



Alta California Regional Center Program Design Template for Residential Services

Requirements:

- Program Design is to be no more than 50 pages.
- Program design is to be typewritten.
- Pages of the program design are to be numbered in sequential order.
- All pages are required to have a footer or header of the facility's name and address.
- The licensee is responsible for all content of the program design; the program design shall be composed by the licensee.
- Meet requirements set forth in Title 17 Sect 56013.
- Meet the principles of normalization as measured by resident participation in a variety of integrated, age appropriate activities which take place in natural environments, at home, at work, in the community, and during leisure time.
- The Residential Service Provider (RSP) is required to have full knowledge of California Code of Regulations Title 17, Title 22, Code of Federal Regulations 441.301 (HCBS Final Rules), Person Centered Planning and Alta California Regional Center Policies and Procedures (presented at Vendor Orientation).

Definitions:

- Program Design means the description of consumer services offered by a facility, the functional characteristics of the consumers the facility will serve, and the resources available to meet individual service needs consistent with the facility's service level. Title 17 Section 56002(a)(30).
- Normalization means life conditions which enable consumers to lead more independent, productive and normal lives which approximate the pattern of daily living of non-disabled persons of the same age and reflect personal choice. Title 17 Section 56002(a)(27).

Name of Facility

Type of facility

Service Level

Address

Label Facility Telephone Number

Label Cell Phone Number

Administrator Name

Email Address

Instruction: Copy/paste the following into your program design and update page numbers.

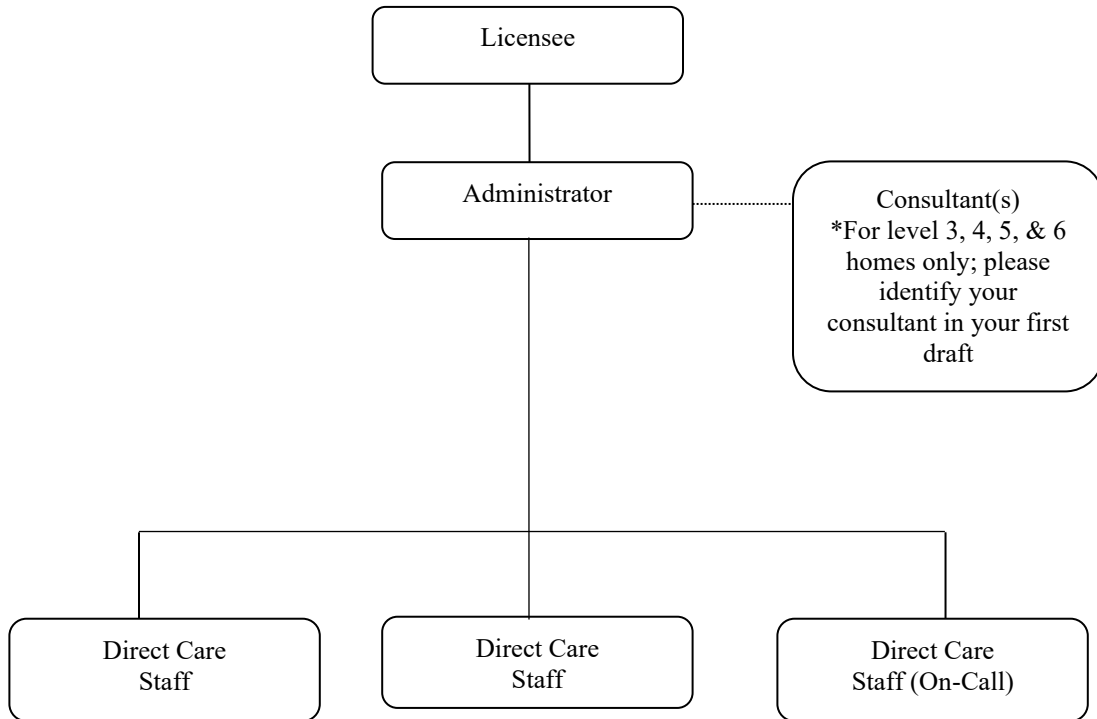
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Instruction: copy/paste the following format into your program design and update information:

ORGANIZATIONAL STRUCTURE

Name of Facility
Address
Telephone Number



Providers initials: _____

By initialing here, I understand what is expected and what is outlined in Title 17. I agree to not make any changes to the organizational chart without prior authorization from ACRC CSS.

STATEMENT OF PURPOSE

The section below may not go beyond 1 page in length

Instruction: Copy/paste the following into your program design, then answer the following information using the format shown:

- Name of facility: _____
- Address of the facility (including County): _____
- Type of facility (i.e. small family home, adult residential facility, elderly facility) : _____
- Service level: _____
- Staff operated or owner operated:
 - ☐ Staff-operated: licensee does not live in the care home
 - ☐ Owner-operated: licensee lives in the care home
- Capacity: _____
- Number of single bedrooms: _____
- Number of ambulatory _____
- Number of non-ambulatory beds: _____
- Age: _____
- Gender: _____
- Medical conditions (general and/or restricted health conditions): _____
- Mental health conditions (including psychiatric diagnosis): _____
- Behavior excesses: _____
- Developmental disabilities:
 - ☐ Cerebral Palsy
 - ☐ Intellectual disability
 - ☐ Autism
 - ☐ Epilepsy
 - ☐ 5th category: Other substantially disabling conditions closely related to intellectual disability or which require treatment similar to the treatment required by persons with intellectual disability may be eligible for service

Instruction: Write a narrative describing the approach or philosophy utilized in providing care (4 sentences max).

RESIDENT SERVICES

****The section below must use the format as shown****

Instruction: Copy/paste the following checklist using the format shown in your program design, then check the boxes for the training the home will provide.

Categories of Function

Training in Personal Hygiene

- ☐ Hand washing
- ☐ Grooming (hair care)
- ☐ Teeth brushing
- ☐ Shaving
- ☐ Using deodorant
- ☐ Bathing (use of soap, washcloth, & towel, etc.)
- ☐ Feminine hygiene (menses)
- ☐ Male hygiene (Ex: beard care)
- ☐ Other (Please specify)

Training in Dressing Skills

- ☐ Dressing completely & independently
- ☐ Dressing appropriately for specific seasons and events
- ☐ Age appropriate dressing
- ☐ Clothes selecting & matching
- ☐ Other (Please specify)

Sensory/Motor Skills Development

- ☐ Positioning
- ☐ Eye/hand coordination
- ☐ Aerobics
- ☐ Ambulation
- ☐ Range of motion
- ☐ Other (Please specify)

Toileting Training

- ☐ Bowel and bladder training
- ☐ Washing hands after toileting
- ☐ Independent toileting
- ☐ Other (Please specify)

Appropriate Eating Skills

- ☐ Using appropriate utensils
- ☐ Table manners
- ☐ Appropriate social and behavior during meal time
- ☐ Other (Please specify)

Communication Skills Training

- ☐ Appropriate communications with others (including voice level, personal space issues)
- ☐ Sign Language (must be fluent)
- ☐ Communication boards and other adaptive equipment
- ☐ Use of more complex words and sentences
- ☐ Other (Please specify)

Recreation & Leisure Skills Development

- ☐ Learning a sport, game
- ☐ Learning a hobby
- ☐ Use of leisure time
- ☐ Assisting in planning monthly activities
- ☐ Other (Please specify)

Community Integration

- ☐ Beauty/barbershop
- ☐ Shopping (clothes, food)
- ☐ Church
- ☐ Library
- ☐ Cultural events
- ☐ Movies
- ☐ Sporting events
- ☐ Community centers
- ☐ Other (Please specify)

Social Skills Development

- ☐ Facilitating & maintaining friendships
- ☐ Initiating interpersonal relationships
- ☐ Participating in social activities
- ☐ Other (Please specify)

Training in Independent Living

- ☐ Household chores & maintenance (Includes yard work, vacuuming, sweeping, taking out the garbage, pet care, setting the table at meal times)
- ☐ Bed making
- ☐ Self-medication
- ☐ Basic medical self-help awareness
- ☐ Dish washing and drying (includes learning to use dishwasher)
- ☐ Food preparation (includes meal planning, preparation of simple foods and preparing complete meals)
- ☐ Reading skills development
- ☐ Writing skills development
- ☐ Use of telephone (includes appropriate use of 911)

Training in Independent Living – Continued

- ☐ Training in the use of appliances (includes electric and gas stoves, microwaves, blenders, etc.)
- ☐ Safety awareness (including when accessing the community independently)
- ☐ Money management (includes coin & money recognition)
- ☐ Use of public transportation
- ☐ Recognition & independent movement in various geographical locations (include learning own address and telephone number)
- ☐ Time telling
- ☐ Making appointments
- ☐ Problem solving
- ☐ Ordering food in public (includes reading menus)
- ☐ Other (Please specify)

PROVISION OF SERVICES

Title 17, Section 56013(c)

This section below must not go beyond 2 pages in length

This section is only for Level 3 homes – Instruction: Copy/paste the following format in your program design, then address each bullet point in your own words. Each bullet may be up to 2 sentences max. Level 4-6 homes, skip this section.

