LOUISIANA
DEPARTMENT OF HEALTH
Office for Citizens with Developmental Disabilities

HCBS RIGHTS AND RESPONSIBILITIES

INDIVIDUAL RIGHTS

In Louisiana, all participants in Home and Community Based Services (HCBS) are afforded certain rights as participants in an HCBS program. In certain situations, your rights may be limited due to legal status. You may also choose to give up certain rights in order to receive the support/supervision your needs and in order to continue receiving waiver services. Typically, after accepting HCBS and/or a waiver, the support coordinator will hold a face-to-face meeting and review the participant's rights and responsibilities. Your rights include:

1. To be treated with dignity and respect, free of any abuse, neglect, and/or exploitation on the part of direct service providers, support coordinators, or state personnel, to be informed of what abuse, neglect and exploitation is, and how to report suspected incidents of abuse, neglect, exploitation or other serious incidents, in a way that is understood. Participants also have a right to be educated and empowered so that they can protect themselves from abuse, neglect, and exploitation, including specific strategies in their plans of care if necessary.
2. To report grievances, abuse, or neglect without suffering retribution, retaliation, or discharge.
3. To be free from coercion, restraint (physical and chemical), and seclusion.
4. To make your own decisions about where to live and who to live with.
5. To have freedom of movement within your home and to have access to every space in one's home (with the exception of roommate/housemate bedrooms).
6. To have privacy in your home, including your bedroom and bathroom.
7. To make decisions about who you spends time with and/or communicates with, and to have unrestricted access to a telephone, computer, cell phone or other communication devices, and to have privacy to send/receive unsupervised mail, emails, text messages, and telephone calls
8. To have visitors over to your home when desired, and to have privacy to meet with visitors.
9. To make decisions about daily routine and activities, including when to wake up and when to go to bed, what to eat/drink, what to wear, what activities to participate in, and who to interact with.
10. To have unrestricted access to your personal possessions (including one's food), to keep and use personal possessions as desired, including what to watch/read on television, computer, etc.
11. To make decisions about finances, budgeting and spending money.
12. To have freedom of movement away from one's home and to leave home when desired.
13. To make decisions about who your supporters/caregivers are.
14. To make decisions about having unsupported time, or alone time.

15. To be informed about you rights with regard to the Health Insurance Portability and Accessibility Act (HIPAA) and to be treated with respect and dignity by team members with regard to assurances of privacy of Protected Health Information (PHI) in verbal and written formats.
16. To be informed about your rights (in a way that you understand) pertaining to the Americans with Disabilities Act (ADA), including being free from discrimination in various settings, access to reasonable accommodations (environmental and policy), alternate forms of communication, access to integrated services and settings (i.e., ADA's integration mandate), and grievance procedures.
17. To receive accurate, complete, and timely information which includes a written explanation of the process of evaluation and participation in Home and Community Based Services, including how a person qualifies for it and what to do if they are not satisfied, and to have these things explained to them in a way that is understood so that they can advocate for themselves and make informed decisions.
18. To receive in writing any rules, regulations, or other changes that affect your participation in Home and Community Based Services and to have these things explained to you in a way that is understood so that you can advocate for yourself and make informed decisions.
19. To work with competent, capable people in the service system who are trained in the person-centered planning process and who are knowledgeable about the service delivery system and types of services available to meet the needs of participants. Participants have a right to be educated by knowledgeable professionals so that they can make informed decisions about their own lives.
20. To receive information about support coordinator and direct service provider responsibilities and requirements in providing services to participants and to have these things explained to you in a way that is understood so that you can advocate for yourself and make informed decisions.
21. To participate in and receive person-centered, individualized planning of supports and services, meaning the person is directing the planning process (to the extent possible) and you are empowered to make informed decisions about your services, treatments, providers and all other aspects of your life. This includes deciding time, date and locations of your team meetings.
22. To receive information about all available Medicaid services and how to access them. To receive support to ask your treating providers about your health condition and services/resources that might help the person to advocate for yourself and make informed decisions.
23. To have the Freedom of Choice process explained to you in a way that you understand, and to be given the opportunity to make an informed choice of service/support providers

(when there is a choice available) by being given meaningful and easily understood information about the providers and the supports/services each provides.

24. To have timely access to all approved services identified in the plan of care.
25. To receive services and supports in the most autonomous and integrated way possible, and in the most inclusive setting.
26. To have an interpreter as needed at all meetings.
27. To receive assistance formulating an emergency plan in case of a hurricane or other disaster (weather-related or manmade), and assistance in following that plan if needed.
28. To request a review or revision of his/her plan of care, at any time, when you believe a change is warranted.
29. To change your support coordinator or support coordination agency: Participants may change their support coordination agency after every 6 months **without good cause** or at any time **with good cause**. Good cause involves the support coordinator and/or support coordination agency failing to properly engage in one or more aspects of their job or failing to uphold identified responsibilities. This may include failing to respond to phone call or emails from the participant or other support team members, failing to conduct monthly contacts with the participant/family, failing to respond to and address participant questions or concerns, failing to assist participant/family with understanding participant rights/responsibilities and/or other aspects of the planning process/plan of care, failing to assist the participant/family with finding qualified service providers or other resources, both Medicaid and non-Medicaid, waiver and non-waiver services, which may meet participant support needs, and failing to communicate and/or interact with participant/family in a respectful, courteous way.
30. To receive written notice of the Medicaid appeal and fair hearing process upon signing (and giving written informed consent to) your plan of care, and to have the right of a fair hearing explained to you in a way you understand. You are entitled to a fair hearing when a Medicaid agency denies, reduces, terminates, suspends, or limits authorization of requested services, including the type or level of services, including when you disagree with what is in your plan of care.
31. To contact your Local Governing Entity (LGE) with general questions/concerns about your waiver services and/or contact Medicaid or one's health plan with general questions/concerns about one's Medicaid Healthy Louisiana health plan, including behavioral health services.
32. To file a complaint or grievance with a support coordination agency, a service provider, or the Louisiana Department of Health/Office for Citizens with Developmental Disabilities (LDH/OCDD) regarding services provided, the planning process, the plan of care, mishandling of a concern, or mistreatment of a participant.
33. To file a complaint or grievance with Medicaid, or your Healthy Louisiana health plan regarding coverage, services provided, mishandling of a concern, or mistreatment of a participant.

INDIVIDUAL RESPONSIBILITIES

All HCBS participants, and as applicable, their authorized representatives, legal guardians/parents, and/or supporters identified in the Supported Decision-Making Agreement also have responsibilities which they are expected to uphold. Support coordinator must assist participants with understanding their responsibilities. These include:

1. To actively participate and cooperate in the support planning process and make decisions on supports and services that you believe is needed.
2. To cooperate with your chosen service providers and with delivery of all services and supports that you will be receiving.
3. To obtain assessment information/documentation requested by the support coordinator or a service provider that is required for accessing the services that the participant is requesting (i.e., Bureau of Health Services Financing (BHSF) *Form 90-L Request for Level of Care Determination*, 1508 Evaluation/Update, Individual Education Plan (IEP), etc.)
4. To understand and agree to the risks or consequences if you chooses not to receive particular services or supports identified by the support team as important for optimal outcomes. These are to be distinguished from services which are determined to be required (via objective assessment completed by state agency or health/behavioral health care professional) for reasonable assurances of health and safety
5. To understand that your participation in HCBS waiver services may be compromised if the risk to your health and safety becomes detrimental, if you engages in illegal activity, or if you refuse certain services determined to be required to reasonably assure health and safety. This responsibility involves the participant understanding and agreeing to try particular risk mitigation strategies and/or other compromises in support or service strategies so that health and safety assurances may be reasonably assured.
6. To provide all necessary information about yourself, including identifying natural supports and/or community resources which may meet your needs. This will help the support coordinator and other team members to assist the participant in developing a plan of care and identify both waiver services and supports, and non-waiver services and supports that are needed.
7. To refuse to sign your plan of care, or any other paper that you do not understand or that is not complete. Participants must provide informed consent with regard to the plan of care.
8. To not ask service providers or support coordinators to do things in a way that are against the laws and procedures they are required to follow.

9. To cooperate with the Local Governing Entities (LGE), as well as the support coordinator by allowing them to contact you by phone and make face-to-face visits as required.
10. To let the support coordinator know if there are changes in availability of natural/community supports, including access to new natural/community supports.
11. To immediately notify the LGE, support coordinator and/or service provider (as applicable) if your health, medications, service needs, address, phone number, alternate contact number, or financial situation changes.
12. To report medical visits, emergency room visits, and hospitalizations to your service provider (if applicable) and support coordinator as soon as possible after the event, but within 24 hours, to ensure continuity of care.
13. To understand the definition of a Critical Incident and the HCBS waiver program requirements for reporting them timely to your service provider (if applicable) and support coordinator.
14. To communicate changes in needs/whereabouts when evacuating your home due to an emergency (weather-related or manmade disaster), as well as after the emergency has subsided, so that the support coordinator can report your needs, and/or safety status to the Governor’s Office of Emergency Preparedness.
15. To follow the requirements of the program, and if information is not clear, ask the support coordinator, or service providers to explain it to you.
16. To verify that the participant has received the waiver and medical services you are authorized for and has chosen to receive, and when applicable, to verify that the services received are consistent with what is reported by one’s service provider, including the number of hours the Direct Support Worker (DSW) worked. Participants must report any discrepancies to the support coordinator.
17. To understand as a participant in the waiver program, if a person does not use at least one waiver service for longer than thirty (30) calendar days in the Residential Options Waiver (ROW) or the New Opportunities Waiver (NOW), their waiver case may be closed.
18. To follow the policies and planning expectations as outlined in the Tiered Waiver Process Guidelines.

HCBS RIGHTS AND RESPONSIBILITIES

I have read and understand my rights and responsibilities in applying for / participating in Home and Community-Based Waiver services. I understand my responsibility to cooperate with OCDD in this process. I understand that Waiver Services may be discontinued for me or the person whom I am authorized to represent in this matter. Listed below are ***some*** of the reasons that waiver services ***may*** be discontinued:

- Loss of Medicaid eligibility, per Medicaid;
- Loss of eligibility for an Intermediate Care Facility for Persons with Developmental Disabilities (ICF/DD) level of care;
- Incarceration or placement under the jurisdiction of penal authorities, courts or state juvenile authorities;
- Change of residence to another state;
- Admission to an ICF/DD or nursing facility;
- Health and welfare of the waiver participant cannot be assured in the community;
- Failure to cooperate in either the eligibility determination process, or the initial or annual implementation of the Comprehensive Plan of Care (CPOC); or
- Continuity of service is interrupted.

Applicant/Participant Name **(Please print name)**	
Signature of Applicant/Participant/Authorized Representative **(Signature of parent or guardian if individual is a minor)**	Date:

If this form is sent to you at the time a waiver offer is submitted to you, please complete this page and return this page only to:

Statistical Resources, Inc.
11505 Perkins Rd., Suite H
Baton Rouge, LA 70810
Phone: 1-800-364-7828
Fax: 225-767-0502

NOTE: This form may also be given to you for your signature by your support coordinator or by the Local Governing Entity Waiver Supports and Services Office.