



## OPERATIONAL MEMO

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### **Purpose and Audience:**

The purpose of this Joint Operational Memo is to inform providers and case management agencies (CMAs) serving participants in the Children's Habilitation Residential Program (CHRP) of the expectations of the Department of Health Care Policy & Financing (HCPF) and the Colorado Department of Human Services (CDHS) regarding simultaneous compliance with two sets of authorities: (1) the federal Home- and Community-Based Services (HCBS) Settings Final Rule, along with HCPF's implementing guidance and rule codification; and (2) the state child welfare regulations applicable to out-of-home placements, along with CDHS's implementing guidance.

## Information:

### Background

The CHRP waiver provides services for children and youth who are 20 years old or younger and have an intellectual or developmental disability (IDD) and extraordinary needs that put them at risk of, or in need of, out of home placement. Participants receive supports to learn and maintain skills needed to live in their communities. These supports can include habilitative services provided in the following types of 24-hour residential out-of-home placements: child placement agency (CPA) certified foster care homes, kinship homes, specialized group facilities, residential child care facilities (RCCFs), and qualified residential treatment programs (QRTPs).<sup>1</sup> As relevant to this memo, these placements are subject to two bodies of law:

- The Child Care Licensing Act, C.R.S. 26-6-101 *et seq.*, and CDHS's regulations for child welfare services and facilities, as set forth in 12 CCR 2509-1 through -10, also known as Staff Manual Volume 7. In this memo, we call these the child welfare authorities, although some children served in covered settings are not in child welfare.
- Medicaid authorities, including the statutes and regulations governing the provision of HCBS to various populations, the CHRP waiver itself, and HCPF's regulations for this specific waiver as set forth in 10 CCR 2505-10 8.508.

In 2014, the federal Centers for Medicare & Medicaid Services (CMS) published a [rule](#) that applies to all settings (locations) where people live or receive Medicaid-funded HCBS, including services under the CHRP waiver. There are no excluded waivers or populations. The rule says that people have rights to receive HCBS in settings that are integrated in the community; ensure privacy, dignity, and respect; support their autonomy and freedom to make their own choices; allow visitors and access to food at any time; and more. The rule also sets out a process for modifying those rights where appropriate. The process includes documenting the individualized assessed need for the modification, the person's informed consent, and other criteria.

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<sup>1</sup> CHRP participants may also be served in their own homes, and older youth may be served in host homes, but such settings are outside the scope of this memo. For guidance on the application of the HCBS Settings Final Rule to private homes and host homes in general, see HCPF's codification of the federal rule at new 10 CCR 2505-10 8.484.

In implementing the federal rule, HCPF has taken steps to ensure a smooth transition toward compliance for CHRP providers serving youth in out-of-home placements. These steps have included:

- Summarizing the existing legal authorities applicable to such settings, along with a roadmap of changes that might be needed, in the [Systemic Assessment Crosswalk](#). HCPF consulted with CDHS in preparing this crosswalk, which addresses CHRP settings. HCPF also addressed certain child welfare rules in a supplemental Excel crosswalk shared more recently with stakeholders (available upon request).
- Addressing CHRP-specific situations in responses to frequently asked questions (FAQs), such as [FAQ Part II](#), item 36 and [FAQ Part III](#), item 71; as well as child-specific situations in the rights modification trainings presented in January 2019 (see [slide deck](#) at slide 18 and [transcript](#) and [recording](#) segments accompanying this slide) and June 2021 (see [slide deck](#) at slide 29 and [pre-recorded training](#) segment accompanying this slide). More recently, HCPF issued an extensive set of [responses to CHRP waiver FAQs](#) that, among other things, reiterated the application of the HCBS Settings Final Rule to the CHRP program.
- Creating a [Provider Transition Plan \(PTP\) template](#) specifically for CHRP residential settings. The template walks the provider through the process of identifying compliance issues, along with remedial actions it can take to address such issues. The Colorado Department of Public Health & Environment (CDPHE) has been reviewing and verifying PTPs from all providers, including those serving CHRP participants, and providing 1:1 technical assistance as needed. CDPHE and CDHS staff also jointly visited a random selection of CHRP settings in 2017.
- Including provisions specific to children under the age of 18 in its codification of the federal requirements. See new 10 CCR 2505-10 8.484. HCPF engaged in extensive informal stakeholder engagement on its draft codification and obtained additional public comment through the formal rulemaking process.
- With the codification in effect, HCPF will implement the crosswalks mentioned above through additional rule/waiver amendment processes. The end result will be a clear, streamlined regulatory environment that allows all HCBS providers to comply with both the federal settings criteria and other requirements.