1. Training in Personal Hygiene

- Describe the evidence-based practices you will provide that will enhance the capabilities of residents with *significant* self- help skills, *some limitations* in physical coordination, and/or *disruptive* and/or self- injurious behaviors
- Describe your reporting on progress of IPP objectives - identify *who* provides the reports to ACRC and *what* reports are provided and *when*

2. Training in Dressing Skills

- Describe the evidence-based practices you will provide that will enhance the capabilities of residents with *significant* self- help skills, *some limitations* in physical coordination, and/or *disruptive* and/or self- injurious behaviors
- Describe your reporting on progress of IPP objectives - identify *who* provides the reports to ACRC and *what* reports are provided and *when*

3. Sensory/Motor Skills Development

- Describe the evidence-based you will provide that will enhance the capabilities of residents with *significant* self-

- help skills, *some limitations* in physical coordination, and/or *disruptive* and/or self- injurious behaviors
- Describe your reporting on progress of IPP objectives - identify *who* provides the reports to ACRC and *what* reports are provided and *when*

4. Toileting Training

- Describe the evidence-based you will provide that will enhance the capabilities of residents with *significant* self-help skills, *some limitations* in physical coordination, and/or *disruptive* and/or self- injurious behaviors
- Describe your reporting on progress of IPP objectives - identify *who* provides the reports to ACRC and *what* reports are provided and *when*

5. Appropriate Eating Skills

- Describe the evidence-based you will provide that will enhance the capabilities of residents with *significant* self-help skills, *some limitations* in physical coordination, and/or *disruptive* and/or self- injurious behaviors
- Describe your reporting on progress of IPP objectives - identify *who* provides the reports to ACRC and *what* reports are provided and *when*

6. Communication Skills Training

- Describe the evidence-based you will provide that will enhance the capabilities of residents with *significant* self-help skills, *some limitations* in physical coordination, and/or *disruptive* and/or self- injurious behaviors
- Describe your reporting on progress of IPP objectives - identify *who* provides the reports to ACRC and *what* reports are provided and *when*

7. Training in Independent Living

- Describe the evidence-based you will provide that will enhance the capabilities of residents with *significant* self-help skills, *some limitations* in physical coordination, and/or *disruptive* and/or self- injurious behaviors
- Describe your reporting on progress of IPP objectives - identify *who* provides the reports to ACRC and *what* reports are provided and *when*

8. Social Skills Development

- Describe the evidence-based you will provide that will enhance the capabilities of residents with *significant* self-help skills, *some limitations* in physical coordination, and/or *disruptive* and/or self- injurious behaviors
- Describe your reporting on progress of IPP objectives - identify *who* provides the reports to ACRC and *what* reports are provided and *when*

9. Recreation & Leisure Skills Development

- Describe the evidence-based you will provide that will enhance the capabilities of residents with *significant* self-help skills, *some limitations* in physical coordination, and/or *disruptive* and/or self- injurious behaviors
- Describe your reporting on progress of IPP objectives - identify *who* provides the reports to ACRC and *what* reports are provided and *when*

10. Community Integration

- Describe the evidence-based you will provide that will enhance the capabilities of residents with *significant* self-help skills, *some limitations* in physical coordination, and/or *disruptive* and/or self- injurious behaviors
- Describe your reporting on progress of IPP objectives - identify *who* provides the reports to ACRC and *what* reports are provided and *when*

11. Behavior Management

- Describe the evidence-based you will provide that will enhance the capabilities of residents with *significant* self-help skills, *some limitations* in physical coordination, and/or *disruptive* and/or self-injurious behaviors
 - Describe your reporting on progress of IPP objectives - identify *who* provides the reports to ACRC and *what* reports are provided and *when*
-

CONSULTATION SERVICES

The section below must use the format as shown

For level 3-6 homes if contracting with other types of consultation, other than behavior consultation – Instructions: Copy/paste the following format in your program design then address the bullet points. If you have contracted with only a behavior consultant, disregard this section and move on to the next section.

- Type of consultation: _____
- What are the benefits of this type of consultation:
 - 1.
 - 2.
 - 3.
- Minimum Number of Hours: _____

Training on Evidence Based Practices

Instructions: Copy/paste the following format in your program design then address the bullet points.

- Who will be providing the training: _____
- Title and citation for training to be provided to staff: _____
- Number of hours of training that will be provided: _____
- Frequency of refresher training: _____
- Describe how and when emergency services will be accessed during crisis situations: _____
 -
 -
 -

Providers initials: _____

By initialing here, I understand what is expected and will follow the above expectations.

Instructions: copy/paste the following information using the format as shown then utilize Title 17 Sections 56040, 54319, 54342 to develop the list.

Consultant Job Duties (other than behavior consultant, name the type)

-
-
-

Consultant Job Qualifications (other than behavior consultant, name the type)

-
-

Provider Initials: _____

By initialing here, I understand what is expected and what is outlined in Title 17 as well as ACRC expectations outlined in Vendor Orientation and will follow the above expectations.

CONSULTANT VERIFICATION

For level 3-6 homes if contracting with other types of consultation, other than behavior consultation – Instructions: In this section, provide a copy of the consultant’s resume, license and service agreement/contract with the home.

Resume – Max of 1 page

License – Max of 1 page

Service Agreement/Contract – Max of 3 pages

CONSULTATION EXPECTATIONS

The section below must use the format as shown

Instructions: Levels 3-6: Copy/paste the following format in your program design then address the bullet points.

- ☐ I understand that all consultation hours must be direct services to the individual client and are completed in-person only.
- ☐ For behavioral consultation, I understand that if the behavior consultant is not a Behavior Analyst or Behavior Management Consultant, 10% of their hours over the course of 6 months will be supervised by a Behavior Analyst or Behavior Management Consultant.
- ☐ I understand that if supervision occurs via tele-supervision/supervision is not conducted in-person, the Administrator is responsible for maintaining electronic documentation supporting each instance of tele-supervision consultation.
- ☐ I understand that documentation must clearly identify the date, time, client, consultant, individuals participating, and general meeting information. Types of electronic verifications can include:
 - Follow-up email – An email sent immediately following the session, from supervising BCBA, confirming that the consultation occurred and identifying the date, time, client, participants, and general purpose of the consultation.
 - Electronic case note – A case note entered into the provider's electronic record system, with an electronic signature/attestation and sufficient details to verify the session.
 - Consultation notes that document the supervision/consultation and include the BCBA’s physical signature.
 - Electronic calendar/meeting record: A calendar invitation or completed meeting record showing the date, time, participants, and duration of the tele-meeting.
 - Telehealth platform attendance record: Zoom, Microsoft Teams, Google Meet, or another platform-generated attendance/participant report showing who attended and the meeting date, time, and duration.
 - Electronic meeting confirmation: A system-generated confirmation or meeting summary that identifies the participants and duration.
 - Electronic signature platform: A consultation note or supervision form signed electronically, to include time stamp, by both the consultant and provider.
 - Electronic service/consultation log: An electronic log documenting the date, start/end time, client, consultant, participants, and purpose of the consultation, with an electronic attestation by the consultant.
- ☐ I understand that documentation is maintained and readily available for Regional Center review

in client binders. Documentation must be sufficient to establish that the reported supervision or consultation hours occurred as billed or reported.

Providers initials: _____

By initialing here, I understand what is expected and will follow the above expectations.

BEHAVIOR INTERVENTION

The section below must use the format as shown

Instructions: This section is required for all Level 4, 5, & 6 homes.

Level 3 homes: Complete this section only if you have contracted with a behavior consultant.

1. Narrative description:

Instructions: Copy/paste the information and format shown below and address each prompt:

- a) ☐ I understand and agree that this home will use evidence based and least restrictive interventions.
- b) Describe services designed to enhance the skills of residents with behavior excesses, severe deficits in self-help skills, and/or severe impairment in physical coordination and mobility:
 - a.
 - b.
 - c.
- c) Describe the methods of completing functional behavior assessment (FBA) and data collection during FBA process and following the completion of FBA:
 - a.
 - b.
 - c.
- d) Describe the instructional methods and techniques (evidence based practices) to be utilized within the home that are evidence based and least restrictive:
 - a.
 - b.
 - c.
- e) Your methodology for measurement of resident progress toward achievement of identified goals and objectives. Please include:
 - a. Describe types of data to be collected (e.g., paper data collection, excel, electronic, etc.):
 - i.
 - ii.
 - iii.
 - b. Describe data collection systems (e.g., frequency, duration):
 - i.
 - ii.
 - iii.
 - c. Identify how often you will be recording data: _____

d. Identify how often the Administrator will review data tracking for accuracy and efficacy:

e. Method for summarizing data and reporting progress:

- i. ☐ I understand and agree the consultant must complete quarterly reports.
- ii. ☐ I understand and agree the Administrator will complete quarterly progress reports using the ACRC reporting document.
- iii. ☐ I understand and agree the Administrator will submit the progress reports to the Service Coordinator quarterly.

f. Staff participation and training

- i. ☐ I understand and agree the staff will be trained on the Behavior Intervention Plan during their on-site orientation, if they are new hires.
- ii. ☐ I understand and agree the staff will receive training on how to best support the client and how to track baseline and ongoing data within the first 30 days of the client's admission into the home.
- iii. ☐ I understand and agree the staff will receive training on the Behavior Intervention Plan within 90 days of the client's admission into the home.
- iv. ☐ I understand and agree the staff will receive a refresher training at least annually and when/if the Behavior Intervention Plan changes.
- v. ☐ I understand and agree the staff will receive training on a client's Individual Emergency Intervention Plan and the home's Emergency Intervention during their on-site orientation, if they are new hires.
- vi. ☐ I understand and agree the staff will receive training on a client's Emergency Intervention Plan within 30 days of the client's admission into the home.

