MEDICAID SHARED LIVING PROVIDERS: KEY ROLES AND RESPONSIBILITIES UNDER CFCM

Overview:

This document is a DRAFT and is intended to delineate roles and responsibilities of RIte @ Home Shared Living Providers and other stakeholders (as listed below) under Rhode Island's conflict-free case management (CFCM) initiative. The intended audience for this document is State agency staff, case managers, and RIte @ Home Shared Living Providers. The Rhode Island Executive Office of Health and Human Services (EOHHS) anticipates making further changes to this document based on stakeholder feedback.

This document applies to Medicaid HCBS Participants who are enrolled in the EOHHS Shared Living Program. It does not apply to Participants enrolled in the Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals (BHDDH) Shared Living Program.

Stakeholders included:

1. *Medicaid Shared Living Participant*: The individual eligible for Medicaid Long Term Services and Supports (LTSS) and receiving direct Home and Community-Based Services (HCBS) through the RIte @ Home Shared Living Program according to their person-centered plan.
2. *State agency staff:* State staff under the BHDDH, Department of Human Services (DHS), Office of Healthy Aging (OHA), or EOHHS.
3. *Conflict-free case managers:* Individuals who conduct person-centered planning to support Medicaid HCBS Participants to develop a person-centered plan that will help them gain access to services and supports (paid and unpaid), and helps the Participant to access services and supports to achieve their identified goals, and maintain independence.
4. *Medicaid RIte @ Home Shared Living Providers*: The agency approved by EOHHS to be responsible for the administration of Shared Living Program services, including Caregiver certification, oversight, training, and support of the Caregiver; home safety certification and monitoring to ensure that the Participant is in a safe environment; and clinical assessment, planning and care coordination to ensure that Participants receive appropriate, daily, ongoing personal supports in a safe and home-like setting as specified in the person-centered plan.
5. *Caregiver:* The primary Caregiver for the Participant, responsible for personal care, including assistance with Activities of Daily Living (ADLs), homemaker services, meals, transportation, being on call 24/7, providing socialization, and providing a home-like environment. The Caregiver receives a daily stipend from the RIte @ Home Provider Agency. The Caregiver is not an employee of the RIte @ Home Provider Agency.

Activities included:

1. *Point of entry*: The starting point for the Participant or entity involved in CFCM (new applicant to LTSS).
2. *Functional needs assessment*: The process for completing the state's functional needs assessments which are used for eligibility purposes and ancillary assessments that focus on specific areas of need or potential risks.
3. *Person-centered plan development*: The process of completing the Participant's person-centered plan.
4. *Clinical assessment and plan*: A Licensed Nurse will conduct a clinical assessment and create/manage a clinical nursing plan and medication management plan.
5. *Shared Living home placement:* If a Shared Living Applicant applies *without* a home/Caregiver in mind, a Shared Living Home Placement will be identified for Shared Living Applicants.

6. *Caregiver and home certification and oversight*: The assessment and certification of the home and Caregiver, including initial and ongoing training, coaching, and supervision.
7. *Communication of program information*: Communication of rights and responsibilities as well as roles of the Participant, Caregiver, RIte @ Home Provider, and CFCM.
8. *Connecting to services and supports*: The process of connecting the Medicaid HCBS Participant to services and supports.
9. *Person-centered plan revisions*: The process of updating the Medicaid HCBS Participant's person-centered plan.
10. *Person-centered plan and services implementation plan monitoring and oversight*: The process for monitoring the person-centered plan to ensure that the plan is effectively implemented and adequately addresses the needs of the Medicaid HCBS Participant.
11. *Medicaid eligibility renewal:* The process for conducting state Medicaid eligibility renewals.

