1. HCBS can be provided in community settings. True or False

2. Which of the following settings are presumed to not meet the HCBS settings requirements. (Select all that apply)
    a. A privately-owned facility providing inpatient treatment.
    b. A residential setting located on the grounds of a public institution
    c. A facility that isolates individuals from the broader community.
    d. A group home located in a residential neighborhood.

3. Individuals receiving Medicaid HCBS have the same rights, protections and assurances in all living arrangements as those not receiving Medicaid HCBS. True or False.

4. Providers are responsible for ensuring all staff are fully trained in implementing HCBS and the IPOS. True or False.

5. Under the HCBS Final Rule, individual's right to civil rights, privacy, dignity and choice in services can only be restricted under certain circumstances. Which of the following conditions must be met for such a restriction to be justified?
    a. The restriction only needs to be included in the service provider's policies.
    b. The restriction must be identified and justified in the IPOS.
    c. The restriction is based on health and safety reasons with evidence provided.
    d. The restriction must meet federal requirements as outlined in the Medicaid Provider Manual and be included in an HCBS compliant IPOS.

6. Which of the following are restrictions? (select all that apply)
    a. Individuals are prevented from having alcohol.
    b. Individuals do not have access to food outside of meals.
    c. Individuals cannot have visitors in their bedroom.
    d. Individuals are served meals at specific times.

7. Which of the following provide evidence to show community engagement and participation in activities reflect the individuals wishes, choices, and preferences? (Select all that apply)
    a. Where activities/events took place (e.g., in the home or a specific setting elsewhere)
    b. Whether the individual participated.

c. Information about the nature and extent of the individual's interaction with others, including those not receiving services.
d. Provide a description of the individual's response/reaction to the activity.

I hereby attest and certify that I have successfully attended, completed, and comprehensively reviewed the entirety of the HCBS Provider Training. I confirm that I understand the core materials, concepts, standard operating procedures, and compliance standards presented during this session. By signing below, I acknowledge that I agree to apply these principles and practices faithfully in the execution of my professional duties.

Employee Printed Name: _____

Signature: _____

Date: _____

Supervisor Printed Name: _____

Signature: _____

Date: _____

Date Training Completed: _____

**Send to Julie.streeter@wellvance.org**