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| **DEPARTMENT OF HEALTH SERVICES**  Division of Medicaid Services  F-03288A (06/2024) | | | | | **STATE OF WISCONSIN** | |
| **HCBS 100% COMMUNITY-BASED NON-RESIDENTIAL PROVIDER ATTESTATION** | | | | | | |
| Providers of 100% community-based non-residential adult day services, prevocational services, and children’s long term support day services are not subject to the federal home and community-based services (HCBS) settings rule, and therefore, are not required to undergo a compliance review by the Department of Health Services (DHS) HCBS review team. All 100% community-based providers must meet and attest to the criteria below to be exempt from a compliance review. | | | | | | |
| **Instructions:** Complete Section I or Section II of this form as applicable. Place your initials next to statement(s) that are true and sign and date the form. | | | | | | |
| Provider – Name | | | Provider Address (if applicable) – Street | | | |
|  | | |  | | | |
| City | | | State | | | ZIP Code |
|  | | |  | | |  |
| Primary Contact Person | | | Email Address | | | Phone |
|  | | |  | | |  |
| Service Types Offered by Provider: | | | | | | |
| Adult day services  Prevocational services  Children’s long-term support day services | | | | | | |
| **SECTION I** | | | | | | |
| **As a provider serving Medicaid waiver recipients, I attest to the following statement, as indicated by my initials below.** | | | | | | |
| Initials | | Statement | | | | |
|  | | There is no physical location owned, leased, or operated by the provider named above, at which services are taking place. | | | | |
| **SECTION II** | | | | | | |
| **As a provider serving Medicaid waiver recipients, I attest to each of the following statements, as indicated by my initials below.** | | | | | | |
| Initials | Statement | | | | | |
|  | 1. At no time is the provider owned, leased, or operated setting named above, used as a back-up service location for any reason including, but not limited to inclement weather; limited staff availability; reduced availability of transportation resources; or cancellation of community-based programs. | | | | | |
|  | 1. Medicaid waiver recipients do not return to the provider owned, leased, or operated setting named above for meals or other break times. | | | | | |
|  | 1. The only time waiver recipients are in the setting owned, leased, or operated by the provider named above is to await transportation to the broader community at the start and/or end of the service day. | | | | | |
|  | 1. Person-centered planning meetings, assessments, and other similar services are not conducted in the setting that is owned, leased, or operated by the provider named above. They are conducted in a setting that has been selected and/or agreed upon by each waiver recipient. Such locations may include the waiver recipient’s home or another location within the broader community that affords a reasonable measure of privacy. | | | | | |
|  | 1. At no time will the provider named above seek reimbursement for facility-based services provided to Medicaid waiver recipients. | | | | | |
| I attest that to the best of my knowledge, the setting identified above, provides 100% community-based services to Medicaid waiver recipients and is therefore not subject to the HCBS settings rule.  If at any time, the provider named above decides to offer facility-based HCBS services to Medicaid-waiver recipients, the provider will request an HCBS compliance review from DHS and secure a **Notice of Compliance prior to offering such services**. | | | | | | |
| **SIGNATURE** — Provider | | | | Date Signed | | |
|  | | | |  | | |

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