LEVEL 1 – INDIVIDUAL INTERVIEW TOOL

1	What is the individual's ID number from the sample key?				
	Answer Key	**YES**	**NO**	**NOT APPLICABLE** **(NOT IMPORTANT TO OR FOR)**	**ACTION TAKEN** (REQUIRED FOR NEGATIVE OUTCOMES)
2	Are you able to make choices about your life?				
3	Did you participate in developing your person-centered service plan?				
4	Are you receiving services from your provider that are important to or for you?				
5	Are you competitively employed (e.g. same or similar benefits and wage as non-disabled co-workers) in an integrated community job?				
6	Do you get to participate in activities in the community with individuals with and without disabilities (e.g. shopping, religious services, vacations and dating)?				
7	Do you have friends that you spend time with who don't live with you, work with you, or provide you services?				
8	Have you ever been yelled at or treated mean by anyone?				
9	Have you ever been hit or hurt by anyone?				
10	Did you know you can select your day program/ provider/support staff and change them if you want?				
11	If you are not satisfied with services do you know what to do/who to contact? (i.e. who to contact, how to initiate changes/advocate for themselves)?				
12	Do you feel healthy and know what to do or who to talk to if you don't feel well or want to go to the doctor?				
13	Do you have your own bedroom or do you have a roommate? If you have a roommate, did you get to decide who to share your room with?				
14	Are you able to get around your home and go in all the rooms? (If individual answers No, but restrictions are approved and in the plan, this would be marked YES).				
15	Are you able to eat/have a snack whenever you want? (If individual answers No, but restrictions are approved and in the plan, this would be marked YES).				

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The following questions are for CMS data collection only and will come from the records review. Non-compliance in these answers should be reflected as non-compliance in the provider review tool. (Data is being kept per person.)					
	Answer Key	**YES**	**NO**	**N/A**	
16	**Using person centered planning, has the plan been developed based on the results of the assessment as it relates to:** • **Ensure health and welfare,** • **Assist the individual to engage in meaningful activities** • **Support community connections** • **Assist in improving self-advocacy skills** • **Ensure achievement of outcomes** • **Identify risks include supports to prevent or minimize risks** **Are employment services consistent with the individual's identified employment outcome?**				
17	**Does the ISP specify the provider type, frequency, and funding source for each service and activity?**				
18	**Was the service plan reviewed annually?**				
19	**Was the service plan revised based on the changes in the individuals needs/wants?**				
20	**Does the waiver service delivery documentation for all waiver billing codes include scope?**				
21	**Does the waiver service delivery documentation for all waiver codes include the type of service?**				
22	**Does the waiver service delivery documentation for all waiver billing codes include the number of units (amount) provided?**				
23	**Does the waiver service delivery documentation for all waiver billing codes include frequency?**				
24	**Does the waiver service delivery documentation for all waiver billing codes include duration?**				
25	**Did the county board comply with Free Choice of Provider requirements?**				
26	**Was the "Freedom of Choice" form for this individual reviewed on an annual basis?**				

27	**If the individual's assessment indicates that they are unable to self-administer medication, does the service plan address their medication administration needs?**				
28	**If the staff person administers medication does the person have the appropriate certification for:** • **Oral or topical medications (Category 1)** • **G-tube/J-tube (Category 2)** • **Insulin injections (Category 3)**				
29	**Was the individual's PLOC/LOC reviewed at least annually and/or based on changes in the individual's needs?**				