Community Choices Waiver Provider Update

Please update the following provider agency information so we can update our records.

Date:

1. **Company (or Doing Business As – DBA):**
2. **Legally Authorized Representative:** **Phone:**
3. **Agency Address(es):**

Physical Address:

City **State** **Zip code**

Mailing Address:

City **State** **Zip code**

Physical Address:

City **State** **Zip code**

Mailing Address:

City **State** **Zip code**

Reason for Update:

- ☐ **Add Service**
- ☐ **End Service**
- ☐ **Change Contact Information**
- ☐ **Add Employee/CM/Other**
- ☐ **Remove Employee/CM/Other**
- ☐ **Agency Termination**
- ☐ **State Requested Update**

4. **Agency Contact Info: Main Phone: ( ) Fax ( )**

Office email:

5. **Program(s):** ☐ **Assisted Living Facility Services**
   ☐ **In-Home Services - Agency Option** ☐ **In-Home Services - Self-Directed Option**

6. **Services:** ☐ **Case Management** ☐ **Personal Care**
   ☐ **Skilled Nursing** ☐ **Non-Medical Transportation**
   ☐ **Home-Delivered Meals** ☐ **Personal Emergency Response System (PERS)**
   ☐ **Adult Day Care** ☐ **Respite**

   Currently Not Accepting Clients For:

7. **Counties Served:**

(Additional copies of these pages may be made, as needed)

Community Choices Waiver Case Management Update

8. Provider Staff **(Only fill out if you provide Case Management services)**

Staff Name: **Position:** ☐ **Case Manager** ☐ **Delegate**

Phone: (   ) **Email:**

Office Location:

Case Manager - Counties Served:

CM Type: ☐ *Registered Nurse ☐ *Independent Living Specialist

☐ *Access Care Coordinator ☐ *Social Worker

☐ Other, specify

Staff Name: **Position:** ☐ **Case Manager** ☐ **Delegate**

Phone: (   ) **Email:**

Office Location:

Case Manager - Counties Served:

CM Type: ☐ *Registered Nurse ☐ *Independent Living Specialist

☐ *Access Care Coordinator ☐ *Social Worker

☐ Other, specify

Staff Name: **Position:** ☐ **Case Manager** ☐ **Delegate**

Phone: (   ) **Email:**

Office Location:

Case Manager - Counties Served:

CM Type: ☐ *Registered Nurse ☐ *Independent Living Specialist

☐ *Access Care Coordinator ☐ *Social Worker

☐ Other, specify

(Additional copies of these pages may be made, as needed)

The agency certifies that all information contained on this update is true and complete. The agency understand that any omissions or falsifications may result in denial of certification or suspension of current certification. The agency gives the State of Wyoming and its authorized agents permission to verify any job related information given with this application.

The agency is responsible for ensuring that all employees who will be providing services meet the established qualifications for their role and have met all required background checks. All owners/ operators/employees must abide by current Medicaid Documentation Standards and must complete and sign a current Medicaid Enrollment Application and Agreement. Any failure, on the part of the agency, to ensure that the the established qualification of all service providers are met could result in termination of the Medicaid Provider Agreement and referral to the Medicaid's Program Integrity Unit for possible reimbursement of all services performed by a case manager that was not qualified to provide services.

Person completing this form: **Date:**

Please complete and email to alice.zimmerman@wyo.gov or fax to (307) 777-8685.