

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. Screenings are not transferable between employers.)	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) <ul style="list-style-type: none"> ● No ● Yes 	Annual Screening Documented? <ul style="list-style-type: none"> ● No ● Yes
Current Driver's License <i>(if applicable)</i>	<ul style="list-style-type: none"> ● No ● Yes Expiration: _____
Current Insurance <i>(if applicable)</i>	<ul style="list-style-type: none"> ● No ● Yes Expiration: _____
Case Manager Resume/Diploma/Transcripts	<ul style="list-style-type: none"> ● No ● Yes ● N/A
Provider Evidence of Annual Case Manager Training (initial CM training videos)	<ul style="list-style-type: none"> ● No ● Yes
Provider Evidence of Participant-Specific Training	<ul style="list-style-type: none"> ● No ● Yes Date of Training: _____