Providers initials: _____

By initialing here, I understand what is expected and will follow the above expectations.

2. Training and Data Tracking Systems

Instructions: In this section provide two examples of the training and data tracking systems for two skills of your choice from the skill categories above. Please ensure the samples meet Title 17 Section 56013(d) requirement. Each sample must not exceed one page in length.

3. Behavior Intervention Plan:

Instructions: Do not provide a sample BIP. Copy/paste the information and format shown below and address each prompt:

- ☐ I understand and agree that each client receiving behavior consultation will have a Behavior Intervention Plan (BIP) developed by the home's contracted Behavior Consultant.
- ☐ I understand and agree that each BIP will be developed within 60 days of a client's admission into the home.
- ☐ I understand and agree that each BIP will be updated as needed.
- ☐ I understand and agree that each BIP will include at minimum the following information:
 - Client name, age, DOB, Service Coordinator
 - Name of consultant

- Name of residential provider
- Client's background information:
 - Pertinent medical and diagnostic information
 - Other information effective service delivery
 - Other services received
- Functional Assessment Information
 - Description of assessment procedure including name of any assessment tools utilized and a brief description of each
 - Summary of baseline data collection (individuals interviewed, pertinent historical information, type of data collection and dates of baseline data collection phase)
- Operational Definition(s) of Target Behavior(s)
 - Behavior is named and described in specific, observable and measurable language
- Baseline Rates of Behavior(s)
 - Rate/Frequency of behavior prior to intervention plan implementation
- Environmental Antecedents & Setting Events
 - Description of what occurs both immediately before the behavior occurs
 - Description of other factors reliably occasion behavior such as lack of sleep etc. (separate by function and possibly topography when appropriate)
- Behavioral Antecedents
 - Behavior client demonstrates prior to behavior excess. Example: "Johnny yells prior to hitting" (separate by function and possibly topography when appropriate)
- Past Consequences (separate by function and possibly topography when appropriate)
- Hypothesized Function(s) of Behavior(s)
 - Description of why the behavior occurs/what does the client appear to be trying to get from engaging in the behavior
- Functionally Equivalent Alternative Responses or Replacement Skill(s)
 - Replacement skill that is a more appropriate way of meeting the client's need/want
- Related Skills to Teach
 - Skills that will aide in the client's success over time such as waiting, coping etc. (separate by function and possibly topography when appropriate)
- Preventions listed/described
 - Description of what will be changed to prevent future occurrences of the target behavior (separate by function and possibly topography when appropriate)
- Description of Differential Reinforcement Procedure(s) (separate by function and possibly topography when appropriate)
 - 1) Behavior(s) to be reinforced
 - 2) Reinforcement procedure & schedule
 - 3) Schedule or frequency of teaching alternative response(s)
- Plan to Thin Reinforcement
 - Description of how the client will move to a level/amount of reinforcement that would be obtained in the natural environment
 - 1) Current reinforcement schedule
 - 2) Date implemented
 - 3) Date reinforcement schedule discontinued
 - 4) Proposed next reinforcement schedule(s) 5) Criterion to move to next schedule
- Procedures/Consequences for Target Behavior(s)

- Description of how staff/parent will respond to the client when the behavior occurs (separate by function and possibly topography when appropriate)
- Data Collection Method
 - Description of what type of data will be collected ongoing to assess for progress (for challenging behavior as well as replacement skills)
- Graph of Data Over Time
 - Visual representation of the change in behavior over time (for challenging behavior as well as replacement skills)
- Client Goals & Objectives
 - 1) Reduction goal for each target behavior
 - 2) Acquisition goal for each replacement and related skill to teach
 - 3) Current rates for both replacement skills as well as target behaviors
 - 4) Plans for generalization & maintenance
- Barriers to Progress
- Transition Plan
 - 1) Criteria to be met in order to transition to less restrictive service (e.g., discontinuing or reducing supplemental staffing support, level 6 to 3, behavior management to community-based day program) and/or exit the program
- Brief Summary and Recommendations
- Consultant/Author Signature
- Contact information (email and/or phone number) of the author of report
- Optional:
 - Descriptions of resources and special materials used
 - Description of teaching/training plans utilized
 - Other qualitative or anecdotal stories

☐ I understand and agree that the BIP narrative is written behaviorally and objectively.

☐ I understand and agree the BIP will have a summary of data included (% of goals met, % not met etc.).

☐ I understand and agree the BIP narrative content supports and logically leads up to the approaches/methods recommended.

☐ I understand and agree that the BIP will demonstrate progress made over time in order to show program effectiveness.

☐ I understand and agree the BIP will act as a guide for planning team meeting discussion.

☐ I understand and agree that the intervention must conform to all local, state and federal statutes.

☐ I understand and agree the intervention must conform to the policies and codes of ethical conduct of relevant professional organizations, including a review and approval of any Behavior Modification Procedure that may cause pain or trauma or result in the restriction of any client's rights.

☐ I understand and agree the behavior consultant/analyst

(a) Designs programs that are based on behavior analytic principles, including assessments of effects of other intervention methods

(b) Involves the client or the client-surrogate in the planning of such programs

(c) Obtains the consent of the client

(d) Respects the right of the client to terminate services at any time.

Providers initials: _____

By initialing here, I understand what is expected and will follow the above expectations.

4. Crisis Intervention Training (Levels 4, 5 & 6) - WIC 4511(a)(b)(d)

Instruction: *Prior to developing the program design, choose one of the following for both admin and all direct care staff. ACRC strongly recommends that the home's Administrator be the certified trainer.*

- Pro-ACT: <https://proacttraining.com/>
- Nonviolent Crisis Intervention Training: <https://www.crisisprevention.com/>
- Ukeru: <https://www.ukerusystems.com/>
- If you are interested in another crisis intervention training agency not listed here connect with your CSS to have the curriculum reviewed before authorization to use.

Instruction: *Copy/paste the information and format shown below and address each bullet point. ACRC strongly recommends that the home's Administrator be the certified trainer.*

- Name of the crisis intervention training this home will utilize: _____
- Name and title of the certified trainer for this home: _____
- ☐ I understand and agree that the Administrator must be trained by a certified trainer prior to first day of employment.
- ☐ I understand and agree that all direct care staff and Admin shall receive training from the same crisis intervention organization.
- ☐ I understand and agree that all direct care staff shall complete crisis intervention training within 30 days of their hire date.
- ☐ I understand and agree that all direct care staff shall receive an annual refresher.
- ☐ I understand and agree that the training shall be provided by an individual holding a valid instructor certificate from a program for preventing and safely managing dangerous behavior.
- ☐ I understand and agree that the licensee shall maintain a copy of the trainer's certificate and make it available for review, inspection, audit and copy, upon request, by the Department.
- ☐ I understand and agree that the licensee shall maintain a written record of the staff training which includes: dates, hours, and description of the training completed, including name of the instructor and organization providing the training, as well as written verification from the instructor that the staff member has successfully completed the required training and passed the competency test(s).
- ☐ I understand and agree that this home will utilize the documentation provided by the crisis intervention training organization to support training that occurred per the training certification requirements.
- ☐ I understand and agree that in a direct care staff's first year of employment, their crisis intervention training may be counted for up to 12 CEUs depending on how long certification training is (1 hour = 1 CEU)
- ☐ I understand and agree that as a level 4, 5, or 6 this home will be accepting resident with
 - Severe deficits in self-help skills; and/or
 - Severe impairment in physical coordination and mobility; and/or
 - Severely disruptive or self-injurious behavior

Providers initials: _____

By initialing here, I understand what is expected and what is outlined in Title 22 and will follow the above expectations.

