Wyoming Department of Health
Commit to your health.

Wyoming
Home and Community Based Services
Community Choices Waiver

Provider Duties Sheet

PLEASE FAX OR MAIL A SIGNED COPY TO THE CASE MANAGER LISTED BELOW

WITHIN 5 BUSINESS DAYS *FROM DATE OF RECEIPT*

TO BE COMPLETED BY THE CASE MANAGER

Provider:____ Fax Number: _______________

(Check all that apply)

- ☐ New or Renewal Plan of Care
- ☐ Change of Case Manager/Case Mgmt Agency
- ☐ Place Service "on Hold"
- ☐ Remove "on Hold" status
- ☐ Service Modification**
- ☐ Move to participant-directed option
- ☐ Move off participant-directed option
- ☐ End of Plan Period Notification (PERS)
- ☐ Terminate Services

Change Effective Date ________________ (if applicable)

Participant Name ____ Phone Number_______________
Address ____
Medicaid ID Number __________________________________ Date of Birth _____/_____/_______

Services Requested for Plan of Care Dates (MM/YY) ________________**TO** (MM/YY) ______________________

Service Name_______________________________________ **Service Rate**____________________

Name of Month												
Total # of Units												
**Reason for modification												

Service Name_______________________________________ **Service Rate**____________________

Name of Month												
Total # of Units												
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Service Name_______________________________________ **Service Rate**____________________

Name of Month												
Total # of Units												
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Service Name_______________________________________ **Service Rate**____________________

Name of Month												
Total # of Units												
**Reason for modification												

FOR PERSONAL CARE SERVICES

In boxes below, mark with an X specified activities as identified within the Person-centered Plan of Care

Tasks	*Requires stand-by assistance*	*Requires full assistance*	*Total Care*
Bath/Shampoo/Nails/Skin	☐	☐	☐
Dressing/Grooming	☐	☐	☐
Oral Hygiene	☐	☐	☐
Toileting/eliminating/bowl or bladder care	☐	☐	☐
Transfer/Ambulate/Exercise	☐	☐	☐
Feeding/Meal Preparation	☐	☐	☐
Shopping	☐	☐	☐
Changing bed linens	☐	☐	☐
Light Cleaning/Laundry	☐	☐	☐

CM Printed Name _____

Signature _____ Date_____

CM Agency _____

Address _____

Fax # _____ Phone # _____

TO *ALL* PROVIDERS: THIS PROVIDER DUTY SHEET DOES *NOT* AUTHORIZE PAYMENT FOR SERVICES, IT IS AN AGREEMENT TO PROVIDE SERVICES. THERE IS NO AUTHORIZATION FOR PAYMENT UNTIL A PRIOR AUTHORIZATION (PA) NUMBER IS RECEIVED. IF YOU DO NOT RECEIVE A PA LETTER, PLEASE CONTACT THE CASE MANAGER OF RECORD LISTED ABOVE. PLEASE DO NOT USE WHITE OUT OR MAKE CHANGES TO THE REQUESTED UNITS FOR ANY SERVICE. IF YOU ARE UNABLE TO PROVIDE A SERVICE OR THE REQUESTED NUMBER OF UNITS REQUESTED FOR A SERVICE, CHECK THE APPROPRIATE BOX BELOW AND RETURN TO THE CASE MANAGER WITH A NOTATION OF WHAT YOU ARE ABLE TO PROVIDE.

TO BE COMPLETED BY THE SERVICE PROVIDER

- ☐ **I agree to provide the services requested as listed on page one (1) for this participant.**
- ☐ **I am unable to provide one or more of the services listed above. (Please note which services)**
- ☐ **I acknowledge the services are on a temporary hold.**
- ☐ **I acknowledge the termination of one or more services based on the units listed above.**

Provider Signature _____ Date _____

Guidelines for completing form CCW- 6:

THIS FORM MUST BE COMPLETED AND FAXED OR EMAILED TO THE SERVICE PROVIDER BY THE CASE MANAGER

THE SIGNED COPY MUST BE RETURNED TO THE CASE MANAGER AND UPLOADED TO THE EMWS RECORD BEFORE THE SUBMISSION OF THE PLAN OF CARE

1. This form is to be completed **prior** to:

The initial start of a Plan of Care	Renewal of a Plan of Care
Each modification to a Plan of Care	The end of a Plan period (for PERS)
Any change in delivery option	Any service hold or release of hold
Any termination of a service or multiple services	Any change in Case Manager or Agency

2. Complete the form in its entirety based on the information below.

Provider, Fax Number:	Print the name and fax number of the service provider of the requested service.
New or Renewal Plan of Care **OR** Change Case Manager / Case Management Agency **OR** Temporary Hold of Services **OR** End of Plan Period **OR** Move to or off of participant-directed option **OR** Service Modification **OR** Terminate Services	Check the appropriate selection(s) and include the effective date, if applicable. *An effective date is NOT required for New/Renewal plans of care because the start date is listed on the plan of care dates*.
Participant Name, Address, Phone Number, Medicaid ID #, Date of Birth:	Enter information as it appears on the participant screen in the EMWS.
Services Requested for Plan of Care Dates:	Enter dates indicated for the Plan of Care, begin and end dates.
Service information:	**Service Name** – Enter the name of the service requested. **Service Rate** – Enter the unit cost for the requested service **Name of Month –Total # of Units** – Enter the total number of units to be provided for the month (this is NOT the # of hours but the # of units.) Enter "0" if no units are to be provided in a month. **Description**: Describe what is changing about the service and why
For Personal Care: *(see provider Policy and Procedure Manual for allowed Personal Care services)*	Write the name of each plan month at the top of the month column. For each month, put an **X** in the corresponding box for each specified task as related to an identified level of care need during the Plan of Care development.
Case Manager printed name and signature with date, Case Management Agency with address and fax number.	Signature verifies that the services and dates of service are correct based on the Plan of Care. Case Manager is **REQUIRED** to print, sign and date.
Service Provider check boxes	The requested provider is **REQUIRED** to check only one box.

3. Fax or email the completed form to the service provider for signature.
4. The document is not valid until both the Case Manager **AND** the service provider has signed and dated the document and returned it to the Case Manager.
5. If the service provider agrees to the information listed on the document, services can be entered and submitted for approval. If the service provider **DOES NOT** agree to provide a service that is requested, a new service provider must be chosen by the participant or those services will not be provided.