

## Required Document Definitions

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**\*Please note required documents vary based on services applying for\***

Each document required will be uploaded individually. For ease of reference, please save each document to match the corresponding document title in this document.

## Documents to Gather

### Background Check Results

<p>Required for all services*</p>	<ul style="list-style-type: none"> <li>- Limited, National, Fingerprint, or Expanded criminal history check.             <ul style="list-style-type: none"> <li>o If the background check is Limited, a copy of driver's license is required to be uploaded.</li> <li>o The following <b>convictions</b> will result in an automatic denial:                 <ul style="list-style-type: none"> <li>i. Sex crime</li> <li>ii. Exploitation of an endangered adult</li> <li>iii. Abuse or neglect of a child</li> <li>iv. Failure to report battery, neglect or exploitation of an adult or child</li> <li>v. Theft (within the last 10 years)</li> <li>vi. Murder</li> <li>vii. Voluntary manslaughter</li> <li>viii. Involuntary manslaughter</li> <li>ix. Battery</li> </ul> </li> </ul> </li> <li>- Submit a copy of background checks for the following:             <ul style="list-style-type: none"> <li>o Owner</li> <li>o All current employed</li> </ul> </li> <li>- Background check must be dated within 90 days of the application submission date.</li> <li>- Be sure to include all pages and results of the background check.</li> <li>- Background check must be completed for Indiana and any previous state(s) of residence.</li> <li>- <b>Cannot</b> be completed by county or sheriff office.</li> </ul>
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*\*If seeking certification for Attendant Care or Specialized Medical Equipment and Supplies, a provider will be required to complete a fingerprint background check from the Indiana State Police (ISP) for the IHCP enrollment process. <https://www.in.gov/medicaid/providers/files/instructions-for-fingerprinting-registration-in-indiana.pdf>*

*Purpose of Document: to determine whether an applicant may be unqualified due to a record of criminal conviction. The following convictions would result in a failed background check: sex crime, exploitation of an endangered adult, abuse or neglect of a child, failure to report battery, neglect, or exploitation of an endangered adult or dependent, theft, murder, voluntary manslaughter, involuntary manslaughter, and battery.*

### Back Up Plan

<p>AFC, AL, SMCU, CCBM, IHCC, SFC, and sole proprietors</p>	<ul style="list-style-type: none"> <li>- What is the agency's plan to cover back up services which must be provided by a qualified individual familiar with the individual/client's needs for those times when the primary caregiver is absent from the home or otherwise cannot provide the necessary level of care?</li> </ul>
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	<ul style="list-style-type: none"> <li>- Must specify that backup services must be provided by a qualified individual familiar with the client's needs for those times when the primary caregiver is absent.</li> </ul>
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*Purpose of Document: to ensure individuals served do not go without care when the primary caregiver is unavailable.*

### Caregiver Communication Policy

CCBM	<ul style="list-style-type: none"> <li>- Policy must include detailed information on how the caregiver coach and caregivers will communicate and include the type of contact method (telephone/virtual interventions through HIPAA secure electronic communication platforms) used for service delivery to the caregiver. <ul style="list-style-type: none"> <li>o The policy should also include information on collaborations with waiver case managers and case coordinators.</li> </ul> </li> </ul>
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*Purpose of Document: to ensure that information is handled securely.*