HCPF and CDHS have heard concerns from providers serving children in out-of-home placements that it may be difficult to comply with the federal (and now state) settings criteria while remaining in compliance with existing rules, particularly the state child welfare rules. Both HCPF and CDHS value the services providers are making available

for children and youth and are willing to work with providers through compliance scenarios. Both departments want to assure providers that it is possible to comply with both sets of authorities. This memo outlines how providers should address particular questions that have arisen, and how CMAs should navigate their role in these situations.

## Guidance

### I. HCBS Settings Final Rule general principles

In applying the federal rule, keep in mind its overarching values of person-centeredness and community integration for individuals with disabilities. Consistent with these values, participants in HCBS programs should live and receive services in settings that are truly homelike and not operated like institutions, which tend to be regimented and segregated from society at large.

As a default, people receiving HCBS should experience the places where they live and spend their time in ways that would be typical for others not receiving HCBS. For example, an adult residing in a group home for adults with IDD would have the same rights as an adult renting a unit in a typical apartment building: they would have a lease or other written agreement giving them protections against eviction, be able to come and go when they want, have visitors of their choosing, have privacy in their room or unit, decide when and what to eat, and so on. Similarly, the expectation for children in HCBS programs is that they be treated comparably to typical children of their age, not necessarily that they be treated like adults.

The federal rule recognizes that the default approach may not work in every situation. Therefore, it allows for rights to be modified on an individualized basis—but not on a group basis (as with house rules, for example). The process includes documenting in the individual's person-centered service plan the assessed need for the rights modification (i.e., a health/safety risk to the individual or others that is specific to them and not presumed on an across-the-board basis), the positive interventions and less-intrusive supports that were tried and failed, specification of the positive behaviors and objective results that the individual can achieve to demonstrate that the modification is no longer needed (along with the plan to help the individual learn how to achieve these results), how the provider will mitigate any undesired effects of the modification, a timeline for reviewing the modification at least annually, and the informed consent of the individual (or, if authorized, their guardian/other legally authorized representative). HCPF's regulations for the CHRP waiver already codify these federal criteria at 10 CCR 2505-10 8.508.102. HCPF's codification of the federal rule now does the same for all waivers. See new 10 CCR 2505-10 8.484.5.

The provider may initiate the rights modification process by filling out the [Informed Consent Template](#) with all of the required information, except for documentation of informed consent. The case manager at the Community Centered Board (CCB) or Single Entry Point (SEP) should review the form to confirm that it meaningfully addresses all of the required criteria. If it does, then the case manager discusses the proposed rights modification with the individual (and as applicable, their parent/guardian) to be sure they understand the proposal, the alternatives to consenting and the likely pros/cons of each option, and additional considerations. The individual (or as applicable, their parent/guardian) decides whether the proposed rights modification—with any revisions they may make—is acceptable to them, and if it is, they sign it to show their informed consent. The case manager, not the provider, collects the signature. If consent is granted, the case manager records the details in the individual’s person-centered service plan on the Rights Modification screens and gives a copy of the completed documentation back to the provider. See [HCPF OM 21-032](#).

For additional information on the rights modification process, see [FAQ Part I](#), items 28-33; [FAQ Part II](#), items 51-69; the January 2019 rights modification training (see [slide deck](#), [transcript](#), and [recording](#)); and the June 2021 rights modification training (see [slide deck](#) and [pre-recorded training](#)). In addition, the [Informed Consent Template](#) includes guidance regarding the process as well as what to enter in each area of the form.

Consistent with the principles set out above, new 10 CCR 2505-10 8.484.2.N provides:

For children under age 18, a limitation or restriction to any of the rights [protected in the rule] that is typical for children of that age, including children not receiving HCBS, need not be handled as a Rights Modification . . . . Consider age-appropriate behavior when assessing what is typical for children of that age. If the child is not able to fully exercise the right because of their age, then there is no need to pursue the Rights Modification process. However, if the proposed limitation or restriction is above and beyond what a typically developing peer would require, then it must be handled as a Rights Modification . . . .

