Wyoming Department of Health

Commit to your health.

Wyoming
Community Choices
Home and Community Based Service Waivers

Participant Directed Care Option
Authorized Representative Review

Name of Participant: ____

Medicaid Number: ________________________________ **Phone:** ( ) ____________________

Address: ____

City: ____ **Zip:** ____________________

Designated Representative

Name: ____

Address: ____

City: ____________________________________**State:**____________**Zip:**___________

For Waiver Office Use Only:

☐ **Information has been reviewed regarding this participant. The request HAS BEEN APPROVED for the designated representative identified above to serve as the representative under the Participant Directed Care option.**

☐ **Information has been reviewed regarding this participant. The request IS NOT APPROVED for designated representative identified above to serve as the representative under the Participant Directed Care option.**

____

Program Manager or Designee **Date**
Community Choices Home and Community Based Waiver