sight words. He does multiple step addition and subtraction problems. John says that multiplication is difficult for him and that he does not currently do division or word problems. He uses a calculator to solve four digit problems in addition and subtraction. There were no behavioral issues noted in the school or work experience setting. John chose to graduate with a special education attendance diploma with his same-age peers in 2008, when he was eighteen years old.

b. Academic Programming:

John's academics in his early school experience were consistent with a functional skills class for students with developmental disabilities. Since returning to Alaska for high school, John has had both special education and regular classes. Almost

all academic skill training that John received was in his special education class where the focus was on functionality in areas such as reading, basic math, communication, writing and other similar topics. John also attended regular computer, history, physical education and shop classes.

c. Community/Recreation Programming:

John chose not to participate in extra-curricular activities while in high school. Instead, he plays video games in his spare time, sometimes for hours at a time. His special education class went on field trips together, but John says the trips were not good experiences because he felt that they were treated like they were stupid and little children.

John says that he wants to live in an apartment with friends, but will need assistance with tasks such as bill paying, emergencies and someone to just check on him to make sure everything is fine. He takes care of his own basic daily living skills, but feels he may need supervision at home to make sure that home and personal care are consistently maintained. He rides a bus and reads a schedule, but needs help planning out a specific activity. He says he would like to get a driver's license and was studying the manual when he left high school.

He is learning to do laundry and cook with appliances. John's teacher says he needs further support to learn how to plan menus, shop, and wash dishes after a meal. She feels that he still needs instruction in math and personal finances and consumer skills. Objectives included on his last IEP included: use of a calculator, measuring dry and liquid ingredients, developing a monthly budget, using multiplication to determine a yearly budget, comparing prices of household items at different stores, writing a menu for a day, writing a shopping list for thirty days of menus, writing paragraphs, correcting punctuation, retelling a story, reading new words and matching definitions to them, getting details from material read, filling out application forms, finding jobs in the newspaper, calling and inquiring about jobs.

d. Vocational Experiences and Programming:

John had several employment experiences during school. In his various job placements, John was described by supervisors as a good worker who kept working until the task was completed. He routinely completed tasks within the time allotted and with acceptable quality. He will try anything asked of him, putting forth his best effort. He follows multi-step directions and asks for help if he gets stuck or is unclear about the directions. His bosses say that he is consistent and calm. When John is working he rarely talks to others, focusing on his tasks.

At Little Caesar's, his duties consisted of wiping windows, putting the pizzas in the ovens, and boxing the pizzas. Although John says he does not want to work with fast food, the thing he particularly liked about this experience was his relationship with his boss. He described him as "OK" to talk to and said that he had a good sense of humor. When he worked at Head Start, he wiped down and set tables. John was described as proficient at these skills. He states clearly that he does not want to work

with children. At McDonald's he cooked French fries and cleaned windows. There was nothing he could remember about this experience that he enjoyed.

John also attended a conference in Portland, Oregon during the first week in October of 20xx for five days. He applied for scholarships online to obtain funding to travel there. The conference had four sessions a day dealing with topics such as Microsoft, accessibility websites and devices, self advocacy for persons with disabilities, online courses for individuals with disabilities. While in Portland, he met a young lady who had Tourette's syndrome. He said that she described situations in which people had been unkind to her, and he said he learned to be an advocate for people with disabilities.

Team Member / Title	Method of Observation	Section	Date Observed	Time/ Duration
Jessica Worster, Emp. Spec	Supported interview w/ staff at Eagle River High School	2 a,b,c 5 f, g,h, k	12/11/2016	10:00am-12:30/ 2.5hr.
Julie Kaloha, DSP	1:1 interview at Library	2d	12/14/2015	2:30-3:30 / 1hr.

3. Employment and Related Activity

a. Informal work performed at home and for others:

John occasionally unloads the dishwasher without being asked, about once a week on average. His mom says he is capable of doing the laundry and washing the dishes, although his mom and sisters usually perform these tasks. He often cooks for himself, specializing in waffles, grilled cheese sandwiches, omelets, microwave foods and pizza in a conventional oven. He brings in wood for his dad for use in the wood stove. He sometimes chops wood for his dad if the weather is not too cold. He cooks a simple meal, such as frozen pizza or soup, for his mom and sisters if mom seems tired after work.

Because of the isolated location of John's home, he has no immediate neighbors to offer to help. His former special education teacher says that John occasionally offered to assist her with tasks such as erasing the chalk board, taking messages to the school office and picking up supplies from the storeroom at school. One of his supervisors noted that John often offered to help out if, "We needed more help."

b. Formal chores and responsibilities:

He takes out the garbage for his family as a regular chore, always remembering to close the bear-proof lids. He keeps his room clean, although his mom says she is, "... pretty flexible as to the definition of clean." According to John's dad, instead of having an array of formal chores, he is often asked to help other family members while they are doing the necessary tasks to maintain the home. John participates in light household cleaning such as dusting and vacuuming, scooping up moose "droppings" in the yard, shoveling snow from the front steps and walk and using the

snow blower, with supervision from his dad.

c. Entrepreneurial activities:

Like many Alaskans, John's family engages in informal bartering of time and excess goods. When John's dad helps friends from the air force base with tasks such as light construction, equipment repair and land clearing, John often accompanies his dad and works alongside him as an assistant. John helps lift and hold materials, retrieves construction and repair tools and provides logistical support to the group of friends by bringing beverages, cleaning up as others work and communicating with other family and friends who are not working. John's dad and his friends routinely pay him a lump sum for helping out, ranging from \$5 - \$15 depending on the time spent assisting.

d. Internships, structured work experiences, sheltered work, volunteering:

John was paid a stipend by the Eagle River High School HIRE Program. A summary of his job experiences is included in the educational section above. He also participated in a GIS training in Anchorage during the first week in January. He explained that the course taught him how to make area maps. The training was sponsored by Nine Star Enterprises to prepare him for the paid position of Community Youth Mapping in the summer. He also learned about making legends, geological maps and how to make a map three-dimensional. He began working with Access Alaska and the community-mapping project in March 2004. When he started with them, he was described as "shy" by his supervisor, but he is felt to be much more outspoken now.

