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

Program Application

Section 1: Programs

Please check the appropriate program(s) below that you wish to apply for:

☐ **Long Term Care (LTC) waiver**- provides personal care services to an individual in their home
- ☐ Agency option- services are scheduled and provided by agency staff
- ☐ Self-Directed option- applicant can hire and train their own Self Help Assistant and the LTC program pays for the services

☐ **Assisted Living Facility (ALF) waiver**- provides personal care services to an individual who is living in, or planning to move into, an Assisted Living Facility

Section 2: Referral Source:

Check the box(es) next to the agency that told you about our programs?

- ☐ 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

Section 3: Case Management/Care Coordination Agency:

Please write the name of the agency you have chosen from the enclosed list on the line below

Name of Case Management/Care Coordination Agency:_____

Section 4: Applicant Information

Applicant Name:_____

Physical Address:_____ **City, State Zip:** _____

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

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

Is the applicant currently at an address other than their physical address or in a healthcare facility? If yes, please complete the following:

Healthcare Facility Name (if applicable):_____

Address:_____ ***City, State Zip:*** _____

E-MAIL: _____ **Preferred Contact method:** _____

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

What is your Preferred Language?_____ **Sex: Male / Female**

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

Section 5: 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: _____

Section 6: Guardian or Power of Attorney (POA)

Please fill out the following, if the applicant has a legal court-appointed Guardian or POA:

Name of Guardian or POA: _____

Physical Address:_____ **City, State, Zip:**_____

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

Phone Number: (____)_____ **Other:** (_____)_____

E-MAIL: _____

Section 7: 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 or POA **Date**

_____

Printed Name of Applicant or Guardian or POA

Signature of Witness:_____ _____

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

Return to: Home Care Services Unit 6101 Yellowstone Rd, Ste. 210 Cheyenne, WY 82002
Or Fax to: (307) 777-8685