

# DD Provider Certification Renewal Required Documents



Providers are required to submit all recertification documentation through the Wyoming Health Provider portal (WHP). All documentation shall be legible, and shall be submitted so that it is easy to read and review. This includes assuring that all items are oriented top to bottom, and all files are named as specified in the **Naming Convention Guidelines** document which can be found on the Division website, [HCBS Document Library](#), under the *Certifications and Renewals* tab. If policies are contained within a larger policy manual, indicate the specific page number on which the required policy can be found.

It is the responsibility of the provider to review all documentation after it is uploaded and before it is submitted. If submitted documentation does not meet these minimum standards, the Division will consider the documentation unacceptable, and the provider will be required to resubmit within the required timeframes.

\_\_\_\_\_ Please submit evidence of the following background screenings with each Provider Renewal Application. Visit the [HCBS DD Waivers Background Screening](#) page for details.

- United States Department of Health and Human Services, Office of Inspector General (OIG), [List of Excluded Individuals/Entities](#) (rescreen at least annually)
- Wyoming Department of Family Services [Central Registry Check](#) (rescreen every 5 years)
- National Criminal Background Screening based on Name & Social Security Number (rescreen every 5 years)

\_\_\_\_\_ Please submit a copy of the following **administrative forms**, which can be found on the Division website, [HCBS Document Library](#), under the *Certifications and Renewals* tab:

- Conflict Free Case Manager Confirmation CM29 - (for case managers)
- Continuing Education Tracking Record CERT02 - (8 hours CE required for renewal certification of case managers and providers of individual habilitation training)
- Documentation Standards - CERT03
- Declination of Medication Assistance - PV05 (If the provider does not offer medication assistance.)
- Incident Reporting Demonstration of Understanding - CERT12 (Provider)/ CERT13 (Case Manager)
- No Services in a Provider Operated Setting - PV03 (If the provider does not offer services in a provider owned or operated setting.)
- Provider Staff File Checklist - CERT11 for 5 employees. If the provider has fewer than five employees, the checklist shall be submitted for all employees. For providers with more than five (5) employees, Division staff will request additional staff to be reviewed. Providers must provide a **staff roster**.
- Provider Statement of Confidentiality - CERT10
- Provider Vehicle Information Form - CERT05
- If billing agency rates, submit evidence of IRS filings (IRS Form W-3, IRS Form 1096, or electronic confirmation of filings)

\_\_\_\_\_ Please submit the following **policies**, including information on how these policies are shared with participants, legally authorized representatives, and employees. Please provide the individual policy that corresponds with each category. If the provider submits a complete manual, they will be required to identify the page number for the identified policy. (Providers may choose to use the **Example General Policies and Procedures** available on the **HCBS Document Library**.)

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|--|---|
| <input type="checkbox"/> Backup Procedures for Providers without Employees   | <input type="checkbox"/> Participant Privacy                                |
| <input type="checkbox"/> Complaints and Grievances   | <input type="checkbox"/> Pets   |
| <input type="checkbox"/> Conflict of Interest (if provider permits the hiring of legally authorized representatives of a participant receiving services from the provider, or permits the hiring of relatives of provider employees working for the organization.) | <input type="checkbox"/> Provider Requirements                              |
| <input type="checkbox"/> Confidentiality   | <input type="checkbox"/> Providers who Subcontract                          |
| <input type="checkbox"/> Employment First  | <input type="checkbox"/> Provider Qualifications                            |
| <input type="checkbox"/> Food  | <input type="checkbox"/> Restraints   |
| <input type="checkbox"/> Incident Reporting (reportable and internal)  | <input type="checkbox"/> Rights Restrictions                                |
| <input type="checkbox"/> Outings During Waiver Services  | <input type="checkbox"/> Smoking  |
| <input type="checkbox"/> Participant Rights & Freedoms (including right to refuse service)   | <input type="checkbox"/> Supervision  |
| <input type="checkbox"/> Participant Choice and Community Integration  | <input type="checkbox"/> Transportation                                     |
| <input type="checkbox"/> Participant Funds & Notice of Costs   | <input type="checkbox"/> Visitors   |
|  | <input type="checkbox"/> Weapons & Ammunition                               |
|  | <input type="checkbox"/> Community Living Services Policies for Residential |
|  | <input type="checkbox"/> Locks  |
|  | <input type="checkbox"/> Customization                                      |
|  | <input type="checkbox"/> Choice of Housemates                               |

\_\_\_\_\_ Medication Assistance Training (If the provider offers medication assistance)

- Medication assistance policies and procedures
- Current medication assistance training certificate

\_\_\_\_\_ Please submit the following **emergency plan information**, including demonstration that plans are reviewed with participants and staff on routine shifts, document one drill per page, and demonstration that concerns were identified and addressed, for the sites identified. **Provider may choose to use the Example Emergency Plans for Community-Based and/or Home Based Services - Example 16/Example 18**

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|--|--|
| <input type="checkbox"/> Fire - including evacuation drill   | <input type="checkbox"/> Provider incapacity   |
| <input type="checkbox"/> Bomb threat   | <input type="checkbox"/> Staffing shortages/service coverage due to other emergency situations |
| <input type="checkbox"/> Natural disasters (including, but not limited to, earthquakes, blizzards, floods, tornadoes, wildfires) | <input type="checkbox"/> Safety during violent or other threatening situations                 |
| <input type="checkbox"/> Power and other utility failures  | <input type="checkbox"/> Vehicle emergencies   |
| <input type="checkbox"/> Medical emergencies   | <input type="checkbox"/> Contingency plan (to ensure the continuation of essential services)   |
| <input type="checkbox"/> Missing persons   |  |

\_\_\_\_\_ Evidence of Inspections (found as a task in the provider portal; see Provider Safety Standards - TOOL47)

- Evidence of one self-inspection for each certified location for each year of the last certification period, including evidence that deficiencies were addressed.
- Evidence of one inspection completed by an outside entity, for each certified location, completed within the last 24 months.