Activity	HCBS Applicant/Participant	State Agency Staff	Conflict-Free Case Manager	Shared Living Provider
1. Point of entry and person-centered options couseling (PCOC)	1. Contacts MyOptionsRI, The Point, or any other community partner to learn about their LTSS options within the State, including Shared Living. 2. Participant engages in an interactive decision-support process to receive education about RI LTSS options. 3. If Medicaid LTSS, including Shared Living, is the desired option for the applicant based on their goals, they can apply through DHS via online, mail, or in-person.	1. MyOptionsRI/The Point, Aging and Disability Resource Center (ADRC), DHS or BHDDH provide Person-Centered Options Counseling (PCOC), an interactive decision-support process to receive education about RI LTSS options. 2. Provides application assistance for Medicaid HCBS. 3. Determines Medicaid LTSS eligibility based on financial and clinical eligibility criteria. 4. Explains CFCM to the Participant and support Participant choice. 5. Explains Shared Living Option if that is what the applicant is interested in. 6. Auto assigns the Participant to a CFCM entity if the Participant does not want to choose a CFCM entity.	1. Refers applicants to DHS or BHDDH in the event an applicant first contacts a case manager regarding the application process for Medicaid HCBS. 2. May provide information regarding their services as well as other LTSS options, including Shared Living. 3. Receives an HCBS Participant referral from DHS or a BHDDH social case worker after the HCBS Participant is determined eligible for Medicaid HCBS. 4. Educates HCBS Participant about the shared living service delivery option so they can make an informed choice in choosing traditional, or shared living arrangement for their service delivery. 5. Assesses and document whether the Shared Living Program applicant may be physically aussaltive to self or others and therefore not appropriate for the program. 6. If two LTSS-eligible individuals apply to live together in a shared living home, the HCBS case manager will assess whether the applicants meet the requirements for a two Participant Shared Living Arrangement. 7. Accepts or denies the HCBS Participant referral and notifies the appropriate State agency. 8. If a Shared Living applicant does not have a preferred RIte @ Home Provider Agency,	1. Refers applicants to DHS or BHDDH in the event an applicant first contacts the HCBS provider regarding the application process for Medicaid HCBS. 2. The HCBS provider may provide information to the HCBS Participant regarding the Shared Living option, and their services. 3. Receives and reviews referral requests from the HCBS Participant's case manager. 4. Communicates acceptance or denial of referral requests to the case manager. 5. Follows internal procedure for new enrollments (tours, staff matching, etc.).

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			assign them one in accordance with client choice/appropriateness for the applicant, and contact the provider agency.	
2. Functional needs assessment	1. Coordinates with their case manager or State agency to complete a functional needs assessment.	1. For Elders and Adults with Disabilities (EAD), performs the initial functional needs assessment (InterRAI). 2. For Participants with Intellectual and Developmental Disabilities (I/DD): (1) continues to perform the initial functional needs assessment (SIS-A) and reassessments at five-year intervals; and (2) conducts an additional needs questionnaire and interview every year.	1. During the person-centered planning meeting, analyzes the HCBS Participant's initial functional needs assessment with an in-depth review of all sections and additional supporting information. 2. For EAD, completes an annual reassessment of functional need (InterRAI). 3. Shares the InterRAI functional assessment with the Shared Living Provider.	1. The Licensed Nurse reviews and considers the Participant's functional needs assessment in developing a clinical / nursing plan and a medication management plan.
3. Person-centered plan development	1. Drives the person-centered planning process and conversation to the best of their ability. 2. Chooses who they would like to participate in the planning process and who is invited to the meeting. 3. May request that the RIte @ Home Provider Agency participate in the person-centered planning meeting and process. 4. Communicates their desires, hopes, and dreams for their future, including what is working now in their life, what is not working, and what they would like to see different; this can happen anytime during the year. 5. Signs their person-centered plan.	1. All person-centered plans are subject to review by the State for quality assurance purposes. 2. May attend meeting(s) and/or provide information.	1. Contacts the HCBS Participant no more than three (3) business days after the CFCM entity is notified of a new Medicaid HCBS Participant. 2. Prepares and conducts information gathering: a. Gathers and reviews previous assessments and all other existing information for the HCBS Participant. b. Analyzes the HCBS Participant's initial functional needs assessment with an in-depth review of all sections and additional supporting information. 3. Supports/encourages the Participant to lead/co-facilitate the person-centered planning process. 4. Works with the HCBS Participant to develop their person-centered plan. a. Introduces the applicant to the upcoming process of developing a person-centered plan and explain the different roles of the CFCM, the RIte @ Home Provider Agency, and the Caregiver b. Learns about the HCBS Participant's vision for a good life and life	1. Provides details regarding the services available within their agency. 2. Submits any relevant information to the HCBS Participant's case manager that may support the person-centered planning meeting. 3. Participates in the initial and annual person-centered planning meeting at the request of the HCBS Participant. 4. Works with the case manager to ensure appropriate and necessary services are included in the Participant's person-centered plan. 5. Assists with the establishment of units, start/end dates, etc. for identified services and confirming their accuracy within the person-centered plan. 6. Recommends revisions to the draft person-centered plan (as needed) to the case manager prior to implementation. 7. Signs the person-centered plan.

