

2018 Individual Experience Assessment Survey - DIDD

In January 2014, the Centers for Medicare and Medicaid Services (CMS) announced a requirement for states to review and evaluate current Home and Community Based Settings (HCBS), including residential and non-residential settings, and to demonstrate compliance with the new federal HCBS Setting rules that went into effect March 17, 2014. These rules were developed to ensure that individuals receiving long-term services and supports through HCBS programs under Medicaid waiver authorities have full access to benefits of community living and the opportunity to receive services in the most integrated setting appropriate. The following individual assessment is intended to measure each member's level of awareness of and access to the residents' rights, privacy requirements and member experience expectations, as outlined in the HCBS requirements. Each section will walk you through characteristics that are expected to be present in all home and community-based settings that individuals in those settings might experience.

Instructions

Individual Experience Assessment process: January 1, 2018 – December 31, 2018

The Case Manager/ISC shall assess each member's experience in receiving Medicaid HCBS using the Individual Experience Assessment (IEA) annually as prescribed by TENNCARE. Participants in the IEA shall include the member and his or her family members and/or representative, as appropriate. The individual's input should be used first, and input from others involved may be used when the person is not able to respond to one or more of the questions independently. Service provider staff may participate as requested by the member and his or her family and/or representative.

In addition, the member's Case Manager/ISC, as applicable, shall address any issues regarding compliance with the HCBS Settings Rule or other concerns identified during the IEA. Each NO response should be investigated to determine if it is appropriately supported by the ISP or if it is truly Non-Compliant. Individual remediation should occur for any response that is determined to be Non-Compliant.

Section A – General Information	
<u>A response to each question is required unless otherwise indicated.</u>	
1. Member First and Last Name:	
2. Member SSN: <i>Enter as xxx-xx-xxxx</i>	
3. Date of birth:	Month/Day/Year (MM/DD/YYYY)
4. Does the member have a conservator? <i>A conservator is a person appointed by the probate court to oversee the personal and/or financial affairs of an adult who is determined to be incapable of managing his or her own affairs or unable to care for himself or herself.</i> If no, skip to question 5. If yes, answer 4a – 4b.	<input type="checkbox"/> Yes <input type="checkbox"/> No
4a. If yes, is the conservator a paid/corporate conservator (i.e. the conservator works for an agency), or an unpaid family/friend?	<input type="checkbox"/> Paid Conservator <input type="checkbox"/> Unpaid Conservator
4b. If Unpaid Conservator, enter the name of the Conservator:	
4b. If Paid Conservator, select the name of the Conservator Agency:	<input type="checkbox"/> Comcare <input type="checkbox"/> Michael Dunn <input type="checkbox"/> Other Please explain:
5. LTSS Program:	Select one: <input type="checkbox"/> CHOICES Group 2 <input type="checkbox"/> CHOICES Group 3 <input type="checkbox"/> ECF CHOICES Group 4 <input type="checkbox"/> ECF CHOICES Group 5 <input type="checkbox"/> ECF CHOICES Group 6 <input type="checkbox"/> Comprehensive Aggregate Cap Waiver (CAC) <input type="checkbox"/> Statewide Waiver <input type="checkbox"/> Self-Determination Waiver
6. Date IEA Survey Completed: <i>Day/Month/Year</i>	

