DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES

Community First Choice Services Home and Community-Based Services Settings Verification and Attestation Tool

Members who receive Community First Choice Services (CFCS) are required to live in residences that meet the Home and Community-Based Services (HCBS) setting requirements outlined in 42 CFR 441.530. This tool is intended to help members and providers identify the type of setting in which a member lives and to track compliance with the federal regulation. It is required at intake, annually thereafter, and any time there is a change in the member's living situation. A completed copy of this attestation should be kept in the member's file. Providers will fill out the applicable section, either 1, 2 or 3.

Member Name: Date:

Medicaid ID: DOB:

CFCS Provider: Intake ◯ Annual ◯ Change ◯

Section 1: Attestation for Homelessness

Members who attest they are temporarily in a setting that meets the definition of homeless may be eligible to receive CFCS services.

Homeless is defined as: (1) lacking a fixed, regular, and adequate nighttime residence, and/or (2) the primary nighttime residence is: (a) a supervised publicly or privately operated shelter designed to provide temporary living accommodations of three or less months, or (b) a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings (e.g., on the street, in a tent community).

By my signature, I attest I meet the criteria for homelessness as defined above.

Member Signature Date

ONLY FILL OUT SECTON 1 IF THE MEMBER'S LIVING SITUATION IS "HOMELESS"

Section 2: Attestation for Private/Independent Home Setting

An individual's private home (owned or leased), or a relative's home where the individual resides (owned or leased), is considered to be a "Private/Independent Home." Though the Centers for Medicare & Medicaid Services (CMS) allows providers to presume that a "Private/Independent Home" meets HCBS setting requirements, these settings must still be assessed using the Verification and Attestation Tool.

By my signature, I attest that:

1. I live in a "private/independent home" setting as defined above,
2. I have the opportunity for full access to the greater community, AND
3. The residence is not owned or operated by an agency that provides HCBS Services, AND
4. The residence is not located in or on the grounds of a hospital, nursing home, or other facility that provides inpatient institutional care.

Member Signature Date

ONLY FILL OUT SECTION 2 IF THE MEMBER'S LIVING SITUATION IS "PRIVATE/INDEPENDENT HOME"

Section 3: Attestation for Provider-Owned, Controlled, or Operated Residential Setting

A provider-owned, controlled, or operated residential setting is a physical place that is owned, co-owned, and/or operated by a provider of HCBS services. Any residence an individual lives in that is owned by a paid caregiver who is not a family member must be treated as provider owned, controlled, or operated.

By my signature, I attest that:

1. I live in a "provider-owned, controlled, or operated" setting as defined above,
2. I have a legally enforceable agreement, such as a lease or resident agreement, that specifies the responsibilities of the member and the provider, AND
3. The agreement specifies the circumstances under which my residency may be terminated, AND
4. The agreement addresses steps I can take to request a review or appeal the termination of residency, AND
5. The setting allows me full access to the greater community and provides privacy, choice, and control.

Note: If the member cannot attest to ALL the above, the setting does not meet the criteria for CFCS. Please contact the regional program officer.

Member Signature _____ Date _____

ONLY FILL OUT SECTION 3 IF THE MEMBER'S LIVING SITUATION IS "PROVIDER OWNED, CONTROLLED, OR OPERATED"

This attestation was completed as part of the person-centered planning process.

CFCS Provider Signature _____ Date _____