LOUISIANA DEPARTMENT OF HEALTH
Aging and Adult Services

Rights and Responsibilities

OF APPLICANTS OF WAIVER & HOME AND COMMUNITY-BASED SERVICES (HCBS)

You Have the RIGHT to:

- Always be treated fairly and with respect, no matter your race, religion, gender, age, ethnicity, or disability.
- Be told how to get Medicaid and non-Medicaid services.
- Be told about the waiver services in a way that you understand them.
- Receive information about how to get and maintain HCBS waiver services.
- Know that all of your conversations are kept private as you apply for services.
- Choose a person to help you make decisions about you waiver services.
- Get services from people trained to help you.
- Get help to register to vote.
- Not to be abused or forced to do anything you do not want to do or you think is wrong.
- You have the right to choose:
  - How, where and with whom you live;
  - What you do during the day;
  - The agency that provides you services (from a list of qualified providers); and
  - To have an in-person visit from your support coordinator instead of a virtual visit (by video), if available.
  - To sign your plan of care documents physically (wet signature) or to sign electronically, if available.
- Tell your support coordinator if you want to change providers.
- Call your OAAS Regional Office if you want to change your Support Coordination Agency (SCA).

You have the right to choose how your type and amount of services are determined:

- You will be assessed using the interRAI Home Care (iHC) assessment, a comprehensive, clinical, validated tool.
- The iHC assessment determines the amount of services you may get, not your assessor/Support Coordinator.
- Your assessor will the assessment results with you to help you decide what services you need and want within your waiver budget. You can refuse any service you do not want.

Report suspected mental or physical abuse, neglect, extortion, or exploitation:

Adult Protective Services (APS)
For individuals aged 18-59
1-800-898-4910

Elderly Protective Services (EPS)
For individuals aged 60 and older
1-833-577-6532

If you have any questions about the rules of your HCBS waiver program or your **RIGHTS** and **RESPONSIBILITIES,** please contact any of the following:

Support Coordination Agency:

_____

OAAS Regional Office:

_____

OAAS Helpline:

_____

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It is your RESPONSIBILITY to:

- Participate in one (1) Medicaid waiver program at a time.
- Be active in the process of the following:
  - Figuring out what services you need;
  - Talking in meetings and letting your team know what is important to you;
  - Creating your Plan of Care (POC);
  - Answering all questions truthfully;
  - Attending all meetings with your support team;
  - Letting your support coordinator and provider know if you need to cancel a visit;
  - Inviting people to your meetings that you want to be there; and
  - Answering phone calls from members of your support team.

NOTE: If you do not participate and follow the process above, you could lose your waiver.

- Follow rules of the program, including but not only:
  - Having a safe, crime free home to receive your services in.
  - Be courteous and respectful to the worker(s) and support coordinator.
- Ask for only the services you need to stay safe in your home. Do not ask for services because someone like your provider or support coordinator wants you to have them. **This is about you and what you need.**
- Not sign any paperwork from your direct service provider or your support coordinator that is not right or that you do not agree with.
  - Examples:
    - Service logs/progress notes that are wrong or blank.
    - Your Plan of Care (POC) with services that you do not need or want.
- Make sure you get the waiver services that are in your POC. If you do not get waiver services for 30 or more days (90 days if you are admitted to a facility) you could lose your waiver.
- Make sure your home is safe and nothing against the law happens in/at your home.
- Pay the amount of Medicaid Patient Liability Income (PLI) that you owe every month to your provider or Fiscal Employer Agent (FEA), **if required**.
- Tell your support coordinator and call Health Standards at 1-800-660-0488 if you think your provider is not telling the truth about when you get services or if you think they may be involved in fraud.
- Tell your support coordinator if you have any changes in your:
  - Health;
  - Medications; and/or
  - Living situation (if you move or if someone moves in with you).

- Tell your provider and your support coordinator as soon as possible if any of these things happen to you:
  - Falls;
  - Major Injury;
  - Major medical events (medical procedure, new treatment, hospitalization, etc.
  - Involvement with law enforcement; and/or
  - Mental or physical abuse, neglect, extortion, or exploitation.

How to file a COMPLAINT:

- If you are not satisfied with the waiver services you are receiving, you may file a complaint in one of the following ways:
  - To file a complaint about your **Provider**, call:

Health Standards Section (HSS):
1-800-660-0488

  - To file a complaint about your **Support Coordination Agency**, call:

Office of Aging and Adult Services (OAAS)
1-866-758-5035

  - To file a complaint about your **OAAS Regional Office**, call:

Office of Aging and Adult Services (OAAS)
1-866-758-5035

How to file an Appeal:

- If you are told that you will no longer get services, you are told that you cannot have a service that you want, or you are told that your services will be reduced, you have the right to file an appeal.
- If you file an appeal timely, you will have a fair hearing that will be heard by an impartial judge.
- To file an appeal, call:

The Division of Administrative Law at **1-225-342-5800.**

- If you need help with your appeal, you may call:

Disability Rights Louisiana at **1-800-960-7705.**

Signature Page

I have read and understand my rights and responsibilities for applying for/participating in Home and Community-Based Services (HCBS) Waiver programs administered and managed by the Louisiana Department of Health, Office of Aging and Adult Services. I also understand that if I do not comply with the rights and responsibilities as outlined, I may be discharged from my waiver program.

Name of Applicant/Participant (print): _____

_____ _____
(Signature of Applicant/Participant) (Date)

_____ _____
(Signature of Assessor) (Date)

_____ _____
(Signature of Responsible Representative, if applicable) (Date)

This page is to be retained by the assessor.