Under this standard, one might determine, for example, that it is typical for a 17-year-old but not a five-year-old to have a key to the home. Therefore, not giving a 17-year-old a house key would be a rights modification, but not giving a five-year-old a house key would not be.

The Departments acknowledge that there will be gray areas under this standard, particularly for pre-teen and teenage youth, who experience wide variations in restrictions/freedoms even in typical households. If in doubt as to whether a measure is

a rights modification under this standard, proceed as though it is, as (a) this process will help ensure that less-restrictive methods are considered and that the provider is working to help the youth learn skills so that the restrictive measure is no longer needed, and (b) when the youth becomes an adult, the measure (if still needed) likely will have to be treated as a rights modification anyway.

This is not to say that CHRP participants must be treated in all respects like their typical peers (or in the example above, that every single 17-year-old participant in CHRP absolutely must have a house key). Rather, if it is appropriate to modify someone's rights, the process for doing so is available and must be followed to ensure that there is an individualized assessed health/safety need for the measure and that the other federal criteria are documented.

## II. Child welfare rules and appeals

The Division of Child Welfare is charged with licensing all child care foster homes, specialized group facilities, CPAs, RCCFs, and QRTPs in Colorado. Just as HCPF regulates Medicaid providers in a way that protects individual health and safety while also promoting individual choice, CDHS also licenses these providers who serve youth and families in the same way. Out-of-home services must be provided in a way that honors the best interests of the child, balancing child- and family-centered policies and rules with health and safety. For those children and youth who reside in an RCCF or QRTP, the array of services provided is required to include behavioral health treatment based on each youth's identified needs.

To allow for case-by-case balancing of these interests, CDHS has a process under which licensed child care providers may appeal rules established for these facilities. There are several types of appeals, including a hardship appeal: "Any applicant or licensee who has applied for or been issued a license to operate a child care facility or child placement agency has a right to appeal, pursuant to § 26-6-106(3), C.R.S., any rule or standard which, in his or her opinion, poses an undue hardship on the person, facility, or community." 12 CCR 2509-8 7.701.13.A.

## III. Unified approach

The Departments expect that between the age-appropriateness analysis, the rights modification process, and the established process for appealing rules based on hardships, it will be possible for providers to navigate the complexities they face in serving CHRP participants. The basic approach should work as follows:

1. The youth's multidisciplinary and/or permanency team will assess the youth and determine whether it makes sense for them to exercise the right in question. Can

they do so without undue risks to themselves or others? Could supports help them to exercise this right safely? To what extent do typical children of their age, outside of the HCBS and child welfare systems, exercise this right? (There is no need to assess age-appropriateness for adults, who are presumed to exercise all of their rights.)

2. If the youth cannot exercise the right safely, but this is simply because of their age, the provider should restrict the right as warranted, without the need for formal action under CDHS or HCPF rules. The provider would be protecting health and safety as required by both agencies' rules, and it would not be implementing a rights modification under the HCBS Settings Final Rule (as the limitation is typical for a child of that age).
3. If the youth cannot exercise the right safely for some reason other than their age, or if they are age 18 and older and cannot exercise the right safely, the provider should propose a rights modification. Restricting the youth's exercise of the right might be consistent with the child welfare rules, but doing so would be a rights modification under the HCBS Settings Final Rule (as the limitation is not typical for a child of that age or for an adult). The case manager should help the youth (and their guardian/other legally authorized representative, if applicable) understand and evaluate the proposed rights modification and decide whether to consent. Rights modifications may not be implemented without consent.
4. If the youth can exercise the right safely (potentially with supports), the provider should seek to support them in doing so.
  - a. The provider should identify whether any child welfare rule conflicts with this expectation under the HCBS Settings Final Rule. Sometimes, there is no such rule—only historical practice or habit.
  - b. If a child welfare rule poses a conflict, the provider can engage in the formal process established by the Division of Child Welfare to appeal the rule so that the youth can fully exercise the right (with supports if needed), as expected under the HCBS Settings Final Rule. CDHS will consider whether there are continued health and safety concerns for the youth or other youth in the home with the proposed supports for the youth, or whether "compliance with the rule creates a substantial, unnecessary burden" on the provider and the youth it serves, taking into



account the youth's abilities and needs and the value the youth derives from being served in the given home under the CHRP program.

