Wyoming Department of Health
Commit to your health.

Wyoming Home and Community Based Services Waiver
Case Manager / Care Coordinator Monthly Evaluation

Participant Name:			**Month:**
County:		Medicaid Number:	
Receives LTC Waiver services		**OR**	Receives ALF Waiver services

Participant Signature:	
Case Manager/Care Coordinator:	Date of Visit:

Service Satisfaction	Use E~S~P	**Area Assessed**	**How Info was obtained**	Use 1~2~3~4
		Physical		
		Emotional		
		Social		
		Cognitive		
		Risk / Safety		
		Other		

Visit Outcomes (Check Y=YES or N=No)	Y	N
APS information kit provided / reviewed		
Other Medicaid services needed		
Other Medicaid service referral made		
Other non Medicaid services needed		
Other non Medicaid service referral made		
Safety Planning reviewed		
Incident or critical event occurred		
Change in Plan needed		

Case Manager/Care Coordinator has verified that service provider has provided the services on the Care Plan for the month

Case Management/Care Coordination		Lifeline Installation		Skilled Nursing	
Personal Care Attendant		Lifeline Monthly		Self Help Assistance	
Respite Care		Non-Medical Transportation		Fiscal Management	
Home Delivered Meals		Adult Day Care		ALF Daily Rate	
Nurse Supervision Documented		PERS Unit physically checked that it is working properly		Timesheets checked by CC	

If no services provided by service provider for the month, note service and why not provided

COMMENTS:

Guidance for completing this form is located on the other side of this page

Guidance for Case Manager / Care Coordinator Monthly Evaluation (HCBS-7)

Participant receives ( ) Waiver service	Indicate which Waiver provides the Participant services ~ with a check mark to the appropriate box
Participant Signature	Have the Participant sign (if able) to indicate their participation
Case Manager/Care Coordinator	Fill in the name of the Case Manager or Care Coordinator making the visit

Participant Satisfaction:

Service : Enter the type of Waiver service the Participant is receiving

Indicate the level of the Participant's satisfaction with each Waiver service using the following:
E = Excellent ~ the service meets the Participant's expectations.
S = Satisfactory ~ the service is adequate but not exceptional.
P = Poor ~ the service does not meet the Participant's expectations.

Participant Response to Services:

How Info was Obtained: Enter the method used to obtain the information about the areas listed in the left side of the box.

These methods could include:
- Your own observation of the Participant/home
- Conversation with the Participant
- Conversation with the family
- Conversation with other service providers / caretakers

Indicate the level of the Participant response using the following:
1 = Improving
2 = Maintaining
3 = Deteriorating
4 = New diagnosis which impacts the assessed area

Visit Outcomes:

APS information kit was provided.
Was the booklet provided or topic discussed at this visit?
Are other Medicaid services needed? (excluding Waiver services)
Will a referral be made for these services?
Are other non-Medicaid services needed? (including Medicare or private pay)
Will a referral be made for these services?

Was the Participant's personal safety plan discussed, developed or reviewed at this visit?
Are they prepared for a weather or power outage emergency?
Do they know what to do in case of a medical emergency?
Do they have a plan which includes help from family or friends?

Did a reportable incident or critical event occur with this Participant during this month?
"Incident" as defined by your agency protocol for reporting extra ordinary occurrences.

"Critical events" include:
- Referral to Adult Protective Services
- Law enforcement agency notified / involved
- Injury requiring medical attention
- Wander away / Elopement from ALF
- Hospitalization

Is a change needed to the current Plan of Care?

Service Verification:

★ For Services; the Case Manger/Care Coordinator checks the EMWS to validate service units in the service detail screen for each service listed in the POC. If no units are documented refer to "When validating services".

★ For Nurse Supervision; by checking this box the Case Manager/Care Coordinator has verified that, when required, an RN has done supervision on CNA services

★ For PERS Unit; by checking this box the Case Manager/Care Coordinator has physically checked or has received documentation by the service provider that checked the PERS unit is in good working order.

★ For Timesheets; by checking this box the Care Coordinator has verified the timesheets for each SHA for each participant

★ When validating services; if EMWS does not show services have been provided, the Case Manager/Care Coordinator must contact the service provider to document why services were not provided

Use the "Comments" area to clarify or detail any responses

All copies must be uploaded into the EMWS on a monthly basis.