**Provider/Agency:**

**Employee:**

**Employee DOB:**

**Employee Job Title:**

[ ]  I do not currently have employees, but I acknowledge that it is my responsibility to ensure that all future staff members meet requirements as outlined in Chapter 45 of Wyoming Medicaid Rules.

**Professional License Required?** [ ]  **Yes** [ ]  **No License Number:**

**Certification Required?** [ ]  **Yes** [ ]  **No Certification Date:**

**Hire/Start Date:**

Is employee a biological, step, or adoptive parent, or a legally authorized representative of a participant receiving services from the provider?

[ ]  **Yes** [ ]  **No Participant Name:**

|  |  |
| --- | --- |
| **Standard** | **Comments** |
| Background screening (includes DFS Central Registry, DCI/FBI Fingerprint results, and Office of Inspector General Exclusions List) | DFS/DCI/FBI received: OIG Received:  |
| Subsequent 5-year background screening required? [ ]  Yes[ ]  No | Date of prior screening: Date of subsequent screening:  |
| Monthly OIG Exclusions Database screening required? [ ]  Yes[ ]  No | Monthly screening documented? [ ]  Yes[ ]  No[ ]  N/A |
| CPR *(delivered by a certified instructor)* | Date of training: Expiration:  |
| First Aid *(delivered by a certified instructor)* | Date of training: Expiration:  |
| Restraint certification *(if applicable)**(delivered by a certified instructor)* | Expiration: Expiration of trainer:  |
| Medication Assistance Training *(if applicable)**(delivered by a certified instructor)* | Date of training: Expiration:  |
| Division Specific Training *(prior to working with participants)* | Date of training: Staff member employed prior to last certification period [ ]  |
| Annual policy review | Date of review:  |
| Current driver’s license *(if applicable)* | Expiration:  |
| Current insurance *(if applicable)* | Expiration:  |
| Documentation present indicating that decertification has not occurred under Chapter 45, Section 30? | [ ]  Yes[ ]  No |

[ ]  I attest that the information reported on this form is accurate, complete, and available for review and verification.

|  |
| --- |
|   |

Printed name of information reporter

|  |  |  |
| --- | --- | --- |
|  |  |  |

Signature of information reporter Date

**Provider/Agency:**

**Employee:**

[ ]  Information was not verified by Division representative

OR

|  |  |  |  |
| --- | --- | --- | --- |
| [ ]  Information verified by Division representative | [ ]  On-site | [ ]  Virtually - Method |   |

|  |  |  |
| --- | --- | --- |
|  |  |  |

Signature of Division representative Date

**Comments:**

|  |  |
| --- | --- |
| **Services that require a professional license** | **Services that require a certification or additional training** |
| Behavioral Support Services | Case Management |
| Cognitive Retraining | Child Habilitation (if operating a day care) |
| Specialized Equipment | Individual Habilitation Training |
| Home Modifications |  |
| Occupational Therapy |  |
| Speech, Language, and Hearing |  |
| Physical Therapy |  |
| Dietician |  |
| Skilled Nursing |  |