In this experience, a group of students would go out to businesses, introduce themselves, ask to speak to the manager and conduct a survey about the services offered. John mentioned that some folks were not so nice to them and they would just leave without conducting the survey. John and his coworkers would then return to Access Alaska and enter the data that they had just collected into the computer. The survey had approximately twenty questions. They practiced data entry skills by entering the questions and answers into the computer. John's supervisors at Access Alaska were deliberately not given the password for the computer that they worked on, so that the project would clearly be only the youth's work. John reported that he was shyer when they went into larger stores like Fred Meyer, and preferred smaller, friendlier places. If there was only one person in a business, he said it was easier. He says that he is still hesitant about approaching new people. He only missed one day of work all summer. For transportation for this project, John and other students used day passes and rode the borough buses or were driven by a Department of Labor employee.

e. Wage employment:

At this point, John has had no formal wage employment with an employer. Both John and his parents are hopeful that he will have at a part time job prior to graduation.

f. General areas of previous work interest:

John has said that he has liked all the work he has done thus far as long as it was performed outside or that it referenced the outdoors such as his current work with Access Alaska. His father says that John is always eager to volunteer to operate the snow blower in the winter or to mow grass in the summer. The clearest previous interest, however, seems to be related to his use of computers to research anything related to the out of doors. His teacher in high school allowed John to research ATVs and snow machines as an assignment for math that the other students did in a general textbook manner.

Team Member / Title	Method of Observation	Section	Date Observed	Time/ Duration
Jessica Worster, Emp. Spec	Face to face home interview	3 a,b,c	01/11/2016	5:30pm-6:30pm/ 1hr.
Julie Kaloha, DSP	1:1 interview and site visit at Access Alaska	3 d,e,f	01/13/2016	2:30pm-4:30pm/ 2hrs.

4. Life Activities and Experiences

a. Friends and social group(s):

John's says his very best friend is Luke, a young man he met in school. They talk about an assortment of issues and try to get together to go to movies and just hang out. Sometimes, John goes to the Eagle River Community Church for services with Luke. John feels that it is difficult to get together at this point, since Luke is still in school during the day, and he lives six miles into Eagle River, making weekend get-togethers difficult, too. Luke and John say they are both Republican in their political beliefs. Two other friends, Richard and Tyler, seem to enjoy the same type of movies and recently they all saw a movie together. They share an interest in guns, shooting skeet and, yet, do not have the same conservative political views. John also has a friend from his time at Eagle River High School by the name of Zach. They get together to play adventure games that involve shooting and adventure, like Grand Theft Auto and San Andreas, but John says neither likes to play little kid games. The family does not belong to a church or any other formal social groups at this time.

b. Personal activities, including hobbies, performed at home:

John says he enjoys science fiction and medical shows on television such as Star Trek, House and ER reruns. He watches his favorite shows every week and, if for some reason he cannot watch them, he sets the VCR to automatically tape the shows for later viewing. His mother says that if he ever fights with his sisters, it is

usually over the use of the television or that they have erased one of his videotapes. He uses the computer to research TV shows he enjoys. To do this, he logs on, without assistance, enters the internet and "goggles" information about various shows. He watches other television specials about the stars of his favorite shows, and he talks with Luke and other friends about the information on these topics.

c. Family and friend activities, including hobbies, performed at home:

John often talks about his birthday and Christmas, with receiving gifts being the favorite activity. He spends a considerable amount of time researching the items that are most desired at these holidays, but he is careful not to make too many requests, understanding his family's tight finances.

d. Personal activities, including hobbies, performed in the community:

Due to the rural nature of where they are and the distance from the center of Eagle River that John lives, he does not perform many hobbies or personal activities in his community. Occasionally, when John and Luke are together after school, waiting for a ride home, they walk to a small video arcade about two blocks from the high school and play games both separately and together. To do this, John knows to call home using the school's phone to let his mom know that they will be at the arcade. Doris says that John can always be counted on to call. John says he loves going to the movies, but will only go if he has researched the movie to make sure it is worth seeing in the theater. If the reviews say that the film is just OK, he waits until it comes out in video to save on money.

e. Family /friend activities, including hobbies, performed in the community:

John's family has adopted the lifestyle of most Alaskans by engaging in both hunting and fishing. John says he looks forward especially to the family fishing trips on the Susitna River about 60 miles from his home. The family sets up camp near the highway bridge over the river and they run upstream to fish for most of the day. John sets up his fishing rod and reel, ties the hook or lure to the line, makes casts and, when he is lucky, retrieves the fish that he has caught. John's dad says that John is the "luckiest fisherman in the family" catching fish when no one else does. When Bart goes moose hunting in the fall, John is allowed to accompany him but he does not carry a rifle. John carries a canister of bear spray in a holster that he has been taught to use in case they confront a brown bear in the woods.

f. Specific events and activities that are of critical importance:

The annual holidays, especially Christmas and the Fourth of July, are of particular importance to John. Doris says that John could never work on Christmas day and, if expected to do so, "He would just quit." The holiday on the Fourth is the time for the annual family camping/fishing outing and John says that, "I wouldn't miss it for anything." The family takes a long weekend holiday on Memorial Day, Labor Day, Columbus Day and Thanks giving. The entire family goes to the lower forty-eight to visit relatives one week per year.

