Community Choices Waiver Provider Case Manager/Delegate Approval Form

Please complete all pages and submit any required additional documentation

Note: ***This application DOES NOT guarantee certification. Applicants must meet all certification requirements. This application will not be process if not complete.***

1. **Federal Employer Identification Number (FEIN): _____**
2. **Legally Authorized Representative: _____ Phone:_____**
3. **Agency Address(es): Physical Address: _____**

   City _____, State _____ Zip _____

4. **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**

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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, 122 W 25th Street, 4 West, Cheyenne, WY 82002, Attn: Provider Support Manager

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