**DEPARTMENT OF HEALTH SERVICES STATE OF WISCONSIN**

Division of Medicaid Services Wis. Stat. § 49.45

F-03301 (02/2025)

**WISCONSIN MEDICAID**

**LONG-TERM CARE (LTC) WAIVER HCBS SETTINGS RULE COMMUNITY-BASED PROVIDER ATTESTATION**

**INSTRUCTIONS:** Type or print clearly.

I attest:

 Service provider does not own, lease, or operate a physical location where services are being rendered **or** if the service provider owns, leases, or operates a physical location, where services are being rendered, provider attests to the following:

* At no time is the provider owned, leased, or operated physical location, 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.
* Members/participants do not return to the provider owned, leased, or operated physical location for meals or other break times.
* The only time members/participants are in the physical location owned, leased, or operated by the provider is to await transportation to the broader community at the start and/or end of the service day.
* Person-centered planning meetings, assessments, and other similar services are not conducted in the physical location that is owned, leased, or operated by the provider. They are conducted in a setting that has been selected and/or agreed upon by each member/participant. Such locations may include the member/participant’s home or another location within the broader community that affords a reasonable measure of privacy.
* At no time will the provider seek reimbursement for facility-based services provided to members/participants.

I agree and attest to the above. The individual signing must be the applicant or legal representative of your organization.

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| --- | --- | --- |
| First Name | Last Name | |
| Title | | Date Signed |
| **SIGNATURE** | | |