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? (Registered Nurse, Licensed Practical Nurse, Certified Nursing Assistant)

- ☐ **No**
- ☐ **Yes** **License Number:** _____

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

- ☐ **No**
- ☐ **Yes** **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/Expires: _____ National Sex Offender Public Website Received/Expires: _____ DFS Central Registry Received/Expires: _____ OIG Received/Rechecked: _____
Annual OIG Exclusions Database Screening Required? Wyoming Medicaid Rule, Chapter 3, Section 4 42 CFR 455.436(c)(2) ☐ No ☐ Yes	Annual Screening Documented? ☐ No ☐ Yes ☐ TA Offered
Current Driver's License *(if applicable)*	☐ No ☐ Yes Expiration: _____
Current Insurance *(if applicable)*	☐ No ☐ Yes Expiration: _____
Case Manager Resume/Diploma/Transcripts	☐ No ☐ Yes ☐ N/A
Provider Evidence of Annual Case Manager Training *(initial CM training videos)*	☐ No ☐ Yes
Provider Evidence of Participant-Specific Training	☐ No ☐ Yes Date of Training: _____