5. Restraints

Title 22 Section 85100

Instruction: Copy/paste the information and format shown below and address each bullet point:

This home will be trained in manual restraints: Yes ☐ No ☐

If yes:

- ☐ I understand and agree that ACRC prohibits the use of mechanical restraints, chemical restraints and seclusion.
- ☐ I understand and agree that the use of restraints can cause pain or trauma. Any Behavior Modification Procedures That May Cause Pain or Trauma must be reviewed and approved through ACRC's Behavior Modification Review Committee process prior to implementation.
- ☐ I understand and agree that the admin and direct care staff shall be trained in the manual restraint technique utilized in the home.
- ☐ I understand and agree that all direct care staff and any other person in their direct management chain, up through and including the licensee, shall be trained in the facility Emergency Intervention Plan and on each resident's Individual Emergency Intervention Plan.
- ☐ I understand and agree that the admin and direct care staff shall only use techniques specified in the Emergency Intervention Plan and which are not prohibited in Title 22 Section 85102.
- ☐ I understand and agree that training for manual restraint shall have a written competency test and a hands-on competency test administered by a certified trainer. The certified trainer shall be present for the hands-on competency test.
- ☐ I understand and agree that the admin and direct care staff shall have a minimum of 16 hours of emergency intervention training and be certified for having successfully completed the training
- ☐ I understand and agree that the admin and direct care staff shall maintain valid certification
- ☐ I understand and agree that the admin and direct care staff shall have a minimum of 6 hours of annual refresher training following the initial training certification. The provisions specified in Section 85165(c)-(e)(g) shall also apply to this training.

Providers initials: _____

By initialing here, I understand what is expected and what is outlined in Title 22 and will follow the above expectations.

6. Emergency Intervention Plans: Do not provide a sample EIP. An Emergency Intervention Plan is to be used when a resident's behavior poses imminent danger or serious injury to self or others and will assist staff in addressing crisis situations.

If this home does not provide restraints:

- ☐ I understand and agree this home will have an Emergency Intervention Plan that describes nonphysical de-escalation methods (e.g., crisis communication, redirection, evasion)
- ☐ I understand and agree this home will have an Emergency Intervention Plan that describes the circumstances and types of client behaviors for which the use of these strategies are needed how other residents will be kept safe during crisis situations.

☐ I understand and agree to follow the ACRC Service Standards and Emergency Intervention Plan template that can be located on the ACRC website.

☐ I understand and agree this home's Emergency Intervention Plans will incorporate items outlined in Title 22 Section 85100 and 85122, which include the following:

- Less restrictive or non-physical de-escalation methods that will be used prior to restraint or seclusion. §85122(b)
- Staff qualifications sufficient to implement the plan. §85122(d)(1)
- A list of job titles of staff, trained to use manual restraint [§85122(d)(2)] and a statement clarifying that only staff which are trained as required by Title 22 section 85165(b), may use emergency interventions.
- Staff who participate in, approve or provide visual checks of manual restraint, shall have a minimum of 16 hours of emergency intervention training and be certified for having successfully completed the training. Staff shall have a minimum of 6 hours of refresher training annually following initial certification.
- A description of the circumstances and types of client behaviors for which the use of emergency interventions are needed. §85122(d)(4)
- The purpose or expected outcome for clients. §85122(d)(3)
- A list of emergency intervention techniques beginning with the least restrictive intervention, which shall include: §85122(d)(3)
- A description of each emergency intervention technique that may be used. Procedures must be well defined and accompanied by graphic representation when possible. §85122(d)(3)(A)
- Prone containment shall only be used in compliance with section 1180.4(f) of the Health and Safety Code. §85122(3)(A)(1)
- Client safety when a manual restraint is used, including the title(s) of staff responsible for checking the clients' breathing and circulation, §85122(e)(1), as well as responding immediately and appropriately to a client's request for services, assistance, and repositioning. §85122(e)(4)
- The maximum time limits for each manual restraint technique, not to exceed maximum time limits as specified in §85102(a)(14) & §85122(e)(6)
- A determination for when to cease a manual restraint, which should be limited to when the client is presenting an imminent danger of serious injury to self or others. §85122(e)(3)
- A determination for when a medical examination is needed during or after a manual restraint, as specified in section 85169. §85122(e)(1)(A) & §85169
- Procedures for re-integration of the client into the facility routine after the need for emergency intervention has ceased. §85122(d)(7)
- Criteria for assessment of when community emergency services are necessary to assist staff during an emergency intervention and a list of community emergency services to assist staff. §85122(d)(10) & §85122(e)(11)
- Procedures for maintaining care and supervision and reducing the trauma of other clients when staff are required for the use of emergency interventions. §85122(d)(5)
- Procedures for crisis situations, when more than one client requires the use of emergency interventions simultaneously. §85122(d)(6)
- Description of post emergency intervention procedures including but not limited to debriefing, behavior consultant review and possible modification to behavior plan etc.

§85122(e)(10). A description of the debriefing requirements can be found in §85168.3

- Criteria for assessing when an Individual Emergency Intervention Plan needs to be created, modified, and terminated. §85122(d)(12)Criteria is defined in Title 22 section 85168.3.
- Criteria for assessing when an Emergency Intervention Plan needs to be created, modified, and terminated. §85122(d)(8)
- A description of documentation and reporting requirements (Documented in the client chart, Special Incident Reporting including the completion of the Post-Emergency Restraint Report, monthly incident reporting, six-month EIP evaluation etc.). §85122(e)(9), §85122(g), §85161
- Criteria for assessing when the licensee does not have adequate resources to meeting the needs of a specific client. §85122(d)(9)

Providers initials: _____

By initialing here, I understand what is expected and what is outlined in Title 22 and will follow the above expectations.

7. Behavior Consultant Qualifications and Job duties

Instruction: Using the following format only, list out the behavior consultant's qualifications and separately list out the behavior consultant's job duties. Qualifications must be in line with Title 17 Section 56040, 54319, 54342.

Behavior Consultant Qualifications

-
-
-
-

Behavior Consultant Job Duties

-
-
-

Providers initials: _____

By initialing here, I understand what is expected and what is outlined in Title 17 and will follow the above expectations.

8. Behavior Consultant Qualification Verification

Instruction: In this section, provide a copy of the behavior consultant's resume, license and service agreement/contract with the home.

Resume – Max of 1 page

License – Max of 1 page

Service Agreement/Contract – Max of 3 pages

EXPECTED OUTCOMES

The section below must use the following format

Instructions: copy/paste the following format in your program design and address the prompts.

3 expected outcomes for residents receiving direct supervision and special services as described in the facility program design:

- 1.
- 2.
- 3.

Instructions: copy/paste the following statement in your program design:

On an annual basis, the Administrator will utilize the Service Quality Provider's Handbook and the self-assessment within. The self-assessment will be used to review the home's contracted service delivery plan in comparison to how services are actually being implemented.

Pursuant to Title 17 Section 56048(d)(5) [View Document - California Code of Regulations](#)

Providers initials: _____

By initialing here, I understand what is expected and what is outlined in Title 17 and will follow the above expectations.

ADMISSION CRITERIA

The section below must use the following format

Instructions: Copy/paste the information using the format shown below into your program design and address each prompt.

Preferred age range: _____

Service Level: _____

- | | | |
|--|--|--|
| ☐ Male | ☐ Female | ☐ Both Male and Female |
| ☐ Verbal | ☐ Nonverbal | |
| ☐ Blind* | ☐ Deaf* | ☐ Canes* ☐ Walkers* ☐ Artificial Limbs* |
| ☐ Ambulatory | ☐ Non-ambulatory | ☐ Functionally Non-amb* ☐ Bedridden** |
| ☐ Hospice, capacity approved for hospice: _____ | | ☐ Dementia |
| ☐ Wheelchair | Number of wheelchairs you can accommodate: _____ | |
| If in wheelchair, weight limit _____ lbs. | | Wheelchair transfer skills ☐ Yes ☐ No |
| ☐ Out-of-Home Respite | | |

Will accept:

- ☐ Cerebral Palsy
☐ Autism
☐ Epilepsy
☐ Intellectual Disability (if checked indicate the level accepted below)
 ☐ Mild ☐ Moderate ☐ Severe ☐ Profound*

Seizures:

- ☐ Will not accept residents with seizures.
☐ Will accept residents with controlled seizures
☐ Will accept residents with uncontrolled seizures.

Other conditions:**Please provide detailed explanation on your plan to serve each condition**

- ☐ Behavior Excesses (specify on the Behaviors Accepted form)
☐ PICA ☐ Traumatic Brain Injury (TBI)
☐ Mental Health/Psychiatric Diagnosis ☐ Prader-Willi Syndrome
☐ General Health Conditions (i.e., special diet, allergies, etc.); Provide a list: _____

☐ Restricted Health Conditions (fill out restricted health conditions section for IMS and Specialized Health Care Facilities for Children)

*** May require non-ambulatory license. Please contact your licensing evaluator and local Fire Marshal Office about specific requirements in your area. Identify how you are going to modify the facility to make it accessible.**

*** Functionally Non-amb: resident cannot exit the home under two minutes without assistance, this will require a non-amb license**

****Bedridden license required. Please contact your licensing evaluator and local Fire Marshal Office about specific requirements in your area. Identify how you are going to modify the facility to make it accessible.**

Activities of Daily Living Skills / Self Help Skills

Instructions: Check only the highest level of assistance you will provide to residents in each skill area.

