**Home and Community Based Services (HCBS)**

**Referral for Review of Setting Form**

Settings presumed to have the qualities of an institution can be identified by, but not limited to individual and/or family members, provider self-assessments, support monitoring, provider reviews, licensure and certification, quality enhancement, and any other state staff. Once a setting is identified, the Referral for Review of Setting form (Form) must be completed by the identifying party and submitted to the local Regional Office Provider Relations Team. If the Individual and/or family members do not wish to complete the Form, they may contact the support coordinator for completion and submission.

Consider making a referral when you feel the setting can be described as:

* The setting is located in or adjacent to a publicly or privately owned facility that provides inpatient treatment.
* The setting is on the grounds of, or immediately adjacent to, a public institution.
* Any other settings that have the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS.

Completed by the Referring Person:

|  |  |
| --- | --- |
| Provider Name: | Date of Referral: |
| Service Address Being Referred: | |
| Reason for Referral: | |
| Person Referring: | |
| Contact Information for Person Referring: | |

**FOR DIVISION USE ONLY**

Demographics completed by Provider Relations and submitted to the Federal Programs Unit for joint decision.

|  |  |  |
| --- | --- | --- |
| Regional Office: | | Date Received: |
| Provider Contracted Name: |  | |
| Service Address Confirmation: |  | |
| DMH Provider #: |  | |
| MHD Provider #: |  | |
| Regional Office Contact:  Name, phone number & email address |  | |

|  |  |  |
| --- | --- | --- |
| Division Review Members: |  |  |
|  | Yes | No |
| 1. The setting is located in or adjacent to a publicly or privately owned facility that provides inpatient treatment. |  |  |
| 1. The setting is on the grounds of, or immediately adjacent to, a public institution. |  |  |
| 1. The setting has the effect of isolating individuals receiving Medicaid-funded HCBS from the broader community of individuals not receiving Medicaid-funded HCBS. |  |  |
| 1. Due to the design or model of service provision in the setting, individuals have limited, if any, opportunities for interaction in and with the broader community, including individuals not receiving Medicaid-funded HCBS. |  |  |
| 1. The setting restricts beneficiary choice to receive services or to engage in activities outside of the setting. |  |  |
| 1. The setting is located separate and apart from the broader community without facilitating beneficiary opportunity to access the broader community and participate in community services, consistent with a beneficiary’s person-centered plan. |  |  |

Date:       Stakeholder Review is not needed as setting does not meet the definition of Heightened Scrutiny.

Date:      Evidence package to be initiated for Stakeholder review.

Comments: