

Medicaid Waiver Application

Home and Community Based Services (HCBS)



Behavioral
Health
Division

Complete this form and mail to the BHD Participant Support Specialist.

Waiver Information

Please Check the Appropriate Waiver:

- Adult (DD) Waiver Comprehensive Waiver
 Child (DD) Waiver Supports Waiver
 Acquired Brain Injury (ABI) Waiver

Are you currently on a waiver? Yes No

Waiver Type: _____

If yes, current Case Manager name: _____

Applicant Contact Information

Applicant: _____ **DOB:** ____/____/____
Last Name First Name M.I.

Medicaid #: ____ - ____ **Social Security Number:** ____ - ____ - ____

Gender: Male Female **Ethnicity:** _____ **Town to Receive Services:** _____

Physical Address: _____ **Mailing Address:** _____

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

Phone Number: (____) _____ - _____ **E-mail Address:** _____

Preferred Method of Contact? Mail Phone E-mail

I am interested in the Wyoming Life Resource Center and would like more information. Yes No

Guardian Contact Information

Please fill out the following section if the person above is under 18 years of age or the person above has a legal, court-appointed guardian (full or limited).

Name of Parent(s)/Legal Guardian(s): _____

Address: _____ **City:** _____ **State:** ____ **Zip:** _____

E-mail Address: _____ **Preferred Method of Contact?** Mail Phone E-mail

Is this person a legal court-appointed guardian (full or limited)? Yes No

Emergency Contact Information

Emergency Contact: _____ **Phone:** (____) _____ - _____
Last Name First Name

Relationship to Participant: _____

Address: _____ **City:** _____ **State:** ____ **Zip:** _____

Signatures

_____ **Date:** ____/____/____
Signature of Applicant or Legally Responsible Representative

(If Responsible Representative, relationship to the applicant?): Parent Guardian Family Member Grandparent Other

Signature of Witness _____ **Date:** ____/____/____
 (Required if signature is marked with an "X")

Case Management Selection



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Complete this form and mail to the BHD Participant Support Specialist.

Applicant Name: _____
Last Name *First Name*

Legal Guardian: _____
Last Name *First Name*

Please Check the Type of Waiver: Adult (DD) Waiver Comprehensive Waiver Child (DD) Waiver
 Supports Waiver Acquired Brain Injury (ABI) Waiver

Acknowledgement of Choice of Providers and Case Manager Conflict of Interest Disclosure

Please *initial* each line to verify that services available through the waiver program have been explained to you.

- _____ I understand that I have the ability to make decisions regarding what services will be provided and which providers we will work with while he/she is a waiver participant.
- _____ I understand that I have a right to request informal dispute resolution or an Administrative Hearing if not given the choice of providers.
- _____ I understand that I can choose a case manager not affiliated with any of my other services; however, if the case manager is providing other services on my plan or works for an organization providing me other services, this may be a conflict of interest and it must be disclosed.

Targeted Case Manager & Case Manager Selection

A list of certified case managers available in my area/region has been shared with me and my questions have been answered. I have chosen the following individual to act as my case manager, to assist in gathering the necessary information to prepare my clinical eligibility, and if eligible for services, to assemble and submit the Individualized Plan of Care. I understand that I may choose a different case manager at a later date.

Case Manager Name: _____ Organization: _____

Federal Provider ID (NPI): _____ Wyoming Provider ID: _____

If this selection is to make a change, my current Case Manager is: _____

Federal Provider ID (NPI): _____ Wyoming Provider ID: _____

Effective Date of Change to New Case Manager: ____/____/____

Consent for Information Release

Please *initial* each line verifying your understanding of this information.

- _____ I agree to participate in assessments/screenings to determine clinical eligibility and the need for HCBS waiver services.
- _____ I authorize the release of information by my physician, hospital, community mental health center, other social service providers, school, health service providers and family members to and among state agencies and their agents on my child's medical condition and other relevant information necessary to determine appropriate HCBS waiver services. I understand I may revoke this release of information in writing at any time.

Signatures

_____ Signature of Applicant or Guardian ____/____/____ Date	_____ Signature of Witness ____/____/____ Date (Required if the signature is marked with an "X")
_____ Signature of Selected/Current Case Manager ____/____/____ Date	_____ Signature of New Case Manager ____/____/____ Date