Provider Cost and Wage Survey ("Short Survey")
Rate Rebasing Project: Comprehensive and Supports Medicaid Waiver Programs
Wyoming Department of Health, Division of Healthcare Financing

INSTRUCTIONS:
This survey should be completed by waiver providers with $1,000,000 or more in SFY 2023 waiver revenues. Providers earning less than $1,000,000 are asked to fill out a separate survey, but are welcome to fill out the “full” cost and wage survey if they are able.

Providers should use data from their most recent fiscal year (i.e., FYE 12/31/2022 or 6/30/2023).

Providers with multiple locations/sites are encouraged to submit one survey that encompasses data for all of their locations/sites; however, providers may choose to submit a separate survey for each location/site if necessary.

Please submit your completed survey or any questions that you have to the email: wyratestudy@guidehouse.com

EXCEL INSTRUCTIONS:
Complete all applicable worksheets within this Excel file.
Please fill in the "yellow" filled cells throughout the survey.
If entering information into the "other" fields please be specific.
The bottom right-hand corner allows you to adjust the zoom in or out on the spreadsheet.

WORKSHEET A: PROVIDER INFORMATION

1. PROVIDER IDENTIFICATION

1	PROVIDER NAME:	
2	PRIMARY NPI NUMBER:	
3	CITY:	
4	COUNTY:	
5	CARF CERTIFICATION STATUS:	
6	PROVIDER FISCAL YEAR BEGINNING:	
7	PROVIDER FISCAL YEAR ENDING:	

2. CONTACT INFORMATION

8	CONTACT PERSON:	
9	TITLE:	
10	PHONE NUMBER:	
11	EMAIL ADDRESS:	

3. PROVIDER SITES

SITE 1		
12	CITY	
13	COUNTY	
14	NUMBER OF WAIVER PARTICIPANTS SERVED DURING PROVIDER FISCAL YEAR (ENTERED ABOVE)	
15	PERCENT OF PARTICIPANTS THAT LIVE:	
	0-25 MILES FROM LOCATION	
	26-50 MILES FROM LOCATION	
	GREATER THAN 50 MILES FROM LOCATION	

Provider Cost and Wage Survey ("Short Survey")
Rate Rebasing Project: Comprehensive and Supports Medicaid Waiver Programs
Wyoming Department of Health, Division of Healthcare Financing

INSTRUCTIONS:
This survey should be completed by waiver providers with $1,000,000 or more in SFY 2023 waiver revenues. Providers earning less than $1,000,000 are asked to fill out a separate survey, but are welcome to fill out the “full” cost and wage survey if they are able.

Providers should use data from their most recent fiscal year (i.e., FYE 12/31/2022 or 6/30/2023).

Providers with multiple locations/sites are encouraged to submit one survey that encompasses data for all of their locations/sites; however, providers may choose to submit a separate survey for each location/site if necessary.

Please submit your completed survey or any questions that you have to the email: wyratestudy@guidehouse.com

EXCEL INSTRUCTIONS:
Complete all applicable worksheets within this Excel file.
Please fill in the "yellow" filled cells throughout the survey.
If entering information into the "other" fields please be specific.
The bottom right-hand corner allows you to adjust the zoom in or out on the spreadsheet.

WORKSHEET A: PROVIDER INFORMATION		
SITE 2		
16	CITY	
17	COUNTY	
18	NUMBER OF WAIVER PARTICIPANTS SERVED DURING PROVIDER FISCAL YEAR (ENTERED ABOVE)	
19	PERCENT OF PARTICIPANTS THAT LIVE WITHIN:	
	0-25 MILES FROM LOCATION	
	26-50 MILES FROM LOCATION	
	GREATER THAN 50 MILES FROM LOCATION	
SITE 3		
20	CITY	
21	COUNTY	
22	NUMBER OF WAIVER PARTICIPANTS SERVED DURING PROVIDER FISCAL YEAR (ENTERED ABOVE)	
23	PERCENT OF PARTICIPANTS THAT LIVE:	
	0-25 MILES FROM LOCATION	
	26-50 MILES FROM LOCATION	
	GREATER THAN 50 MILES FROM LOCATION	
SITE 4		
24	CITY	
25	COUNTY	
26	NUMBER OF WAIVER PARTICIPANTS SERVED DURING PROVIDER FISCAL YEAR (ENTERED ABOVE)	
27	PERCENT OF PARTICIPANTS THAT LIVE:	
	0-25 MILES FROM LOCATION	
	26-50 MILES FROM LOCATION	
	GREATER THAN 50 MILES FROM LOCATION	
If your organization has multiple provider sites and collects cost data individually for each site, you may choose to submit information for each site using separate surveys.		
28	Are you completing this survey for a particular site?	
29	If yes, please indicate the relevant site (from above).	

Provider Cost and Wage Survey ("Short Survey")
Rate Rebasing Project: Comprehensive and Supports Medicaid Waiver Programs
Wyoming Department of Health, Division of Healthcare Financing

INSTRUCTIONS:
This survey should be completed by waiver providers with $1,000,000 or more in SFY 2023 waiver revenues. Providers earning less than $1,000,000 are asked to fill out a separate survey, but are welcome to fill out the “full” cost and wage survey if they are able.

Providers should use data from their most recent fiscal year (i.e., FYE 12/31/2022 or 6/30/2023).

Providers with multiple locations/sites are encouraged to submit one survey that encompasses data for all of their locations/sites; however, providers may choose to submit a separate survey for each location/site if necessary.

Please submit your completed survey or any questions that you have to the email: wyratestudy@guidehouse.com

EXCEL INSTRUCTIONS:
Complete all applicable worksheets within this Excel file.
Please fill in the "yellow" filled cells throughout the survey.
If entering information into the "other" fields please be specific.
The bottom right-hand corner allows you to adjust the zoom in or out on the spreadsheet.

WORKSHEET A: PROVIDER INFORMATION		
4. PROVIDER STAFFING		
30	TOTAL NUMBER OF FULL-TIME EMPLOYEES AT END OF PROVIDER FISCAL YEAR (30 or more hours/week or 130 hours/month)	
31	TOTAL NUMBER OF PART-TIME EMPLOYEES AT END OF PROVIDER FISCAL YEAR (Less than 30 hours/week or 130 hours/month)	

5. AGENCY OR INDEPENDENT		
32	Are you an AGENCY provider or INDEPENDENT provider?	

Provider Cost and Wage Survey ("Short Survey")
Rate Rebasing Project: Comprehensive and Supports Medicaid Waiver Programs
Wyoming Department of Health, Division of Healthcare Financing

PROVIDER NAME:	N/A
PROVIDER SITE:	N/A
PROVIDER FISCAL YEAR BEGINNING:	N/A
PROVIDER FISCAL YEAR ENDING:	N/A

If your provider accounting books and records clearly distinguish waiver and non-waiver costs, please directly allocate those costs in Lines 1-64. If your organization cannot break out costs for particular sections you may choose to add the total amount into the "Other" line items.
Please use the comments section to explain your reasoning for not being able to break out the information and explain what is contained within the total value.
To the extent that waiver and non-waiver program costs are not easily distinguishable, you may fill out the table below to estimate proportion of resources used to support DD waiver service delivery.