- c. If CDHS denies the appeal, then the provider may propose a rights modification (assuming the youth is of an age typically able to fully exercise the right, or is 18 and older), with the individualized assessment of need citing CDHS's denial of the appeal and any reasoning included therein. Rights modifications may not be implemented without consent.
5. All rights modifications and approved appeals shall be documented in the Individual Child's Plan. If, as a result of a rights modification or approved appeal, any child is provided rights, a restriction to their rights, or other accommodation that differs from that of other children placed in the home, the justification shall be documented in the Individual Child's Plan.

#### IV. Examples

The examples that follow illustrate how to apply the unified approach set out above. These examples address questions and concerns frequently raised by CHRP providers. Other situations should be resolved using the same basic approach.

Medication self-administration: Under the HCBS Settings Final Rule, people that can safely self-administer their medications should be allowed to do so. Therefore, HCPF expects that if interested in and capable of doing so, youth participating in CHRP can self-administer over-the-counter and prescription medications (following their doctor's instructions)—at least as of the age where their typical peers are doing so.

At the same time, under CDHS child welfare rules,

- In foster care homes, "[a]ll medication must be kept in a clean storage area inaccessible to foster children," "[a]ll prescriptive medications shall be administered only upon the written prescription of a physician," and "[t]he foster care home shall . . . obtain written authorization from the prescribing physician to administer any non-prescriptive medication." 12 CCR 2509-8 7.708.41.J.
- In specialized group facilities and RCCFs, the same basic standards apply. *See id.* 7.714.81.J. In addition, "[o]nly staff members trained and authorized by State statute shall administer medications." *Id.* For RCCFs, the rules further specify that "[a]dministration of any medication at the facility shall be done only by a person licensed and authorized by law or staff member having passed a [CDPHE] approved competency evaluation for medication administration, verification of which is maintained in the staff member's personnel file." *Id.* 7.705.31.



CDHS interprets these rules as meaning that youth may not self-administer medications. HCPF's regulations for the CHRP waiver incorporate the CDHS standards in part. *See* 10 CCR 2505-10 8.508.103.

Under the unified approach, providers serving CHRP participants should:

1. Determine whether the child wants to self-administer any medication(s). If they do, assess them and determine whether they can safely do so. In assessing safety, it is appropriate to consider risks to the child as well as to others (for example, other children in the household, if the first child tends to leave their belongings unsecured). Also consider whether other children of that age typically self-administer the medication(s) in question. Youth age 18 and older are adults, who are presumed to self-administer.
2. If the child cannot safely self-administer certain medications, but that inability is typical for a child of their age, then there is no need for formal action as to those medications. Not allowing self-administration is consistent with the child welfare rules cited above (as interpreted by CDHS) and is not a rights modification under the HCBS Settings Final Rule (as the limitation is typical for a child of that age).
3. If the child wants to self-administer certain medications but cannot do so safely for some reason other than their age, or if they are age 18 and older and want to but cannot safely self-administer, then the provider should propose a rights modification. Not allowing self-administration is consistent with the child welfare rules cited above (as interpreted by CDHS) but would be a rights modification under the HCBS Settings Final Rule (as the limitation is not typical for a child of that age or for any adult). The case manager should help the youth (and their guardian/other legally authorized representative, if applicable) understand and evaluate the proposed rights modification and decide whether to consent to it.
4. If the youth wants to and can safely self-administer certain medications, then the provider should request that CDHS waive the applicable rules cited above so that the youth can self-administer. If CDHS denies the appeal, then the provider may propose a rights modification (assuming the youth is of an age typically able to self-administer these medications), with the individualized assessment of need citing CDHS's denial of the appeal and any reasoning included therein.

In some cases, the youth might be able to safely self-administer some medications (such as ibuprofen or antacids) but need more supervision or assistance with others. The provider should follow the relevant approach above for each type of medication.

