

Provider Vehicle Information



HOME AND
COMMUNITY-
BASED
SERVICES

WYOMING MEDICAID
DIVISION OF HEALTHCARE FINANCING

Yes	*No	
		Will you/do you provide transportation for Developmental Disability (DD) Waiver participants?

****If you answered no, stop and sign the bottom of this form. If you answered yes, answer the remaining questions before you sign the bottom of this form***

Yes	No	
		Is current insurance and registration information in the vehicle?
		Does the vehicle have safety equipment?
		Do you have a properly installed child safety seat, if required?
		Do you carry a stocked first aid kit in the vehicle?
		Do you carry emergency supplies adequate for all weather and emergency conditions?

I certify that I have answered the above questions honestly and accurately. I will take my driving responsibilities seriously, and will exercise caution to ensure the safety of passengers in my vehicle. I understand that additional liability insurance may be required if I am to transport individuals for business purposes.

If I have chosen ***not*** to provide transportation for Waiver participants in my own vehicle, I understand that additional requirements must be met ***prior*** to using my vehicle to provide transportation for DD Waiver participants. Should I choose to use my vehicle to provide transportation for DD Waiver participants, I will contact the Provider Credentialing Team at wdh-hcbs-credentialing@wyo.gov to ensure I have met these requirements before providing transportation. I understand that providing transportation in my vehicle, without meeting the additional standards, is a violation of Medicaid rule and may result in adverse actions pursuant to Chapter 45 of the Department of Health's Medicaid Rules.

Provider's name (please print) _____

Provider's Signature _____ Date _____