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| **DEPARTMENT OF HEALTH SERVICES**  Division of Medicaid Services  F-03288 (06/2024) | | | | **STATE OF WISCONSIN** | | | |
| **HOME AND COMMUNITY-BASED NON-RESIDENTIAL SETTINGS ATTESTATION** | | | | | | | |
| The Division of Medicaid Service’s home and community-based services (HCBS) compliance review team, monitors non-residential providers of setting-based adult day services (ADS), prevocational services, children’s long-term support (CLTS) day services, and group supported employment (GSE) for compliance with the HCBS settings rule. Adult day care centers are monitored by the Division of Quality Assurance, and do not need to be included in the information provided on this attestation form.  HCBS service providers must complete a compliance review and receive a Notice of Compliance from DMS every three years, for each setting-based service provided to waiver participants to be eligible for Medicaid waiver funding. Settings whose services take place within the broader community 100% of the time, are not subject to the HCBS settings rule and will therefore not require an HCBS review.  **Instructions:** Provide the information requested below for each applicable provider setting that you operate. (You do not need to include the setting name and address listed directly below.) | | | | | | | |
| Setting – Name | Corporate – Name | | | | | | |
|  |  | | | | | | |
| Setting Address – Street | | City | | | State | ZIP Code | |
|  | |  | | |  |  | |
| Primary Contact – Name | Phone | | | | Email | | |
|  |  | | | |  | | |
| **Additional Setting Name and Address**  **Including City, State, ZIP Code** | **List all Setting-Based HCBS Services at This Address (ADS, Prevoc, CLTS, GSE)** | | | | | | **Date on Which Setting Received a Notice of Compliance from DMS** |
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| Are you submitting information related to additional settings on a separate attestation form? | | | | | | | Yes  No |
| Does your setting(s) plan to relocate any of the above settings within the next year? | | | | | | | Yes  No |
| Do you plan to open a new setting (not a relocation) within the next year? | | | | | | | Yes  No |
| Do you plan to close a setting within the next year? | | | | | | | Yes  No |
| By my signature below, I attest that all information provided above is complete and accurate. I agree to notify DHS if any setting named above permanently closes or plans to relocate. I also agree to notify DHS of any plans to open a new setting. I agree that settings that do not have a Notice of Compliance are not eligible to receive Medicaid waiver funding. | | | | | | | |
| Name of Person Completing this Form (Please Print) | | | | | | | |
| **SIGNATURE** — Provider | | | Date Signed | | | | |
|  | | |  | | | | |

Email the completed form to [dhshcbsreview@dhs.wisconsin.gov](mailto:dhshcbsreview@dhs.wisconsin.gov).