Bedroom door locks with keys: Under the HCBS Settings Final Rule, people have a right to privacy in their bedrooms, and this includes having a door with a lock and key. HCPF expects providers to install locks for and distribute keys to all adult waiver participants, including CHRP participants, and to younger individuals as appropriate. This allows the individual to have privacy while they are in their room and to secure their belongings while they are away; they also get reassurance and pride from having these things, like typical people in the community. It is rarely appropriate for the provider to refrain from giving an adult a lock and key for their bedroom, which would be a rights modification. However, young children typically cannot lock their doors.

Under child welfare rules, “[e]very child has the right to a reasonable degree of privacy.” 12 CCR 2509-8 7.714.31 (rules for specialized group facilities and RCCFs); *id.* 7.708.33 (same standard for foster care homes). These rules neither require nor prohibit bedroom door locks and keys. Although some RCCF providers historically have withheld locks and keys from all children, doing so on an across-the-board basis is not required and, under the unified approach, is no longer allowed for settings in which CHRP participants reside.

Under the unified approach, providers serving CHRP participants should:

1. Assess the youth and determine whether it makes sense for them to have a lock and key. Could alternatives that are easier to use, such as fobs, be used? To what extent do typical youth of their age, outside of the HCBS and child welfare systems, have a lock and key? (All typical adults are presumed to have them.)
2. If the child is young enough that they would not typically be able to lock their door, the provider may withhold the lock and key, without the need for formal action under CDHS or HCPF rules.
3. If the youth typically would be able to lock their room at their age, but doing so would be unsafe in their individual case (for example, because they might need assistance during a seizure), the provider should propose a rights modification, to be finalized with the case manager. The provider should mitigate the effects of the rights modification as much as possible: perhaps the youth can shut the door but not lock it, and can have a locker to secure their belongings; in addition, staff/caregivers will knock and only enter the room with permission, unless there is an emergency (such as the youth’s having a seizure).
4. If the youth can safely have a lock and key, they should have them. The provider should work with them to help them get comfortable with the lock/key or alternative such as a fob (showing them how to operate these things on a different door, assuring them that they will never be locked in, etc.). As noted

above, the child welfare rules do not prohibit this approach, so there is no need for a hardship appeal to CDHS.

Interior cameras: Under the HCBS Settings Final Rule, individuals have a right to privacy in their homes. In accordance with CMS guidance, HCPF interprets this right as including the right to be free of cameras in typically private spaces. Therefore, HCPF's codification of the federal rule specifies (at 10 CCR 2505-10 8.484.3.A.3.a):

- i. The use of cameras . . . in . . . interior areas of residential settings, including common areas as well as bathrooms and bedrooms . . . is acceptable only under the standards for modifying rights on an individualized basis . . . .
- ii. If an individualized assessment indicates that the use of a camera . . . in the areas identified in the preceding paragraph is necessary for an individual, this modification must be reflected in their Person-Centered Support Plan. The Person-Centered Support Plans of other individuals at that setting must reflect that they have been informed . . . of the camera(s) . . . and any methods in place to mitigate the impact on their privacy. The provider must ensure that only appropriate staff/contractors have access to the camera(s) . . . and any recordings and files they generate, and it must have a method for secure disposal or destruction of any recordings and files after a reasonable period.
- iii. Cameras . . . on staff-only desks and exterior areas [and] cameras on the exterior sides of entrances/exits . . . generally do not raise privacy concerns, so long as their use is similar to that practiced at non-HCBS settings. In provider-owned or -controlled settings, notice must be provided to all individuals that they may be on camera and specify where the cameras are located. If such devices have the effect of restricting or controlling egress or monitoring the coming and going of individuals, they are subject to [the rule for rights modifications].

As noted above, under CDHS child welfare rules, children have the right to a reasonable degree of privacy. In addition, the rules for specialized group facilities, RCCFs, and QRTPs provide: "A child may be photographed upon admission for identification and administrative purposes . . . . No other non-medical photographs or videotaping shall be taken or used without the written consent of the child's parent or legal guardian except in the case of a child abuse or police investigation." 12 CCR 2509-8 7.714.31. Some RCCFs historically have used interior cameras in common areas for all children, with the intent of deterring or at least documenting any instances of mistreatment, abuse, or

exploitation perpetrated by other children or staff. However, doing so across the board is not required.

