CCW Monthly Home Visit Verification

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

Form Instructions

This form shall be completed and signed for each monthly visit in order to verify that the visit has occurred. Once completed, the form shall be uploaded in the Electronic Medicaid Waiver System (EMWS).

Participant: _____

Date of Visit: _____

Start Time: _____ **End Time:** _____

Participant/Legally Authorized Representative Signature:_____

Legally Authorized Representative Printed Name:_____ Date:_____
(If applicable)

ALF Staff Signature[1]:_____Date:_____
(If applicable)

Case Manager: _____

Agency: _____

Signature: _____ Date:_____

Notes:

[1] If the participant or LAR is unavailable or unable to sign, a member of the ALF staff may sign the form.