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			experiences that have/will move them closer to their vision or away from it. c. Educates HCBS Participants on the self-direction service delivery option so they can make an informed choice in choosing traditional, or self-direction service models for their service delivery. d. Assists the HCBS Participant to identify person-centered goals based on identified wants and assessed needs. e. Assists the Participant to build specific and measurable goals and corresponding action steps to achieve goals. f. Assists the Participant to identify services and supports that align with their goals and needs. g. Identifies a course of action to respond to the assessed needs of the HCBS Participant, including a timeline for action steps and who can assist with each action step. h. Identifies how the HCBS Participant wants to be assisted with each action step and who is responsible for each action step. 5. Distributes the person-centered plan to the HCBS Participant, HCBS providers, and any other entity/person that is required to support the HCBS Participant in implementing their plan. 6. Signs the person-centered plan.	8. Coordinates with HCBS Participant and case manager regarding information sharing and logistical planning prior to initiation of direct services.
4. Clinical assessment and plan	N/A	N/A	1. Ensures that person-centered plan supports the clinical and medication management plan.	1. Gathers information about each applicant's clinical needs. A Licensed Nurse will conduct a clinical assessment and create a clinical nursing plan. 2. Contacts applicant's primary care physician (PCP) to gather any appropriate clinical information and needs as well as detailed

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				prescribed and over-the-counter medication needs. 3. Conducts an assessment of the applicant's medical needs, dental and mental health needs, existing health care providers, and clinician visit frequency. 4. Develops an individual nursing plan, including: plans to monitor provider visit schedule; identification of any unmet clinical needs (PCP, specialty provider, dentist, behavioral health, home nursing or therapy needs); identification of and plans for new referrals needed to meet potential unmet needs. 5. Ensures referrals are made, visits are scheduled and responsibility for appointment reminders and transportation to clinician visits is clear. 6. Develops a Medication Management Plan, including detailed medication needs, who will be responsible for refills, safe-keeping, and medication administration.
5. Shared Living home placement **(If Applicant applies *without* a home/Caregiver in mind)**	N/A	N/A	N/A	1. Identifies a potential, appropriate home placement within one month, certifies the home and Caregiver, and offers the placement to the individual. 2. Has a written marketing, recruitment and retention plan that identifies home settings/Caregivers throughout the State. 3. Develops a network of Caregivers adequate to support the needs of Participants eligible for RIte @ Home program services.

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6. Caregiver and home certification and oversight		1. Provides approval status of the Shared Living Program enrollment and placement recommendation. 2. Completes any needed administrative activities and written notifications regarding the approved Participant(s). 3. Communicates the State's decision in writing to the CFCM Agency, the Rite @ Home Provider Agency and the individual Participant(s).	1. Receives documents created and assembled by the Rite @ Home Provider that are needed for EOHHS approval of the Shared Living placement. This will include a written certification recommendation of the Rite @ Home Provider Agency, certifying the Shared Living home as safe and the Caregiver as qualified. The case manager will add the person-centered plan, and provide the documents to EOHHS for review and approval. 2. Obtains EOHHS approval for the Shared Living enrollment, including approval of the person-centered plan, the services implementation plan, and any updates. 3. If EOHHS's decision is to deny Shared Living Program enrollment and placement, offers to assist the individual(s) if they would like to file an appeal.	1. Provides initial and ongoing home safety assessment, certification, and monitoring of the home setting. 2. Determines whether the home is safe and meets the applicant's living requirements. 3. Provides initial and ongoing assessment, and training of the Caregiver. 4. Determines whether the Caregiver is qualified and has the capacity to care for the applicant; if so, certifies the Caregiver. 5. In the case that the Caregiver or home is not able to be certified, the RIte @ Home Provider will inform the HCBS case manager. 6. At the applicant's choice, the RIte @ Home provider will seek an alternative placement offer to the client. 7. Communicates recommendation regarding Shared Living Program enrollment to CFCM. 8. Develops and verifies an emergency back-up plan, with input from the Caregiver, the Participant, the Participant's representative, and the HCBS case manager.
7. Communicate program information	N/A	N/A	1. Serves as the communication liaison between the RIte @ Home provider and EOHHS. 2. Supports RIte @ Home provider by providing consistent information to the Participant about rights and responsibilities, and the role of the CFCM, the Rite @ Home provider, the Caregiver, and the Participant.	1. Reviews and confirms the Participant's understanding as well as inform the Caregiver of the Participant's rights and responsibilities. 2. Reviews and confirms the Participant's and the Caregiver's understanding of the roles and responsibilities of the the RIte @ Home Provider Agency, the CFCM Agency (HCBS case

