Community Choices Waiver Provider Application

Please complete all pages and submit any required additional documentation

Note: ***This application DOES NOT guarantee certification. Applicants must meet all certification requirements.***

In addition to this application, a Wyoming Medicaid Provider Enrollment Application and Agreement must be completed and submitted for the agency. Complete this online by visiting https://wymedicaid.portal.conduent.com/.
Providers will also need to obtain a National Provider Identifier (NPI). For more information regarding the NPI, or to apply for an NPI, visit https://npiregistry.cms.hhs.gov/

1. **Company (or Doing Business As – DBA): _____**
2. **Federal Employer Identification Number (FEIN): _____**
3. **Legally Authorized Representative: _____ Phone:_____**
4. **Agency Address(es): Physical Address: _____**
   City _____, State _____ Zip _____
   Mailing Address: _____
   City _____, State _____ Zip _____
   Physical Address: _____
   City _____, State _____ Zip _____
   Mailing Address: _____
   City _____, State _____ Zip _____
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**

7. **Counties Served: _____**

_____

*****Providers not providing case management please proceed to the signature page.*****

*****Please list below all persons who will be providing case management services.*****

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8. Provider Staff

Staff Name: _____ Position: ☐ Case Manager ☐ Delegate

Phone: ( )_____ Email: _____

Office Location: _____

Case Manager - Counties Served: _____

_____

CM Type:

- ☐ *Registered Nurse
- ☐ *Independent Living Specialist
- ☐ *Occupational Therapist
- ☐ *Access Care Coordinator
- ☐ *Social Worker
- ☐ *Licensed Counselor
- ☐ Other, specify _____
- ☐ *License/Diploma attached

Staff Name: _____ Position: ☐ Case Manager ☐ Delegate

Phone: ( )_____ Email: _____

Office Location: _____

Case Manager - Counties Served: _____

_____

CM Type:

- ☐ *Registered Nurse
- ☐ *Independent Living Specialist
- ☐ *Occupational Therapist
- ☐ *Access Care Coordinator
- ☐ *Social Worker
- ☐ *Licensed Counselor
- ☐ Other, specify _____
- ☐ *License/Diploma attached

(Additional copies of this page may be made, as needed)

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8. Provider Staff (cont.)

Staff Name: _____ Position: ☐ Case Manager ☐ Delegate

Phone: ( )_____ Email: _____

Office Location: _____

Case Manager - Counties Served: _____

_____

CM Type:

- ☐ *Registered Nurse
- ☐ *Independent Living Specialist
- ☐ *Occupational Therapist
- ☐ *Access Care Coordinator
- ☐ *Social Worker
- ☐ *Licensed Counselor
- ☐ Other, specify _____
- ☐ *License/Diploma attached

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The agency certifies that all information contained on this application is true and complete. The agency understands 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 waiver 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 established qualifications of all service providers are met could result in termination of the Medicaid Provider Agreement and a referral to Medicaid's Program Integrity Unit for possible reimbursement of all services performed by a case manager that was not qualified to provide services.

_____ _____

Signature of Legally Authorized Representative **Date**

You will need to print this application, sign and date it, and return it to the Community Choices Waiver, 6101 Yellowstone Rd., Suite 210, Cheyenne, WY 82002, Attn: Provider Support Manager

You may also scan and email it to alice.zimmerman@wyo.gov or fax it to (307) 777-8685.