



Wyoming  
Department  
of Health

# WyHS/WSSB Program & Fiscal Overview

## New Directors Training 2020

Day 1 - Session 2 (2/8) - November 2nd

### *Aging Division Community Living Section*



Hathaway Building  
2300 Capitol Avenue, 4th Floor  
Cheyenne, WY 82002  
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# Objectives

## Day 1 - Session 2 (2/8)

- **Understand WyHS and WSSB program overviews**
- **Outline of WyHS and WSSB fiscal overviews**



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# Wyoming Home Services Program (WyHS)



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# Wyoming Home Services Program (WyHS)

## The goals of the program:

- Fostering self-sufficiency
- Preventing abuse, neglect or exploitation
- Maintaining individuals in the least restrictive safe environment
- Preventing inappropriate or premature institutionalization



# Eligibility

## Eligibility:

- At least 18 years of age
- In need of program services
  - Determined through an on going assessment to be “at-risk” of premature institutionalization



# WyHS Program Services

## The program consists of the following services:

- Care Coordination
- Hospice care
- Personal care
- Home modifications
- Medication Set-up
- Homemaking services
- P.E.R.S. (*Lifeline, etc.*)
- Chore services
- Respite care
- Adult day care



# WyHS Program Overview

- Social program
- Mandated by the State of Wyoming through legislation
- Fully funded by the State General Fund
- Granted to 1 provider in each county
  - Total of 23 providers
  - Each provider can provide up to 10 services (based on availability of provider resources)



# Wyoming Home Services (WyHS) Services/Sub Services

| Service Category     | WyHS – Wyoming Home Services – Service Plans                                     |                             |   |                       |                       |                       |             |
|----------------------|--|-----------------------------|---|-----------------------|-----------------------|-----------------------|-------------|
|                      | Service  | Sub-Service                 | Sub-Service                               | Sub-Service           | Sub-Service           | Sub-Service           | Sub-Service |
| Case Management      | Case Management (Care Coordination – Hourly)                                     | Evaluation Initial          | Follow-up of Evaluation – Case Management | Quarterly Evaluation  | Re-evaluation Renewal |                       |             |
| Personal Care        | Personal Care (Hourly)   | Dressing                    | Skin Care                                 | Bathing/ Showering    | Transferring          | Personal Care - Other |             |
| Homemaker            | Homemaker (Hourly)   | Housekeeping                | Meal Preparation                          | Laundry/ Linen Change | Shopping              | Homemaker – Other     |             |
| Chore                | Chore (Hourly)   | Snow Removal                | Handyman                                  | Yard Maintenance      |                       |                       |             |
| Respite              | Respite (Hourly)   | In Home                     | Assisted Living                           | Adult-Day Care        | Institutional         |                       |             |
| Adult Day Care (ADC) | Adult Day Care/Health (Hourly)   |                             |   |                       |                       |                       |             |
| NAPIS Other          | Hospice (Hourly or Daily)  | In-Home Hospice             | Licensed Facility-Hospice                 |                       |                       |                       |             |
|                      | Home Repair – Minor Home Modifications (\$300 max per year – Caregiver – Hourly) |                             |   |                       |                       |                       |             |
|                      | Nursing (Hourly)   | Medication Management       | Delegation                                | Re-assessment         | Assessment            |                       |             |
|                      | Personal Emergency Response System (PERS)  | Installation Fee (One time) | Monthly Service Fee                       |                       |                       |                       |             |





# Program Fees

## Client Fees

- Utilizing the Community Living Section's sliding fee schedule as a guideline, clients will pay a fee for all services, based on their ability to pay.
- CLIENTS WHO CANNOT PAY WILL NOT BE DENIED SERVICES.
- ABSOLUTELY NO TIPPING ALLOWED!