	Independent	Verbal Prompt	Physical Assist	Total Care	
Bathing	☐	☐	☐	☐	
Dressing	☐	☐	☐	☐	
Hygiene	☐	☐	☐	☐	
Eating	☐	☐	☐	☐	
Toileting	☐	☐	☐	☐	
Bladder	☐	Continent			
	☐	Habit trained for toileting (if on schedule may have occasional accident)			
	☐	Incontinent			
Bowel	☐	Continent			
	☐	Habit trained for toileting (if on schedule may have occasional accident)			
	☐	Incontinent			
		Seldom	Monthly	Weekly	Daily
Bladder incontinence		☐	☐	☐	☐
Bowel incontinence		☐	☐	☐	☐

Frequency and Severity of Behaviors Expected at Each Service Level		
Service Level	Frequency	Severity
2	Monthly/Yearly	Minor
3	Daily/Weekly	Moderate
4	Weekly	Intensive
5	Daily	Intensive
6	Hourly	Intensive

BEHAVIORAL CHARACTERISTICS ACCEPTED

The section below must use the following format

Instructions: Copy/paste the information using the format shown below into your program design and address each prompt. Indicate 'Yes' or 'No' next to every behavior. Indicate the highest frequency and level of severity accepted for each behavior using the key below:

Frequency

H - Hourly
D - Daily
W- Weekly
M -1-2 Times per month
Y- Yearly

Severity

2 - Minor: Requires minimal staff intervention
3 - Moderate: Requires enriched staff intervention/moderate risk
4 - Intensive: Requires structured, planned Intervention/high risk

A. General Behaviors

Behaviors	Yes/No	Frequency	Severity
1. Eating Behaviors			
• Eating inedible objects			
• Binge/purge			
• Compulsive over-eating			
• Fast pace			
• Regurgitation			
• Food stealing at meal time			
2. Hoarding			
• Food			
• Found Objects			
3. Self- Stimulation			
• Rocking			
• Flapping			
• Mouthing objects			
• Playing with spit			
4. Resistive			
• To daily routine/transitions			
• Going to work			
• Getting out of bed			
• To requests			
• To social involvement			
5. Inappropriate Undressing			

• Stripping in facility			
• Stripping in public			
6. Verbal Abuse			
• Yelling/screaming			
• Cursing			
• Making threats			
General Behaviors cont'd	Yes/No	Frequency	Severity
7. Hyperactivity			
• Pacing			
• Bolting			
8. Inappropriate Masturbation			
• In facility/resident areas			
• In public			
9. Feces smearing			
• Attended or unattended			
10. Stealing			
• Going through other's room			
• Taking items from care home			
• Shoplifting			

B. Aggressive/Physical Injury

Frequency	Severity	
H- Hourly	2 - Minor:	Produces scratches/abrasions requiring first aid only.
D-Daily		
W-Weekly	3 - Moderate:	Produces injury to self or others which may require medical attention such as visit to physician.
M -1-2 Times per month		
Y-Yearly	4 - Intensive:	Produces serious injury to self or others which may need immediate medical attention.

Behaviors	Yes/No	Frequency	Severity
1. Temper Tantrums			
• Hitting			
• Kicking			
• Screaming			
2. Self-Injurious Behavior			
• Biting hand			
• Banging head			
• Pulling out hair			
• Picking at skin, nails			
• Poking/slapping self			
• Rectal digging			
3. Physical Aggression/ Assaultive Behavior			
• Toward other residents			
• Toward Staff			
• Toward others in public			

C. Property Destruction

Frequency	Severity	
H - Hourly	2 - Minor:	No damage results from behavior.
D - Daily		
W- Weekly	3 - Moderate:	Minor damage, repairable
M -1-2 Times per month		
Y-Yearly	4 - Intensive:	Damage not repairable

Behaviors	Yes/No	Frequency	Severity
1. Property Destruction (Other's Property)			
• Punch/kick holes in walls			
• Throws furniture			
• Pulls items off walls/tables/curtains			
• Rips curtains/upholstery/bedding			
2. Property Destruction (Own Property)			
• Tears own clothes			
• Breaks possessions			
• Tears up own room			

D. High Risk BehaviorsKey: **Frequency**

H - Hourly

D - Daily

W- Weekly

M - 1-2 Times per month

Y- Yearly

Behaviors	Yes/No	Frequency
1. Other High Risk Behaviors		
• Depressive-like behaviors		
• Suicidal threats		
• Suicide attempts		
• AWOL - leaves area in attempt to runaway, does not return		
• Wanders - leaves area due to distraction, usually returns		
• Fire-setting.....Exhibited in last year (12 months)		
.....Exhibited with 1-3 years		
.....History only more than 3 years		

E. Criminal Behaviors

Behaviors	Yes/No	History Only	Penal Code/ Misdemeanor	Penal Code/Felony
• Burglary				
• Substance abuse				
• Homicidal threats				
• Domestic abuse				
• Homicide				
• Animal Cruelty				
• Rape				
• Child Molestation				
• Exposing self				
• Arson				
• Other:				

RESTRICTED HEALTH CONDITIONS – ARF or Children’s Homes

The section below must use the following format

Instructions: Copy/paste the following list using the format shown then indicate ‘Yes’ or ‘No’ for the medical services your home will provide to residents in need of the service. Your home must be licensed to accept and provide services for these RHC. Some of these RCH may require you to have medical professionals on staff as well as an RN Consultant.

Yes ☐ No ☐ Inhalation-assistive devices as specified in Title 22, Section 80092.3

Yes ☐ No ☐ Colostomy/Ileostomies as specified in Title 22, Section 80092.4

Yes ☐ No ☐ Fecal impaction removal, enemas, and suppositories as specified in Title 22, Section 80092.5

Yes ☐ No ☐ Catheters as specified in Title 22, Section 80092.6

Yes ☐ No ☐ Staph or other serious communicable infections as specified in Title 22, Section 85092.7

Yes ☐ No ☐ Insulin-dependent Diabetes as specified in Title 22, Section 80092.8

Yes ☐ No ☐ Stage 1 and 2 dermal ulcers as specified in Title 22, Section 80092.9

Yes ☐ No ☐ Wounds as specified in Title 22, Section 80092.9

Yes ☐ No ☐ Gastrostomies as specified in Title 22, Section 80092.10

Yes ☐ No ☐ Tracheostomies as specified in Title 22, Section 80092.11

Providers initials: _____

By initialing here, I understand what is expected and what is outlined in Title 22 and will follow the above expectations.

RESTRICTED HEALTH CONDITIONS – RCFE/Elderly Homes

The section below must use the following format

Instructions: Copy/paste the following list using the format shown then indicate ‘Yes’ or ‘No’ for the medical services your home will provide to residents in need of the service. Your home must be licensed to accept and provide services for these RHC. Some of these RCH may require you to have medical professionals on staff as well as an RN Consultant.

Yes ☐ No ☐ Administration of oxygen as specified in Section 87618

Yes ☐ No ☐ Catheter care as specified in Section 87623

Yes ☐ No ☐ Colostomy/ileostomy care as specified in Section 87621

- Yes ☐ No ☐ Contractures as specified in Section 87626
- Yes ☐ No ☐ Diabetes as specified in Section 87628
- Yes ☐ No ☐ Enemas, suppositories, and/or fecal impaction removal as specified in Section 87622
- Yes ☐ No ☐ Incontinence of bowel and/or bladder as specified in Section 87625
- Yes ☐ No ☐ Injections as specified in Section 87629
- Yes ☐ No ☐ Intermittent Positive Pressure Breathing Machine use as specified in Section 87619
- Yes ☐ No ☐ Stage 1 and 2 pressure injuries as specified in Section 87631(a)(3)
- Yes ☐ No ☐ Wound care as specified in Section 87631

Providers initials: _____

By initialing here, I understand what is expected and what is outlined in Title 22 and will follow the above expectations.

INTAKE PROCEDURE

The section below must use the following format

Instructions: Copy/paste the following information using the format as shown below.

Evaluation of New Referrals

1. Admin will receive the referral packet from ACRC.
2. The referral packet must include:
 - a. ACRC Residential Referral Packet Cover Page (first year of vendorization)
 - b. IPP
 - c. CDER
 - d. Aggressive Behavior Statement
3. Admin and consultant (if applicable) will review the referral packet within 3 business days.
4. Admin will accept/decline the referral within 3 business days.
 - a. The justification for declining a referral must be supported by the program design.

Home Tour

1. If referral is accepted, the Admin will work with the planning team to schedule a tour of the home. The tour must include the client.
2. During the tour the Admin will provide a general overview of the services the home offers, the Exit Criteria, Grievance Procedure, Residents Rights, CMS Final Rules and will discuss whether this home is trained in restraints.
3. If there are current residents in the home, the potential new residents shall participate in a meal or activity, as available, with the current residents.

