Wyoming Department of Health
Commit to your health.

Wyoming
Long Term Care/Assisted Living Facility
Home and Community Based Service Waivers

Provider Duties Sheet

COMPLETE AND FAX OR MAIL TO THE SERVICE PROVIDER and RETURN THE SIGNED COPY TO THE CASE MANAGER/CARE COORDINATOR (CM/CC) WITHIN 10 BUSINESS DAYS FROM DATE OF CM/CC SIGNATURE

TO BE COMPLETED BY THE CASE MANAGER/CARE COORDINATOR

Provider:_____ Fax Number: _____

(Check One) ____ New or Renewal Plan of Care ____ Service Modification

____ Change of Case Management/Care Coordination Agency ____ Terminate Services

Client Name _____ Phone Number_____

Address _____

Medicaid ID Number _____ Date of Birth _____/_____/_____

Services Requested for Plan of Care Dates (MM/YY) _____TO (MM/YY) _____

Service Name_____ **Service Rate**_____

Name of Month						
Total # of Units						

Service Name_____ **Service Rate**_____

Name of Month						
Total # of Units						

Service Name_____ **Service Rate**_____

Name of Month						
Total # of Units						

Service Name_____ **Service Rate**_____

Name of Month						
Total # of Units						

Service Name_____ **Service Rate**_____

Name of Month						
Total # of Units						

Service Name_____ **Service Rate**_____

Name of Month						
Total # of Units						

Service Name_____ **Service Rate**_____

Name of Month						
Total # of Units						

FOR PERSONAL CARE SERVICES

	Check mark each month the specific task where Personal Care will be used.					
Task	***Name of Month #1***	***Name of Month #2***	***Name of Month #3***	***Name of Month #4***	***Name of Month #5***	***Name of Month #6***
Bath/Shampoo/Nails/Skin						
Dressing/Grooming						
Feeding/Meal Preparation						
Assist with Self Admin Meds						
Transfer/Ambulate/Exercise						
Toileting						
Cleaning						
Laundry						
Shopping						
Escort						
Other (Specify)						

CM/CC Printed Name _____ Signature _____Date _____

CM/CC Agency _____ Fax # _____ Address _____

TO BE COMPLETED BY THE SERVICE PROVIDER

- ☐ **I agree to provide services requested on the Plan of Care as stated above.**
- ☐ **I am unable to provide one or more of the services listed above.**
- ☐ **I acknowledge the termination of one or more services based on the units listed above.**

Provider Signature _____ Date _____

Guidelines for completing form HCBS 6:

THIS FORM NEEDS TO BE COMPLETED AND FAXED OR MAILED TO THE SERVICE PROVIDER and THE SIGNED COPY RETURNED TO THE CASE MANAGER/CARE COORDINATOR BEFORE SUBMISSION OF PLAN OF CARE

1. This form is to be **completed prior** to the initial start of a Plan of Care, the renewal of a Plan of Care, for each modification to a Plan of Care, and the termination of one or more services to a Plan of Care.

2. Complete form in its entirety based on the information below.

Provider, Fax Number:	Print the name and fax number of the service provider of the requested service.
New or Renewal Plan of Care **OR** Service Modification **OR** Change Case Management/Care Coordination Agency **OR** Terminate Services.	Check the appropriate selection.
Client Name, Address, Phone Number, Medicaid ID #, Date of Birth:	Enter information as it appears on the participant screen in the EMWS.
Services Requested for Plan of Care Dates:	Enter dates indicated for the Plan of Care.
Service information:	Service Name – Enter the name of the service requested. This includes Personal Care Service- specifics are listed below. Service Rate – Enter the unit cost for the requested service, Name of Month – based on the dates listed above put the name of each month- i.e, if dates are 03/12 to 08/12, the first month is March, second is April, etc., Total # of Units – Enter the total number of units to be provided for the month (this is NOT the # of hours but the # of units.) Enter "0" if no units are to be provided in a month.
For Personal Care:	Write the name of the month at the top of the monthly column. For each month, enter a checkmark for each specific task the PCA will be performing during the course of a month.
Case Manager/Care Coordinator printed name and signature with date, Case Management/Care Coordination Agency with address and fax number.	Signature verifies the services and dates of service are correct based on the Plan of Care. Case Manager/Care Coordinator is **REQUIRED** to print, sign and date.
I agree/I am unable…. check boxes	The requested provider is **REQUIRED** to check only one box
Provider Signature and date:	Provider's signature is **REQUIRED** to attest the decision of agreement inability to provide services or termination of services on the Plan of Care. The person who oversees the services should be the signor and is the responsible party for delivery of the services.

3. Fax or mail the completed Case Manager/Care Coordinator portion form to the service provider for completion.

4. The document is not valid until both the Case Manager/Care Coordinator **AND** the service provider have signed and dated the document.

5. If the service provider agrees to the information listed on the document, services can be entered and submitted for approval. If the service provider DOES NOT agree to provide one or more service listed, a new service provider must be located or those services will not be provided.