Under the unified approach set forth above, providers serving CHRP participants should:

1. Assess the youth and determine whether they can safely reside in the home without being on camera. It is appropriate to consider risks to the youth as well as to others (for example, other children in the household, if the first youth has behavioral challenges that may endanger others—or vice-versa). However, less-intrusive measures that can help keep everyone safe without infringing on their privacy must be tried first. In addition, cameras in living areas (as distinct from staff-only areas) may not be used solely to monitor staff; it is the provider's responsibility to prevent mistreatment, abuse, and exploitation by its own employees without placing the burden on children, who have a right to privacy.
2. There is no need to assess age-appropriateness for the use of interior cameras, as people of any age are not typically on camera in their own homes. Stated differently, if cameras are needed, they will always entail a rights modification.
3. If the youth cannot safely reside in the home without being on camera, then the provider should propose a rights modification. Using interior cameras might be consistent with the child welfare rules, but doing so would be a rights modification under the HCBS Settings Final Rule (as being on camera intrudes on privacy and is not typical for a person of any age). The use of the camera must comply with the Section 8.484.3.A.3.a requirements above, including mitigation measures such as turning the camera off when the youth who needs it to be safe (or to be prevented from endangering others) is not home. The consent of the parent/guardian may also be required under 12 CCR 2509-8 7.714.31.
4. If the youth can safely reside in the home without being on camera, then they should do so. The child welfare rules do not require the use of interior cameras, so there is no need for a hardship appeal to CDHS.

Access to food: Under the HCBS Settings Final Rule, individuals have a right to access food at any time.

Under CDHS child welfare rules, children have a right to “[r]eceive adequate and appropriate food.” *Id.* 7.708.33 (foster care homes); *id.* 7.714.31 (specialized group facilities and RCCFs). Additionally,

- A. The foster care home shall provide nutritious foods in the variety and amounts as appropriate for the age, appetite, and activity of each foster child in care.

B. At least three nourishing, wholesome, well-balanced meals a day shall be offered at regular intervals except when foster children receive their morning and/or noon meal(s) at school. No more than fourteen (14) hours shall elapse between the evening and morning meals. Nourishing snacks shall be part of the daily food provided.

*Id.* 7.708.42; *see also id.* 7.714.82 (same basic rule for specialized group facilities and RCCFs). Further, “[d]aily routines shall be established for mealtimes.” *Id.* 7.708.43 (foster care homes); *id.* 7.714.83 (specialized group facilities and RCCFs).

CDHS interprets these rules as meaning that youth must be offered meals on regular schedules, without ruling out flexibility if requested by the youth. For example, if a youth wants to eat a meal at a time different from the regularly scheduled time, the rules cited above do not prevent the provider from allowing them to do so. Nor do the rules prevent the provider from allowing the youth to have a snack when they want.

Under the unified approach, providers serving CHRP participants should:

1. Assess the youth and determine whether they can safely have access to food at any time. In some cases, unlimited access to food could create imminent health risks for the youth. Also consider whether it is typical for a child of their age to have access to food at any time. Very young children typically cannot help themselves to food from the kitchen whenever they want, but older teenagers and all adults generally can.
2. If it would be unsafe for the child to have access to food any time, but this is typical for other children their age, the provider should restrict access to food as warranted, without taking formal action. The provider would be protecting health and safety as required by both agencies’ rules, and it would not be implementing a rights modification (as the limitation is typical for a child of that age).
3. If the youth cannot exercise the right safely for some reason other than their age, or if they are age 18 and older and cannot exercise the right safely, then the provider should propose a rights modification. For example, if the youth has Prader-Willi Syndrome, it could be unsafe for them to have unlimited access to food whenever they want. Restricting access to food on this basis would be a rights modification (as the limitation is not typical for a child of that age or for an adult). Note that even if a doctor has “ordered” a particular diet or meal

schedule, that medical advice would be a reason for proposing a rights modification, not a way around the rights modification process.

4. If the youth can safely have access to food at any time (potentially with supports), then the provider should support them in doing so. The child welfare rules cited above, as interpreted by CDHS, do not stand in the way of this approach, so no hardship appeal is needed.