4. Level 4-6: Admin will inform the client and authorized representative (if applicable) if the home may use manual restraints in the event a resident demonstrates a behavior posing risk or serious injury to themselves or others.
5. Level 4-6: a restraint risk assessment will be completed prior to admission, it will result in identifying:
 - a. Pre-existing medical conditions or physical disabilities that would place the person at greater risk during restraint
 - b. History of trauma or abuse including sexual or physical
 - c. Identification of early warning signs, triggers and precipitants that cause a person to escalate to aggressive behavior
6. Within 3 business days of the home tour, the Admin will determine if they accept or decline admission.
 - a. The justification for declining admission must be supported by the program design.

Transportation

1. This home will provide/offer transportation to move-in, or move-out: Yes ☐ No ☐
2. ☐ I agree and understand that if there is not a licensed driver on staff at any given time, then there will be a contingency plan in place.
 - b. Contingency plan:
 -
 -
 -

Admission Day

1. Admin will be present on admission day.
2. If possible, admission day will be on a weekday to ensure the Service Coordinator can be present.
3. The ACRC Admission Agreement must be completed prior to/on admission day.
 - a. The home will not utilize any other admission agreement.
4. Admin will review the Exit Criteria, Grievance Procedure, Resident's Rights, CMS Final Rules, any Consent for Info Release forms, and the resident will sign each in acknowledgement.
5. Admin will support the client in completing the HCBS Resident Questionnaire.
6. Level 4-6: Admin will re-inform the client and authorized representative (if applicable) if the home may use manual restraints in the event a resident demonstrates a behavior posing risk or serious injury to themselves or others, and a copy of the Emergency Intervention Plan will be provided to the client and authorized representative.
7. Level 4-6: Admin will support the client in completing an advance directive on the use of de-escalation procedures in addition to the use of restraints.
8. Admin will ensure they request, verbally and via email, a copy of the IPP Amendment that outlines the client now lives in this home.

Post-Admission Day (Level 3-6)

1. Within 30 days of admission: the consultant will complete an initial assessment of the new resident, will compose a report and determine baseline data tracking for direct care staff.
2. Within 60 days of admission: the consultant will complete a Behavior Intervention

Plan/Individual Service Plan.

3. Within 90 days of admission: the consultant will train the Admin and all direct care staff.

Providers initials: _____

By initialing here, I understand what is expected and will follow the above expectations.

HCBS AND PERSON CENTERED PLANNING

CFR 441.301

The section below must use the following format

Instructions: Copy/paste the following information using the following format into your program design and address the prompts.

Weekly Resident Meetings

- ☐ I understand and agree that the Admin will host and support weekly resident meetings.
- ☐ I understand and agree that the purpose of the weekly house meetings is to gather resident input on various topics such as: daily schedules, menu/meal planning, activity planning, problem solving amongst housemates, etc.
- ☐ I understand and agree that the Admin will maintain copies of and utilize documentation to record decisions and resident input for each weekly resident meeting.

Instructions: Copy/paste the following information into your program design.

CMS Final Rules

Upon admission and annually, the CMS Final Rules will be reviewed with each resident, signed in acknowledgement and maintained in their client file in the home.

Federal Requirement 1: Access to the Community

The setting/service is integrated in and supports full access to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving regional center services

Federal Requirement 2: Choice of Setting

The setting/service is selected by the individual from among various options, including non-disability specific options and an option for a private room in a residential setting. The options are identified and documented in the Individual Program Plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.

Federal Requirement 3: Right to be Treated Well

The setting/service ensures an individual's rights of privacy, dignity, respect, and freedom from coercion and restraint.

Federal Requirement 4: Independence

The setting/service optimizes but does not regiment individual initiative, autonomy and

independence in making life choices, including daily activities, physical environment and with whom to interact.

Federal Requirement 5: Choice of Services and Supports

The setting/service facilitates individual choice regarding services and supports, and who provides them.

Federal Requirement 6: Residential Agreement

A lease, residence agreement or other form of written agreement is in place for each participant and the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.

Federal Requirement 7: Privacy

Each individual has privacy in his/her sleeping or living unit:

1. Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors as needed.
2. Individuals sharing units have a choice of roommates in that setting.
3. Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.

Federal Requirement 8: Schedule and Access to Food

Individuals have the freedom and support to control their own schedules and activities and have access to food at any time.

Federal Requirement 9: Right to Visitors

Individuals are able to have visitors of their choosing at any time.

Federal Requirement 10: Accessibility

The setting is physically accessible to the individual.

Client Name and Signature: _____ Date: _____

Admin Name and Signature: _____ Date: _____

Pursuant to 42 CFR § 441.301 [42 CFR § 441.301 - Contents of request for a waiver. | Electronic Code of Federal Regulations \(e-CFR\) | US Law | LII / Legal Information Institute](#)

Providers initials: _____

By initialing here, I understand what is expected and what is outlined in CFR 441.301 and will follow the above expectations.

Instructions: Copy/paste the following information into your program design.

HCBS RESIDENT QUESTIONNAIRE

Upon admission and annually, the HCBS Resident Questionnaire will be completed with each resident, signed and maintained in their client file in the home.

- What services do/will you receive in the community, and how can we support you? (Services should be obtained in natural settings as much as possible, and may include health care, dental care, therapies, gym membership, haircuts, nail care, religious worship services, etc.)
- Where in the community do you like to spend your time, how frequently, and how can we support you? (Activities may be social and/or recreational in nature, and should not be solely disability specific. The care home should offer opportunities for individualized activities as well as group activities, and support residents to enjoy activities with friends, family, neighbors, etc., as a means of building and maintaining meaningful relationships)
- Do you currently use public transportation independently, and if not, would you like to learn? Where do/would you like to go?
- Do you currently have a job, and if not, are you interested in starting to work or volunteer? How can we support you?
- Do you need any support with your finances, and if so, how can we support you to be as independent as possible with your finances?
- Who is important to you, and how can we support you in those relationships? (Who are friends, family members, significant other, coworkers, fellow members of clubs or religious groups, etc., that resident would like to spend time with?)
- Is it your choice to live here? If not, how can we support you to prepare to move to your setting of choice? Even if this is your preferred living situation now, where do you see yourself living 5-10 years from now? If you choose to move, how can we help support you to prepare to move to your future setting of choice (i.e. learn independent living skills, save money, etc.)?
- Do you prefer to reside in a single room, or in a shared room with a roommate of choice? Are you aware that you have the right to choose either of these arrangements? Are you familiar with the process to request a change in roommates (if applicable)? Do you need help requesting or obtaining your preferred living situation?
- Are you familiar with your rights to privacy, dignity, respect, and freedom from coercion and restraint? Is there any way that you would especially like your staff and housemates to show you respect in these ways?
- What are your preferences in regards to daily activities? Tell us about your daily routine and what is important to you. Some people like to talk to family on the phone every day, some people like to have a cup of coffee before doing anything else, some people have favorite snacks, hobbies, or a favorite TV show for unwinding. What would you like to incorporate into your schedule in your new home?
- What are your preferences in regards to physical environment? You have the right to furnish and decorate to your preference. Are there any special items you will be bringing with you? Is there anything you will need that we can assist you with?
- What kinds of activities do you need support with, and what things do you prefer to do by/for yourself?
- Are there any accommodations that would assist you to be as independent as possible in the home? Consider what activities a caregiver does for you currently. Might there be training or technology that could assist you to be less dependent on staff (i.e. front-loading washing machine, bidet, plans to team up with peers, etc.)?
- What are your preferences in regards to people with whom you interact? Are you a “people person”, or do you prefer your space? Who would you like to spend more time with? Are

- there people that you would like help avoiding? Do you prefer to dine alone or in a group?
- What are your needs and preferences in regards to communication (language, device, pictures, etc.)? What tips do you have for optimal communication?
 - What are your preferences about what to wear, hairstyle, shaving, makeup, etc.?
 - Are you interested in exercising your right to vote?
 - How can we support you to have maximum autonomy and independence in the above areas?
 - Do you know how to file a grievance if you are unhappy about something?
 - Are you satisfied with your work and/or day services? If retirement age, is this something you would like to do now or in the future?
 - What are your preferences in regards to people that support you? Are you more comfortable with male / female staff for certain activities? Are there personality types or personal characteristics that tend to be a good match (i.e. physically strong, gentle, funny, able to communicate with you in your preferred language/method, etc.)?
 - You have the right to privacy, including dining alone, and having lockable bedroom and bathroom doors. However, you are not required to keep your door locked (or even closed). What is your preference? Is there a certain type of lock/key that works best for you (typical key, card key, keypad, biometric, etc.)? Would you like assistance or training on how to lock and unlock doors?
 - You have the right to access food at any time. Do you have any preferred snacks, beverages, or meals that we can plan to have available for you?
 - You have the right to have visitors of your choosing at any time. Who are some people that you would like to visit with, both at the home and out? Is there a visiting schedule that you prefer?
 - Do you understand the admissions agreement; what you can expect from the home/staff, and what is expected of you?
 - Is there anything else you would like us to know about you, about what is important to you, and how best to help you have a great day?