### Crisis Management/Emergency Plan

CCBM	<ul style="list-style-type: none"> <li>- Details what each crisis management/emergency plan must at a minimum contain.</li> <li>- Details how often it is reviewed/modified and who will receive copies of the plan.</li> <li>- Use template below: <ul style="list-style-type: none"> <li>o The caregiver coach will assist the caregiver and participant in creation of a crisis management/emergency plan to address the person and environment. Plan will be reviewed and updated on a monthly basis (and more often as needed) and provided to the care manager and waiver/Medicaid State Plan/Hospice providers as well as emergency contacts and backup caregiver. Plan shall include but is not limited to the following: <ul style="list-style-type: none"> <li>▪ Health conditions</li> <li>▪ Advanced directives, will planning, physician orders for life sustaining treatment.</li> <li>▪ Medications and medication management/assistance to prevent medication errors.</li> <li>▪ Fall prevention interventions.</li> <li>▪ Healthcare providers including contact information.</li> <li>▪ Emergency contacts</li> <li>▪ Identification and contact information for backup caregiver.</li> <li>▪ Contact information for caregiver coach and waiver care manager.</li> <li>▪ Caregiver resources available within the caregiver's/participant's community of choice.</li> </ul> </li> </ul> </li> </ul>
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*Purpose of Document: to ensure individuals served do not go without care in the event of an emergency or unforeseen event.*

## Employee’s Rights and Responsibilities

Required for all services	- Document provided to employees that contains their rights and responsibilities.
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*Purpose of Document: to layout the rights an employee has such as fair pay and respect for personal and professional boundaries along with their responsibilities such as fulfilling their job role and adhering to policies and procedures.*

## File Retention Policy

Required for all services	<ul style="list-style-type: none"> <li>- Include that all employee records will be kept for 1 year from the date of termination.</li> <li>- Include that records for services provided will be kept for 7 years from the last date of service.</li> </ul>
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*Purpose of Document: to provide evidence of employment history, training, certifications, and compliance with organizational policies and to provide a clear record of products and treatments that an individual received.*

## HIPAA Compliance Policy

Required for all services	<ul style="list-style-type: none"> <li>- Written procedure to ensure compliance with HIPAA confidentiality and privacy requirements.</li> <li>- Require that all employees do the following:             <ul style="list-style-type: none"> <li>o Maintain the confidentiality of individual information consistent with the standards of article 455 IAC- 2-21-1 (8)(A) and all other laws and regulations governing confidentiality of individual information.</li> <li>o Conduct all practice with honesty, integrity, and fairness.</li> <li>o Fulfill professional commitments in good faith.</li> <li>o Inform the public and colleagues of services only by use of factual information.</li> </ul> </li> <li>- Written procedure detailing how the agency will maintain the confidentiality of individual information.</li> </ul>
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*Purpose of Document: to assure that individuals’ health information is properly protected.*

## Incident Reporting (IR) Policy

Required for all services	<ul style="list-style-type: none"> <li>- Procedure for Protecting Individuals as outlined in 455 IAC 2-8-1             <ul style="list-style-type: none"> <li>o Must include a written procedure on what the agency process is to inform:                 <ul style="list-style-type: none"> <li>▪ Individuals of their right to refuse treatment or make changes to care plan</li> <li>▪ Individuals of their right to legal representation or ombudsman</li> <li>▪ Individuals of their right to exercise any or all rights without restraint, interference, coercion, discrimination, or threat of reprisal</li> </ul> </li> </ul> </li> </ul>
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	<ul style="list-style-type: none"> <li>▪ Individuals of their right to file complaints to DDRS and the procedure to do this</li> <li>- What is the agency procedure for filing an IR with APS, CPS, and DDRS within 24 hours for the following: <ul style="list-style-type: none"> <li>○ Any suspected abuse</li> <li>○ Any suspected neglect</li> <li>○ Any suspected exploitation</li> <li>○ Death of a participant</li> </ul> </li> <li>- Must include the entire Unusual Occurrence policy from the Aging Rule: <ul style="list-style-type: none"> <li>○ 455 IAC 2-8-2</li> <li>○ Copied exactly and in full - points 1-16 and all subpoints.</li> </ul> </li> <li>- Must include reporting website (<a href="https://ddrsprovider.fssa.in.gov/IFUR/">https://ddrsprovider.fssa.in.gov/IFUR/</a>) <ul style="list-style-type: none"> <li>○ Specifically state the report will be completed online and include the link.</li> </ul> </li> <li>- Must include timelines agency will follow. <ul style="list-style-type: none"> <li>○ Refer to 455 IAC 2-8-2 for compliant timelines.</li> </ul> </li> </ul>
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*Purpose of Document: to ensure that both staff and individuals served are safe and that staff know when and how to report incidents.*

### Job Descriptions

Required for all services	<ul style="list-style-type: none"> <li>- Provide a job description for each position including minimum qualifications and major job duties. <ul style="list-style-type: none"> <li>○ Qualifications must be applicable to the service position</li> </ul> </li> <li>- Include exact allowable and unallowable activities for the services applicable to the position. These activities can be found in the: <ul style="list-style-type: none"> <li>○ <a href="#">OMPP HCBS Waiver Manual</a></li> <li>○ <a href="#">DDRS HCBS Waiver Manual</a></li> </ul> </li> <li>- Must have a job description for each position noted on the organization chart and titles must match exactly.</li> </ul>
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*Purpose of Document: to document the essential job functions and the skills, knowledge, abilities, and other characteristics needed for satisfactory performance of the job.*

### Job Performance Evaluation Policy

Required for all services	<ul style="list-style-type: none"> <li>- Include a written procedure for evaluation of job performance at the end of a training period and annually.</li> <li>- Include a written procedure from individuals receiving services to give feedback on an employee.</li> <li>- Include a list of grounds for disciplinary action or dismissal of employees.</li> </ul>
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*Purpose of Document: to ensure that both employers and employees are on the same page regarding job expectations and inform employees what is and is not acceptable behavior what the procedure is if violations occur.*

### Negative TB Test or Chest X-Ray Results

ADS, AFC, AL, SCMU, ATTC,	<ul style="list-style-type: none"> <li>- Submit a copy of most recent negative TB test or negative chest x-ray for the following:</li> </ul>
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BMAN, CMGT, IHCC, HCA, RBH, RESPITE, SDP, SFC, SE, and TRAN	<ul style="list-style-type: none"> <li>○ Owner</li> <li>○ All currently employed staff who have direct contact with individuals</li> <li>- Must clearly indicate that the test was done by a medical professional:           <ul style="list-style-type: none"> <li>○ To include medical professional's name and credentials</li> </ul> </li> <li>- Must show date and time administered and read.</li> <li>- If test date is older than 1 year:           <ul style="list-style-type: none"> <li>○ Must present date of business creation for owner</li> <li>○ Must present date of hire for an employee</li> </ul> </li> </ul>
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*Purpose of Document: to determine if any direct staff have been infected with TB to ensure it is not passed onto the vulnerable population being served.*

## Organizational Chart

Required for all services	<ul style="list-style-type: none"> <li>- List all jobs within the organization.           <ul style="list-style-type: none"> <li>○ <i>This includes all positions within the organization regardless of service chosen for certification.</i></li> <li>○ <i>Must be positions associated only with the location submitted for certification.</i></li> </ul> </li> <li>- Filled positions should include employee first and last name.           <ul style="list-style-type: none"> <li>○ If the position is not currently filled, include job title and list as Vacant or TBD.</li> <li>○ <i>Please note that some services require staff to be hired at the time of certification, and the appropriate licensures of staff will be required to be uploaded. Please refer to service definitions.</i></li> </ul> </li> <li>- Titles on the organizational chart must be identical to the titles on job descriptions.</li> </ul>
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*Purpose of Document: to provide an easy-to-understand visualization of the organization's structure and relationship between its various parts.*

