COMPLIANCE ACTION PLAN (CAP)

Provider Agency:	
Point of Contact Name:	
Point of Contact Phone:	
Point of Contact Email:	
Setting Address:	
Setting Type:	
Validation Review Date:	
Provider returned CAP to DDD Date:	
CAP Completion Date:	

Providers – Please identify systems and documentation you will create to address compliance concerns outlined below. You can use the examples in the CAP sample document or identify your own ways to address HCBS settings. Once you have outlined what your organization will do to address compliance concerns, return this CAP with your provider activities to DHS.HCBS@illinois.gov within 14 days of receiving the initial email notification from DDD.

Once the CAP activities are complete and within 60 days, the provider will confirm that they have completed the activities outlined by indicating in the right-hand column they are complete and attesting to completion by signing below. Please email confirmation to DHS.HCBS@illinois.gov. DDD reserves the right to request copies of documents and further evidence of the activities outlined in this CAP. This CAP will be shared with BQM and BALC for use in their future reviews.

If you have questions regarding the process, please email DHS.HCBS@illinois.gov.

Expectation	Compliance issues identified	Actions/activities to achieve compliance	Indicate completion of activities (fill out when CAP activities are complete)
The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including: 1a) Opportunities to seek employment and work in competitive integrated settings	**PROVIDER DOES NOT HAVE TO COMPLETE. DDD IS RESPONSIBLE FOR THIS EXPECTATION.**		
1b) Engage in Community Life			
1c) Control Personal Resources			
1d) Receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.			
2a) The setting is selected by the participant from among setting options including non-disability specific settings and an option for a private unit in a residential setting.	**PROVIDER DOES NOT HAVE TO COMPLETE. DDD IS RESPONSIBLE FOR THIS EXPECTATION.**		

2b) Setting options are based on the individual's needs, preferences	**PROVIDER DOES NOT HAVE TO COMPLETE. DDD IS RESPONSIBLE FOR THIS EXPECTATION.**		
3a) Ensures an individual's rights of privacy			
3b) Ensures an individual's rights of dignity and respect			
3c) Ensures an individual's right of freedom from coercion			
3d) Ensures an individual's right of freedom from restraint			
4a) The setting optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to daily activities			

4b) Optimizes, but does not regiment individual autonomy, and independence in making life choices, including but not limited to physical environment			
4c) Optimizes, but does not regiment individual autonomy, and independence in making life choices, including but not limited to with whom to interact			
5) Facilitates individual choice regarding services and supports, and who provides them			
6a) Individuals have the freedom and support to control their own schedules and activities,			

6b) Individuals have access to food at any time			
7) Individuals are able to have visitors of their choosing at any time.			
8)The Setting is physically accessible to the individual			

FOR RESIDENTIAL SITES ONLY (9-10)

Expectation	Compliance issues identified	Actions/activities to achieve compliance	Indicate completion of activities (fill out when CAP activities are complete)
9) The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the State, county, city,			

or other designated entity. For settings in which landlord tenant laws do not apply, the State must ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS participant, and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law			
10a) Each individual has privacy in their sleeping or living unit.			
10b) Units have entrance doors lockable by the individual, with only APPROPRIATE staff having keys to door			
10c) Individuals sharing units have a choice of roommates in that setting			

10d) Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or agreement			

FOR BOTH CDS AND RESIDENTIAL

Expectation	Compliance issues identified	Actions/activities to achieve compliance	Indicate completion of activities (fill out when CAP activities are complete)
11. Any modification of the additional conditions, under §441.301(c)(4)(vi)(A) through (D), must be supported by a specific assessed need and justified in the person-centered service plan. The following requirements must be documented in the person-centered service plan a) Identify a specific and individualized assessed need. b) Document the positive interventions and supports used prior to any modifications to the person-centered service plan			

c) Document less intrusive methods of meeting the need that have been tried and did not work d) Include a clear description of the condition that is directly proportionate to the specific assessed need e) Include regular collection and review of data to measure the ongoing effectiveness of the modification f) Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated g) Include the informed consent of the individual h) Include an assurance that interventions and supports will cause no harm to the individual			

The provider will return this document within 14 days of receiving the email notification of the need for a CAP for a site. Please email to DHS.HCBS@illinois.gov.

Provider Signature: _____

Date: _____

Once the CAP activities are complete, the provider will confirm within 60 days of sending this Compliance Action Plan back to DDD that they have completed the items outlined above by indicating in the right hand column they are complete and attesting to completion by signing below. Please email confirmation to DHS.HCBS@illinois.gov. Please email confirmation to DHS.HCBS@illinois.gov. DDD reserves the right to request copies of documents and further evidence of the activities outlined in this CAP. This CAP will be shared with BQM and BALC for use in their future reviews.

I certify that the activities listed above are complete and the HCBS settings compliance issues have been addressed.

Provider Signature: _____

Date: _____