COST ALLOCATION:

a.	**Total FTEs**	
b.	# FTEs for DD waiver activities	
c.	# FTE for non-waiver activities	0.00

Calculated DD Waiver FTE Allocation: N/A

Setting Space

d.	Do you or your organization have dedicated space?	
e.	If yes, what is the total square footage of your setting?	
f.	How many square feet are used for delivery of waiver services?	
g.	Square feet remaining / used for other activities	0.00

Calculated DD Waiver Square Footage Allocation: N/A

WORKSHEET B: PROVIDER COSTS

Line No.	1 Cost Centers	2 Uniform Chart of Accounts Code	2 All Costs from Provider General Ledger	3 Calculated DD Waiver Costs Based on Cost Allocations Above	4 Comprehensive and Supports Waiver Program Costs	5 Additional Information
	SALARIES AND WAGES					
	Employee Salaries and Wages					
1	Program Employee Salaries and Wages	5010		$ -		
2	Program Support Employee Salaries and Wages			$ -		
3	Maintenance Employee Salaries and Wages	5020		$ -		
4	Administration Employee Salaries and Wages	5030		$ -		
5	Client and Other Salaries and Wages	5040		$ -		
6	**TOTAL SALARIES AND WAGES**		**$ -**	**$ -**	**$ -**	☐ Check to confirm that Col. 4 does not include room and board
	EMPLOYEE TAXES, INSURANCE AND BENEFITS					
7	**Employee Payroll Taxes**			$ -		☐ Check to confirm that Col. 4 does not include room and board
8	FICA	5710				
9	FUI	5720				
10	SUI	5730				
11	Workers Compensation and Other Payroll Taxes	5740-5750				

Provider Cost and Wage Survey ("Short Survey")
Rate Rebasing Project: Comprehensive and Supports Medicaid Waiver Programs
Wyoming Department of Health, Division of Healthcare Financing

PROVIDER NAME:	N/A
PROVIDER SITE:	N/A
PROVIDER FISCAL YEAR BEGINNING:	N/A
PROVIDER FISCAL YEAR ENDING:	N/A

If your provider accounting books and records clearly distinguish waiver and non-waiver costs, please directly allocate those costs in Lines 1-64. If your organization cannot break out costs for particular sections you may choose to add the total amount into the "Other" line items.
Please use the comments section to explain your reasoning for not being able to break out the information and explain what is contained within the total value.
To the extent that waiver and non-waiver program costs are not easily distinguishable, you may fill out the table below to estimate proportion of resources used to support DD waiver service delivery.

COST ALLOCATION:

a.	**Total FTEs**	
b.	# FTEs for DD waiver activities	
c.	# FTE for non-waiver activities	0.00

Calculated DD Waiver FTE Allocation: N/A

Setting Space

d.	Do you or your organization have dedicated space?	
e.	If yes, what is the total square footage of your setting?	
f.	How many square feet are used for delivery of waiver services?	
g.	Square feet remaining / used for other activities	0.00

Calculated DD Waiver Square Footage Allocation: N/A

WORKSHEET B: PROVIDER COSTS

	1		2	2	3	4	5
Line No.	**Cost Centers**		**Uniform Chart of Accounts Code**	**All Costs from Provider General Ledger**	**Calculated DD Waiver Costs Based on Cost Allocations Above**	**Comprehensive and Supports Waiver Program Costs**	**Additional Information**
12	**Employee Insurance**				$ -		☐ Check to confirm that Col. 4 does not include room and board
13	Health						
14	Vision		5810				
15	Dental		5860				
16	Life Insurance		5820				
17	Short-Term and Long-Term Disability		5830				
18	Client Fringe Benefits		5840				
19	Other Employee Insurance, excluding any categories listed above	*(Specify)*	5850				
20	**Employee Benefits**				$ -		☐ Check to confirm that Col. 4 does not include room and board
21	Retirement		5910				
22	Other Benefits	*(Specify)*	5920				
23	**TOTAL EMPLOYEE TAXES, INSURANCE AND BENEFITS**			**$ -**	**$ -**	**$ -**	☐ Check to confirm that Col. 4 does not include room and board
	CONTRACTED SERVICES						
24	**Contracted Services**						
25	Contracted Program Services		6010		$ -		
26	Contracted Maintenance Services		6020		$ -		
27	Contracted Administration Services		6030		$ -		
28	**TOTAL CONTRACTED SERVICES**			**$ -**	**$ -**	**$ -**	☐ Check to confirm that Col. 4 does not include room and board

Provider Cost and Wage Survey ("Short Survey")
Rate Rebasing Project: Comprehensive and Supports Medicaid Waiver Programs
Wyoming Department of Health, Division of Healthcare Financing

PROVIDER NAME:	N/A
PROVIDER SITE:	N/A
PROVIDER FISCAL YEAR BEGINNING:	N/A
PROVIDER FISCAL YEAR ENDING:	N/A

If your provider accounting books and records clearly distinguish waiver and non-waiver costs, please directly allocate those costs in Lines 1-64. If your organization cannot break out costs for paticular sections you may choose to add the total amount into the "Other" line items.
Please use the comments section to explain your reasoning for not being able to break out the information and explain what is contained within the total value.
To the extent that waiver and non-waiver program costs are not easily distinguishable, you may fill out the table below to estimate proportion of resources used to support DD waiver service delivery.

COST ALLOCATION:

a.	**Total FTEs**	
b.	# FTEs for DD waiver activities	
c.	# FTE for non-waiver activities	0.00

Calculated DD Waiver FTE Allocation: N/A

Setting Space

d.	Do you or your organization have dedicated space?	
e.	If yes, what is the total square footage of your setting?	
f.	How many square feet are used for delivery of waiver services?	
g.	Square feet remaining / used for other activities	0.00

Calculated DD Waiver Square Footage Allocation: N/A

WORKSHEET B: PROVIDER COSTS

Line No.	1 Cost Centers		2 Uniform Chart of Accounts Code	2 All Costs from Provider General Ledger	3 Calculated DD Waiver Costs Based on Cost Allocations Above	4 Comprehensive and Supports Waiver Program Costs	5 Additional Information
	NON-PAYROLL/NON-SALARY ADMINISTRATION EXPENSES						
29	**Administration Expenses**				$ -		☐ Check to confirm that Col. 4 does not include room and board
30	Advertising		6710				
31	Bank Service Charges / Fee / Interest		6720				
32	CARF Survey		6730				
33	Office Supplies and Services (e.g., office supplies/postage/shipping/printing)		6740-6760				
34	Information Technology Expenses		6770				
35	Central Corporate Office Other Administration Expenses Allocated to Local Level		6780				
36	Dues, Memberships and Subscriptions		6790				
37	Fundraising Activities		6800				
38	Legal and professional services		6820				
39	Other Administrative Expenses (e.g., meeting expenses, etc.)	*(Specify)*					
40	**Licenses/Taxes**		7010-7030		$ -		☐ Check to confirm that Col. 4 does not include room and board
41	**Liability and Other Insurance**				$ -		☐ Check to confirm that Col. 4 does not include room and board
42	All Other Insurance	*(Specify)*	7110-7140, 7160				
43	**Non-Payroll Related Personnel Expenses**				$ -		☐ Check to confirm that Col. 4 does not include room and board
44	Background Checks / Drug Testing		6620				
45	Recruitment		6630				
46	Training		6640				
47	Other Non-Payroll Personnel Expenses	*(Specify)*					
48	**TOTAL NON-PAYROLL/NON-SALARY ADMINISTRATION EXPENSES**			**$ -**	**$ -**	**$ -**	☐ Check to confirm that Col. 4 does not include room and board