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				manager), the Caregiver, and the Participant. 3. Obtains signed Participant Agreement.
8. Connecting to services and supports	1. Chooses and selects available services and supports.	1. Processes service authorizations for Medicaid HCBS. 2. Regularly assesses Medicaid HCBS provider capacity as part of the State's quality assurance activities.	1. Works collaboratively in partnership with the RIte @ Home provider to ensure the applicant's successful approval and ongoing participation in the Shared Living Program. 2. If the applicant is accepted by EOHHS as a Participant in the Shared Living Program, and the home Caregiver placement approved, discusses move-in requirements, and move-in date with the RIte @ Home Provider Agency, the Caregiver, and the Participant, and recommends a move-in or service start date. The case manager will make move-in arrangements with the assistance of the RIte @ Home provider, if needed. 3. Accesses community resources and other programs/agencies by: a. Using resources and supports available through natural supports within the Participant's community. b. Developing a thorough understanding of programs and services operated by other local, State, and federal agencies. c. Ensuring these resources are used and making referrals as appropriate. d. Coordinating services between and among the varied agencies so the services funded by agencies complement, but do not duplicate, services funded by the other agencies. 4. During the person-centered planning process, links the HCBS Participant with medical, social, educational, and employment HCBS providers or other programs and services (both formal and informal) capable of providing needed services to address identified needs and	1. Develops a service implementation plan that specifies how authorized services in the person-centered plan will be delivered. 2. Ensures that the Caregiver provides services and supports within the parameters indicated in the person-centered plan. 3. Provides assistance in scheduling healthcare appointments (if the HCBS provider is identified as the responsible party in the HCBS Participant's person-centered plan). 4. Provides ongoing training, coaching, and oversight of the Caregiver. 5. Verifies emergency back-up plan on an ongoing basis. 6. Provide 24/7 on-call emergency availability for Participant or Caregiver. 7. Reports all health and safety critical incidents to the Participant's HCBS case manager and EOHHS within 5 days. 8. Reports(to CFCM): a. Shared Living placement interruption greater than 14 days b. Health and safety critical incidents c. Suspicion of abuse or neglect d. Voluntary or involuntary disenrollment of the

Activity	HCBS Applicant/Participant	State Agency Staff	Conflict-Free Case Manager	Shared Living Provider
			achieve goals specified in the person-centered plan. 5. For Medicaid services (identified in the person-centered plan), submits a service referral. a. Conducts follow-up with HCBS providers if a response has not been received. b. If necessary, obtains additional documentation from the HCBS provider (e.g., the HCBS Participant's assistance plan and resident agreement from an assisted living facility). c. Confirms the HCBS Participant's acceptance of any modifications proposed by the HCBS provider. d. Assists the HCBS Participant in choosing a new HCBS provider for any referrals denied by the HCBS provider or when plan modifications requested by the HCBS provider are denied by the HCBS Participant. 6. For non-Medicaid services or informal networks within the community (identified in the person-centered plan), refers, advocates, and provides application assistance if requested. a. Example of non-Medicaid services includes non-LTSS Medicaid services, (e.g., medical or behavioral health services), social services (e.g., SNAP, LIHEAP, or local food banks) or community organizations and resources (e.g., Special Olympics, NEWSLINE, or local art classes). 7. Confirms connections are made and referrals are completed and followed through on. 8. Coordinates service authorization with HCBS provider(s) and the State. 9. Receives and follows-up on notifications, as follows, from the RIte @ Home	Participant from the Shared Living arrangement e. Any known or suspected misuse or misapplication of restraints or restrictive interventions 9. Documents all complaints, evidence of follow-up, and resolution with applicable dates. 10. Maintains the Services Implementation Plan, makes any needed updates, and shares with the HCBS case manager. 11. See licensing, certification, and/or payment standards for other HCBS provider specific requirements on this topic.

