ATTACHMENT A

ARMAC Participant Post-Test

ARMAC PARTICIPANT POST-TEST

LEA #: _____ **LEA Name:** _____

Please circle one answer per question.

1. What is Medicaid?
   a. A way for people to receive food.
   b. A public health insurance program.
   c. A scheme devised to make school district staff lose their minds.

2. What 2 populations of individuals does Medicaid serve?
   a. Individuals with very low incomes.
   b. Individuals with severe disabilities.
   c. Both a and b.

3. Which of the following services is NOT a School-Based Medicaid Program?
   a. School-Based Mental Health
   b. Speech, Physical, and Occupational Therapy
   c. Personal Care
   d. All of these are school-based Medicaid programs.

4. Arkansas Medicaid Administrative Claiming (ARMAC) allows public education agencies the opportunity to receive federal reimbursement for what activities?
   a. Direct services (individual, group therapy)
   b. Medicaid related administrative activities like Medicaid outreach/eligibility activities, referral and monitoring of Medicaid related services, coordination of health services, and health related training.
   c. Education activities (teaching, grading papers).
   d. All of the above.

5. As a participant in the ARMAC time study, you may receive one or more questions by email per quarter. What is the purpose of the random moment time inquiry?
   a. To determine the statewide percent of time spent on Medicaid related administrative activities.
   b. To monitor how each employee spends his or her day.
   c. To test the email delivery system maintained by the ADE.

6. When answering the question, "What were you doing …", you must think in terms of health related services and health insurance, not just education.
   a. True
   b. False

7. How should the reimbursement collected from the ARMAC program be spent within the public education agency?
   a. On a new parking lot.
   b. On health related services.
   c. In any way the agency sees fit.

_____

Please complete all fields below. *(Incomplete fields may delay training verification.)*

Participant Name: _____ Date Post-test Completed: _____
        (Please print)

Position/Job Title: _____ Email Address: _____

Participant Signature: _____