Provider Cost and Wage Survey ("Short Survey")
Rate Rebasing Project: Comprehensive and Supports Medicaid Waiver Programs
Wyoming Department of Health, Division of Healthcare Financing

PROVIDER NAME:	N/A
PROVIDER SITE:	N/A
PROVIDER FISCAL YEAR BEGINNING:	N/A
PROVIDER FISCAL YEAR ENDING:	N/A

If your provider accounting books and records clearly distinguish waiver and non-waiver costs, please directly allocate those costs in Lines 1-64. If your organization cannot break out costs for particular sections you may choose to add the total amount into the "Other" line items.
Please use the comments section to explain your reasoning for not being able to break out the information and explain what is contained within the total value.
To the extent that waiver and non-waiver program costs are not easily distinguishable, you may fill out the table below to estimate proportion of resources used to support DD waiver service delivery.

COST ALLOCATION:

a.	**Total FTEs**	
b.	# FTEs for DD waiver activities	
c.	# FTE for non-waiver activities	0.00

Calculated DD Waiver FTE Allocation: N/A

Setting Space

d.	Do you or your organization have dedicated space?	
e.	If yes, what is the total square footage of your setting?	
f.	How many square feet are used for delivery of waiver services?	
g.	Square feet remaining / used for other activities	0.00

Calculated DD Waiver Square Footage Allocation: N/A

WORKSHEET B: PROVIDER COSTS

	1	2	2	3	4	5
Line No.	**Cost Centers**	**Uniform Chart of Accounts Code**	**All Costs from Provider General Ledger**	**Calculated DD Waiver Costs Based on Cost Allocations Above**	**Comprehensive and Supports Waiver Program Costs**	**Additional Information**
	NON-PAYROLL PROGRAM SUPPORT EXPENSES					
49	**Supplies (related to materials used in client care or program support services)**	6510-6590		$ -		☐ Check to confirm that Col. 4 does not include room and board
50	**Vehicle**					
51	Transportation - service related (providers must maintain detailed mileage records to support expenses reported)	6910		$ -		
52	Transportation/Travel - non-service related	6920		$ -		
53	**Total Transportation**		$ -	$ -	$ -	☐ Check to confirm that Col. 4 does not include room and board
54	**TOTAL NON-PAYROLL PROGRAM SUPPORT EXPENSES**		$ -	$ -	$ -	☐ Check to confirm that Col. 4 does not include room and board
	FACILITY, VEHICLE AND EQUIPMENT RELATED EXPENSES					
55	Rental and Property Expenses	7210-7270		$ -		
56	Maintenance and Repairs	7310-7340		$ -		
57	Depreciation and Amortization Expenses	7410-7460		$ -		
58	Utilities	6410-6470		$ -		
59	**TOTAL FACILITY, VEHICLE AND EQUIPMENT RELATED EXPENSES**		$ -	$ -	$ -	☐ Check to confirm that Col. 4 does not include room and board
60	**GRAND TOTALS**		$ -	$ -	$ -	☐ Check to confirm that Col. 4 does not include room and board

Provider Cost and Wage Survey ("Short Survey")
Rate Rebasing Project: Comprehensive and Supports Medicaid Waiver Programs
Wyoming Department of Health, Division of Healthcare Financing

PROVIDER NAME:	N/A
PROVIDER SITE:	N/A
PROVIDER FISCAL YEAR BEGINNING:	N/A
PROVIDER FISCAL YEAR ENDING:	N/A

If your provider accounting books and records clearly distinguish waiver and non-waiver costs, please directly allocate those costs in Lines 1-64. If your organization cannot break out costs for particular sections you may choose to add the total amount into the "Other" line items.
Please use the comments section to explain your reasoning for not being able to break out the information and explain what is contained within the total value.
To the extent that waiver and non-waiver program costs are not easily distinguishable, you may fill out the table below to estimate proportion of resources used to support DD waiver service delivery.

COST ALLOCATION:

a.	**Total FTEs**	
b.	# FTEs for DD waiver activities	
c.	# FTE for non-waiver activities	0.00

Calculated DD Waiver FTE Allocation: N/A

Setting Space

d.	Do you or your organization have dedicated space?	
e.	If yes, what is the total square footage of your setting?	
f.	How many square feet are used for delivery of waiver services?	
g.	Square feet remaining / used for other activities	0.00

Calculated DD Waiver Square Footage Allocation: N/A

WORKSHEET B: PROVIDER COSTS

	1	2	2	3	4	5
Line No.	**Cost Centers**	**Uniform Chart of Accounts Code**	**All Costs from Provider General Ledger**	**Calculated DD Waiver Costs Based on Cost Allocations Above**	**Comprehensive and Supports Waiver Program Costs**	**Additional Information**
	PROVIDER REVENUES					
	(If you operate multiple sites, enter total revenues earned across all your sites)					
61	Total DHCF Waiver Revenues (Comprehensive and Supports)					
62	Total Targeted Case Management (TCM) Revenues, if applicable					
63	Total Revenues from Other Sources, if applicable					
64	**TOTAL PROVIDER REVENUES**		**$ -**			

ADDITIONAL QUESTION	
65	**Please explain if your agency incurred partial year expenses during the provider fiscal year reported for any services, operations, or facilities.**
66	**Has your agency experienced significant changes in costs since the fiscal year period for which you are reporting data? If so, please explain.**

Provider Cost and Wage Survey ("Short Survey")
Rate Rebasing Project: Comprehensive and Supports Medicaid Waiver Programs
Wyoming Department of Health, Division of Healthcare Financing

PROVIDER NAME:	N/A
PROVIDER SITE:	N/A
PROVIDER FISCAL YEAR BEGINNING:	N/A
PROVIDER FISCAL YEAR ENDING:	N/A

Instructions:
Enter the wages, supplemental pay, and training time for your current employees as well as annual average percentage change, if questions are not applicable or if information is not available, please input ***"N/A"*** in the corresponding yellow cells. For average annual pe
-**Columns 1-3:** Enter average, lowest, and highest hourly baseline wage for employed staff (exclude overtime, premiums, or other supplemental pay). If employees are paid on a salary basis, hourly wages can be calculated by dividing the annual salary by 2,080 (the nun work overtime, the salary may be divided by more than 2,080 as appropriate.
-**Column 4-6:** Enter average wage increase in percentage for the corresponding time periods.
-**Column 7:** Record the number of full-time equivalent (FTE) staff in each job title employed by your agency. For example, if you employ eight (8) full-time direct service professionals and four (4) half-time direct service professionals, enter "10" in the line for which you se
-**Column 8-11:** Enter the total regular pay (non-overtime), total overtime pay, total other supplemental pay, and total bonus amounts for each staff.
-**Column 12:** Enter the annual average paid training hours per year per staff or supervisor.
-**Column 13-14:** Enter the total full-time and part-time positions that are unfilled.

WORKSHEET C: PROGRAM EMPLOYEE WAGES

Note: Please provide the below information based on the "snapshot" date of the end of the most recent quarter, or September 30, 2023).

		1	2	3	4	5	6
Line No.	**Description**	**REGULAR WAGES**			**Annual Average Percentage Change in Wages**		
		Average Hourly Wage (as of Sept. 30, 2023) [1]	**Lowest Hourly Wage**	**Highest Hourly Wage**	**2020 to 2021**	**2021 to 2022**	**2022 to 2023 (Sept. 30, 2023)**
	Example	**$15.00**	**$12.50**	**$18.00**	**3%**	**4%**	**5%**
	Program Employee Salaries and Wages						
1	Direct Care Workers - Daytime						
2	Direct Care - Swing Shift/Overnight						
3	Direct Care Workers - Overnight Workers Allowed to Sleep (if different)						
4	Direct Care Trainers						
5	Shift and Unit Supervisors						
6	Case Managers						
7	Job Coaches and Vocational Trainers						
8	Dieticians						
9	Registered Nurse (RN)						
10	Licensed Practical Nurse (LPN)						
11	Certified Nursing Assistant (CNA)						
12	Board Certified Behavior Analyst (BCBA)						
13	Board Certified Assistant Behavior Analyst (BCaBA)						
14	Registered Behavior Technician (RBT)						
15	Psychiatrists						
16	Psychologists						
17	Licensed Clinical Social Worker (LCSW)						
18	Physical Therapists						
19	Occupational Therapists						
20	Speech Therapists						
21	Drivers						
22	Other Program Employees *Specify:*						
23	Other Program Employees *Specify:*						
24	Other Program Employees *Specify:*						

Notes:
(1) If your employees are paid on a salary basis, you can calculate hourly wages by dividing the annual salary by 2,080 (the number of working hours in a year based on a 40-hour work week), or for part-time salaried positions, a reasonable estimate of the number of hou

Provider Cost and Wage Survey ("Short Survey")
Rate Rebasing Project: Comprehensive and Supports I
Wyoming Department of Health, Division of Healthcare

PROVIDER NAME:	_
PROVIDER SITE:	_
PROVIDER FISCAL YEAR BEGINNING:	_
PROVIDER FISCAL YEAR ENDING:	

Instructions:
Enter the wages, supplemental pay, and training time for yrcentage change, if percentage can not be determined, please leave blank.
-**Columns 1-3:** Enter average, lowest, and highest hourly hber of working hours in a year based on a 40-hour work week), or for part-time salaried positions, a reasonable estimate of the number of hours worked over the course of a year. If employees regularly work overtime, the salary may be divided by more than 2,0
-**Column 4-6:** Enter average wage increase in percentage
-**Column 7:** Record the number of full-time equivalent (FT lected "direct service professional" under this column.
-**Column 8-11:** Enter the total regular pay (non-overtime),
-**Column 12:** Enter the annual average paid training hours
-**Column 13-14:** Enter the total full-time and part-time posi

WORKSHEET C: PROGRAM EMPLOYEE WAGES

Note: Please provide the below information based on the '

		7	8	9	10	11	12	13	14
		FULL TIME EQUIVALENT (FTE)	**TOTAL WAGES PAID**				**TRAINING HOURS**	**UNFILLED POSITIONS**	
Line No.	**Descript**	**Total Number of FTE Positions**	**Total Regular Wages Paid**	**Total Overtime Pay**	**Total Other Supplemental Pay (e.g., premium, shift differentials, incentives, nonproduction bonuses)**	**Bonus (one-time or lump sum premiums)**	**Average Annual Paid Training Hours per Employee**	**Full-Time**	**Part-Time**
	Example	**10**	**$30,000**	**$4,000**	**$6,000**	**$2,000**	**20**	**1**	**2**
	Program Employee Salaries and Wages								
1	Direct Care Workers - Daytime								
2	Direct Care - Swing Shift/Overnight								
3	Direct Care Workers - Overnight Workers Allo								
4	Direct Care Trainers								
5	Shift and Unit Supervisors								
6	Case Managers								
7	Job Coaches and Vocational Trainers								
8	Dieticians								
9	Registered Nurse (RN)								
10	Licensed Practical Nurse (LPN)								
11	Certified Nursing Assistant (CNA)								
12	Board Certified Behavior Analyst (BCBA)								
13	Board Certified Assistant Behavior Analyst (BC								
14	Registered Behavior Technician (RBT)								
15	Psychiatrists								
16	Psychologists								
17	Licensed Clinical Social Worker (LCSW)								
18	Physical Therapists								
19	Occupational Therapists								
20	Speech Therapists								
21	Drivers								
22	Other Program Employees *Specify:*								
23	Other Program Employees *Specify:*								
24	Other Program Employees *Specify:*								

Notes:
(1) If your employees are paid on a salary basis, you can rs worked over the course of a year. If your employees regularly work overtime, you may divide the salary by more than 2,080 as appropriate.

Provider Cost and Wage Survey ("Short Survey")
Rate Rebasing Project: Comprehensive and Supports Medicaid Waiver Programs
Wyoming Department of Health, Division of Healthcare Financing

PROVIDER NAME:	N/A
PROVIDER SITE:	N/A
PROVIDER FISCAL YEAR BEGINNING:	N/A
PROVIDER FISCAL YEAR ENDING:	N/A

INSTRUCTIONS: Fill out each section for the total amounts across all locations/sites. Providers should use data from their most recent fiscal year (i.e., FYE 12/31/2022 or 6/30/2023).

WORKSHEET D. INDEPENDENT PROVIDER

This worksheet is specific to independent providers. **You should only complete this worksheet if you selected "INDEPENDENT" on Worksheet A, Line 32.**

Line No.	1 Question		2 Response
	1. ADMINISTRATIVE EXPENSES:		
	As an independent provider, do you have the following Administrative expenses?		
1	Advertising		
2	Bank Service Charges / Fee / Interest		
3	Office Supplies and Services (e.g., office supplies/postage/shipping/printing)		
4	Information Technology Expenses		
5	Dues, Memberships and Subscriptions		
6	Fundraising Activities		
7	Legal and professional services		
8	Training		
9	Other Administrative Expenses (e.g., meeting expenses, etc.)	*(Specify)*	
	2. BENEFIT AND TAX EXPENSES:		
	As an independent provider, do you have the following Tax and Benefit expenses?		
	Insurance		
10	Health		
11	Vision		
12	Dental		
13	Life Insurance		
14	Short-Term and Long-Term Disability		
15	Fringe Benefits	*(Specify)*	
16	Other Employee Insurance, excluding any categories listed above	*(Specify)*	
	Benefits		
17	Retirement		
18	Other Benefits	*(Specify)*	
	3. PROGRAM SUPPORT EXPENSES		
	As an independent provider, do you have the following Program Support expenses?		
19	Transportation - service related		
20	Rental and Property Expenses		
21	Maintenance and Repairs		
22	Depreciation and Amortization Expenses		
23	Utilities		

Provider Cost and Wage Survey ("Short Survey")
Rate Rebasing Project: Comprehensive and Supports Medicaid Waiver Programs
Wyoming Department of Health, Division of Healthcare Financing

PROVIDER NAME:	N/A
PROVIDER SITE:	N/A
PROVIDER FISCAL YEAR BEGINNING:	N/A
PROVIDER FISCAL YEAR ENDING:	N/A

WORKSHEET E1: SERVICE DELIVERY for GENERAL SERVICES

Instructions:
If questions are not applicable or if information is not available, please input "N/A" in the corresponding yellow cells.
Follow the below instructions for each section:
Please toggle line 1 to either "Yes" or "No" depending on which services your organization provides. Any service toggled to "Yes" in line 1 will be able to fill out sections 1 through 6.
-Section 1 (Questions 2-9): Identify the percent of total time a service provider spends completing each of the activities. The sum of all activities should add up to 100% in Line 10.
-Section 2 (Question 12-13): Identify the current average staffing patterns - i.e., the average number of individuals served by one staff or practitioner.
-Section 3 (Question 14-15): Identify the current supervisor span of control - i.e., the average number of staff or practitioners supervised by one supervisor and the number of hours a supervisor spends performing supervisor activities.
-Section 4 (Questions 16-20): Identify the capital and program supply costs for each service wihtin the requested time period, adjusted as needed.
-Section 5 (Questions 21-25): Identify the staff transportation requirements for each service; this should be for staff. If you are unable to provide the information by individual service, provide the totals within your organization. This is intended to capture the additional cost required for services where providers need to travel into the community.
-Section 6 (Questions 26-30): Identify the client transportation requirements for each service; this should be for transporting clients. If you are unable to provide the information by individual service, provide the totals within your organization. This is intended to capture any built-in costs required for services where clients need to travel to a site.

		Example	Behavioral Support Services	Child Habilitation Services	Cognitive Retraining	Companion Services	Crisis Intervention Support	Homemaker Services	Individual Habilitation Training	Personal Care Services	Respite	Skilled Nursing Services	Special Family Habilitation Home	Supported Employment Services - Individual	Supported Employment Services - Small Group	Supported Employment Services - SEFA
1	Does your organization provide this service?	Yes	-	-	-	-	-	-	-	-	-	-	-	-	-	-
1. Service Delivery & Staffing Patterns																
2	Client-facing services - Delivered **In Person**	60%														
3	Client-facing services - Delivered **with remote monitoring or via technology**	10%														
4	Recordkeeping and documentation for services	10%														
5	Recordkeeping and documentation for activities outside of services (e.g., travel planning, time keeping, etc.)	10%														
6	Participating in scheduled care planning meetings with other professionals, interdisciplinary team members, or collaterals	3%														
7	Travel time to/from and between client residences/locations	5%														
8	Employer administrative or training activities (e.g., staff meetings, program coordination/development, etc.)	2%														
9	Other activities	0%														
10	Auto populated: Total percentage	100%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%		
11	Auto populated: Has all time been allocated? (Total in Line 10 should equal sum of Lines 2-9)	Yes	No	No	No	No	No	No	No	No	No	No	No	No		
2. STAFFING PATTERNS (STAFF TO PARTICIPANT RATIO)																
12	How many unique participants received this service in the fiscal year?	1250														
13	What is the average group size for this service (i.e., how many individuals, on average, are typically served by one staff or practitioner at a **single point in time**)?	5														
3. SUPERVISOR SPAN OF CONTROL (STAFF TO SUPERVISOR RATIO)																
14	How many staff or practitioners on average are typically supervised by one supervisor?	10														
15	How many hours per week do supervisors spend supervising staff?	2														
4. EQUIPMENT AND SUPPLIES																
16	Cost of capital equipment related to service provision	$ 600.00														
17	Average life (in years) of purchased equipment related to service provision	10														
18	If equipment costs are noted in line 16, list the types of equipment included in the expense.	IT system														
19	Cost of program supplies directly related to service provision	$ 1,200.00														
20	If program supply costs are noted in line 19, list the types of supplies included in the expense.	Art supplies														
5. STAFF TRANSPORTATION AND SERVICE TRIP INFORMATION																
21	Average number of trips per day for each service	5														
22	Average minutes per trip per day for each service	30														
23	Average miles per trip per day for each service	40														
24	If you are unable to provide the average number of trips by individual service, what is the average total across all of your services?	15														
25	If you are unable to provide the average number of miles by individual service, what is the average total across all of your services?	35														
6. CLIENT TRANSPORTATION AND SERVICE TRIP INFORMATION																
26	Average number of trips per day for each service	5														
27	Average minutes per trip per day for each service	30														
28	Average miles per trip per day for each service	40														
29	If you are unable to provide the average number of trips by individual service, what is the average total across all of your services?	15														
30	If you are unable to provide the average number of miles by individual service, what is the average total across all of your services?	35														

Provider Cost and Wage Survey ("Short Survey")
Rate Rebasing Project: Comprehensive and Supports Medicaid Waiver Programs
Wyoming Department of Health, Division of Healthcare Financing

PROVIDER NAME:	N/A
PROVIDER SITE:	N/A
PROVIDER FISCAL YEAR BEGINNING:	N/A
PROVIDER FISCAL YEAR ENDING:	N/A

WORKSHEET E2: SERVICE DELIVERY for ADULT DAY SERVICES AND COMMUNITY SUPPORT SERVICES

Instructions:
If questions are not applicable or if information is not available, please input "***N/A***" in the corresponding yellow cells.
Follow the below instructions for each section:
Please toggle line 1 to either "Yes" or "No" depending on which services your organization provides. Any service toggled to "Yes" in line 1 will be able to fill out sections 1 through 6..
-Section 1 (Questions 2-9): Identify the percent of total time a service provider spends completing each of the activities. The sum of all activities should add up to 100% in Line 10.
-Section 2 (Question 12-13): Identify the current average staffing patterns - i.e., the average number of individuals served by one staff or practitioner.
-Section 3 (Question 14-15): Identify the current supervisor span of control - i.e., the average number of staff or practitioners supervised by one supervisor and the number of hours a supervisor spends performing supervisor activities.
-Section 4 (Questions 16-20): Identify the capital and program supply costs for each service.
-Section 5 (Questions 21-25): Identify the staff transportation requirements for each service; this should be for staff. If you are unable to provide the information by individual service, provide the totals within your organization. This is intended to capture the additional cost required for services where providers need to travel into the community.
-Section 6 (Questions 26-30): Identify the client transportation requirements for each service; this should be for transporting clients. If you are unable to provide the information by individual service, provide the totals within your organization. This is intended to capture any built-in costs required for services where clients need to travel to a site.
-Section 7 (Questions 31-36): Identify staffing patterns for Basic, Intermediate, and High Levels of Care for services if applicable.

		Example	Adult Day Services	Community Support Services
1	Does your organization provide this service?	Yes	-	-
1. Service Delivery & Staffing Patterns				
2	Client-facing services - Delivered **In Person**	60%		
3	Client-facing services - Delivered **with remote monitoring or via technology**	10%		
4	Recordkeeping and documentation for services	10%		
5	Recordkeeping and documentation for activities outside of services (e.g., travel planning, time keeping, etc.)	10%		
6	Participating in scheduled care planning meetings with other professionals, interdisciplinary team members, or collaterals	3%		
7	Travel time to/from and between client residences/locations	5%		

8	Employer administrative or training activities (e.g., staff meetings, program coordination/development, etc.)	2%		
9	Other activities	0%		
10	Auto populated: Total percentage	100%	0%	0%
11	Auto populated: Has all time been allocated? (Total in Line 10 should equal sum of Lines 2-9)	Yes	No	No
2. STAFFING PATTERNS (STAFF TO PARTICIPANT RATIO)				
12	How many unique participants received this service in the fiscal year?	1250		
13	What is the average group size for this service (i.e., how many individuals, on average, are typically served by one staff or practitioner at a **single point in time**) across all levels or tiers of this service?	5		
3. SUPERVISOR SPAN OF CONTROL (STAFF TO SUPERVISOR RATIO)				
14	How many staff or practitioners on average are typically supervised by one supervisor?	10		
15	How many hours per week do supervisors spend supervising staff?	2		
4. EQUIPMENT AND SUPPLIES				
16	Cost of capital equipment related to service provision	$ 600.00		
17	Average life (in years) of purchased equipment related to service provision	10		
18	If equipment costs are noted in line 16, list the types of equipment included in the expense.	IT system		
19	Cost of program supplies directly related to service provision	$ 1,200.00		
20	If program supply costs are noted in line 19, list the types of supplies included in the expense.	Art supplies		
5. STAFF TRANSPORTATION AND SERVICE TRIP INFORMATION				
21	Average number of trips per day for each service	5		
22	Average minutes per trip per day for each service	30		
23	Average miles per trip per day for each service	40		
24	If you are unable to provide the average number of trips by individual service, what is the average total across all of your services?	15		
25	If you are unable to provide the average number of miles by individual service, what is the average total across all of your services?	35		
6. CLIENT TRANSPORTATION AND SERVICE TRIP INFORMATION				
26	Average number of trips per day for each service	5		
27	Average minutes per trip per day for each service	30		

28	Average miles per trip per day for each service	40		
29	If you are unable to provide the average number of trips by individual service, what is the average total across all of your services?	15		
30	If you are unable to provide the average number of miles by individual service, what is the average total across all of your services?	35		
7. DAY SERVICE DETAILS				
31	Number of participants receiving each level or tier of care (value should equal sum of lines 31a-31c):	150		
31a	Basic Level of Care	80		
31b	Intermediate Level of Care	60		
31c	High Level of Care	10		
32	Expected group size at this level of care (i.e., number of participants receiving services at each level or tier of care per one staff or practitioner)	-		
32a	Basic Level of Care	6		
32b	Intermediate Level of Care	3		
32c	High Level of Care	1		
33	Average hours of Personal Care provided during one service day by level of care	-		
33a	Basic Level of Care	0.5		
33b	Intermediate Level of Care	1		
33c	High Level of Care	2		
34	Average absences or "no-shows" per day	1		
35	Number of days per year that your organization is open	280		
36	Number of days per year that participants attend services	250		

Provider Cost and Wage Survey ("Short Survey")
Rate Rebasing Project: Comprehensive and Supports Medicaid Waiver Programs
Wyoming Department of Health, Division of Healthcare Financing

PROVIDER NAME:	N/A
PROVIDER SITE:	N/A
PROVIDER FISCAL YEAR BEGINNING:	N/A
PROVIDER FISCAL YEAR ENDING:	N/A

WORKSHEET E3: SERVICE DELIVERY for COMMUNITY LIVING SERVICES

Instructions:
If questions are not applicable or if information is not available, please input "***N/A***" in the corresponding yellow cells.
Follow the below instructions for each section:
Please toggle line 1 to either "Yes" or "No" depending on which services your organization provides. Any service toggled to "Yes" in line 1 will be able to fill out sections 1 **through 6.**
-Section 1 (Questions 2-9): Identify the percent of total time a service provider spends completing each of the activities. The sum of all activities should add up to 100% in Line 10.
-Section 2 (Question 12-13): Identify the current average staffing patterns - i.e., the average number of individuals served by one staff or practitioner.
-Section 3 (Question 14-15): Identify the current supervisor span of control - i.e., the average number of staff or practitioners supervised by one supervisor and the number of hours a supervisor spends performing supervisor activities.
-Section 4 (Questions 16-20): Identify the capital and program supply costs for each service.
-Section 5 (Questions 21-25): Identify the staff transportation requirements for each service; this should be for staff. If you are unable to provide the information by individual service, provide the totals within your organization. This is intended to capture the additional cost required for services where providers need to travel into the community.
-Section 6 (Questions 26-30): Identify the client transportation requirements for each service; this should be for transporting clients. If you are unable to provide the information by individual service, provide the totals within your organization. This is intended to capture any built-in costs required for services where clients need to travel to a site.
-Section 7 (Questions 31-36): Identify staffing patterns for Basic, Intermediate, and High Levels of Care for services if applicable.

		Example	**Community Living Services**
1	Does your organization provide this service?	Yes	-
1. Service Delivery & Staffing Patterns			
2	Client-facing services - Delivered **In Person**	60%	
3	Client-facing services - Delivered **with remote monitoring or via technology**	10%	
4	Recordkeeping and documentation for services	10%	
5	Recordkeeping and documentation for activities outside of services (e.g., travel planning, time keeping, etc.)	10%	
6	Participating in scheduled care planning meetings with other professionals, interdisciplinary team members, or collaterals	3%	

7	Travel time to/from and between client residences/locations	5%	
8	Employer administrative or training activities (e.g., staff meetings, program coordination/development, etc.)	2%	
9	Other activities	0%	
10	Auto populated: Total percentage	100%	0%
11	Auto populated: Has all time been allocated? (Total in Line 10 should equal sum of Lines 2-9)	Yes	No
2. STAFFING PATTERNS (STAFF TO PARTICIPANT RATIO)			
12	How many unique participants received this service in the fiscal year?	1250	
13	What is the average group size for this service (i.e., how many individuals, on average, are typically served by one staff or practitioner at a **single point in time**) across all levels or tiers of this service?	5	
3. SUPERVISOR SPAN OF CONTROL (STAFF TO SUPERVISOR RATIO)			
14	How many staff or practitioners on average are typically supervised by one supervisor?	10	
15	How many hours per week do supervisors spend supervising staff?	2	
4. EQUIPMENT AND SUPPLIES			
16	Cost of capital equipment related to service provision	$ 600.00	
17	Average life (in years) of purchased equipment related to service provision	10	
18	If equipment costs are noted in line 16, list the types of equipment included in the expense.	IT system	
19	Cost of program supplies directly related to service provision	$ 1,200.00	
20	If program supply costs are noted in line 19, list the types of supplies included in the expense.	Art supplies	
5. STAFF TRANSPORTATION AND SERVICE TRIP INFORMATION			
21	Average number of trips per day for each service	5	
22	Average minutes per trip per day for each service	30	
23	Average miles per trip per day for each service	40	
24	If you are unable to provide the average number of trips by individual service, what is the average total across all of your services?	15	
25	If you are unable to provide the average number of miles by individual service, what is the average total across all of your services?	35	
6. CLIENT TRANSPORTATION AND SERVICE TRIP INFORMATION			

