Wyoming Department of Health

Case Management Selection Form

Applicant Information - Submit this form to a Developmental Disabilities Participant Support Specialist

Applicant: _____ Legally Authorized Representative: _____

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

Please initial each line to verify services available through this Waiver Program have been explained to you.

____ I understand I have the ability to make decisions regarding which services will be provided to me and which providers I will work with as a waiver participant.

____ I understand I have the right to request an informal dispute resolution or an administrative hearing if I am not given the choice of providers.

____ I understand I must choose a case manager not affiliated with any of my other services, so a conflict of interest will not exist.

Case Manager Selection

A list of certified case managers available in my region was provided to me and I have completed my case manager interviews. I have chosen the following individual to serve as my case manager, who will assist me in gathering the necessary information to determine my clinical eligibility and, if I am eligible for services, develop, and submit my Individualized Plan of Care.

Case Manager Name: _____ Organization: _____

Phone Number: _____

If you are changing your case manager, who is your current case manager: _____

Phone Number: _____ Effective Date of Change to new case manager: ___/___/_____

Backup case manager:_____ Organization: _____

____ My current case manager will have access to my case for up to 7 days after my new case manager begins, in order to complete required duties from the previous month of service. (Please initial if you understand and agree.)

Consent for Information Release

Please initial each line to verify you understand and agree to the following information:

____ I agree to participate in assessments and screenings to determine my clinical eligibility and need for waiver services.

____ I authorize the release of my information by my physician, hospital, community mental health center, other social service providers, school, health service providers, and family members to and among Wyoming state agencies, and their agents, as it relates to my medical condition and ability to determine appropriate waiver services. I understand I may revoke this release of information in writing at any time.

Signatures

_____ ___/___/____
Applicant or Legally Authorized Representative Signature — Date

_____ ___/___/____
New or Current Case Manager Signature — Date

_____ __/___/____
Witness Signature — Date
(required if signature is marked with an "X")

_____ __/___/____
New Selected Case Manager Signature — Date