Team Member / Title	Method of Observation	Section	Date Observed	Time/ Duration
Jessica Worster, Emp. Spec	On-site observation at John's friend Luke's home; interview with John's dad	4 a,b,c 5h	01/20/2016	3:30pm-4:30pm/ 1hr.

5. Description of Skills, Interests and Conditions in Life Activities

a. Domestic/Home skills:

John washes dishes and clothing, but his sisters and mother usually assume these tasks in the household. He cooks basic dishes such as waffles and oatmeal and washes the dishes afterward. He takes out the trash for his family as a regular chore. He chops wood with an axe and hauls it into the house for use in the woodstove. He pick up his room, but not always to the level of cleanliness that his mother would like to see. John vacuums, dusts, puts items away and cleans surfaces such as counters and tables. According to Doris, John has little interest in domestic tasks and will only do them when asked or expected to do them.

b. Community participation skills:

John gives a bus or cab driver the correct directions to get to a familiar location in Eagle River and his home. He rides the public borough buses around town with his high school class, but his teacher says he is hesitant to try out this new skill in his everyday life. He needs assistance reading the bus schedules for specific destinations. If a companion points out the number/route, John finds the correct times for the next bus. He goes grocery shopping with his mom and compares prices when he is with her to help her get the best deal. He has a bank account and keeps track of how much money he has on the computer. He makes deposits and withdrawals and understands the concept of each. Although he has a checking account, he uses his cash card to make purchases and withdraw cash because he says it is easier than writing a check.

c. Recreation/leisure skills:

John goes to the movies at the local cinema in Eagle River about once every two weeks. When he walks in the lobby of the theatre, he hesitates before he opens the doors as if waiting for a prompt and stands far back from the cashier to remove the needed cash from his wallet. He does this to prevent theft, because he says his Access Alaska worker taught him that "there are all kinds of people in the world and you never know who is watching you take your money out." John says that he eats out as often as he can. During discovery, we went to a local fast food restaurant for lunch. When we arrived, he hesitated outside of the outer doors as if unsure of what to do. He eventually opened the door, and stood back from the ordering counter and studied the menu. He removed his cash and put away his wallet before approaching the cashier who would take his order. He ordered his meal and presented the cashier with a five dollar bill. When asked later how he knew how much to give the clerk, he said that he had ordered that meal before and had learned then how much to give her.

When John shops at his favorite stores (video and music stores), he does not typically return the greeting of the store clerk, however he responds if he is asked if he needs help, and lets clerks know if he is just looking. He strolls around the store, looking sporadically around, but doesn't stay long if he does not read anything positive about the games or CDs that he sees on the shelves. He says that he "does not spend his money on just anything the way that some people will. I do not waste money."

d. Academic skills:

John looks over the Anchorage newspaper in the afternoon and seems to be very interested in current events and politics. He expresses that he likes Tom Clancy novels, but has been reading one for quite a few months and has not finished it. He reads menus and makes a selection at fast food restaurants. On the internet, he finds movie schedules and summaries in order to decide which movie he wants to see. He reads both a digital and analog clock to determine the correct time, but he needs assistance anticipating timed events. For instance, he used his cell phone to keep track of time before going to the movie theatre. Once there, he put on his wristwatch and turned his phone off. He kept checking his watch to see if the time matched the time on the ticket of his movie, but he said that he could not judge when he should enter the movie. He asked repeatedly if it would be about time to go in. With cash, he sometimes confuses the numerical value of bills but he says he rarely feels cheated. His mother and teacher feel John needs assistance with more complicated and costly purchases, especially when purchasing multiple items. Whenever possible, John uses his debit card instead of cash. He has learned numerous basic routines for money, such as knowing that ten dollars will always cover the cost of a movie, but he has difficulty counting bills and change to see if he received the correct amount. His mother says he is careful with his money and rarely takes his wallet or debit card out in front of other people. John signs his name in cursive and copies text using block print. He takes brief telephone messages by making a written note for his parents and sisters.

e. Physical fitness skills:

John seems to be in excellent physical health, as confirmed by a recent physical exam performed at the base hospital. He lifts objects up to about 50 pounds of weight and stands and walks for periods up to an hour without expressing fatigue. John does not engage in a fitness routine such as jogging or lifting weights but his dad says that he walks for hours during their moose hunts. The only conditions to avoid seem to be dusty environments and being outside in the rain and cold. Although John works well in the winter; according to his mother, he complains about the cold and wants to come inside as soon as he can.

f. Arts and Talents:

According to his family and teacher, John does not seem to have an interest in the arts, beyond film and television shows. John expressed on several occasions that he is an amateur film critic. He prefers action, high-tech animation and comedy as genres and he complains if the action and technology is not up to his standards.

g. Communication skills:

John's teacher says he has an excellent vocabulary and that he easily expresses a variety of ideas. He connects ideas from historical concepts to present day situations. In discussing a movie that dealt with abuse of power, he related the concept to a policewoman who pulled his dad over one day and was less than cordial in her interactions with them. He went on to comment that people have been power hungry since ancient times. He then inquired as to why men want power. When speaking, John will occasionally pause as if trying to recall the specific word he is looking to use, but he usually comes up with word he wanted. John listens intently when others speak. His teacher feels his "transition from one topic to another is slow." She noted that even when the speaker has moved on, he is still thinking about what was being discussed previously. He usually makes at least one more comment about the topic before shifting to the new one. John gives numerous details about a topic such as a favorite movie, but he does not summarize his thoughts regarding the topic. He sometimes speaks in bursts of information, taking considerable time to think about what he wants to say. He occasionally repeats information that he has recently discussed.