26	Average number of trips per day for each service	5	
27	Average minutes per trip per day for each service	30	
28	Average miles per trip per day for each service	40	
29	If you are unable to provide the average number of trips by individual service, what is the average total across all of your services?	15	
30	If you are unable to provide the average number of miles by individual service, what is the average total across all of your services?	35	
7. DAY SERVICE DETAILS			
31	Number of participants receiving each level or tier of care (value should equal sum of lines 31a-31c):	150	0
31a	Basic Level of Care	70	
31b	Level 3	30	
31c	Level 4	20	
31d	Level 5	10	
31e	Level 6	10	
31f	Host Home	10	
32	Expected group size at this level of care (i.e., number of participants receiving services at each level or tier of care per one staff or practitioner)	-	-
32a	Basic Level of Care	6	
32b	Level 3	3	
32c	Level 4	2	
32d	Level 5	1	
32e	Level 6	0.5	
32f	Host Home (for Host Home, how many participants in one home)	1	
33	Average hours of Personal Care provided during one service day by level of care	-	-
33a	Basic Level of Care	0.5	

33b	Level 3	1	
33c	Level 4	1	
33d	Level 5	2	
33e	Level 6	2	
33f	Host Home	1	
34	Average absences or "no-shows" per day	1	
35	Number of days per year that your organization is open	280	
36	Number of days per year that participants attend services	250	

Provider Cost and Wage Survey ("Short Survey")
Rate Rebasing Project: Comprehensive and Supports Medicaid Waiver Programs
Wyoming Department of Health, Division of Healthcare Financing

PROVIDER NAME:	N/A
PROVIDER SITE:	N/A
PROVIDER FISCAL YEAR BEGINNING:	N/A
PROVIDER FISCAL YEAR ENDING:	N/A

WORKSHEET E4: SERVICE DELIVERY for THERAPIES AND DIETICIAN SERVICES

Instructions:
If questions are not applicable or if information is not available, please input "***N/A***" in the corresponding yellow cells.
Follow the below instructions for each section:
Please toggle line 1 to either "Yes" or "No" depending on which services your organization provides. Any service toggled to "Yes" in line 1 will be able to fill out sections 1 through 6.
-Section 1 (Questions 2-9): Identify the percent of total time a service provider spends completing each of the activities. The sum of all activities should add up to 100% in Line 10.
-Section 2 (Question 12-13): Identify the current average staffing patterns - i.e., the average number of individuals served by one staff or practitioner.
-Section 3 (Question 14-15): Identify the current supervisor span of control - i.e., the average number of staff or practitioners supervised by one supervisor and the number of hours a supervisor spends performing supervisor activities.
-Section 4 (Questions 16-20): Identify the capital and program supply costs for each service.
-Section 5 (Questions 21-25): Identify the staff transportation requirements for each service; this should be for staff. If you are unable to provide the information by individual service, provide the totals within your organization. This is intended to capture the additional cost required for services where providers need to travel into the community.

		Example	Physical Therapy	Occupational Therapy	Speech, Language and Hearing Services	Dietician Services
1	Does your organization provide this service?	Yes	-	-	-	-
1. Service Delivery & Staffing Patterns						
2	Client-facing services - Delivered **In Person**	60%				
3	Client-facing services - Delivered **with remote monitoring or via technology**	10%				
4	Recordkeeping and documentation for services	10%				
5	Recordkeeping and documentation for activities outside of services (e.g., travel planning, time keeping, etc.)	10%				
6	Participating in scheduled care planning meetings with other professionals, interdisciplinary team members, or collaterals	3%				
7	Travel time to/from and between client residences/locations	5%				
8	Employer administrative or training activities (e.g., staff meetings, program coordination/development, etc.)	2%				
9	Other activities	0%				
10	Auto populated: Total percentage	100%	0%	0%	0%	0%
11	Auto populated: Has all time been allocated? (Total in Line 10 should equal sum of Lines 2-9)	Yes	No	No	No	No
2. STAFFING PATTERNS (STAFF TO PARTICIPANT RATIO)						
12	How many unique participants received this service in the fiscal year?	1250				
13	What is the average group size for this service (i.e., how many individuals, on average, are typically served by one staff or practitioner at a **single point in time**)?	5				

3. SUPERVISOR SPAN OF CONTROL (STAFF TO SUPERVISOR RATIO)						
14	How many staff or practitioners on average are typically supervised by one supervisor?	10				
15	How many hours per week do supervisors spend supervising staff?	2				
4. EQUIPMENT AND SUPPLIES						
16	Cost of capital equipment related to service provision	$ 600.00				
17	Average life (in years) of purchased equipment related to service provision	10				
18	If equipment costs are noted in line 16, list the types of equipment included in the expense.	IT system				
19	Cost of program supplies directly related to service provision	$ 1,200.00				
20	If program supply costs are noted in line 19, list the types of supplies included in the expense.	Art supplies				
5. TRANSPORTATION AND SERVICE TRIP INFORMATION (ONLY FOR STAFF TRANSPORTATION)						
21	Average number of trips per day for each service	5				
22	Average minutes per trip per day for each service	30				
23	Average miles per trip per day for each service	40				
24	If you are unable to provide the average number of trips by individual service, what is the average total across all of your services?	15				
25	If you are unable to provide the average number of miles by individual service, what is the average total across all of your services?	35				

Provider Cost and Wage Survey ("Short Survey")
Rate Rebasing Project: Comprehensive and Supports Medicaid Waiver Programs
Wyoming Department of Health, Division of Healthcare Financing

PROVIDER NAME:	N/A
PROVIDER SITE:	N/A
PROVIDER FISCAL YEAR BEGINNING:	N/A
PROVIDER FISCAL YEAR ENDING:	N/A

WORKSHEET E5: CASE MANAGEMENT

Note: Complete this worksheet only if your organization provides waiver case management services, otherwise leave blank. Please provide information from the current provider fiscal year.