Cell phones: HCPF's existing regulations for the CHRP waiver provide that "[e]very Client has the right to access age appropriate forms of communication including text, email, and social media." 10 CCR 2505-10 8.508.180.C. Elaborating on this right for all populations, HCPF's codification of the federal rule provides that "[i]ndividuals are allowed to maintain and use their own cell phones, tablets, computers, and other personal communications devices, at their own expense." *Id.* 8.484.3.A.1.e.

CDHS's child welfare rules provide that youth have a right to "[c]ommunicate with 'significant others.'" 12 CCR 2509-8 7.708.33 (foster care); *id.* 7.714.31 (similar rule for specialized group facilities and RCCFs). In addition, youth have a right to "[h]ave access to telephones to both make and receive calls in private"; however, this right "may be limited[] to reasonable periods during the day or restricted according to routine of the . . . home to ensure the protection of" others in the home. *Id.* 7.708.33 (foster care); *id.* 7.714.31 (similar rule for specialized group facilities and RCCFs). Homes "must develop a plan . . . regarding the following rights of foster children and these rights must be explained to the foster children upon admission. . . . How and when telephone, including cell phone use, and written communications, including, but not limited to, social networking and other electronic communication, will take place." *Id.* 7.708.33 (foster care); *id.* 7.714.31 (similar rule for specialized group facilities and RCCFs).

Under the unified approach, providers serving CHRP participants should:

1. Assess the youth and determine whether it makes sense for them to have their own cell phone. Can they do so without undue risks to themselves or others? Could supports help them to engage safely? To what extent do typical children of their age, outside of the HCBS and child welfare systems, have cell phones?
2. If it would not be safe for the child to have their own cell phone, but this is typical for their age, the provider should restrict the right as warranted, without the need for formal action other than developing the plan required by CDHS rules. The provider would be protecting health and safety as required by both

agencies' rules, and it would not be implementing a rights modification under the HCBS Settings Final Rule (as the limitation is typical for a child of that age).

3. If the youth cannot safely have their own cell phone for some reason other than their age, or if they are age 18 and older and cannot do so safely, then the provider should propose a rights modification. Restricting the youth's access to their own phone would be a rights modification under the HCBS Settings Final Rule (as the limitation is not typical for a child of that age or for an adult).
4. If the youth can safely have their own phone, then the provider should seek to support them in doing so. The child welfare rules cited above do not stand in the way of this approach, so no hardship appeal is needed.

Leases: Under the HCBS Settings Final Rule, adults living in provider-owned or -controlled settings have the right to a legally enforceable agreement (lease or residential agreement) giving them protections against eviction that are at least comparable to those provided under the jurisdiction's landlord/tenant law. This includes "CHRP and other waiver participants age 18 and older." [FAQ Part III](#), item 71. However, the rule "does not require leases for children. In addition, in Colorado, (a) children live where their parents or guardians decide, and this location may change quickly and without the child's input, and (b) the age of majority for purposes of entering into a binding contract is 18. This means that in Colorado, children do not have an ordinary tenant's protections against sudden involuntary moves or evictions, the right to advance notice of such moves, or the right to appeal such moves." *Id.*

CDHS child welfare rules do not require leases or residential agreements for youth, even those who are legal adults. That said, both agencies' rules "do protect CHRP participants against sudden, involuntary moves from one setting to another." *Id.* n.2 (citing regulations providing for child's input into placements, requiring justification for moves to more restrictive settings and for termination of services, disfavoring repeated moves, prohibiting termination of placement leading to homelessness, and allowing children and families to contest moves).

Under the unified approach, providers serving CHRP participants should:



1. Assess the youth and determine whether it makes sense for them to have a lease or residential agreement giving them protections against eviction comparable to other tenants in the area.
2. It is typical for all minors not to have a lease/residential agreement with such protections. For youth under age 18, there is no need for formal action under CDHS or HCPF rules.
3. If the youth is age 18 or older (an adult) but should not have typical protections against eviction for some reason, then the provider should propose a rights modification. Restricting the young adult's ability to have enforceable protections against eviction would be a rights modification under the HCBS Settings Final Rule (as the limitation is not typical for an adult). This situation should be rare; for more information, see [FAQ Part III](#), item 82.
4. If the youth is age 18 and older and it makes sense for them to have a lease/residential agreement, then they should have one. The child welfare rules cited above do not stand in the way of this approach, so no hardship appeal is needed.