Activity	HCBS Applicant/Participant	State Agency Staff	Conflict-Free Case Manager	Shared Living Provider
			Provider Agency. This includes notifying EOHHS and other parties of: a. Shared living Placement interruption greater than 30 days b. Health and safety critical incidents c. Reports of abuse or neglect d. Voluntary or involuntary disenrollment of the Participant from the Shared Living arrangement	
9. Person-centered plan revisions	1. Requests changes and approves changes to their person-centered plan. 2. Communicates any concerns or feedback with the case manager throughout the year; if disagreements are not resolved, they may request that they are noted on the person-centered plan before signing it.	1. Authorizes any new Medicaid services or reauthorizes changes to existing services.	1. Contacts the HCBS Participant and RIte @ Home Provider within 24 hours upon discovery of an actual or potential significant change of condition. 2. Updates the person-centered plan in response to a major change in the HCBS Participant's health, functional capacity, social or physical environment, formal or informal support system, or if other circumstances require re-evaluation of the person-centered plan. 3. Provides a copy of the current person-centered plan to the RIte @ Home Provider Agency whenever there is a change to the document. 4. If the update to the person-centered plan does not require service authorization, completes person-centered plan updates as soon as possible but no later than five (5) business days of a request or identified need. 5. If the update to the person-centered plan requires a reauthorization or change in authorization of services, updates the written person-centered plan and initiates contact with HCBS providers and other resources as soon as possible, but no later than ten (10) business days of a request or identified need.	1. Communicates with the case manager within 24 hours if the Participant's service needs/preferences may cause the need for changes to the person-centered plan or effect the provision of services. 2. As requested, participates in meetings with the case manager and the HCBS Participant to update their person-centered plan. 3. If the person-centered plan changes, develops specific strategies for implementation, as noted in person-entered plan development section.
10. Person-centered plan and Service Implementation	1. Monitors the delivery of services and notifies their case manager if services are not provided as intended.	1. Regularly tracks CFCM entity performance standards. 2. Adheres to federal reporting requirements and any other	1. For new Medicaid services, contacts the Rite @ Home provider to verify delivery of services in the amount, scope, and duration as identified in the person-centered plan no later than three (3)	1. Ensures ongoing care continuity and coordination: a. conducts a weekly home visit for the first two months of enrollment.

Activity	HCBS Applicant/Participant	State Agency Staff	Conflict-Free Case Manager	Shared Living Provider
Plan monitoring and oversight		licensing or quality assurance reporting standards.	business days after the scheduled service start date. 2. Conducts a monthly non-face-to-face contact with the HCBS Participant or individual representative. As part of the monthly check-in, the case manager is expected to complete a monthly monitoring form included in the State's LTSS case management system. 3. Conducts a face-to-face contact with the HCBS Participant at least once every 6 months. As part of the 6-month contact, the case manager is expected to complete a 6-month monitoring form included in the State's LTSS case management system. 4. Monitors service provision, progress on goals, and the HCBS Participant's satisfaction with their services and HCBS providers. 5. Conducts additional telephonic or face-to-face contacts based on HCBS Participant needs. 6. May assist, when needed, with resolution of concerns with Shared Living provider.	b. conducts monthly home visits for the duration of enrollment. 2. Monitors Caregiver service quality and ensures that Caregiver services are being delivered in accordance with the HCBS Participant's person-centered plan. 3. For new Medicaid services, communicates with the case manager before and after the scheduled service start date. The case manager will contact the Rite @ Home Provider for this discussion.
11. Medicaid eligibility renewal	1. Submits requested documentation to the State to support their Medicaid eligibility renewal.	1. Requests documentation from the Participant to support the Medicaid. eligibility renewal process. 2. Completes Medicaid eligibility renewals and notifies the Participant.	1. If requested by the HCBS Participant, assists in completing any forms required for annual renewal necessary to ensure that there are no service disruptions. 2. If necessary, coordinates with State agency eligibility representatives as well as with HCBS Participants and their families.	1. If requested by the HCBS Participant, assists in completing any forms required for annual renewal necessary to ensure that there are no service disruptions.