h. Social interaction skills:

When interacting with others, John takes turns in the conversation. He is seen as a friendly and open young man by his family and his teachers and he converses readily with someone who expresses interest in his ideas and interests. He smiles and laughs when he hears something funny. He tends to walk with his head down until he is addressed by others. When asked a question, he sometimes turns to an adult who he knows for guidance, but he will usually answer the question himself. His close friends and classmates describe John as a loyal friend. They also say he has a good sense of humor. His teacher describes him as shy but that he is becoming more outgoing. When speaking to another person, John makes occasional eye contact and then glances above and around the speaker. There are lapses and silences in the conversation and then long stretches of dialogue. When

left alone in a social setting such as school, John typically finds something to do that he can do alone rather than chatting with others or entering a conversation.

i. Mobility skills:

One of John's strengths is his mobility across a number of domains. Physically, he walks, runs and moves around his environment in an efficient manner. He rides his bicycle around his small village and, in the winter, drives his family's snow machine on village roads and trails. John rides public transportation between Eagle River and Anchorage (approximately 25 miles) and he rides the school bus safely and effectively. John arranges rides with his friends and family, especially with his friend Luke, to get to special events, school activities and Saturday trips into Anchorage. At this point John does not drive but he often **asks** his parents when he can get his driver's license. Bart and Doris feel that when John gets a job they will consider beginning to teach him to drive. John has driven 4-wheelers and snow machines owned by family and friends. His mother says as long as he wears a helmet and stays off paved roads that she doesn't mind for him to drive these machines.

j. Sensory skills: (sight, hearing, smell, touch)

John seems to have excellent sensory skills without any areas of concern or sensitivity. During his recent physical exam his eyesight was 20/20 and his hearing was deemed to be "excellent." Doris indicates that certain disagreeable odors such as in toilets and around livestock tend to make John nauseous and he moves out of the area quickly.

k. Vocational skills:

John uses a mouse to navigate computer screens, he opens programs by clicking on the appropriate icon and he logs on the internet and navigates various web sites where he researches movies, music and other areas of interest. To type, he places his fingers on the "home" keys and reaches for keys with the correct fingers, but watches the keys as he types. He uses search engines to find information. His supervisors and teachers describe John as reliable and they say that he prides himself on his timeliness and never missing work. His teacher said that he only missed one day of work at his summer job. He calls his employer if he is going to be late or absent. When he does not understand a direction, he does not hesitate to ask questions to get further clarification. His job coaches describe him as easy to train and get along with.

Team Member / Title	Method of Observation	Section	Date Observed	Time/ Duration
Jessica Worster, Emp. Spec	Chart Review,	5 j,	01/11/2016	5:30pm-6:30pm/ 1hr.
Julie Kaloha, DSP	Observation shopping at market taking cab and making purchase	5b,	01/13/2016	2:30pm-3:30pm/ 1hrs.
Julie Kaloha, DSP	Observation at McDonalds and video store	5c	1/15/2016	2:30pm-3:30pm/ 1hrs.
Julie Kaloha, DSP	Observation at theater	5d	1/17/2016	1:00pm-3:00pm / 2hrs.

6. Connections for Employment

a. Potential connectors in family (or staff, as appropriate):

Since the extended family of John's parents all live in the lower forty-eight, the only family connections would be with John's immediate family. Since Bart works on both on the air force base and Anchorage a nearby community, with NOAA, he could be called on to offer access to both work settings if necessary. Bart expresses caution but says that if he sees through the plan what John might be able to offer either the air force base or the NOAA facility that he would consider opening a door to a decision-maker. Doris works for a dentist in Anchorage and feels that she could help identify unmet needs in a small dental practice. However, she doesn't feel that John would be interested in the medical/dental field.

b. Potential connectors among friends/neighbors and work colleagues:

Bart, John's dad, has most of his connections through the air force base, where he has worked for three years during the family's current stay in Alaska. They had lived in the area about ten years earlier but many of the relationships of Bart's had moved on, transferred to other bases. In his new job with NOAA, Bart has a few non-military connections but none that he feels might lead to a job for John. When asked if any of his work colleagues might attend a planning meeting for John, Bart felt that one friend from work who knows the North Pole area well might be willing to participate. Doris works in Anchorage, nearly 40 miles from Eagle River, but she feels her dentist/employer might be willing to offer information of unmet needs in a small medical practice if such information was needed.

c. Potential connection sites in community relationships:

John's family takes him shopping at the commissary on Elmendorff Air Force Base to do the grocery shopping. They provide him with transportation to get together with his friends. John's dad also trades with local merchants in Eagle River and Anchorage for purchasing and repair of equipment around the home. There is an Alaska version of a general store near their home in Eagle River with which Bart is well connected. The store sells convenience food items, tools, building materials and hunting and fishing supplies. The owner of the store knows John by first name and occasionally asks John to do small chores while Bart is shopping. John is paid with a choice of certain food items such as ice cream or refrigerated sandwiches.

d. Potential connections through clubs, organizations, or groups (such as church or school):

John's family does not belong to any organization or church, this area is not likely to provide connections. However, since John occasionally attends church with his friend Luke, it may be possible to develop connections within Luke's family and the community church that they attend. The church pastor has asked John to join the church and he would be an individual who might join the planning meeting.

e. List of local employers (determined by proximity, relationships, interest areas, etc.)

According to the Internet, there are approximately 25,000 people in Eagle River and over 1,600 businesses: Eagle River:

(List 5 - 15 businesses here that are Close to John's home, that his family shops at, services they use, that are close to his high school and that are owned by people known to his family)

Eagle River is a suburb within the municipality of Anchorage and is approximately 25 miles to the city center of Anchorage. According to the Internet there are 290,000 people in Anchorage and over 25,000 businesses.