## Wyoming Home Services (WyHS) Program

### 2020-2021 Suggested Eligible Participant Sliding Scale Fees

Effective from July 1, 2020 through June 30, 2021

| Household Income per month       |                | \$1,063 - \$1,328 | \$1,329 - \$1,594 | \$1,595 - \$1,859 | \$1,860 - \$2,125 | \$2,126 - \$2,391 | \$2,392 +   |
|----------------------------------|----------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------|
| Care Coordination                | Per occurrence | 10% of cost       | 15% of cost       | 20% of cost       | 25% of cost       | 30% of cost       | 40% of Cost |
| Licensed Nurse Care Coordination | Per occurrence | 15% of cost       | 20% of cost       | 25% of cost       | \$30% of cost     | 35% of cost       | 45% of Cost |
| Personal Care                    | Per hour       | \$7.00            | \$9.00            | \$11.00           | \$17.00           | \$20.00           | \$22.00     |
| Homemaker/Chore                  | Per hour       | \$4.00            | \$6.00            | \$8.00            | \$10.00           | \$12.00           | \$16.00     |
| In-home Respite                  | Per hour       | \$5.00            | \$7.00            | \$9.00            | \$11.00           | \$14.00           | \$16.00     |
| Hospice/Facility Services        | Per occurrence | 10% of cost       | 15% of cost       | \$20% of cost     | \$25% of cost     | 30% of cost       | 35% of cost |
| PERS Installation                | One time       | 20% cost          | 40% of cost       | 60% of cost       | 80% of cost       | 90% of cost       | Full cost   |
| PERS Maintenance                 | Per month      | 20% of cost       | 40% of cost       | 60% of cost       | 80% of cost       | 90% of cost       | Full cost   |
| Adult Day Care Services          | Per occurrence | 10% of cost       | 15% of cost       | 20% of cost       | 25% of cost       | 30% of cost       | 35% of cost |

The fee is based on the household net income. Clients, who are unable to pay, will not be denied services. However, please keep in mind that the program relies on client fees to serve the most clients possible.



# Program Effectiveness

- **WyHS provides a unique set of services, at a very low cost to participants.**
  - Smaller communities might not have these services at all without WyHS.
- **Resource coordination for participants**
  - ACCs are trained to assist participants in finding additional resources in their communities.

# Program Output & Efficiencies

- **2020 Stats**
  - 1,882 Participants
  - 81,839 Service hours provided
- **Average State Cost Per Person**
  - \$1,517
- **Average State Cost Per Unit of Service**
  - \$35
- **Average Annual Cost Per Participant**
  - \$211



# WyHS Program Funding

## Funding

- 100% state funded.
- Each grantee must provide at least five (5) percent of the contracted amount, based on actual expenses, to be applied as local match.
- Program income must be a part of the grantee's program budget, and it must be spent first.

# Wyoming Home Services Program (WyHS) Match

- **WHAT IS THE MATCH REQUIREMENT FOR THE WyHS PROGRAM?**
  - 5% of the total state grant funds expended
- **SO, HOW DO I FIGURE THE MATCH FOR THE WyHS PROGRAM?**
  - Total cumulative state funds expended
  - $(\$25,000) * 5\% = \$1,250$  Local Match Required





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¿Hablas Español?  Sí  No  
 ¿Necesitas un documento en Español?  Sí  No

**Aging Needs Evaluation Summary (AGNES) - One Form**

This form may not be altered. Revised 6/7/19. Effective 7/1/19.