Glossary

Term	Definition
Assessment	Process of learning about a person to determine their health or behavioral health status, functional capability, and need for services. For the purposes of CFCM, there are two kinds of assessments: functional needs assessments which are used for eligibility purposes and ancillary assessments which focus on specific areas of need or potential risks. There are two functional needs assessment tools that State staff will complete. The functional needs assessments are required as part of the eligibility process and are used by the LTSS agencies to determine the scope, amount, and duration of Medicaid HCBS required to meet a Participant's needs. This varies by population. 1. For elders and adults with disabilities (EAD): InterRAI for Home Care 2. For intellectual and developmental disabilities (I/DD): SIS-A
Conflict-Free Case Management (CFCM)	CFCM means that the entity assisting a Participant to gain access to services should be different than the entity providing those services (e.g., an HCBS provider agency), as a potential conflict may exist if the same entity is providing both case management and the referred service(s). CFCM is the Center for Medicare or Medicaid Services' (CMS) concept to prevent HCBS Participants from being taken advantage of or being prevented from having access to the services they need. CFCM is a service system that includes four core components, each of which encompasses a discrete set of tasks that are specifically designed to help HCBS Participants access the services they need and want. The core components of the CFCM service system include: 1. *Information Gathering:* A comprehensive review of a HCBS Participant's goals, needs, and preferences. 2. *Person-Centered Plan Development*: A written person-centered plan that articulates a HCBS Participant's care needs, wants, and supports (paid and unpaid) that will assist a Participant to achieve their goals. 3. *Connecting to Services & Supports:* Connect the HCBS Participant to paid and unpaid supports. 4. *Plan Monitoring & Follow-up:* Regular contact to review goal progress and effectiveness of services.
Home and Community-Based Services (HCBS)	Types of person-centered care delivered in home and community settings HCBS programs address the needs of people with functional limitations who need assistance to perform activities of daily living (ADLs) and instrumental activities of daily living (IADLs). HCBS are often designed to enable people to stay in their homes and the community, rather than moving to a facility for care.
HCBS Participant	A person who is Medicaid LTSS eligible and receives Medicaid HCBS according to their person-centered plan.
Shared Living Provider	The agency approved by EOHHS to be responsible for the administration of Shared Living Program services, including Caregiver certification, oversight, training, and support of the Caregiver; home safety certification and monitoring to ensure that the Participant is in a safe environment; and clinical assessment, planning and care coordination to ensure that Participants receive appropriate, daily, ongoing personal supports in a safe and home-like setting as specified in the person-centered plan.
Caregiver	The primary Caregiver for the Participant, responsible for personal care, including assistance with ADLs, homemaker services, meals, transportation, being on call 24/7, providing socialization, and providing a home-like environment. The Caregiver receives a daily stipend from the RIte @ Home Provider Agency. The Caregiver is not an employee of the RIte @ Home Provider Agency.
Long-Term Services and Supports (LTSS)	LTSS encompass the broad range of paid and unpaid medical and personal care services that assist with activities of daily living (such as eating, bathing, and dressing) and instrumental activities of daily living (such as preparing meals, managing medication, and housekeeping). They are provided to people who need such services because of aging, chronic illness, or disability, and include nursing facility care, adult daycare programs, home health aide services, personal care services, transportation, and supported employment. These services may be provided over a period of several weeks, months, or years, depending on a HCBS Participant's health care coverage and level of need.
Medicaid LTSS Coverage	Medicaid is a state and federal health insurance program that assists families or HCBS Participants in paying for LTSS and medical care. Medicaid LTSS coverage includes a broad spectrum of services for HCBS Participants with clinical and functional impairments and/or chronic illness or diseases that require the level of care typically provided in a healthcare institution (e.g., hospital or nursing facility). In Rhode Island, Medicaid LTSS covers:

Term	Definition
	1. Skilled or custodial nursing facility/intermediate care facilities for HCBS Participants with intellectual and developmental disabilities (ICF-IDD), community-based supportive alternatives, therapeutic, rehabilitative, and habilitative services, and personal care as well as various home and community-based supports. 2. Primary care essential benefits for acute care services with Medicaid as the payer of last resort if a HCBS Participant also has Medicare or commercial coverage for these services.
Person-Centered Options Counseling (PCOC)	An interactive decision-support process whereby HCBS Participants, with support from family members, Caregivers, and/or others, are supported in their deliberations to make informed long-term services and support choices in the context of the HCBS Participant's preferences, strengths, needs, values, and personal circumstance.
Person-Centered Planning (PCP)	A process for selecting and organizing the services and supports that an older adult or person with a disability may need to live in a home or community-based setting. Most importantly, it is a process that is directed by the HCBS Participant who receives the support. This process is more of a conversation and includes a review of any functional needs assessments that have been completed as well as a discussion of what is important to the HCBS Participant.
Shared Living Program (RIte @ Home)	Provides a home-like setting for individuals who choose not to live alone, and who want to continue to live in the community as long as possible, but need a considerable amount of assistance to support the individual in performing ADL. The RIte @ Home Shared Living Program is an alternative to institutional care.