V. Additional considerations

Who has the authority to consent to a rights modification: As noted in HCPF's recent [responses to CHRP waiver FAQs](#), the identity of the person with final decision-making authority "depends on the child/youth's individual situation."

- If the youth is under 18, their parent, guardian, or custodian (potentially the county child welfare case worker) is the one who will decide whether to consent to a rights modification. A guardian ad litem (GAL) may also be involved in decision-making, if there is a nexus between the court proceeding in which the GAL represents the child and the proposed rights modification.
- If the youth is 18 or older, they will decide, unless they have a guardian or other person with legal authority to make the decision. In Colorado, guardianship of adults is limited, and the guardianship order must be consulted to determine whether it speaks to the kind of decision at issue.

Under the federal rule, the individual leads the person-centered planning process where possible. This means that even if someone else has the legal authority to make the decision, the youth must still be consulted and have their preferences heard as part of the decision-making process. Also, the fact that a parent/guardian/custodian wants a rights modification does not necessarily mean the modification is appropriate. Informed

consent is only one of several criteria that must be documented. There must also be documentation of individualized assessed need and other factors, and if these other factors are not present, then the rights modification is not appropriate.

Human Rights Committee (HRC) review: For CHRP participants not residing in host homes (which are outside the scope of this memo), there are no provisions for HRC review other than as to investigations of mistreatment, abuse, neglect, and exploitation. The lack of HRC review for a rights modification does not affect the underlying documentation requirements relating to informed consent and the other federal criteria.

What if the youth or their parent/guardian/custodian does not consent to a rights modification: HCPF's codification of the federal rule provides (at Section 8.484.5.G):

If there is a serious risk to anyone's health or safety, a Rights Modification may be implemented or continued for a short time without meeting all the requirements of [the rule], so long as the provider immediately (a) implements staffing and other measures to deescalate the situation and (b) reaches out to the case manager to set up a meeting as soon as possible, and in no event past the end of the third business day following the date on which the risk arises. At the meeting, the individual can grant or deny their Informed Consent to the Rights Modification. The Rights Modification may not be continued past the conclusion of this meeting or the end of the third business day, whichever comes first, unless all the requirements of this [rule] have been met.

Outside of emergencies, the provider may not impose a rights modification without consent. The provider may determine that without the rights modification, it cannot safely serve the youth. In these cases, the provider should discuss the proposed rights modification with the youth. It would be a best practice to document that discussion. The provider may wish to fill out the unsigned informed consent form for the proposed rights modification and go over it with the youth, laying out the risks that it is concerned about. It would be a best practice to keep a copy of the form, even if it remains unsigned (along with documentation of the overall conversation, as noted). These materials may help show, if needed, that the youth was informed of the relevant risks. Ultimately, the provider may consider whether to stop serving the youth. Termination of services should be a last resort—not the default response every time someone does not agree to a rights modification—and would be subject to existing legal requirements and processes. The case manager must help the youth (and/or their parent, guardian, or custodian, if legally authorized) understand the alternatives to consenting and the possible consequences that may arise.

To help the youth understand the risks and alternatives, it may be helpful to encourage them to consult with trusted friends, peers, and others. [Recent state legislation](#) provided more official recognition and expectations for the supported decision-making process for adults, some of whom may be CHRP participants. A trusted natural support may be more persuasive than paid provider staff or case managers. It may also be helpful to encourage the youth to consult with independent advocates, such as those who work with local Arcs. Advocates may be able to help negotiate a solution that works for everyone. For additional information on this “what if” question, see [FAQ Part I](#), item 32; [FAQ Part II](#), item 55; the January 2019 rights modification training (see [slide deck](#) at slides 30-21 and [transcript](#) and [recording](#) segments accompanying these slides); and the June 2021 rights modification training (see [slide deck](#) at slide 29 and [pre-recorded training](#) segment accompanying this slide).

**Attachment(s):**

None

**Department Contact:**

Both HCPF and CDHS are available to discuss scenarios not included in the Joint Operational Memo’s examples, as well as any other questions and concerns that may arise in the CHRP context. As a starting point, inquiries may be sent to the following shared inbox maintained by HCPF: [hcpf\\_STP.PublicComment@state.co.us](mailto:hcpf_STP.PublicComment@state.co.us). HCPF will coordinate as needed with CDHS.