Team Member / Title	Method of Observation	Section	Date Observed	Time/ Duration
Jessica Worster, Emp. Spec	Interview with Mom and Dad/ Site visit to Air Force Base	6 b, c	1/24/2016	1:00pm-4:00pm/ 3hr.
Julie Kaloha, DSP	Supported Research with John	6e	1/26/2016	2:30pm-3:30pm/ 1hrs.

APPENDIX 11E: DISCOVERY AND CAREER PLANNING PROFILE 3

Plan Preparation Summary Profile Part III Sample

Participant's Name: John Dawson
Facilitator: Jane Jones

Date: June 20, 20xx

1. Conditions for Success

a. General conditions for participant:

In order for employment to be successful, John's job would need to either be within his local neighborhood so he could walk or ride his bicycle. If work was in Eagle River, John would need to walk or ride his bike to the bus stop or coordinate with his parent's or sister's commuting schedule. If John worked in Anchorage, the hours would need to coincide with his parent's commute schedule. John is likely to need initial job coaching support for as much as two months. Inside work for John would be most successful, but he can work outside episodically in all weather conditions.

He can work standing or seated and would likely prefer a balance of both, including the opportunity to move around the work area. He works best alone or with a person he sees as a mentor. Weekends are important to John and his family so weekday work would be best. If he worked locally in Salchow, he would be willing to work a range of hours, including early mornings and evenings. He would not likely want night work. At this point, John wants to earn an income but would be willing to start at minimum wage. He would likely want to start as close to full time hours as possible but would settle for 20 - 25 hours per week. As he is currently receives Medicaid and an SSI check, a job with paid health benefits is not necessary at this time.

b. General conditions for family (or staff, as appropriate):

John's mother and father are excited about the possibility of John getting a job but worry about transportation. They are willing to help out if a job could be obtained in fairly close time and location proximity to their commutes. They have suggested that perhaps one parent could take John to work and the other pick him up on their way home. Neither felt they could afford to transport John to/from North Pole after they came home from their work schedules. Neither parent has expressed concern about John walking, bicycling or riding with others. In fact, Bart suggested that supporters for John try to arrange a shared ride at his workplace, which is common in their rural area. Both parents want a benefits analysis prior to the planning meeting. An appointment has been made with a WIPPA specialist in Fairbanks for next week.

c. Conditions for task performance:

John clearly prefers to have specific duties for which he is responsible. He has complained at school when other students do not do their share of a joint assignment. He seems to prefer a clear mentor or supervisor to give him information and direction instead of a range of people. He has argued with

peers who have attempted to supervise or teach him. John seems to enjoy having his own work area and could easily work a full day in a seated or standing position. It would likely be best to avoid noisy and chaotic environments with numerous people moving in and out of the work area.

d. Instructional strategies:

John seems to benefit from individualized instruction, according to his former teachers. He reads sequential instructions as long as the information is to the point and written in everyday language. His instructors at Access Alaska feel he has a knack for using information provided on a computer screen and they say he navigates well through several click tabs in web sites. They also feel that he is comfortable with computer-based instructional strategies as the mapping project tasks were presented in that manner. John's dad feels that he benefits from watching others perform tasks and then trying to repeat what he observed. He learned to operate the family snow-blower in that manner.

It also seems to be effective to talk to John about what he has to do, and explain things step by step. It is important to make sure that the directions are not too simplistic, as he takes offense to being treated "like a little kid." Therefore, stating directions in an adult tone of voice is important, since he describes one of his prior work sites as having a "mean" environment and another as "childlike." John followed directions effectively when he participated in the map making activity. The instructor commented that he did not need to modify any of the instructions to accommodate him. John was also described as the most accurate of the group that he was instructing. He was focused and did not tire until he had worked on the task for approximately forty-five minutes.

e. Environmental conditions:

John does well in both inside and outside work situations and would likely enjoy a job that featured aspects of both environments. However, he would not likely enjoy a job that was primarily outside, especially in the Alaskan winter. John sits working in front of a computer screen for hours without becoming bored or antsy. He sees himself in an office setting or other inside workplace with a defined work area and with his own equipment/materials with which to work.

f. Supervisory strategies:

One of John's greatest strengths is his attitude towards supervision. His teachers, school personnel, Access Alaska counselor and work experience supervisors all commented positively on his willingness to accept supervision, even in tense situations. However, it seems that a single supervisor rather than multiple supervisors would be best. When other co-workers and students tried to give John direction, he occasionally would say to them, "You're not my boss." A workplace that had a mentor figure, ideally a male, would likely fit John's style well.

g. Supports needed for successful task performance:

John would benefit from clear, succinct written expectations, either on paper or on a computer screen, that detail his duties and steps to various tasks. Based on reports from his teachers, he needs someone to check his work often early in training as John rarely asks for assistance. He would clearly benefit from systematic

instruction that monitored his performance through to criterion. According to his parents, it is particularly important for John to learn tasks the right way from the beginning as he is described as unwilling to change the way he learns tasks. John would definitely benefit from a job coach during the early stages of employment, though most people who know him well feel that on-going job coaching supports would only need to be on a drop-in basis if the job tasks are well matched and negotiated.

h. Conditions to be avoided:

John would not benefit from a job that started too early in the morning, even though transportation might be enhanced. Jobs that involve John working in a team should be avoided. Also, wet and cold working conditions should only be required a minimum of time. Multiple supervisors, particularly if their authority is not clearly established, should be avoided. John's mother feels that air quality is important for him and that he should not work in dusty and poorly ventilated areas. John's high school special education teacher feels that bustling, chaotic environments create problems for him and that tasks involving customer relations should be avoided, especially regarding complaints. Additionally, work hours that would require John to walk to the bus stop in the dark - morning or evening - should be avoided during all seasons. In the winter, John is very sensitive to cold and in warmer months his Mom worries about him running into a brown bear.

