Relative Disclosure and Acknowledgment Form

HOME & COMMUNITY-BASED SERVICES
WYOMING DEPARTMENT OF HEALTH
DIVISION OF HEALTHCARE FINANCING

Per Chapter 45, Section 31 of Wyoming Medicaid Rules, a relative provider (defined as a biological, step, or adoptive parent) who provides or intends to provide services to a related waiver participant shall disclose the relationship to the participant's team, and acknowledge and address safeguards set forth by the Division of Healthcare Financing (Division). This disclosure and acknowledgment process also applies to individuals delivering Comprehensive & Supports Waiver services to their spouse.

FORM INSTRUCTIONS:

- This form must be completed to disclose a relative provider relationship, verify eligibility, and ensure compliance with Chapter 45 of Wyoming Medicaid Rules and the Comprehensive & Supports Waiver Service Index.
- A separate form must be completed for each participant and each relative provider.
- The case manager is responsible for initiating and overseeing completion of this form.
- This form must be completed and approved by the Division ***prior*** to adding relative-provided services to an Individualized Plan of Care (IPC).
- Once approved by the Division, this form is valid for a maximum of three (3) years or sooner if any information on this form changes, including but not limited to if the participant turns 18, a new case manager is assigned, the service being provided changes, or the relative provider is employed by a different certified provider agency.

FORM CHECKLIST:

The case manager must ensure that all of the following steps have been completed prior to submitting the form to the Division.

- ☐ Verify participant eligibility to receive service(s) delivered by a relative provider.
- ☐ If the participant is <18 and requires a new ICAP, contact the county BES to initiate the process.
- ☐ Review *Medicaid Rule Chapter 45, Section 31: Relative Providers* and the *Comprehensive and Supports Waiver Service Index* to ensure understanding of applicable rules, limitations, and exclusions for relative providers for the selected service(s).
- ☐ Discuss natural supports and natural supervision with the participant's team.
- ☐ Verify that the selected relative provider is a certified waiver provider with a LLC/Corporation or is employed by a certified provider agency.
- ☐ Ensure all parties have reviewed, initialed, and signed their respective sections.

FORM SUBMISSION:

Once all checklist items have been met and the form is complete, save the form using the required naming convention (Waiver.Lastname.Firstname.RELATIVE.YYYY.MM.DD) and email it to WDH-HCBS-approval@wyo.gov for final Division review and approval. Upon return of the approved form from the Division, the case manager is responsible for distributing copies to the relative provider (or their employing certified provider agency) and uploading the completed form along with the IPC submission. **This form must be completed and approved by the Division prior to adding relative-provided services to an Individualized Plan of Care.**

SECTION 1: DEMOGRAPHICS

PARTICIPANT INFORMATION			
Participant Name:			
Participant Physical Address:			
Waiver:	☐ Comprehensive ☐ Supports		
Birthdate:		**Is the participant under the age of 18 years?**	☐ Yes ☐ No
If participant is under the age of 18 years and will be receiving personal care services from the relative provider:			
Date of most recent ICAP:	*Must be within the past 5 years*	***ABQ Score:***	*Must be ≤ 0.35*

CASE MANAGER INFORMATION			
Case Manager Name:		**CM Organization:** *(If Applicable)*	

RELATIVE PROVIDER INFORMATION			
Relative Provider Name:		**Relationship to Participant:**	
Is the relative provider the Legally Authorized Representative/Guardian of the Participant?:			☐ Yes ☐ No
The relative provider is a/an:	☐ Certified Provider ☐ Employee of Certified Provider	**Certified Provider Agency Name:**	
Does the relative provider live at the same address as the participant?			☐ Yes ☐ No

SECTION 2: SERVICES

Please identify the service(s) this relative provider will provide to the participant:

☐ Personal Care ☐ Community Living Services ☐ Specialized Equipment
☐ Adult Day Services ☐ Community Support Services ☐ Environmental Modifications

Notes:

- *Participants <18: Relative providers may only deliver personal care, specialized equipment, and environmental modifications.*
- *Participants ≥18: A participant's legally authorized representative cannot serve as a relative provider.*
- *Community Living Services: A relative provider may only deliver CLS if they live in a separate residence from the participant.*
- *Spouses: A participant's spouse may only be a relative provider if they are not the participant's Legally Authorized Representative.*

SECTION 3: ACKNOWLEDGMENT AND SIGNATURE

The participant or their legally authorized representative, case manager, relative provider, and certified provider agency are required to sign this form, indicating agreement to the provisions listed below by their signatures.

