DD Provider Staff File Checklist

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

Provider/Agency: _____

Employee: _____ **Employee DOB:** _____

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

☐ 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:** _____

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, Criminal Screening based on Name & SSN, and Office of Inspector General Exclusions List.* Subsequent background screening is required every 5 years)	Criminal/Name & SSN received: Expiration: DFS received: OIG received:
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)* *(HCBS online MAT training modules)*	Expiration:
Division Specific Training *(prior to working with participants)*	Date of training: Staff member employed prior to last certification period ☐
Participant Specific Training *(evidence upon request)*	Date of training:
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 Reporting Provider

_____ _____

Signature of Reporting Provider Date

Provider/Agency: _____

Employee: _____

☐ Information was not verified by Division representative

OR

☐ Information verified by Division representative ☐ On-site ☐ Virtually - Method _____

_____

Printed Name of Division Representative

_____ _____

Signature of Division Representative Date

Comments:_____

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Services Requiring Professional License	Services Requiring 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	