**Department of Health Services State of Wisconsin**

Division of Medicaid Services Page 1 of 3

F-20445B (02/2025)

# Home and Community-Based Services (HCBS) Settings Rule Modification Questionnaire – Children’s Long-Term Support (CLTS) Waiver Program

Instructions: The Home and Community-Based Services (HCBS) Settings Rule Modification Questionnaire is applicable to Children’s Long-Term Support (CLTS) Waiver Program participants in a provider-owned or provider-controlled residential setting. When completed this form constitutes documentation in the participant’s individual service plan of the participant’s specific assessed need for modifications to conditions under 42 CFR § 441.301(c)(4)(vi)(A) through (D), as required by [42 CFR § 441.301(c)(4)(vi)(F)](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-441/subpart-G/section-441.301). The participant’s CLTS Waiver Program County Waiver Agency (CWA)/Support and Service Coordinator (SSC) must complete this form with the participant and/or their parent(s) or legal guardian and may collaborate with the residential provider, as needed. The CWA must obtain informed consent to implement the HCBS Settings Rule Modification. If informed consent is not provided, the CWA must discuss potential risk as documented in Section 4, number 1. with the participant and/or their parent(s) or legal guardian and retain this form in participant case notes.

### Section1: Demographics

Name – Participant (Last, First, MI):

Participant Member ID Number:

County Waiver Agency:

Support and Service Coordinator (Last, First):

Date – Need Identified:

Date – HCBS Settings Rule Modification Implemented:

### Section 2: Identify HCBS Settings Rule Modifications

Check each HCBS right that requires a modification based on assessed needs. (Check all that apply.)

Each individual has privacy in their sleeping or living unit:

[ ]  Setting does not utilize electronic monitoring in resident rooms, bathrooms, or other areas where services and supports are provided, or common areas including living and dining areas.

[ ]  Each individual’s bedroom has a lockable entrance door that can be utilized by the individual.

[ ]  Each individual’s bedroom has a key that has been provided to the individual.

[ ]  Setting maintains and implements a list of which staff have access to resident or master keys to the resident’s living and sleeping unit.

[ ]  Individuals sharing their bedroom must have a choice of roommates.

### Section 3: No Harm Assurance

[ ]  The identified HCBS Settings Rule Modification(s) will cause no harm to the participant.

### Section 4: Questionnaire

1. What is the specific and individualized assessed need that warrants the HCBS Settings Rule Modification? Clearly describe the assessed behavior, medical, or other need and indicate that the assessed severity of the need justifies the implementation of the HCBS Settings Rule Modification. Clearly describe potential risks to the participant’s safety and well-being if the HCBS Settings Rule Modification is not implemented.

2. What positive interventions and supports and less intrusive methods were used prior to any HCBS Settings Rule Modification? Include what the positive interventions supports were, how less intrusive methods were tried, a clear timeline of when the positive interventions, supports, and less intrusive methods were in place, and how they were not effective in meeting the need.

3. Provide a clear description of the conditions of the HCBS Settings Rule Modification that is directly proportionate to the specific assessed need. Describe what the HCBS Settings Rule Modification is, how the HCBS Settings Rule Modification will be implemented, and who is responsible for implementing the modification. Ensure the HCBS Settings Rule Modification described in this section aligns with the assessed need identified in Question 1.

4. How will you regularly collect and review data to measure the ongoing effectiveness of the HCBS Settings Rule Modification? Include what data will be collected and who is responsible for collection of the data.

5. What are the established time limits for periodic reviews to determine if the HCBS Settings Rule Modification is still necessary or may be terminated? Include a timeline and plan for reviewing the data to ensure the efficacy of the HCBS Settings Rule Modification.

At minimum, the CWA must discuss and review the effectiveness with the participant and/or their parent(s) or legal guardian annually. Additional discussion and review may be required based on the participant’s unique needs and the reported effectiveness of the HCBS Settings Rule Modification.

### Section 5: Participant Understanding

My signature indicates:

[ ]  My Support and Service Coordinator/CWA and I have discussed what an HCBS Settings Rule Modification is and how it applies to me.

[ ]  My Support and Service Coordinator/CWA and I have discussed and reviewed all the information provided in Section 4 and I understand why it may be required for me to have an HCBS Settings Rule Modification in place.

[ ]  I understand the specific assessed need that warrants the HCBS Settings Rule Modification.

[ ]  I understand the HCBS Settings Rule Modification is required for me to be healthy and safe.

[ ]  I understand that the HCBS Settings Rule Modification will cause me no harm.

### Section 6: Informed Consent and Signature

My signature indicates (check one):

[ ]  I am providing informed consent to implement this HCBS Settings Rule Modification.

[ ]  I am **not** providing consent and understand this HCBS Settings Rule Modification will not be implemented. I understand the potential risk of not implementing this HCBS Settings Rule Modification and have discussed it with my Support and Service Coordinator/CWA.

**Signature** — Participant/Parent/Legal Guardian:

Name — Participant/Parent/Legal Guardian (printed): Date signed:

**Signature** — Support and Service Coordinator:

Name — Support and Service Coordinator (printed): Date signed:

**Distribution:** Original – Support and Service Coordinator/Participant File

Copy – Participant/Parent/Guardian and applicable CLTS Waiver Program Service Provider