	1	2	3	4
Line No.	**Supplemental Information**	**Targeted Case Management**	**Certificate Tier**	**Comprehensive and Supports Waiver Programs**
	PARTICIPANTS			
1	How many participants does your organization currently serve?			
2	What is the average caseload per case manager?			
3	What types of staff are providing case management (e.g., Case Manager, Licensed Clinical Social Worker, etc.). You may type multiple staff types in the associated cell.			
	Looking at your total caseload, approximately how many participants require, on average, the following amounts of case management per month:			
4	0-3 hours per month			
5	4-6 hours per month			
6	7-9 hours per month			
7	10+ hours per month			
	REASONS FOR VARIATION AMONG PARTICIPANTS			
8	What are the most common reasons for exceeding six hours of case management per month for a given participant? Please select all that apply.	☐ Crisis Management ☐ Communicating with Family and Guardians ☐ Difficult Participant Behavior ☐ Recurrent Medical Issues ☐ Finding or Changing Providers ☐ Documentation Other (Please describe below):		
	UNITS			
	For how many participants do you currently bill for using a monthly and a 15-minute unit?			
9	Monthly rate unit			
10	15 minute rate unit			

Provider Cost and Wage Survey ("Short Survey")
Rate Rebasing Project: Comprehensive and Supports Medicaid Waiver Programs
Wyoming Department of Health, Division of Healthcare Financing

PROVIDER NAME:	N/A
PROVIDER SITE:	N/A
PROVIDER FISCAL YEAR BEGINNING:	N/A
PROVIDER FISCAL YEAR ENDING:	N/A

WORKSHEET F: SERVICES DELIVERED REMOTELY

For the purposes of the survey design all remote services (conducted via telephone or video conferencing as 'telehealth') are applicable here.

Please complete Table 1 if you have delivered any services remotely and/or through telehealth or plan to do so in the future, for individuals covered under the Comprehensive and Supports Waivers. Indicate the percentage of service delivery for each column that applies. Complete Table 2 if you provide any services which did not offer remote delivery. For both tables, **you only need to complete the rows for services you deliver.**

Table 1. Services Delivered Remotely

	1	2	3
Service	**% of Services Delivered Remotely Prior to COVID-19 health emergency**	**% of Services Delivered Remotely During COVID-19 health emergency**	**% of Services Planning to Deliver Remotely After COVID-19 health emergency, if this option were available**
Example Service	**0%**	**15%**	**20%**
Adult Day Services			
Behavioral Support Services			
Case Management			
Community Living Services			
Community Support Services			
Companion Services			
Dietician Services			
Occupational Therapy			
Physical Therapy			
Speech, Language and Hearing Services			

Provider Cost and Wage Survey ("Short Survey")
Rate Rebasing Project: Comprehensive and Supports Medicaid Waiver Programs
Wyoming Department of Health, Division of Healthcare Financing

PROVIDER NAME:	N/A
PROVIDER SITE:	N/A
PROVIDER FISCAL YEAR BEGINNING:	N/A
PROVIDER FISCAL YEAR ENDING:	N/A

WORKSHEET F: SERVICES DELIVERED REMOTELY

Table 2. Services Not Offering Remote and/or Telehealth Delivery

Service	1 Question	2 Response
Child Habilitation Services	What would be needed to support the remote delivery of this service?	
Cognitive Retraining		
Crisis Intervention Support		
Individual Habilitation Training		
Personal Care Services		
Respite		
Supported Employment Services		

Additional Questions:

Line No.	1 Question	2 Response
1	If you have delivered services remotely during the COVID-19 health emergency, did you experience any challenges with delivering remote/telehealth services (e.g., technical difficulties, trouble training participants and/or staff, issues with quality of service delivery)?	
2	Do you anticipate providing remote delivery of services for individuals covered under the Comprehensive and Supports Waivers after COVID-19 and the current health emergency?	
2a	If no, why not?	
3	Have you assessed any improvements in quality or cost savings due to expanded use of remote delivery? If so, describe them.	

Provider Cost and Wage Survey ("Short Survey")
Rate Rebasing Project: Comprehensive and Supports Medicaid Waiver Programs
Wyoming Department of Health, Division of Healthcare Financing

PROVIDER NAME:	N/A
PROVIDER SITE:	N/A
PROVIDER FISCAL YEAR BEGINNING:	N/A
PROVIDER FISCAL YEAR ENDING:	N/A

WORKSHEET G: ERROR SELF-CHECK

1	2	3	4	5
Worksheet		**Yes**	**No**	**Not Applicable**
A: Provider Info	Did you input information for up to 4 provider sites operated by your organization, if applicable?			
	Did you input the number of waiver participants served at each provider site during the provider fiscal year entered in Worksheet A?			
	If you are completing this survey for a particular provider site, have you specified the site on Line 29?			
	Did you enter the total number of full-time and part-time employees employed by your organization (not site-specific) at the end of fiscal year 2023?			
B: Costs	Have you included all of the costs from your general ledger in the appropriate cost center and line number?			
	Have you reported all of your waiver program costs in the appropriate cost center and line number in Column 6?			
	If you have reported costs in the "Other" expenses row within any of the cost centers, have you entered a description of the expense(s) in the box provided?			
	Did you check the boxes in Column 7 to indicate that your responses in column 6 do not include room and board costs?			

Provider Cost and Wage Survey ("Short Survey")
Rate Rebasing Project: Comprehensive and Supports Medicaid Waiver Programs
Wyoming Department of Health, Division of Healthcare Financing

PROVIDER NAME:	N/A
PROVIDER SITE:	N/A
PROVIDER FISCAL YEAR BEGINNING:	N/A
PROVIDER FISCAL YEAR ENDING:	N/A

WORKSHEET G: ERROR SELF-CHECK

1	2	3	4	5
Worksheet		**Yes**	**No**	**Not Applicable**
C: Wages	Did you report average hourly wages, as of September 30, 2023, for each employee type in Column 1?			
	Did you report the average amount of paid time off allowed to each employee type in Column 2, including vacation, holiday, and sick time?			
	Did you report the average amount of paid training hours provided annually for each employee type in Column 3?			
	Did you provide the relevant information in Columns 4-5 regarding unfilled full-time and part-time positions?			
D: Benefits	Did you answer all applicable questions?			
E1-4: Service Delivery	Have you identified all the waiver services your organization (or relevant site) delivers to clients?			
	Have you provided adequate detail regarding the staffing and delivery of each service your organization delivers?			
	If you deliver Adult Day Services, Community Support Services, Community Living Services, and/or Therapy Services, did you complete the additional tabs for these services?			
E5: CM Questions	If your agency provides case management services, did you answer each question separately for individuals receiving TCM and waiver case management services?			
F: Remote Delivery	Did you insert percentages into Table 1 for services your organization delivers?			
	Did you complete Table 2 for services your organization delivers?			

Provider Cost and Wage Survey ("Short Survey")
Rate Rebasing Project: Comprehensive and Supports Medicaid Waiver Programs
Wyoming Department of Health, Division of Healthcare Financing

PROVIDER NAME:	N/A
PROVIDER SITE:	N/A
PROVIDER FISCAL YEAR BEGINNING:	N/A
PROVIDER FISCAL YEAR ENDING:	N/A

WORKSHEET G: ERROR SELF-CHECK

1	2	3	4	5
Worksheet		**Yes**	**No**	**Not Applicable**
	Did you answer the additional questions at the bottom of the worksheet?			