2. Interests toward an aspect of the job market

a. General personal interests:

John uses the computer for research and entertainment almost daily. He says he

likes putting pieces together to solve a problem. He seems to prefer talking with people on an individual basis. -When John is on the computer or playing a video game, his mother says that he is totally absorbed in the activity.

John specifically states his love playing video games, using the computer and watching movies. He describes the difference between various games and why certain ones are better than others. He spends hours learning about new movies and whether they are controversial.

b. General family interests (or staff, as appropriate):

John's family's interests seem to center around taking advantage of the environment in which they live. Hunting, fishing, and camping are of particular importance to his mom and dad. Probably due to the remoteness of where they

live, the family doesn't belong to organized clubs, churches or other groups. John's

sisters do not seem to be an important part of John's activities as they are all younger and nearer to each other's ages than to John's. Bart, John's dad, does have online association with a group of weather experts around the country and world and Bart expressed considerable interest in John's mapping course that he took a couple of years ago.

c. Activities participant engages in without being expected to do so:

The most intrinsically motivating activity that John engages in combines the computer with movies. He watches movies 3 - 5 times per week and he is on the computer 2 - 3 hours per day. John also readily joins his father anytime equipment needs to be repaired. He constantly asks to drive the lawn tractor and operate the snow blower. He initiates politically oriented conversation and is interested, rather than angry, when someone disagrees with his positions. John is also energetic about the outdoors. He regularly asks his parents about the next hunting, fishing or camping trip. John also speaks often of Bart's work with both the air force and with NOAA. Even though he kids his dad about being attached to a computer all day, he seems to associate with that role in a positive manner.

d. General areas of current work interest:

John says he would like to work with his hands fixing cars (he has taken small engines class). He would also like a job using or repairing computers. He says he is pretty content with his routine and his life. He did mention that living and working in Hawaii would be nice but that current financial constraints caused by work on the house have prevented his family from even being able to take family trips.

e. Specific areas of past work experience:

John's strongest interests regarding his work experiences seem to focus on the mapping course that he took at Access Alaska. The activity seemed to blend

several of John's interests - computers, outdoors, research and doing something similar to his dad's work.' He also speaks of his interest in small engine and equipment repair, saying that if he had more training that he could "take apart, fix and put back together almost anything."

3. Contributions

a. Strongest positive personality characteristics:

John's willingness to accept supervision from his boss is possibly his strongest personality attribute. Virtually everyone who has supervised him commented positively on this aspect. He is also described as very loyal to family, friends, and any entity that he feels respects and values him. His teacher described John as one of Eagle River High School's biggest supporters.

b. Most reliable strengths regarding performance:

John has a strong interest in solving problems and will keep at an issue until he figures out a solution. His mom says that when he gets stuck on a problem regarding the computer that John will work for hours, including calling his friends, Luke and Zack, and even a technical assistance number until the problem is resolved.

c. Best current and potential skills to offer to potential employers:

Most of the people who know John well feel that his computer skills are his strongest asset to offer to employers. These current skills include performing internet searches, light data entry, backing up files to a cd, performing inventory queries, and inserting clip art and photos into documents. Potential skills related to computers might include monitoring a web site for customer orders, burning DVDs, uploading information to a web site and monitoring specific sites for updated information. John also maintains small engines with tasks such as fueling, checking oil levels, checking air and fuel filters, adding oil, and starting engines with a pull rope. He uses mechanic's tools to disassemble small engines with supervision. John uses a snow blower to clear the family sidewalk and driveway and he uses a push lawnmower to mow the lawn in front of his home. He reads instructions that are written in everyday language.

d. Credential training, certifications and recognized skills:

At this point, John has not completed any specific training courses that establish a level of performance. He has a special education attendance diploma from North Pole High School which is offered to all departing seniors in special education who do not pursue a regular diploma.

e. Possible sources for recommendations:

John's high school principal, Ms. Sullivan, has offered to write a general recommendation. Additionally his supervisor at the Access Alaska GPS mapping project has indicated that he would write a letter detailing John's

experiences and competencies regarding his computer mapping. His preacher has offered to provide a personal recommendation.

f. Resources/Financial assets:

At this point, John does not have appreciable financial assets or personally-owned resources to offer to a potential employer such as a laptop computer, work tools, etc.

4. Challenges

a. Areas potentially needing matching to employment sites:

John's interest areas will likely comprise the most critical matching needs along with the balance of inside/outside work and avoiding janitorial and food service duties.

He will also need a workplace that is respectful of young people and that challenges him to learn and succeed.

b. Areas potentially needing negotiation with local employers:

For any job outside of his local neighborhood, the hours of work for John will need to be negotiated around transportation availability from home into Eagle River or beyond. If a workplace has both inside and outside work, a predominance of inside work will need to be negotiated. If a workplace has both teams and individual work situation, a personal work area and set of tasks will need to be negotiated.

