TCM Plan of Care

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

Case Managers are required to develop this plan upon notification that the individual has been determined initially eligible, and any time there is an update to contact information or other plan of care components.

Individual Legal Name:	**Case Manager:**
Physical Address:	**Medicaid #:**
Mailing Address: ☐ **Same as Physical**	**Birth Date:**
Phone Number: ☐ **Cell** ☐ **Home** ☐ **Work**	**Plan Start Date:**

Support Needs:

For each category, briefly describe the individual's support needs. Describe how these needs may be met through natural supports or other non-waiver services.

Category	Support Needed	Natural Supports/Non-Waiver Services
MEDICAL		
SOCIAL		
EDUCATION OR EMPLOYMENT		
OTHER		

Case Manager Support:

Briefly describe the case management support plan, including the frequency of case manager check-ins or visits, and how the individual or their support network may contact you:

All parties listed on this plan are required to notify other parties of changes to contact information in a timely fashion.

Individual Signature _____ Date _____

Legally Authorized Representative (If applicable) _____ Date _____

Case Manager Signature _____ Date _____