7. First and Last Name of Person Conducting IEA:	
8. Title of Person Conducting IEA:	<p>Select one:</p> <ul style="list-style-type: none"> <input type="checkbox"/> ISC (DIDD Waiver) <input type="checkbox"/> Case Manager (DIDD Waiver) <input type="checkbox"/> Care Coordinator (CHOICES) <input type="checkbox"/> Support Coordinator (ECF CHOICES)
<p>9. Organization Name:</p> <p><i>If ISC Agency, answer 9a.</i></p>	<p>Select one:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Amerigroup <input type="checkbox"/> BlueCare <input type="checkbox"/> United <input type="checkbox"/> ISC Agency <input type="checkbox"/> DIDD
9a. Name of ISC Agency (if applicable):	
10. Number of months assigned to member:	
11. Region:	<p>Select one:</p> <ul style="list-style-type: none"> <input type="checkbox"/> East <input type="checkbox"/> Middle <input type="checkbox"/> West
<p>12. Is someone other than the member responding to the survey if the individual is not able to answer one or more of the questions independently?</p> <p>If no, skip to Section B. If yes, answer 12a – 12b.</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Yes <input type="checkbox"/> No
12a. If yes, what is the First and Last name of the person assisting with responses?	
12b. What is his/her relationship to the member?	<p>Select one:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Child <input type="checkbox"/> Spouse/Partner <input type="checkbox"/> Other Family <input type="checkbox"/> Friend <input type="checkbox"/> Personal Care Attendant / Direct Care Worker <input type="checkbox"/> Voluntary Conservator

	<input type="checkbox"/> Paid Conservator <input type="checkbox"/> Other
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Section B – HCBS Setting Experience Overall

All participants are required to complete this section.

The remaining sections **C, D,** and **E** will be completed based on the services selected by each individual.

Question:	Response:	HCBS Setting Requirement:
1. Do you have your own bank account?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Allows individual to control personal resources.</i>
2. Do you have access to your money?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
3. Can you buy the things you need?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
4. Did someone tell you about the services and supports available to you?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Facilitates individual choice regarding services and supports and who provides them.</i>
5. Did you choose the services and supports you receive?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
6. Were you given options to choose from when selecting the agency that provides your services and supports?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
7. Did you choose the person/people who provide your services and supports?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
8. Do you know how to request a change in your services and supports?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
9. Do you know how to request a change in who provides your services and supports?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

<p>Does this individual participate in Employment or Day Services?</p> <p><i>If yes, complete Section C.</i> <i>If no, SKIP Section C.</i></p>	<p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p>
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Section C - Employment and Day Services

<p>Select the Employment/Day service(s) the individual is receiving:</p>	<p>Check all that apply –</p> <p>DIDD Waiver:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Supported Employment <input type="checkbox"/> Facility Based Day <input type="checkbox"/> Community Based Day <input type="checkbox"/> In-Home Day <p>CHOICES:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Adult Day Care <p>ECF CHOICES:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Exploration <input type="checkbox"/> Discovery <input type="checkbox"/> Situational Observation and Assessment <input type="checkbox"/> Job Development Planning <input type="checkbox"/> Self-Employment Planning <input type="checkbox"/> Job Development Start-Up <input type="checkbox"/> Self-Employment Start-Up <input type="checkbox"/> Job Coaching for Individual Integrated Employment <input type="checkbox"/> Job Coaching for Self-Employment <input type="checkbox"/> Co-Worker Supports <input type="checkbox"/> Career Advancement <input type="checkbox"/> Benefits Counseling <input type="checkbox"/> Supported Employment – Small Group <input type="checkbox"/> Integrated Employment Path Services
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Name of Service Provider: <i>If the Provider name does not appear on the list in FormStack, please reach out to your Organization Contact.</i>	
Provider Medicaid ID #:	
Does the individual have more than one Employment/Day services provider? If yes, enter the 2nd provider name and Medicaid ID#. If no, skip to question 1.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Name of Service Provider 2 (if applicable): <i>If the Provider name does not appear on the list in FormStack, please reach out to your Organization Contact.</i>	
Provider 2 Medicaid ID #:	

Question:	Response:	HCBS Setting Requirement:
1. Do you have a job?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Provides opportunities to seek employment and work in a competitive environment.</i>
2. Could you have a job if you want one?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
3. Do you have the help you need to look for a job if you want one?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
4. Can you be alone if you want to?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Ensures individual's rights of privacy, dignity, respect and freedom from coercion and restraint.</i>
5. Can you have a private conversation without others listening?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
6. Is your personal information kept secure so others can't see it?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
7. Do the people who care for you treat you the way you want to be treated?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
8. Do the people who care for you listen to your questions or concerns?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
9. If you want to, can you go out in the community?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Integrated, and supports access to the broader community.</i>