Client Name and Signature: _____ Date: _____

Admin Name and Signature: _____ Date: _____

Providers initials: _____

By initialing here, I understand what is expected and what is outlined in CFR 441.301 and will follow the above expectations.

EXIT CRITERIA

The section below must use the following format

Instructions: Copy/paste the following information using the format as shown then address the prompts. Exit criteria must be supported by the program design, see Admission Criteria and Behavior Characteristics Accepted sections. Do not copy/paste Title 22 exit criterion.

Exit Criteria

- 1.
- 2.
- 3.

Preventative Measures Prior to Exit

- ☐ I understand and agree that the Admin will take preventative measure prior to providing the

resident with a written 30-day notice to exit.

- If the notice is due to the client's maladaptive behavior the administrator of the home should ensure that the BIP is modified to address the concern, staff are implementing the plan with fidelity, and appropriate consultation has been sought to address the concern prior to the issuing of the notice.
- Preventative measures must include a planning team meeting to discuss concerns and barriers.
- Preventative measures will also include:
 -
 -

Exit Procedure

- ☐ I understand and agree that once all preventative measures have been exhausted the Admin will submit a written 30-day notice to the resident, their authorized representative (if applicable), as well as the Service Coordinator and CCL Licensing Program Analyst.
- ☐ I understand and agree that the reason for exit must meet the criteria listed above.

Acknowledgement

- ☐ I understand and agree that the Exit Criteria will be reviewed with the resident and their authorized representative (if applicable) upon admission and annually.
- ☐ I understand and agree that the resident will sign in acknowledgement, and a copy will be maintained in the resident's file.

Client Name and Signature: _____ Date: _____
Conservator and Signature: _____ Date: _____
Admin Name and Signature: _____ Date: _____

Providers initials: _____

By initialing here, I understand what is expected and will follow the above expectations.

STAFF QUALIFICATIONS
The section below must use the following format

Instructions: copy/paste the following information using the format as shown below into your program design. You may add more items but cannot have less than what is listed below. Lists must be comprehensive. Review the list and ensure to remove any information that is not related to your home's level.

Note: House Manager, House Supervisor, Staff Supervisor, Lead Staff: these titles are to meet the same requirements as a Direct Care Staff and are not held to the regulations, qualifications and job description as the Administrator.

Direct Care Staff

- L4-6: Have a minimum of 6 months of prior experience providing direct supervision and special services; or within 6 months of beginning to provide direct supervision and special services in the facility, complete at least 12 additional hours of continuing education as specified in subsection T17 Section 56038 (a)(3).
- Completion of competency-based training: DSP1 and DSP2 in the appropriate timeframes.
- Compliance with staff trainings (on-site orientation, on-the-job training).
- Compliance with continuing education units; a minimum of 12 hours (L3/4/5/6) or 8 hours (L2) of continuing education within each twelve-month period following the assumption of the duties.
- Understand person-centered planning and commitment to Person Centered Practices.
- Possess vehicle insurance.
- Proof of identification or CA driver's license.
- Criminal clearance.
- First Aid and CPR certification.
- Health clearance, TB clearance within the last 12 months (6 months for RCFE) prior to being hired or within 7 days after.
- Shall have adequate written and verbal language skills to communicate effectively with clients, clients' parents, medical and emergency personnel, day programs and other community professionals (Title 22, Sections 80064(a)(2), 80065(f)(3)(g)).
- L4/5/6: Compliance with crisis intervention training and completion of training within 30 days of employment.

Administrator

- Experience:
 - L2: 6 months prior experience, part-time – at least 20 hours per week
 - L3: 9 months prior experience, part-time – at least 20 hours per week
 - L4-6: 12 months prior experience, full-time – 40 hours per week
- Current Admin certificate.
- Shall have adequate written and verbal language skills to communicate effectively with clients, clients' parents, medical and emergency personnel, day programs and other community professionals (Title 22, Sections 80064(a)(2), 80065 (f)(3)(g)).
- Must complete and comply with competency-based training: DSPT1 and DSPT2.

- L4/5/6: Certified trainer/trained in CPI/Pro-ACT/Crisis Prevention Training prior to the assumption of duties.
- Administrator may not be the administrator for more than 2 facilities.
- Required to attend Residential Vendor Orientation prior to assumption of duties.
- Complete Accounting, Record Keeping, Medication, P&I, SIR, Mandated Reporter and Accounting training hosted by ACRC prior to assumption of duties.
- Understand person-centered planning and commitment to Person Centered Practices.
- Possess vehicle insurance.
- Proof of identification or CA driver's license.
- Criminal clearance.
- First Aid and CPR certification.
- Health clearance, TB clearance within the last 12 months (6 months for RCFE) prior to being hired or within 7 days after.
- Compliance with continuing education units; a minimum of 12 hours (L3/4/5/6) or 8 hours (L2) of continuing education in the areas specified in T17 Section 56037(a) within each twelve-month period following the assumption of the duties of an administrator.
- L4/5/6: Has working knowledge of positive behavior management practices, and who demonstrates the ability to work with the community consultants in developing and implementing behavior intervention plans.

Pursuant to Title 17 Section 56033 and 56037, 56038

Provider Initials: _____

By initialing here, I understand what is expected and what is outlined in Title 17 as well as ACRC expectations outlined in Vendor Orientation and will follow the above expectations.

STAFF JOB DESCRIPTIONS

The section below must use the following format

Instructions: copy/paste the following information using the format as shown below into your program design. You may add more items but cannot have less than what is listed below. Lists must be comprehensive. Review the list and ensure to remove any information that is not related to your home's level.

Note: House Manager, House Supervisor, Staff Supervisor, Lead Staff: these titles are to meet the same requirements as a Direct Care Staff and are not held to the regulations, qualifications and job description as the Administrator.

Direct Care Staff

- Complete a minimum of 12 hours (L3/ L4/5/6) or 8 hours (L2) of continuing education in the areas specified in T17 within each twelve-month period following the assumption of the duties.
- Implement person centered planning.
- Support clients in developing and maintaining meaningful relationships with family, friends, and others in the community.
- Ongoing daily notes and data tracking through consultant (L4/5/6) created tracking forms.

Administrator

- Complete a minimum of 12 hours (L3/L4/5/6) or 8 hours (L2) of continuing education in the areas specified in T17 Section 56037(a) within each twelve-month period following the assumption of the duties of an administrator.
- Obtain signed consent forms from all clients confirming approval to receive assistance with self-care and ADLs.
- Implement person centered planning.
- Support clients in developing and maintaining meaningful relationships with family, friends, and others in the community.
- Responsible for the emergency plan/procedure.
- Responsible for composing and submitting quarterly (L4/5/6) or semi-annual (level 2 and 3) progress reports to be submitted to ACRC Service Coordinator.
- Responsible for ensuring the consultants prepare and submit their reports in the required timeframes (30-day assessment, BIP within 60 days of admission, quarterly progress reports/L3 may have semi-annual progress reports).
- Responsible for submitting consultant reports to ACRC Service Coordinator.
- Responsible for the intake procedure of referred individuals.
- Responsible for staff training (on-site orientation and on-the-job training) and keeping track of staff earned annual CEUs and DPST 1 and DPST2 completion.
- Responsible for the annual program evaluation .
- Manage and review clients cash resources on a routine basis for accuracy and ensure that clients' accounts do not exceed allowable limits.
- Maintain and oversee all facility records.
- Responsible for the grievance procedure.
- Responsible for the exit criteria procedure.
- Attend and participate in IPP meetings and planning team meetings.
- Collaborate with other service providers the resident has to best meet the needs of the resident in the home.
- Responsible for staff weekly schedule.
- Responsible for hosting a reoccurring meeting for residents to attend and voice their interest in things such as: daily schedule, menu, activity calendar, etc.
- Transport/accompany client on tours of prospective day programs.
- Accommodate client's program/work schedule.
- Be flexible with scheduling meals, providing transportation, and providing assistance in keeping required uniforms washed and in good condition.
- Provide adequate staffing if client is unable or chooses not to attend program or work or works part time.
- Meet with the SC every 3 months to review client's progress.
- Participate in the annual T17 review meeting held by ACRC.
- Participate in any necessary Triennial Quality Assurance (QA) Evaluation meetings.
- Be available for emergencies and to respond to client's needs 24 hours a day.
- Notify ACRC CSS in writing 30 days prior to any changes needed in the program design, to include: changes in ownership, consultants, etc.
- Notify ACRC CSS if Admin is taking a leave of absence/vacation.

Provider Initials: _____

By initialing here, I understand what is expected and what is outlined in Title 17 as well as ACRC expectations outlined in Vendor Orientation and will follow the above expectations.

STAFF TRAINING PLAN

The following section must use the format shown

Instructions: Copy/paste the following information using the format as show and initial where requested.

