Participant and Guardian Verification Form

WDH- Behavioral Health Division
Developmental Disabilities Section
Phone (307) 777-7115
Fax (307) 777-6047

Participant Name:		**Waiver:** ☐ Adult DD	☐ Child DD	☐ ABI

After discussing these items with the case manager, the Participant or Guardian shall verify the following:	
1. I have participated in the development of this plan and acknowledge my responsibilities as a waiver participant.	☐Yes ☐No
2. The restrictions in the rights and restoration plan have been explained to me along with my responsibilities.	☐Yes ☐No
3. I agree with the rights, restrictions, and restoration plan.	☐Yes ☐No ☐N/A
4. I have reviewed my choices through a current provider list and have reviewed the waiver services available.	☐Yes ☐No
5. I know I have a choice between home and community based services and the Wyoming Life Resource Center. I understand I can contact the Division to review possible changes to my providers. For this plan, I have made an informed choice about my providers.	☐Yes ☐No
6. I have been informed of my right to a Fair Hearing if I am denied a provider, service, or eligibility to the waiver	☐Yes ☐No
7. I agree that providers can administer medications as trained.	☐Yes ☐No ☐N/A

Comments *(use the above item numbers to describe your comments)*

Participant/Guardian Signature:	_____	**Date:**	__/__/____