<p>Does this individual participate in Residential Services?</p> <p><i>If yes, complete Section D.</i> <i>If no, SKIP Section D.</i></p>	<p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p>
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Section D – Residential Services

<p>Select the Residential service the individual is receiving:</p>	<p>DIDD Waiver:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Supported Living <input type="checkbox"/> Residential Habilitation <input type="checkbox"/> Family Model Residential <input type="checkbox"/> Medical Residential <input type="checkbox"/> Semi-Independent Living <p>CHOICES:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Assisted Living Facility (ACLF) <input type="checkbox"/> Community Living Supports <input type="checkbox"/> Community Living Supports - Family Model <input type="checkbox"/> Adult Care Home <input type="checkbox"/> Companion Care <p>ECF CHOICES:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Community Living Supports <input type="checkbox"/> Community Living Supports – Family Model
<p>Name of Service Provider:</p> <p><i>If the Provider name does not appear on the list in FormStack, please reach out to your Organization Contact.</i></p>	
<p>Provider Medicaid ID #:</p>	
<p>How long have you lived in your current residence?</p>	

<i>Enter # in Weeks/Months/Years.</i>	
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Question:	Response:	HCBS Setting Requirement:
1. Did you choose where you live and receive your services?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>The setting was selected by the individual from among setting options, including non-disability specific settings.</i>
2. Did you visit other places before choosing this one?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
3. Do you know how to relocate and request new housing?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
4. Do you own your home or have a lease?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Specific unit or dwelling is owned, rented or occupied under a legally enforceable agreement.</i>
5. Do you know your rights as a tenant and protections from eviction?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
6. Can you close and lock your front door?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Unit has lockable entrance door.</i>
7. Do you have the key to your front door?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
8. Does anyone else have a key to your front door?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
9. Do others knock before entering your front door?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
10. Can you close and lock your bedroom door?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Each individual has privacy in their sleeping or living unit.</i>
11. Can you close and lock your bathroom door?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
12. Did you get to decide who has a key to your bedroom or bathroom?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
13. Do others knock before entering your bedroom?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
14. Were you given the option of a private room if you could afford it?	<input type="checkbox"/> Yes	<i>Option for a private unit.</i>

	<input type="checkbox"/> No	
15. Can you choose who you share your room with?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Choice of roommates.</i>
16. Did you choose your roommate?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
17. Do you like living with your roommate?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
18. Do you know how to request a roommate change?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
19. Did you decorate your room?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Freedom to furnish and decorate.</i>
20. Can you move the furniture where you want?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
21. Can you hang or put up pictures if you want to?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
22. Can you change the decorations in your room?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
23. Do you participate in activities like shopping, going to church or having lunch with family and friends?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Integrated in and supports full access to the greater community.</i>
24. Do you know how to find out about upcoming events or activities?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Do you have the help you need to participate in the activities you want to do?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
26. Are you able to get to the activities you would to participate in?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
27. Do you make your own schedule?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Freedom and support to control schedules and activities.</i>
28. Can you decide when you get up, take a bath, eat, exercise or participate in other activities?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
29. Can you watch television, listen to the radio and do things that you	<input type="checkbox"/> Yes	

like when you want to?	<input type="checkbox"/> No	
30. Can you eat when you want to?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Access to food at any time.</i>
31. Can you eat where you want to?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
32. Can you eat what you want to?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
33. Can you request a different meal if you want one?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
34. Are snacks accessible and available anytime?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
35. Can you have any visitors?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
36. Can you have visitors at any time?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
37. Can you have private visits with family and friends if you want to?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
38. Do you have the supports you need to move around your room/house as you choose?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Physically accessible.</i>
39. Can you enter and exit your room/house as you choose?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
40. Do you have full access to the common areas such as the kitchen, dining area, laundry, and shared living areas?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
41. Do you have a resident handbook or know how to get one?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Policies outlining residents' rights are available and accessible to the member.</i>
42. Do you understand the handbook or know who to ask if you have questions?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
43. Do you have access to a phone, computer or other technology?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Optimizes individual initiative, autonomy, and independence in making life choices.</i>
44. Do you have access to transportation to go the places you want to go?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
45. Can you make decisions about your schedule, where you go, who you see, and when?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

<p>Does this individual participate in Personal Assistance Services?</p> <p><i>If yes, complete Section E.</i> <i>If no, SKIP Section E.</i></p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
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Section E – Personal Assistance Services

<p>Select the Personal Assistance services the individual is receiving:</p>	<p>DIDD Waiver:</p> <input type="checkbox"/> Personal Assistance
<p>Name of Service Provider:</p> <p><i>If the Provider name does not appear on the list in FormStack, please reach out to your Organization Contact.</i></p>	<p>CHOICES:</p> <input type="checkbox"/> Attendant Care <input type="checkbox"/> Personal Care Visits
<p>Provider Medicaid ID #:</p>	<p>ECF CHOICES:</p> <input type="checkbox"/> Personal Assistance <input type="checkbox"/> Supportive Home Care

Question:	Response:	HCBS Setting Requirement:
1. Do you live with family in a family member’s home?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Choice in living arrangement.</i>
2. Do you live in your own home or apartment?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
3. Can you live in your own home or apartment if you want?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

<p>4. Do you have the help you need to participate in the activities you want to do? <i>For example, are you able to get to the activities you want to participate in and the support you need to participate in those activities?</i></p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><i>Integrated and supports access to the greater community</i></p>
<p>5. If you want to, can you go out in the community during the day? <i>For example, do you participate in activities like shopping, going to church or having lunch out with family and friends?</i></p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>5a. If yes, how often?</p>	<p><input type="checkbox"/> Every time I want to <input type="checkbox"/> Most of the time I want to <input type="checkbox"/> Not as much as I would like</p>	
<p>6. Other than family or paid caregivers, do you spend time with people who do not have disabilities?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>6a. If yes, how often?</p>	<p><input type="checkbox"/> Every time I want to <input type="checkbox"/> Most of the time I want to <input type="checkbox"/> Not as much as I would like</p>	
<p>7. Do you know how to find out about upcoming events or activities in your community?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>8. If you want to, can you have a job or volunteer? <i>For example, do you have the support you need to look for a job or volunteer somewhere if you want?</i></p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><i>Provides opportunities to seek employment or volunteer opportunities.</i></p>
<p>9. Can you change how and where you receive personal assistance if you want to?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><i>The service facilitates individual choice regarding services and supports and who provides them.</i></p>
<p>10. Can you be alone if you want/need to be while receiving personal assistance services? <i>For example, can you have a private conversation without others listening?</i></p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><i>Ensures individual's rights of privacy, dignity, respect and freedom from coercion and restraint.</i></p>
<p>11. Do the staff who support you treat you the way you want to be treated? <i>For example, do staff listen and respond to your questions or</i></p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	

<i>concerns?</i>		
12. Do you have adequate privacy in your home?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Unit has lockable entrance door.</i>
13. Can you close and lock your front door?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
14. Do you have a key to your home?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
15. Are you comfortable with the other people who have keys to your home?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
16. Do others knock before entering your bedroom?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
17. Can you close and lock your bedroom door?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Each individual has privacy in their sleeping or living unit.</i>
18. Can you close and lock your bathroom door?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
19. Are you comfortable with the other people who have a key to your bedroom or bathroom?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
20. Can you eat when you want to?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Access to food at any time.</i>
21. Can you eat where you want to?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
22. Can you eat what you want to?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
23. Are snacks accessible and available anytime?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
24. Do you have the supports you need to move around your room/house as you choose?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Physical accessibility.</i>
25. Can you enter and exit your room/house as you choose?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
26. Do you have full access to the common areas such as the kitchen, dining area, laundry, and shared living areas?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
27. Do you have access to a phone, computer, or other technology?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Optimizes individual initiative, autonomy, and independence in</i>

28. Do you have access to transportation to go the places you want to go?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>making life choices.</i>
29. Can you make decisions about your schedule, where you go, who you see, and when?	<input type="checkbox"/> Yes <input type="checkbox"/> No	