PARTICIPANT / LEGALLY AUTHORIZED REPRESENTATIVE

The participant (or their LAR) must sign below to acknowledge the use of a relative provider for services on their IPC.

_____ _____

Participant (or Legally Authorized Representative) Signature **Date**

_____

Printed Name

SECTION 3: ACKNOWLEDGMENT AND SIGNATURE (CONTINUED)

RELATIVE PROVIDER AND CERTIFIED PROVIDER AGENCY

The relative provider and provider agency must review and initial each statement below to acknowledge compliance.

Relative Provider	*Provider Agency*	
_____	_____	**Prior Authorization Required.** I understand that all waiver services must be prior authorized by the Division. I will not begin delivering relative provider services until I have confirmation this form was approved by the Division and the service is authorized on the individualized plan of care (IPC).
_____	_____	**Relative employees hired by a provider.** I certify that the relative provider is qualified to provide the service and understand that services provided by a relative have strict caps that cannot be exceeded. The certified provider agency agrees to provide supervision and oversight of the relative provider and ensure that claims are submitted only for services rendered as specified in the IPC and in compliance with the service index.
_____	_____	**Division monitoring of relative providers.** I understand that relative providers must meet the same requirements/qualifications as other providers and are subject to the same oversight levels, regulations, and standard service observations by the Division.
_____	_____	**Documentation.** I agree to use a schedule for documenting service delivery in accordance with Wyoming Medicaid Rules, ensuring documentation meets the service definition and reflects the services specified in the IPC.
_____	_____	**Oversight, authority, and action.** I acknowledge that all claims are processed by the Medicaid Fiscal Agent, are subject to post-payment validation, and funds may be recouped or referred to Medicaid if documentation or claims do not meet requirements.
_____	_____	**Service location inspections.** By delivering services to a relative, I acknowledge that the residence or physical location where services are rendered may need to be certified as a service location. I understand that services cannot be delivered at a location until it meets all certification requirements outlined in Medicaid Rule Chapter 45.
_____	_____	**Background screenings.** I understand that if services are provided in the provider or provider employee's home, there are additional background screening requirements that may apply as outlined in Medicaid Rule Chapter 45.

If relative provider will provide personal care services:

_____	_____	**Personal care service limit.** I understand that personal care services provided by a relative shall not exceed 4 hours per participant per day, as family members are expected to contribute natural supports and supervision.

_____ _____ _____ _____

Relative Provider Signature **Date** **Certified Provider Agency Signature** **Date**

CASE MANAGER

The case manager must review and initial each statement below to acknowledge compliance.

_____ **Conflict of interest.** I verify that the individualized plan of care (IPC) has been developed and will be monitored without a conflict of interest between myself, the relative provider, or the participant.

_____ **Unduplicated services.** I verify that the IPC substantiates that these services do not duplicate similar services, natural supports, or services otherwise available to the participant (e.g., assistance normally provided by family, school, Medicaid State Plan, etc.).

_____ **Follow up on concerns or choice of other providers.** If the relative provider is not acting in the best interest of the participant, I will work with the participant's team and the Division to resolve concerns or choose other providers in a timely manner.

_____ **Service observation.** I will observe all relative provider services semi-annually (quarterly for habilitative services) and review them for appropriateness during team meetings every six (6) months.

_____ **Service documentation review.** I will review service documentation monthly to verify that the services delivered by the relative provider align with the approved IPC and, when applicable, are in compliance with EVV requirements.

_____ _____

Case Manager Signature **Date**

SUBMIT COMPLETED FORM TO WDH-HCBS-APPROVAL@WYO.GOV

SECTION 4: DIVISION REVIEW

Approval Status:	☐ Approved ☐ Denied - Reason:		
Reviewer Name:			
Reviewer Signature:		**Date:**	
Approval Effective Date:		**Approval Expiration Date:**	