CCW Provider Staff File Checklist

HOME AND COMMUNITY-BASED SERVICES
WYOMING MEDICAID DIVISION OF HEALTHCARE FINANCING

Provider/Agency: _____

Employee: _____

Employee Job Title: _____ **Hire/Start Date:** _____

Professional License Required? ☐ **Yes** ☐ **No** **License Number:** _____
(Registered Nurse, Licensed Practical Nurse, Certified Nursing Assistant)

Is the employee the legally authorized representative of a participant receiving services from the provider?

☐ **Yes** ☐ **No** **Participant Name:** _____

Standard	Comments
Background Screening Results (Subsequent background screening is required every 5 years.)	Name and Social Security Number based Criminal Background Screening Received: _____ National Sex Offender Public Website Received: _____ DFS Central Registry Received: _____ OIG Received: _____
Annual OIG Exclusions Database Screening Required? ☐ Yes ☐ No https://exclusions.oig.hhs.gov/ Wyoming Medicaid Rule, Chapter 3, Section 4 42 CFR 455.436(c)(2)	Annual Screening Documented? ☐ Yes ☐ No ☐ TA Offered
Current Driver's License *(if applicable)*	Expiration:
Current Insurance *(if applicable)*	Expiration:
CM Resume/Diploma/Transcripts	☐ Yes ☐ No ☐ N/A
Provider Evidence of Annual Case Manager Training *(initial CM training videos)*	☐ Yes ☐ No
Provider Evidence of Participant Specific Training	Date of Training: