Wyoming Department of Health
Home and Community Based Services (HCBS)
Long Term Care (LTC)/Assisted Living Facility (ALF)
Waiver Application

Program

Please check the appropriate waiver program:

- ☐ Long Term Care (LTC) Waiver
  - ☐ Agency Option
  - ☐ Consumer Directed Option
- ☐ Assisted Living Facility (ALF) Waiver
- ☐ Both Long Term Care & Assisted Living Waiver

Referral Source:

- ☐ Department of Family Service
- ☐ Home Health Agency
- ☐ Independent Living Resource Center
- ☐ Nursing Home
- ☐ Public Health Office
- ☐ Assisted Living Facility
- ☐ Aging & Disability Resource Center
- ☐ Other _____
  Please Specify

Case Management/Care Coordination Agency:

Name of Case Management/Care Coordination Agency:_____

Applicant Information

Applicant Name:_____

Physical Address:_____ City, State Zip: _____

Mailing Address (if different):_____ City, State, ZIP: _____

Home Phone Number: (___)_____ Other: (___)_____

E-MAIL: _____ Preferred Contact method: _____

Social Security Number: __ __ __ - __ __ - __ __ __ Date of Birth: ____/____/_____

What is your Preferred Language?_____

Ethnicity (optional): ☐ White ☐ Black ☐ Hispanic or Latino ☐ American Indian/Alaska Native ☐ Asian ☐ Other, specify:

Emergency Contact Information

Please include emergency contact information:

Name: _____ Relationship: _____

Physical Address:_____ City, State, Zip:_____

Mailing Address (if different):_____ City, State, ZIP: _____

Phone Number: (_____)_____ Other: (_____)_____

EMAIL: _____

Guardian

Please fill out the following, if the applicant has a legal court-appointed guardian:

Name of Guardian: _____

Physical Address:_____ City, State, Zip:_____

Mailing Address (if different):_____ City, State, ZIP: _____

Phone Number: (_____)_____ Other: (_____)_____

E-MAIL: _____

Signature

I understand I am giving the Wyoming Department of Health or its designees the authority to release this information to and among state agencies and their agents on my behalf to assist in the application process for the LTC/ALF Waiver program. I understand this application does not guarantee my eligibility or any benefits will be paid on my behalf.

_____ _____

Signature of Applicant or Guardian **Date**

_____

Printed Name

Signature of Witness:_____ _____

(*required if signature is marked with an "X"*) **Date**