

# CCW PCSP Team Modification Signature and Verification Form



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

<b>Participant Name:</b>		<b>Case Manager:</b>			
<b>Plan Dates:</b>		<b>Case Management Agency:</b>			
<input type="checkbox"/> <b>Modification of a Plan</b>	<b>Modification Effective Date:</b>	<b>Case Manager Phone #:</b>			
<b>Service Code &amp; Type</b>	<b>Provider Name</b>	<b>Total Units (12 Months)</b>	<b>Service Rate (\$ Per Unit)</b>	<b>(Mod) Units up down</b>	
			\$	<input type="checkbox"/>	<input type="checkbox"/>
			\$	<input type="checkbox"/>	<input type="checkbox"/>
			\$	<input type="checkbox"/>	<input type="checkbox"/>
			\$	<input type="checkbox"/>	<input type="checkbox"/>
			\$	<input type="checkbox"/>	<input type="checkbox"/>
			\$	<input type="checkbox"/>	<input type="checkbox"/>
			\$	<input type="checkbox"/>	<input type="checkbox"/>
			\$	<input type="checkbox"/>	<input type="checkbox"/>
			\$	<input type="checkbox"/>	<input type="checkbox"/>
<b>Participant Direction:</b> S5125 U5 Personal Support Services S5135 Companion Services S5130 Homemaker A0130 Non-Medical Transportation T1005 or S5151 Respite		<b>Proposed Self-Direction Budget (FMS)</b>		\$	
<b>Total</b>				\$	
<b>Service Reporting and Responsibility of Providers.</b> 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.					
<b>Team Participation.</b> I have participated in the development of this plan and agree with the services and units requested.					
<b>Plan Completion.</b> 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.					
<b>Signature of Approval</b>	<b>Printed Name / Organization</b>	<b>Signature Date</b>	<b>Related to participant</b>	<b>Relationship / Service Provided</b>	
			<input type="checkbox"/>	Participant	
			<input type="checkbox"/>	Legally Authorized Representative	
			<input type="checkbox"/>	Case Manager	
			<input type="checkbox"/>		
			<input type="checkbox"/>		
			<input type="checkbox"/>		
			<input type="checkbox"/>		