Assuring that John has as few supervisors as possible will likely need to be negotiated. John will also benefit from having the discrete work tasks of his job description negotiated to give him access to his area(s) of interest and to more sophisticated areas of the workplace.

c. Physical/health restrictions:

At this point in his life, John has not been asked to work a full eight hour day; in fact, he has only worked for about three hours in a given timeframe. If he targets more than about 4 hours per day in his plan, he will likely need a phase-in to achieve a higher number of hours. As noted earlier, dusty, poorly ventilated environments should be avoided.

d. Habits, routines, idiosyncrasies:

Since he has gotten out of school, John has been staying up until 2:00 AM - 3:00 AM watching movies or using his computer. When he becomes employed, this routine will either need to shift or a job will need to be negotiated for a starting time around noon. John has said that staying up late is not of great importance to him.

e. Challenges related to disability/Need for accommodation & disclosure:

John finds group interactions very difficult and he often responds by moving away from the group to a solitary activity. He takes longer to learn tasks than others but, once learned, retains information well. John is sensitive to others feeling that he might be incompetent. He reacts strongly to those he perceives to be peers who try to

supervise him or direct him to perform tasks. Even though he reads, John needs written information to be provided in succinct, everyday language. He is often described as being either reluctant or unsure to take initiative, even on basic interactions like entering a room, and he needs to be prompted or assured that it is fine to proceed. A problem noted by some teachers from high school relates to John's appearance in relation to his challenges. Several teachers said that since John does not outwardly appear to have a disability, he is often expected to perform at the same level of expectation as student without disabilities. On several occasions, this has caused an angry response from John with him saying that he does not want to participate in the activity or lesson.

As far as disclosure to employers, John and his family do not want diagnostic or educational labels to be used but, rather, to use a functional work impact of disability as the strategy to inform employers of his challenges.

f. Financial issues:

John and his family agree that a job that pays at least Alaska's minimum wage is suitable to start. John currently receives SSI/Medicaid and his family wants a benefits analysis to understand the circumstances around wage earning and reduction/loss of benefits. In general, finances are not a strong concern for John or his family, rather there is a clear desire for him to be fairly reimbursed for the work he does. True to his conservative political philosophy, John feels he should start a savings plan with a portion of his paycheck, give money to his church and one day be off of federal benefits. He also wants to save for a car.

g. Transportation issues:

Transportation comprises perhaps the greatest challenge in assisting John to become employed. The work schedule and travel route for both his parents will need to be carefully examined. If suitable work can be developed in Salcha, John should be able to either walk or ride his bicycle to work; If work is developed in North Pole or beyond, efforts will need to be made to either connect with his parents or to coincide with locals who commute. John agreed to post a note at church indicating his potential transportation needs. He and his family agreed to have the job search with a sequence that starts in his local area then extends to Eagle River and finally to Anchorage as a last resort. Bart and Doris have agreed to poll co-workers to identify existing commuters from around their neighborhood and any car pooling arrangements that might exist. A note will be posted at the general store indicating his general interest in sharing transportation costs.

h. Promising solutions: Current, past or potential:

Aside from matching well to John's interests and negotiating the conditions

and skills for a customized job description, in addition to the provision of post-employment job supports, it is not felt that there will be need for significant problem solving regarding John's employment.

Team Member / Title	Method of Observation	Section	Date Observed	Time/ Duration
Jane Jones, Emp. Spec	Face to face home interview	1 a, b, g, h 2 a,b	10/15/2016	5:00pm-6:30pm/ 1.5hr.
Jane Jones, Emp. Spec	Assisted Interview with previous counselor and supervisors	1 e,f	10/25/2016	2:00 pm-3:00 pm/ 1hr.
Jane Jones, Emp. Spec	Assisted Interview with previous teachers	1 c, d, g, h	10/22/2016	2:30 pm-3:30 pm/ 1hr.
Jane Jones, Emp. Spec.	Assisted Interview with previous teachers	1 c, d, g, h	10/23/2016	3:00 pm – 4 pm / 1hr
Ryan Wodrow, DSW	On-site observation Library and Volunteer site	1 e, f	10/25/2016	2:00 pm- 6pm/ 4 hrs.
Ryan Wodrow, DSW	On-site observation changing oil in lawn tractor organizing garage	3 a, b, c, d	10/27/2016	2:00pm – 6 pm/ 4 hrs.

Note: This is only a sample. A variety of activities and information gathered should appear on the profiles.

APPENDIX 11: RESPONSIBILITIES

APPENDIX 12A: STATE MEDICAID AGENCY RESPONSIBILITIES

1. Submit the Medicaid I/DD Waiver applications and amendments to the Centers for Medicare and Medicaid Services (CMS); serve as the liaison between the DOH-DDD and CMS.
2. Certify initial intermediate care facility for individuals with intellectual disabilities (ICF/IID) level of care for applicants applying for the Medicaid I/DD Waiver prior to their admission.
3. Verify or determine Medicaid eligibility of applicants applying for services from the Medicaid I/DD Waiver prior to admission.
4. Maintain a participant and fiscal information system capturing waiver service expenditures and related participant data for the Medicaid I/DD Waiver according to federal requirements.
5. Submit an annual 372 report to CMS; monitor the number of participants served by the Medicaid I/DD Waiver as well as the average per capita costs and total cost-neutrality expenditure ceilings approved by CMS.
6. Oversee DOH-DDD's quality assurance program including the compliance reviews of all Medicaid I/DD Waiver providers. Report to CMS the summary of results on a regular basis.
7. Cooperate with CMS during reviews of the Medicaid I/DD Waiver; compile fiscal records and other Medicaid I/DD Waiver data and provide these records to CMS upon request.
8. Support DOH-DDD billing efforts by:
 - a. Processing and maintaining Medicaid I/DD Waiver provider agreements with each provider deemed qualified by DOH-DDD to serve participants in the Medicaid I/DD Waiver;
 - b. Maintaining the DHS Hawaii Prepaid Medicaid Management Information System (HPMMIS) information on providers, authorized services, and rates, and providing information to DOH-DDD on a timely basis.
9. Conduct fair hearings to ensure due process to Medicaid I/DD Waiver participants and providers.

