**Please update the following provider agency information as needed to ensure HCBS records are accurate and current. If no changes are necessary, please check ‘No change’ and move on to the next section.**

**Current WY#:** Click here to enter text.

1. **Company (or Doing Business As – DBA):**

[ ]  No Change

New name

1. **Company Representative (Primary contact):**

[ ]  No Change

New Company Representative

1. **Agency Address(es):**

[ ]  No Change

|  |  |  |
| --- | --- | --- |
| [ ]  Physical Address | [ ]  Mailing Address | [ ]  Services Address |

Address: Street/PO Box address.
City: City.
State: State
Zip code: Zip code

1. **Agency Contact Info:**

[ ]  No Change

Main Phone: Main Phone number
Primary Email: Primary Email
Fax: Fax number

1. **Services:**

[ ]  No Change

|  |  |
| --- | --- |
| [ ]  Add Service(s) | [ ]  Remove Service(s) |

 List Service(s):

|  |
| --- |
| List Services. |

 Currently not accepting new participants for the following Service(s):

|  |
| --- |
| List services |

1. **Counties Served (If adding counties, proof of licensure may be required):**

[ ]  No Change

|  |  |
| --- | --- |
| [ ]  Add  | [ ]  Remove |

 List County(ies):

|  |
| --- |
| List counties |

Currently not accepting new participants in the following location(s):

|  |
| --- |
| List Counties |

1. **Provider Staff (Only fill out if you provide Case Management services)**

 [ ]  No Change

|  |  |
| --- | --- |
| [ ]  Add | [ ]  Remove |

Staff Name: Staff Name

Position:

[ ]  Case Manager

[ ]  Delegate

Phone: Staff Phone Number

Email: Staff Email.

Office Location (address): Staff Location

Case Manager - Counties Served (List all that apply):

|  |
| --- |
| Counties served by staff |

(Additional copies of these pages may be made, as needed)

The agency certifies that all information contained on this update 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 agent permission to verify any job related information given with this application.

The agency is responsible for ensuring that all employees who will be providing 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 the established qualification of all service providers are met could result in termination of the Medicaid Provider Agreement and referral to the Medicaid's Program Integrity Unit for possible recovery of funds for all services performed by the provider agency/operators/employees that were not qualified to provide services.

Signature of Person completing this form: Signature

Printed Name of person completing this form: Printed Name

Date (required): Date

Please complete and email to wdh-hcbs-credentialing@wyo.gov