CCW PCSP Team Modification Signature and Verification Form

Participant Name:		Case Manager:			
Plan Dates:		Case Management Agency:			
☐ Modification of a Plan	Mod Effective Date:	Case Manager Phone#:			
Service Code & Type	**Provider Name**	**Total Units (12 Months)**	**Service Rate ($ Per Unit)**	***(Mod)* Units up**	**down**
			$	☐	☐
			$	☐	☐
			$	☐	☐
			$	☐	☐
			$	☐	☐
			$	☐	☐
			$	☐	☐
			$	☐	☐
			$	☐	☐
S5125 U5 PSS under Participant Direction		**Proposed Self-Direction Budget (FMS)**		$	
			Total	$	

Service Reporting and Responsibility of Providers. Providers shall keep a detailed record of services rendered and provide documentation to the case manager in accordance with the Service Documentation Standards found in Chapter 34 of the Wyoming Medicaid rules.

Team Participation. I have participated in the development of this plan and agree with the services and units requested.

Plan Completion. I understand that the Division has the final review of the plan, and if there are changes to the plan during the review process, the case manager will notify all team members. I agree to implement the plan of care as requested by the Division.

Signature of Approval	Printed Name / Organization	Signature Date	Related to participant	Relationship / Service Provided
			☐	Participant
			☐	Legally Authorized Representative
			☐	Case Manager
			☐	
			☐	
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			☐	