## Personnel Policy

Required for all services	<ul style="list-style-type: none"> <li>- Include details of the documentation that must be contained in the employees' files and must state that the files are reviewed annually and updated as needed.           <ul style="list-style-type: none"> <li>○ <i>Please reference 455 IAC 2-14-1 for more information on what records need to be contained in employee files.</i></li> </ul> </li> <li>- Must state that direct care staff will be at least 18 years of age.</li> <li>- Include a written procedure detailing how the agency will conduct reference, employment, and criminal background checks on each prospective employee.           <ul style="list-style-type: none"> <li>○ Specify if background check will be limited, national, or expanded.</li> <li>○ Specify if anyone incurs one of the 9 criminal convictions below during employment that are in direct service role must immediately notify their manager and either be terminated or moved to an indirect care service role.               <ul style="list-style-type: none"> <li>i. Sex crime</li> </ul> </li> </ul> </li> </ul>
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	<ul style="list-style-type: none"> <li>ii. Exploitation of an endangered adult</li> <li>iii. Abuse or neglect of a child</li> <li>iv. Failure to report battery, neglect or exploitation of an adult or child</li> <li>v. Theft (within the last 10 years)</li> <li>vi. Murder</li> <li>vii. Voluntary manslaughter</li> <li>viii. Involuntary manslaughter</li> <li>ix. Battery</li> </ul> <ul style="list-style-type: none"> <li>○ Must state that all background checks, references and employment history checks will be completed prior to employment beginning.</li> </ul> <ul style="list-style-type: none"> <li>- Must state that verification of all professional licensed health professionals will be done through the Indiana Professional Licensing Agency prior to employment beginning and include the link: <ul style="list-style-type: none"> <li>○ <a href="https://mylicense.in.gov/EVerification/Search.aspx">https://mylicense.in.gov/EVerification/Search.aspx</a></li> </ul> </li> </ul>
ADS, AFC, AL, SCMU ATTC, BMAN, IHCC, HCA, RBH, Respite, SDP, SE, and TRAN	<ul style="list-style-type: none"> <li>- Requirement that direct care staff have a negative TB test or negative x-ray, upon hire.</li> <li>- Requirement that agency will provide yearly TB education to direct care staff.</li> <li>- Requirement that testing is required if there is known TB exposure.</li> </ul>

*Purpose of Document: to ensure staff meet qualifications for employment prior to beginning work.*

### Proof of Certification/Degree/Experience

Assisted Living/Memory Care Unit	<ul style="list-style-type: none"> <li>- Must have IDOH license and waiver. <ul style="list-style-type: none"> <li>○ Residential License <ul style="list-style-type: none"> <li>▪ Provisional licenses will not be accepted.</li> </ul> </li> <li>○ The facility must submit a written request for waiver of a health facility rule to the IDOH Division of Long-Term Care at <a href="mailto:ltcproviderservices@health.IN.gov">ltcproviderservices@health.IN.gov</a>. The request for waiver will include: <ul style="list-style-type: none"> <li>▪ The specific rule for which the facility is requesting a waiver.</li> <li>▪ An explanation of why the facility cannot comply with the residential care rules. In this case, it will likely include an explanation of why the facility cannot meet the residential care rules along with the HCBS requirements.</li> <li>▪ Given that these requests will deal with care issues, provide a plan for how the facility will be addressing care issues to assess and meet the needs of the residents.</li> <li>▪ An explanation of how the granting of the waiver will not adversely affect the health, safety, and welfare of its residents.</li> </ul> </li> </ul> </li> </ul>
ATTC/HCA	<ul style="list-style-type: none"> <li>- Must have one of the following:</li> </ul>

	<ul style="list-style-type: none"> <li>○ Personal Services Agency License (Required) <ul style="list-style-type: none"> <li>▪ Provisional licenses will not be accepted.</li> </ul> </li> <li>○ Home Health Agency License (Optional) <ul style="list-style-type: none"> <li>▪ Provisional licenses will not be accepted.</li> </ul> </li> </ul>
Care Management/ New Case Manager	<ul style="list-style-type: none"> <li>- Must have one of the following education/work experiences: <ul style="list-style-type: none"> <li>○ Continuously employed as a CM by a AAA since June 30, 2018</li> <li>○ RN</li> <li>○ Bachelor’s degree in social work, Psychology, Counseling, Gerontology, Nursing, or Health and Human Services</li> <li>○ A bachelor’s degree in any field with a minimum of 2 years full time, direct service experience with the elderly or disabled.</li> <li>○ A master’s degree in social work, Psychology, Counseling, Gerontology, Nursing, or Health and Human Services</li> <li>○ An associate degree in nursing</li> <li>○ An associate degree in any field with a minimum of 4 years full time, direct service experience with the elderly or disabled.</li> </ul> </li> <li>- Case Manager Orientation (CMO) certificate – <a href="#">CMO Training</a>.</li> </ul>
Home Delivered Meals	<ul style="list-style-type: none"> <li>- Must have ServSafe Certificate for owner and any employees handling food. <ul style="list-style-type: none"> <li>○ <a href="https://www.servsafe.com/">https://www.servsafe.com/</a></li> </ul> </li> </ul>
Home Modification	<ul style="list-style-type: none"> <li>- Any applicable licensure based on modification being completed; home inspector, plumber, architect, evaluator certification, residential contractor’s license, etc.</li> </ul>
Home Modification Assessment	<ul style="list-style-type: none"> <li>- Must have one of the following: <ul style="list-style-type: none"> <li>○ License: IC 2520.2 Home Inspector</li> <li>○ Certified Aging In-Place Specialist (CAPS Certification – National Association of Home Builders)</li> <li>○ Executive Certificate in Home Modifications (University of Southern California)</li> </ul> </li> </ul>
Integrated Health Care Coordination	<ul style="list-style-type: none"> <li>- Must have Home Health Agency License <ul style="list-style-type: none"> <li>○ Not required if providing Adult Day Service or Assisted Living</li> <li>○ Not required if provider is an RN, LPN, or LSW providing service</li> </ul> </li> </ul>
Pest Control	<ul style="list-style-type: none"> <li>- Agency must be certified or licensed through the Purdue University Extension Service and the Office of the Indiana State Chemist.</li> </ul>
Respite	<ul style="list-style-type: none"> <li>- Must have Home Health Agency License.</li> </ul>
Specialized Medical Equipment	<ul style="list-style-type: none"> <li>- Must have one of the following: <ul style="list-style-type: none"> <li>○ Home Health Agency License</li> <li>○ Home Medical Equipment Service Provider License <u>and</u> Registered Retail Merchant Certificate.</li> </ul> </li> </ul>
Structured Family Caregiving	<ul style="list-style-type: none"> <li>- Agency owner must demonstrate three years of delivering direct, hands-on care services to elders and adults with disabilities and their caregivers in Indiana or as a Medicaid participating provider in another state or have a national accreditation.</li> <li>- Documents that will be accepted (must upload one): <ul style="list-style-type: none"> <li>○ Resume</li> <li>○ Proof of business providing direct care (3 years)</li> <li>○ Current RN, LPN or CNA licensure</li> </ul> </li> </ul>

	<ul style="list-style-type: none"> <li>○ National Accreditation</li> </ul>
Supported Employment	<ul style="list-style-type: none"> <li>- Must have Certificate from the Commission on Accreditation of Rehabilitation Facilities (CARF).</li> </ul>

*Purpose of Documents: to ensure that the provider has the required certifications/degrees/experience to be able to provide a service.*

### Proof of Liability Insurance

Required for all services	<ul style="list-style-type: none"> <li>- Requires agency name (and DBA if applicable) to be listed on policy.</li> <li>- Ensure current policy is submitted.</li> <li>- Policy to include personal injury, loss of life, and property damage to an individual caused by fire, accident, or other casualty arising from the provision of services to the individual by the provider. <ul style="list-style-type: none"> <li>○ General Liability covers these items.</li> </ul> </li> </ul>
Adult Family Care	<ul style="list-style-type: none"> <li>- Required to have Commercial General Liability Insurance.</li> </ul>

*Purpose of Document: to help cover medical and legal fees if you're held legally responsible for an individual's injury or damage to someone else's property.*

### Quality Assurance/Quality Improvement Policy

Required for all services	<ul style="list-style-type: none"> <li>- Include how the agency will focus on the individual/client and ensure appropriate services are being provided.</li> <li>- Include a written steps procedure for analyzing data for reportable incidents and developing &amp; reviewing recommendations to reduce risk of future incidents.</li> <li>- Requirement for an annual survey of individual satisfaction.</li> <li>- Include a blank copy of the annual survey provided to individuals receiving services.</li> <li>- Include documentation of efforts to improve services based on survey feedback.</li> </ul>
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*Purpose of Document: to ensure the agency provides services that meet the quality standards set by the agency and state.*

### Secretary of State (SOS) Letter

Required for all services	<ul style="list-style-type: none"> <li>- Document must include the state of Indiana seal, signature, and date issued. <ul style="list-style-type: none"> <li>○ Provide the Certificate of Organization. Articles of Organization will not be accepted.</li> </ul> </li> <li>- Name on SOS letter must match legal business name.</li> <li>- SOS Letter must be current. <ul style="list-style-type: none"> <li>○ If expired, SOS letter will not be accepted</li> </ul> </li> </ul>
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*Purpose of Document: certificate of Organization that authorizes company to do business in the state of Indiana.*

## Transfer of Information Policy

Required for all services	<ul style="list-style-type: none"> <li>- Written procedure for the transfer of information to and from each provider listed on the individual/client plan.               <ul style="list-style-type: none"> <li>o Specify the system for internal and external parties on the plan.</li> <li>o Example: printing and hand delivering to the consumer, transferring electronically, faxing, emailing securely, postal mail, etc.</li> </ul> </li> </ul>
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*Purpose of Document: to ensure that information is handled securely.*

## Vehicle Registration, Driver's License, and Insurance Card

TRAN	<ul style="list-style-type: none"> <li>- Official current registration for all vehicles that will be used to transport individuals:               <ul style="list-style-type: none"> <li>o Registration required to be in the name of employee who is involved in the business/agency.</li> <li>o Registration must be completed with State of Indiana.</li> <li>o Expired registration will not be accepted.</li> <li>o Screenshots of BMV website will not be accepted.</li> </ul> </li> <li>- Current driver's license:               <ul style="list-style-type: none"> <li>o Expired driver's license will not be accepted.</li> </ul> </li> <li>- Current insurance card or policy for all vehicles that will be used to transport individuals:               <ul style="list-style-type: none"> <li>o Expired insurance card or policies will not be accepted.</li> </ul> </li> </ul>
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*Purpose of Document: to ensure that the provider has the required certification/documents to be able to provide a service.*

## W-9 Tax Form/EIN Letter

Required for all services	<ul style="list-style-type: none"> <li>- Name on W-9 must match legal business name exactly.</li> <li>- Address on W-9 must match address on application exactly.</li> <li>- Tax classification on application must match W-9.</li> <li>- Must be signed and dated.</li> <li>- Ensure to use current, updated W-9 Form from IRS website.</li> <li>- IRS letter showing the EIN will be accepted if W-9 is not available.</li> </ul>
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*Purpose of Document: to verify the name, address, and tax identification of the business.*

## Warranty Policy

HOM, PERS, PEST, SMES, and VMOD	<ul style="list-style-type: none"> <li>- Coverage for devices/products that are found to be defective or have stopped working satisfactorily because of incorrect or inadequate installation for at least 1 year after the date of installation/receiving the product.</li> </ul>
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*Purpose of Document: to ensure the individuals products are protected.*

## Settings Rule Attestation

\* All providers will be required to answer questions attesting that they understand the settings rule and demonstrating how they will be in compliance. All providers are required to be in compliance with the settings rule.

<p>How will you ensure that the supports you plan to provide will be structured to accommodate each individual's needs?</p> <ul style="list-style-type: none"><li>- Provide examples of age-appropriate activities you will provide</li><li>- Provide examples of how you will provide choice to individual's in deciding daily activities and plans</li></ul>
<p>How will the characteristics of the setting and the support staff ensure that all individuals are able to move freely both within the setting as well as to and from the setting?</p> <ul style="list-style-type: none"><li>- Provide at least two examples of how this will be communicated to the individuals to ensure that they understand their freedom of mobility within and outside of the setting</li></ul>
<p>Will individuals receiving your supports be able to make changes to their DSP's, daily plans, people they interact with, and whether or not they want to participate?</p> <ul style="list-style-type: none"><li>- How will you ensure that the individuals understand the extent of their choice in the aforementioned?</li><li>- How often will these changes be allowed?</li></ul>
<p>Describe how will individual will regularly access the community and will s/he able to describe how s/he accesses the community, who assists in facilitating the activity and where s/he goes?</p> <ul style="list-style-type: none"><li>- List at least two examples of how you would ensure that the individual has regular/frequent access to his/her community</li></ul>
<p>Will the individual choose when and what to eat?</p> <ul style="list-style-type: none"><li>- How will food (meals and snacks) be planned for and prepared in this setting?</li><li>- How much discretion will the individual have in regards to meal/snack planning and preparation?</li></ul>
<p>How do you plan to ensure the individual's right to dignity and privacy respected?</p> <ul style="list-style-type: none"><li>- Will they be able to have privacy for personal care, medical care, etc.?</li><li>- Will they be able to have space for private conversations with visitors/friends and/or phone conversations?</li></ul>

## Site Visits

\*Site visits will be required for Adult Day Service, Adult Family Care, Assisted Living, Structured Day Program, and Supported Employment providers.

\*Please review <https://www.in.gov/fssa/da/projects/home-and-community-based-services-final-rule-statewide-transition-plan/> to ensure compliance.

\*A representative will reach out after your application is submitted to schedule an on-site visit.

## Resources

[Office Of Medicaid Policy and Planning Home- and Community-Based Services Waiver: Indiana PathWays for Aging](#)

[DDRS HCBS Waivers \(Division of Disability and Rehabilitative Services Home- and Community-Based Services Waivers\) \(in.gov\)](#)

[Aging Rule 455 IAC 2](#)

[FSSA: Medicaid Policy: Medicaid HCBS Certification \(in.gov\)](#)

[Provider Certification Portal](#)

## Service Abbreviations

ADS	Adult Day Service
AFC	Adult Family Care
AL	Assisted Living
SCMU	Secure Memory Care Unit
ATTC	Attendant Care
BMAN	Behavior Management/Behavior Program and Counseling
CCBM	Caregiver Coaching and Behavior Management
CMGT	Care Management
HOM	Home Modifications
EXAM SPEC	Home Modification Assessment
IHCC	Integrated Healthcare Coordination
HDM	Home Delivered Meals
HCA	Home and Community Assistance
PERS	Personal Emergency Response System
RBH	Residential Based Habilitation
Respite	Respite Services
SMES	Specialized Medical Equipment and Supplies
SDP	Structured Day Program
SFC	Structured Family Care
SE	Supported Employment
TRAN	Nonmedical Transportation
VMOD	Vehicle Modification

## Additional Guidance

# Process vs Policy vs Procedure



## Process

Process is not only a single task; it is a high-level view of interrelated tasks done to produce a product or a service.

What To Do



## Policy

A particular set of work instructions or business rules that align with the agency's objectives, goals, and management philosophies.

Why Do It



## Procedure

On the flip side of policy, procedures refer to detailed instructions on how to do tasks or perform a sub-process action.

How To Do It

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