10. Develop and oversee the state transition plan for the Home and Community Based Services Community Integration final rule. Hawaii's state transition plan is titled My Choice My Way.

APPENDIX 12B: STATE OPERATING AGENCY RESPONSIBILITIES

1. Certify annually the ICF/IID level of care for Medicaid I/DD Waiver participants.
2. Provide targeted case management services to Medicaid I/DD Waiver participants, including assessment, ISP development, needs identification, service authorization, ongoing monitoring and service coordination.
3. Promote freedom of choice for Medicaid I/DD Waiver participants by informing them of feasible alternatives for choice of providers and waiver services, as well as the choice of institutional versus Medicaid I/DD Waiver services.
4. Provide the State match funds from general fund budget appropriations for the Medicaid I/DD Waiver as is available within the DOH-DDD budget in accordance with Chapter 333F, Hawaii Revised Statutes (HRS).
5. Serve as the lead in developing and drafting of the Medicaid I/DD Waiver application renewal and amendments, including service definitions, service standards, program's P&P, guidelines, and criteria for rate setting; collaborate with DHS-MQD and stakeholder groups (i.e., persons with developmental and intellectual disabilities, self-advocates, families, providers and other interested individuals or groups).
6. Determine eligibility for applicants seeking services under the Medicaid I/DD Waiver that is consistent with Chapter 333F, HRS.
7. Provide consultation to DHS-MQD on services, programs, and best practices for services and supports for persons with I/DD and provide consultation to DHS-MQD on related costs as needed.
8. Provide orientation to prospective providers of Medicaid I/DD Waiver services, review new provider applications, proposals from approved providers to expand its service array, and recommend providers to DHS-MQD for authorization to provide services under a Medicaid Provider Agreement.
9. Provide technical assistance to Medicaid I/DD Waiver providers to ensure these providers render services in accordance with the Medicaid Waiver Standards Manual (as provided in Section 3: Service-Specific Performance Standards) as well as best practices that are recognized at the federal and state levels for HCBS and community integration.
10. Communicate and coordinate with DHS-MQD, QUEST Integration health plans, and others to ensure participants have access to needed services and if necessary, to transition seamlessly from one service system to another.

11. Cooperate and support activities to recover any overpayments or inappropriate payments from Medicaid I/DD Waiver providers:
 - a. Cooperate and assist the DHS-MQD Fraud Unit by providing requested information;
 - b. Monitor Medicaid I/DD Waiver providers for potential fraud or abuse and report any suspected fraudulent activity to DHS-MQD and the Department of Attorney General, Medicaid Fraud Control Unit within thirty (30) calendar days of discovery.
12. Review all complaints and Adverse Event Reports (AER) and maintain a database of all reports; respond to complaints and reports as needed; refer problems that require review and/or possible action to the Department of Attorney General.
13. Conduct quality assurance reviews of Medicaid I/DD Waiver participants and providers to ensure compliance with the CMS performance measures; submit reports to DHS-MQD as scheduled.
14. Cooperate with DHS-MQD in the performance of investigations, audits, quality assurance reviews of providers and CMS requests.
15. Collaborate with DHS-MQD, the My Choice My Way Advisory Group, providers and stakeholders to achieve and maintain compliance with the Home and Community Based Services Community Integration final rule. This includes completion of validation of all Medicaid I/DD Waiver settings that are identified by DHS-MQD as needing remediation to come into compliance; providing training and technical assistance to providers to develop their corrective action plans and remediation milestones; and monitoring provider progress toward achieving and maintaining compliance.

APPENDIX 12**C**: WAIVER PROVIDER RESPONSIBILITIES

1. Adhere to all Provider Agreement and attachments, Medicaid I/DD Waiver Standards, applicable federal, state and local laws, rules, and regulations.
2. Deliver services in accordance with the Medicaid I/DD Waiver Standards.
3. Complete Corrective Action Plans or other remediation requirements within the specified timeframes, including *My Choice My Way* state transition plan requirements.
4. Promote freedom of choice of providers by Medicaid I/DD Waiver participants
5. Assist with transition if participant chooses a different provider upon request of the Case Manager, with releases of information.
6. Perform training and other activities that develop a highly skilled workforce.
7. Stay current on national best practices for services and supports for persons with I/DD.
8. Maintain financial and service delivery records in accordance with Waiver Standards and state and federal laws and regulations.
9. Cooperate with activities to recover any overpayments or inappropriate payments as determined by DOH-DDD or DHS-MQD
10. Respond to inquiries by DOH-DDD or DHS-MQD within two (2) business days.
11. Cooperate with DOH-DDD or DHS-MQD for investigations, audits, and quality assurance reviews, including providing all documentation or records requested.

APPENDIX 13:
**I/DD WAIVER SERVICES
AND SCHEDULE OF RATES**

I/DD Waiver Services and Schedule of Rates

- [Medicaid Waiver Services I/DD Waiver Services Schedule of Rates](#)

APPENDIX 14:
**HYPERLINKS TO HAWAII
ADMINISTRATIVE RULES (HAR)**

HYPERLINKS TO HAWAII ADMINISTRATIVE RULES (HAR)

- [HAR Title 11 Department of Health Chapter 148.1 - “Certification of Adult Foster Homes”](#)
- [HAR Title 11 Department of Health Chapter 100.1- “Adult Residential Care Homes”](#)
- [HAR Title 11 Department of Health Chapter 89 - “Developmental Disabilities Domiciliary Homes”](#)
- [HAR Title 11 Department of Health Chapter 98 - “Special Treatment Facility”](#)