|  |   |   |   |
|--|---|---|---|
| <b>Basic Client Information</b>  |   | Date of Assessment:     /     /   | Nickname:   |
| Legal First Name:  |   | Legal Last Name:  | Middle Initial:   |
| Date of Birth:     /     /   | Age:  | Gender (check one): <input type="checkbox"/> Female <input type="checkbox"/> Male                         | Are you disabled?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |
| Residential Address:   |   | <input type="checkbox"/> Check if same as Residential Address   |   |
|  |   | Mailing Address:  |   |
| Residential City, State and Zip Code:  |   | Mailing City, State and Zip Code:   |   |
| County of Residence:   |   | Email Address:  |   |
| Primary Phone Number: (    )   |   | Secondary Phone Number: (    )  |   |
| Primary Language (check one)<br><input type="checkbox"/> English <input type="checkbox"/> Other  | Race (check one)<br><input type="checkbox"/> White <input type="checkbox"/> American Indian/Alaskan<br><input type="checkbox"/> Asian <input type="checkbox"/> Black/ African American<br><input type="checkbox"/> Other <input type="checkbox"/> Native Hawaiian/ Pacific Islander |   | Ethnicity (check one)<br><input type="checkbox"/> Hispanic or Latino<br><input type="checkbox"/> Not Hispanic or Latino |
| Are you married?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Widowed <input type="checkbox"/> Other   | Do you live alone?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  | Do you live in a rural area?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                  |   |
| Are you eligible for Medicaid?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   | Are you a veteran?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  | Are you the spouse or dependent of a veteran?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |   |
| Is your monthly income at or below this amount?  |   | <input type="checkbox"/> Yes <input type="checkbox"/> No  |   |
| Family size 1-\$1,041    Family size 2-\$1,409   |   | Family size 3-\$1,778    Family size 4-\$2,146  |   |
| Emergency contact name:  | Relationship:   | Phone number:<br>(    )   |   |
| Are you working?<br><input type="checkbox"/> Full Time <input type="checkbox"/> Part time <input type="checkbox"/> No  |   | Are you willing to volunteer?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                 |   |
| How did you hear about our services and what services are you interested in receiving?   |   |   |   |
| <p><i>Use of Information:</i> The information you provide on the AGNES form will be disclosed to the Wyoming Department of Health (WDH), Aging Division, Community Living Section. The WDH will only use or disclose the information as permitted by the Health Insurance Portability and Accountability Act (HIPAA). For more detailed information on how the WDH may use or disclose your health information, please see the WDH Notice of Privacy Practices found online at <a href="https://health.wyo.gov/admin/privacy/">https://health.wyo.gov/admin/privacy/</a> or you may request a copy from the WDH Aging Division by calling 1 (800) 442-2766. If you feel you have been treated inappropriately, received services that have not been of the quality expected, or you have not been provided services as stated in the service plan, you may contact the Wyoming State Long Term Care Ombudsman at 1 (800) 856-4398 or the WDH Aging Division, Community Living Section at 1 (800) 442-2766.</p> |   |   |   |

Signature \_\_\_\_\_ Date \_\_\_\_\_

\*This page is for WDH, Aging Division Title III-B, C1, C2, D, E and WYHS eligible participants.





# Wyoming Home Services (WyHS) Monthly Invoices

Revised 07/07/17

| Wyoming Department of Health, Aging Division, Community Living Section  |                                       |              |                       |                    |               |
|---|---------------------------------------|--------------|-----------------------|--------------------|---------------|
| Provider Monthly Invoice  |                                       |              |                       |                    |               |
| Wyoming Home Services (WyHS) FY2018   |                                       |              |                       |                    |               |
| Legal Name:   | Month:                                |              | Year:                 |                    |               |
| <b>WyHS Income by Source:</b>   |                                       | <b>State</b> | <b>Program Income</b> | <b>Local Match</b> | <b>Totals</b> |
| State   |                                       |              |                       |                    |               |
| Program Income  |                                       | \$0.00       |                       |                    |               |
| WSSB (used as Match)  |                                       |              | \$0.00                |                    |               |
| Local Cash - Match  |                                       |              | \$0.00                |                    |               |
| In-kind - Match:  |                                       |              | \$0.00                |                    |               |
| In-kind - Match:  |                                       |              | \$0.00                |                    |               |
| <b>In-kind - Match Total</b>  |                                       |              | \$0.00                |                    |               |
| Other, ie. CSGB (Non-Matching):   |                                       |              | \$0.00                |                    |               |
| <b>Total Income Received by Provider</b>  |                                       | \$0.00       | \$0.00                |                    | \$0.00        |
| Program Income, WSSB & Local Match Only (Must match, at minimum, the lower section local match expenditures)  |                                       |              | \$0.00                |                    |               |
| <b>WyHS Program Expenditures:</b>   |                                       | <b>State</b> | <b>Program Income</b> | <b>Local Match</b> | <b>Totals</b> |
| Personnel/Employee Benefits & Taxes   |                                       |              |                       |                    | \$0.00        |
| Travel Expenses   |                                       |              |                       |                    | \$0.00        |
| Consumable Supplies   |                                       |              |                       |                    | \$0.00        |
| Other Expenses  |                                       |              |                       |                    | \$0.00        |
| <b>Total Expenses</b>   | \$0.00                                | \$0.00       | \$0.00                | \$0.00             | \$0.00        |
| <b>Monthly Invoice Total</b>  | \$0.00                                |              |                       |                    | \$0.00        |
| The monthly invoice total is: State expenditures (Does not include Program Income or Local Cash)  |                                       |              |                       |                    |               |
| Provider Comments:  |                                       |              |                       |                    |               |
| By signing this report, I certify to the best of my knowledge and belief that the report is true, complete, and accurate, and the expenditures, disbursements, and cash receipts are for the purposes and objectives set forth in the terms and conditions of the Federal and State awards. I am aware that any false, fictitious, or fraudulent information, or the omission of any material fact, may subject me to criminal, civil or administrative penalties for fraud, false statements, false claims or otherwise. |                                       |              |                       |                    |               |
| <b>Authorized Certifying Official:</b>  |                                       |              |                       |                    |               |
| Name of Director:   | CLS Program Manager Signature & Date: |              |                       |                    |               |
| Director Signature (BLUE ink):  |                                       |              |                       |                    |               |
| Date:   |                                       |              |                       |                    |               |





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# Wyoming Home Services (WyHS) Quarterly Financial

| STATE FISCAL YEAR 2018   |  |                 |  |  |  |   |  |   |  |           |
|--|--|-----------------|--|--|--|---|--|---|--|-----------|
| WYOMING DEPARTMENT OF HEALTH, AGING DIVISION<br>QUARTERLY FINANCIAL REPORT OF GRANT EXPENDITURES   |  |                 |  |  |  |   |  |   |  |           |
| Due by October 15, 2017  |  |                 |  |  |  |   |  |   |  |           |
| Grantee:   |  | Address:        |  | City:  |  | State: <b>Wy</b>  |  | Zip Code:   |  | Comments: |
| County:  |  | Phone:          |  |  |  |   |  |   |  |           |
| Quarterly Report Period appropriate block  |  | Please mark the |  | GRANT COVERED BY THIS REPORT   |  |   |  |   |  |           |
| Jul, Aug, Sep 2017   |  |                 |  | State: Wyoming   |  |   |  |   |  |           |
| Oct, Nov, Dec 2017   |  |                 |  | <div style="display: flex; justify-content: space-around; font-size: 2em; font-weight: bold;"> <span>WyHS</span> <span>1st Qtr</span> </div> |  |   |  |   |  |           |
| Jan, Feb, Mar 2018   |  |                 |  |  |  |   |  |   |  |           |
| Apr, May, Jun 2018   |  |                 |  | PROGRAM INCOME RECEIVED:   |  | This Quarter  |  | Cumulative for FY 18  |  |           |
|  |  |                 |  |  |  | \$  |  | -   |  |           |
| EXPENDITURES   |  |                 | Total Expenditures reported from the previous quarters in this grant year (See Instructions) | Expenditures and Adjustments this Quarter (See Instructions)   |  | CUMULATIVE  |  | EXPENDITURES  |  |           |
| 1) PROGRAM INCOME EXPENDED:  |  |                 | \$   | -  |  | \$  |  | -   |  |           |
| 2) STATE FUNDS EXPENDED:   |  |                 | \$   | -  |  | \$  |  | -   |  |           |
| 3) LOCAL CASH EXPENDED:  |  |                 | \$   | -  |  | \$  |  | -   |  |           |
| 4) WSSB FUNDS EXPENDED:  |  |                 | \$   | -  |  | \$  |  | -   |  |           |
| 5) IN-KIND UTILIZED:   |  |                 | \$   | -  |  | \$  |  | -   |  |           |
| 6) CSBG FUNDS EXPENDED:  |  |                 | \$   | -  |  | \$  |  | -   |  |           |
| 7) TOTAL EXPENDITURES for this grant:  |  |                 | \$   | -  |  | \$  |  | -   |  |           |
| X  |  |                 |  |  |  |   |  |   |  |           |
| <i>certify this report is true and correct, that all expenditures reported herein have been made in accordance with the terms and conditions of this grant and are properly reflected in the grantee's accounting records.</i> |  |                 |  | Date Report Received:  |  | Enter your total budget amount:<br>You have expended                      |  | <input type="text"/> #DIV/0!<br>of your total budget this year. |  |           |
| Name of Authorized Certifying Official:  |  |                 |  | Program Manager:   |  | Enter your WyHS state allotted funds:<br>You have used                    |  | <input type="text"/> #DIV/0!<br>of your state funds.            |  |           |
|  |  |                 |  |  |  | Enter the unduplicated number of WYHS clients served during this Quarter: |  | <input type="text"/> #DIV/0!                                    |  |           |
| Printed NAME of Authorized Official:   |  |                 |  | Date:  |  | Your quarterly cost per client is:  |  | <b>Payment or Adjustment</b><br>Amount:                         |  |           |
| Signature of Authorized Official:  |  |                 |  | Date:  |  | <input type="text"/>  |  |   |  |           |
| Date:  |  |                 |  | CLS Manager:   |  | Date:   |  |   |  |           |



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# Wyoming Senior Services Board (WSSB)

## *Aging Division Community Living Section*



**Marge Myers**  
Board President  
(307) 281-0190

[marge.myers@wyboards.gov](mailto:marge.myers@wyboards.gov)



# WSSB Overview

**The Wyoming Senior Services Board (WSSB) consists of seven voting members and a nonvoting, ex-officio member, as follows:**

- (i) The administrator of the Aging Division within the Department of Health or his designee shall serve as a nonvoting, ex-officio member;**
- (ii) One member of the advisory council on aging appointed by the governor;**
- (iii) Three persons who are senior citizens appointed by the governor;**
- (iv) Three members at large appointed by the governor.**



# WSSB Overview

**The board, in consultation with the Aging Division, appropriates funding to eligible senior centers to provide services and meet the needs of older adults.**

**Eligible Senior Center: Must be awarded a Title III-B or Title III-C Federal Grant Award by the Aging Division to be eligible for WSSB funds.**



# WSSB Annual Grants

- **Basic Grant:** Each eligible senior center shall receive (\$30,000.00) annually.
- **Formula Grant:** Of the amounts remaining after the basic grants are awarded, the board shall annually award grants to eligible senior centers based on the formula.

# What are WSSB Funds For?

**To meet the demands of Wyoming's growing elderly population;**

- **To enhance services to Wyoming's senior citizens;**
- **To strengthen the opportunity for senior citizens to age in the least restrictive environment possible;**
- **To be cost effective in the provision of services to senior citizens;**
- **To promote compliance with federal and state mandates requiring placement of people in the least restrictive environment; and,**
- **To supplement and enhance existing programs providing services to senior citizens in the state.**



# WSSB Grant Application

**SFY 2021 FUNDING APPLICATION COVER PAGE**

*signed cover page is needed for multiple applications that are submitted*

|  |   |
|--|---|
| <b>Grant Period for which funds are requested:</b><br>July 1, 2020 through June 30, 2021   |   |
| <b>Type of Application(s): Please check all that apply.</b><br><small>(Only one cover page is needed, if multiple grants are being submitted.)</small>   |   |
| <input checked="" type="checkbox"/> Basic  | <input checked="" type="checkbox"/> Formula |
| Applicant Organization _____   |   |
| Building Owned By: (i.e. County, City, Senior Center) _____  |   |
| Address _____<br><small>(Street Address, P.O. Box, City, State, Zip Code)</small>  |   |
| Phone _____  | Fax _____                                   |
| Email _____  |   |
| Organization Director _____<br><small>(Name and official title)</small>  |   |
| <p><b>Terms and Conditions:</b> It is understood and agreed to by the undersigned that, for the purposes of this agreement:</p> <p>1) Funds awarded as a result of this request are to be expended for the purposes set forth, herein, and in accordance with all applicable laws, regulations, policies and procedures of the Wyoming Senior Services Board, the Wyoming Department of Health - Aging Division, Community Living Section, and the State of Wyoming.</p> <p>2) Any proposed changes to the application shall be submitted in writing to, and approved by, the Wyoming Senior Services Board, in consultation with the Aging Division-Community Living Section. Upon notification of approval, the changes shall be deemed incorporated into, and will become a part of, this agreement.</p> <p>3) Funds awarded by the Wyoming Senior Services Board, in consultation with the Aging Division-Community Living Section, may be suspended or terminated at any time for violations of any terms and requirements of this agreement.</p> |   |
| <b>Signatures:</b>   |   |
| Signature of Applicant's Board Chair: _____  | Date: _____                                 |
| <small>(Signature of Board Chair or other authorized Board member)</small>   |   |



# WSSB Grant Application

- Applications are updated and released once each year.
- Typically in March.
- Providers will have between 30-45 days to complete the application.
- Applications are approved by the WSSB.
- Once approved, the Aging Division will submit contract paperwork to the Attorney General's Office for a formal agreement.