1. Competency-Based Training (Direct Support Professional Training) Year 1 and 2

Pursuant to Title 17 Section 56033

Provider Initials: _____

By initialing here, I understand what is expected and what is outlined in Title 17 and will follow the above expectations.

2. On-site Orientation

☐ I understand and agree that on-site orientation will also include the ACRC Zero Tolerance Policy, Person-Centered Planning, and Elderly & Dependent Adult Abuse and Mandated Reporting Guidelines.

Pursuant to Title 17 Section 56038(a)(1)

Provider Initials: _____

By initialing here, I understand what is expected and what is outlined in Title 17 and will follow the above expectations.

3. On-the-Job Training

In-service trainings will occur: _____

☐ I understand and agree that annually there will be refresher training on the ACRC Zero Tolerance Policy, Person-Centered Planning, and Elderly & Dependent Adult Abuse and Mandated Reporting Guidelines.

Pursuant to Title 17 Section 56038(a)(2)

Provider Initials: _____

By initialing here, I understand what is expected and what is outlined in Title 17 and will follow the above expectations.

4. Continuing Education Units (CEUs)

☐ I understand and agree that only half of the annual required CEUs can be taken online.

Pursuant to Title 17 Section 56038(a)(3)(b-g)

Provider Initials: _____

By initialing here, I understand what is expected and what is outlined in Title 17 and will follow the above expectations.

DIRECT CARE STAFF SCHEDULE
The following section must use the format shown

Instructions: Copy/paste the following information and address each prompt. Use the template on page 36 to provide a sample of your home's staff schedule.

All levels:

- ☐ I understand and agree that there must be a basic staffing level (BSL) of one direct care person at all times when residents are under the supervision of direct care staff (168 hours per week, 24/7).
- ☐ I understand and agree that the home must provide additional weekly direct care staff hours based upon the home's service level and the number of residents residing in the home.
- ☐ I understand and agree that all services levels require staff to be awake at all times.
- ☐ I understand and agree that there may not be any staff who are asleep at any time.
- ☐ I understand and agree that the Administrator hours must be reflected on the schedule.
- ☐ I understand and agree that the Admin should be scheduled for a minimum of 20 hrs/week and that being "on-call" does not count toward those 20 hours.
- ☐ I understand and agree that there must be staff identified on the staff schedule during program/employment/school hours – staff schedule must not be blank for those hours.
- ☐ I understand and agree that staff do not need to be in the home when there are no residents in the home, but that staff must be on schedule ready to work/be available to come to the home/service the clients.
- ☐ I understand and agree that I will use the following format for the weekly staff schedule and that LIC 500 does not replace the staffing schedule required by ACRC.
- ☐ I understand and agree that the staff schedule must be updated and posted on a weekly basis.

Service Level 2 and 3:

- ☐ I understand and agree that I may request an Awake Night Staff Exception from the Service Coordinator.
- ☐ I understand and agree that the Service Coordinator must follow the internal ACRC Awake Night Staff Exception Procedure before authorizing staff do not need to be awake at night.
- ☐ I understand and agree that if at any time, one of the resident's IPPs does not specify they do not need awake night staff the Administrator will immediately ensure the night staff are remain awake.

Provider Initials: _____

By initialing here, I understand what is expected and what is outlined in Title 17 and will follow the above expectations.

Number of Additional Weekly Direct Care Staff Hours by Service Level and Number of Residents							
Service Level	1 Resident	2 Residents	3 Residents	4 Residents	5 Residents	6 Residents	7+ Residents
2	BSL	BSL	BSL	BSL	BSL	BSL	28*
3	BSL	BSL	BSL	12	32	72	40*
4	BSL	BSL	18	52	87	137	50*
5	BSL	12	27	92	141	203	61*
6	BSL	36	90	144	198	252	70*

DIRECT CARE STAFF SCHEDULE

SAMPLE

Staff Key:

1. Staff A Anthony
2. Staff B Erica
3. Staff C William

4. Staff D Daniel
5. Staff E Beth
6. Staff F Paula

7. Staff G Georgia

Facility: Alta California
Capacity: 4
Level: 5

Hours	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
12:00am	F	F	F	G	G	G	G
1:00am	F	F	F	G	G	G	G
2:00am	F	F	F	G	G	G	G
3:00am	F	F	F	G	G	G	G
4:00am	F	F	F	G	G	G	G
5:00am	F	F	F	G	G	G	G
6:00am	A F	A F	A F	A G	A G	C G	B G
7:00am	A F	A F	A F	A G	A G	C G	B G
8:00am	A F	A F	A F	A G	A G	C G	B G
9:00am	A F	A F	A F	A G	A G	C G	B G
10:00am	A	A	A	A	A	C E	B E
11:00am	A	A	A	A	A	C E	B E
12:00pm	A	A	A	A	A	C E	B E
1:00pm	A	A	A	B	B	C E	B E
2:00pm	A C	A C	B	B	B	C E	C E
3:00pm	C E	C D	B D	B D	B D	C E	C E
4:00pm	C E	C D	B D	B D	B D	DE	C E
5:00pm	C E	C D	B D	B D	B D	DE	C E
6:00pm	C E	C D	B D	B D	B D	DE	C E
7:00pm	C E	C D	B D	B D	B D	DE	C E
8:00pm	C E	C D	B D	B D	B D	DE	C E
9:00pm	C E	C D	B D	B D	B D	DE	C E
10:00pm	C	C	B	B	B D	DE	C E
11:00pm	C	C	B	B	B	D	C
♦Total # Add'l Direct Care Hours	12	12	11	11	12	17	17

Total Direct Care Staff Hours: 92

DIRECT CARE STAFF SCHEDULE

Staff Key:

- 1. Staff A
- 2. Staff B
- 3. Staff C

- 4. Staff D
- 5. Staff E
- 6. Staff F

- 7. Staff G
- 8. Staff H
- 9. Staff I

Facility:
Capacity:
Level:

Hours	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
12:00am							
1:00am							
2:00am							
3:00am							
4:00am							
5:00am							
6:00am							
7:00am							
8:00am							
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4:00pm							
5:00pm							
6:00pm							
7:00pm							
8:00pm							
9:00pm							
10:00pm							
11:00pm							
*Total # Additional Direct Care Hours							

Total Direct Care Staff Hours:

GRIEVANCE PROCEDURE

Welfare and Institution Code 4705

The following section must use the format shown

Instructions: copy/paste the following information using the format shown into your program design:

- Residents can file a written grievance using the Internal Grievance Form.
- The grievance should be submitted to the home's Administrator.
- The Administrator will respond with a proposed resolution within _____ calendar days of receiving the Internal Grievance Form.
- If the proposed resolution is not sufficient for the resident, the Administrator will schedule a planning team meeting to discuss further.
- The Grievance Procedure form will be reviewed with the client, their authorized representative (if any) upon admission and annually.
- The Grievance Procedure form will be signed in acknowledgement upon admission and annually.
- The home will utilize the Grievance Procedure form located on the ACRC website: [Residential Provider Forms - Alta California Regional Center](#)

INTERNAL GRIEVANCE FORM

Name of home: _____

Date of the grievance being reported: _____

Date the grievance occurred: _____

Grievance:

Agreed upon resolution:

Resident name and signature: _____ Date: _____

Admin name and signature: _____ Date: _____

Providers initials: _____

By initialing here, I understand what is expected, what is outlined in WIC, I agree to utilize the identified forms and will follow the above expectations.

PROGRAM PREPARATION FUNCTIONS

The following section must not include any further information

Instructions: copy/paste the following information into your program design:

- Pursuant to T17 56004(e)(1) through (6) as well as [D-2024-RateReform-011 REV Attachment B Residential Services Subcodes](#), this home has up to 2 hours of program prep per resident per week.

Providers initials: _____

By initialing here, I understand what is expected and what is outlined in Title 17 and will follow the above expectations.

REQUIRED DOCUMENTATION

Submit the following within the program design:

1. Facility License:
 - The facility license is to be obtained through the licensure process of Community Care Licensing.
2. Floor plan of the facility:
 - Indicate the ambulatory status and single occupancy of each resident bedroom. Indicate location of fire extinguishers and all smoke detectors, property dimensions, position of the house, any bodies of water, and locations of utility shut offs.
3. Administrator's documentation:
 - Resume (Max of 2 pages)
 - Administrator's certificate
 - Crisis intervention training certificate (Pro-ACT, Crisis Prevention Institute, Ukeru)
4. Business Documentation:
 - Submit a copy of documents that relate to the structure of your business i.e., Partnership, LLC, Incorporation, etc. (Articles of Incorporation or Organization).
5. Surety Bond: The amount of the bond shall be according to the following schedule:

<u>Amount Safeguarded Per Month</u>	<u>Bond Required</u>
\$750 or less	\$1,000
\$751 to \$1,500	\$2,000
\$1,501 to \$2,000	\$3,000

Every further increment of \$1,000 or fraction thereof shall require an additional \$1,000 on the bond.