Wyoming
Home and Community Based Services
Community Choices Waivers

Provider Duties Sheet

PLEASE FAX OR MAIL A SIGNED COPY TO THE CASE MANAGER LISTED BELOW
WITHIN 10 BUSINESS DAYS *FROM DATE OF CM SIGNATURE*

TO BE COMPLETED BY THE CASE MANAGER

Provider:____ Fax Number: _______________

(Check all that apply)

____ New or Renewal Plan of Care
____ Change of Case Manager/Case Mgmt Agency
____ Place Service "on Hold"
____ Remove "on Hold" status
____ End of Plan Period Notification
____ Move to participant-directed option
____ Move off participant-directed option
____ Service Modification
____ Terminate Services

Participant Name ____ Phone Number______________
Address ____
Medicaid ID Number __________________________________ Date of Birth _____/_____/________

Services Requested for Plan of Care Dates (MM/YY) __________________**TO** (MM/YY) _________________________

Service Name____ **Service Rate**______________________

Name of Month												
Total # of Units												
Description (what is being changed and reason for change)												

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Description (what is being changed and reason for change)												

Service Name____ **Service Rate**______________________

Name of Month												
Total # of Units												
Description (what is being changed and reason for change)												

Change Effective Date ____________________________________

FOR PERSONAL CARE SERVICES

Task	*Write Plan of Care months in space provided (e.g.: Month 1 = July, Month 2 = Aug, Month 3 = Sept, etc)*											
	Month 1	*Month 2*	*Month 3*	*Month 4*	*Month 5*	*Month 6*	*Month 7*	*Month 8*	*Month 9*	*Month 10*	*Month 11*	*Month 12*
In boxes below, check mark which months specified activities are identified within the Person-centered Plan of Care												
Bath/Shampoo/Nails/Skin												
Dressing/Grooming												
Oral Hygiene												
Toileting/eliminating/bowl or bladder care												
Transfer/Ambulate/Exercise												
Feeding/Meal Preparation												
Shopping												
Changing bed linens												
Light Cleaning/Laundry												

CM Printed Name ____

Signature ______________________________________ Date____________________

CM Agency ______________________________

Address ____

Fax # ______________ Phone # ____________________

TO BE COMPLETED BY THE SERVICE PROVIDER

- ☐ **I agree to provide the services requested as listed above for this participant.**
- ☐ **I am unable to provide one or more of the services listed above.**
- ☐ **I acknowledge the termination of one or more services based on the units listed above.**
- ☐ **I acknowledge the services are on a temporary hold.**

Provider Signature ______________________________________ Date ____________________

TO BE COMPLETED BY THE FINANCIAL MANAGEMENT SERVICE (FMS)

- ☐ **I acknowledge notification of changes that will impact participant-directed services (FMS only).**

FMS Signature______________________________________ Date____________________

FMS Comments:

Guidelines for completing form HCBS 6:

THIS FORM MUST BE COMPLETED AND FAXED OR MAILED TO THE SERVICE PROVIDER BY THE CASE MANAGER.

THE SIGNED COPY MUST BE RETURNED TO THE CASE MANAGER BEFORE THE SUBMISSION OF THE PLAN OF CARE.

1. This form is to be completed **prior** to:
   - The initial start of a Plan of Care
   - Renewal of a Plan of Care
   - Each modification to a Plan of Care
   - The end of a Plan period
   - Any change in delivery option
   - Any service hold or release of hold
   - Any termination of a service or multiple services
   - Any change in Case Manager or Agency
2. Complete the form in its entirety based on the information below.

Provider, Fax Number:	Print the name and fax number of the service provider of the requested service.
New or Renewal Plan of Care **OR** Change Case Manager / Case Management Agency **OR** Temporary Hold of Services **OR** End of Plan Period **OR** Move to or off of participant-directed option **OR** Service Modification **OR** Terminate Services	Check the appropriate selection(s).
Participant Name, Address, Phone Number, Medicaid ID #, Date of Birth:	Enter information as it appears on the participant screen in the EMWS.
Services Requested for Plan of Care Dates:	Enter dates indicated for the Plan of Care.
Service information:	Service Name – Enter the name of the service requested. This includes Personal Care Service- specifics are listed below. Service Rate – Enter the unit cost for the requested service Name of Month – based on the dates listed above put the name of each month (i.e., if dates are 07/16 to 06/17, the first month is March, second is April, etc.) Total # of Units – Enter the total number of units to be provided for the month (this is NOT the # of hours but the # of units.) Enter "0" if no units are to be provided in a month. Description: Describe what is changing about the service and why
For Personal Care: *(see provider Policy and Procedure Manual for allowed Personal Care services)*	Write the name of each plan month at the top of the month column. For each month, put a check mark in the corresponding box for each specified task as identified in the Plan of Care.
Case Manager printed name and signature with date, Case Management Agency with address and fax number.	Signature verifies the services and dates of service are correct based on the Plan of Care. Case Manager is **REQUIRED** to print, sign and date.
Service Provider check boxes	The requested provider is **REQUIRED** to check only one box.
Provider/FMS Signature and date:	Provider's signature is **REQUIRED** to attest agreement to provide services, inability to provide services or termination of services on the Plan of Care. The person who oversees the services should be the signor and the responsible party for delivery of the services. The FMS signature is **REQUIRED** to verify notification of a change that impacts participant-directed services (i.e.: change in number of units, change in case manager or case management agency, termination of services, hold or release of hold, move off of or onto participant-direction)

3. Fax or mail the completed Case Manager portion of the form to the service provider or FMS for completion
4. The document is not valid until both the Case Manager **AND** the service provider or FMS have signed and dated the document and returned it to the Case Manager.
5. If the service provider agrees to the information listed on the document, services can be entered and submitted for approval. If the service provider **DOES NOT** agree to provide one (1) or more service listed, a new service provider must be located or those services will not be provided. The FMS signature verifies that the notification of changes that will impact the participant's self-directed service has been received.