# WSSB Quarterly Invoice

| Wyoming Department of Health, Aging Division, Community Living Section  |  |                                       |                |               |
|---|--|---------------------------------------|----------------|---------------|
| Provider Quarterly Invoice  |  |                                       |                |               |
| Wyoming Senior Services Board SFY21   |  |                                       |                |               |
| Legal Name:   |  | Quarter:                              |                | Year:         |
| <b>WSSB Income by Source:</b>   |  | <b>Basic</b>                          | <b>Formula</b> | <b>Totals</b> |
| Basic Grant   |  |                                       |                |               |
| Formula Grant   |  |                                       |                |               |
| <b>Total Income Received by Provider</b>  |  | \$0.00                                | \$0.00         | \$0.00        |
| <b>WSSB Basic Expenditures:</b>   |  | <b>Basic</b>                          |                | <b>Totals</b> |
| Personnel/Employee Benefits & Taxes   |  |                                       |                | \$0.00        |
| Travel Expenses   |  |                                       |                | \$0.00        |
| Equipment   |  |                                       |                | \$0.00        |
| Consumable Supplies   |  |                                       |                | \$0.00        |
| Other Expenses  |  |                                       |                | \$0.00        |
| <b>Total Expenses (Pre-paid)</b>  |  | \$0.00                                |                | \$0.00        |
| <b>WSSB Formula Expenditures:</b>   |  |                                       | <b>Formula</b> | <b>Totals</b> |
| Personnel/Employee Benefits & Taxes   |  |                                       |                | \$0.00        |
| Travel Expenses   |  |                                       |                | \$0.00        |
| Equipment   |  |                                       |                | \$0.00        |
| Consumable Supplies   |  |                                       |                | \$0.00        |
| Other Expenses  |  |                                       |                | \$0.00        |
| <b>Total Expenses</b>   |  |                                       | \$0.00         | \$0.00        |
| <b>Quarterly Invoice Total</b>  |  |                                       |                | <b>\$0.00</b> |
| Provider Comments:  |  |                                       |                |               |
| By signing this report, I certify to the best of my knowledge and belief that the report is true, complete, and accurate, and the expenditures, disbursements, and cash receipts are for the purposes and objectives set forth in the terms and conditions of the Federal and State awards. I am aware that any false, fictitious, or fraudulent information, or the omission of any material fact, may subject me to criminal, civil or administrative penalties for fraud, false statements, false claims or otherwise. |  |                                       |                |               |
| <b>Authorized Certifying Official:</b>  |  |                                       |                |               |
| Name of Director:   |  | WSSB Representative Signature & Date: |                |               |
| Director Signature (BLUE ink):  |  |                                       |                |               |
| Date:   |  |                                       |                |               |
| Name of Board Member:   |  |                                       |                |               |
| Board Member Signature (Blue ink):  |  |                                       |                |               |
| Date:   |  |                                       |                |               |



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# Contact Us

**Wyoming Department of Health  
Aging Division  
Community Living Section  
Hathaway Building  
2300 Capitol Avenue, 4th Floor  
Cheyenne, WY 82002  
Main Office: (307) 777-7995  
Toll Free: (800) 442-2766  
Fax: (307) 777-5340**

**Email: [wyaging@wyo.gov](mailto:wyaging@wyo.gov)  
WellSky A&D/Data Requests: [aging-sams@wyo.gov](mailto:aging-sams@wyo.gov)  
Website: [health.wyo.gov/aging](http://health.wyo.gov/aging)  
Social Media: [facebook.com/agingdivision](https://facebook.com/agingdivision)**