WYOMING
MENTAL HEALTH & SUBSTANCE ABUSE SERVICES DIVISION
CHILDREN'S MENTAL HEALTH WAIVER

PROVIDER APPLICATION

Part 1 – Demographic Information – should be provider's personal/home information	
Applicant Name:	
SSN:	
Mailing Address *(number and street, city, state, zip code)*	
Telephone number:	
E-mail Address:	
Part 2 – Agency Affiliation ☐ Yes (Complete Part 2) ☐ No (Go to Part 3)	
Agency Name:	
Agency NPI #: _____ Agency WY provider #: _____	
Address *(number and street, city, state, zip code)*	
Telephone number:	Fax number:
Administrator / CEO:	
Agency Contact Person: Title:	
Telephone number:	E-mail Address:
Part 3 – Request for Waiver Services Certification	
☐ Family Care Coordination ☐ Youth & Family Training and Support ☐ Respite Requested Location of Service Provision ☐ City ☐ County ☐ Region List : _____	

Part 4 – Documentation of Waiver Certification Requirements

For all waiver services, complete and submit the following information to the Children's Mental Health Waiver Program in the envelope provided:

☐ Copy of Bachelor's Degree in Human Services or related field OR Completed Employment History form

☐ Completed DCI (orange) and FBI (blue) fingerprint cards WITH money order for $39.00 *payable to the Attorney General*

☐ Application for Child Abuse/Neglect and Adult Central Registry Screens (DFS form SS-26) WITH money order for $8.00 *payable to State of Wyoming*

☐ Completed Provider Confidentiality Statement

☐ Signed Provider "FYI" Form

☐ Proof of current CPR and First Aid certification

☐ Copy of valid driver's license

☐ Copy of current auto insurance card

Part 5 - Assurances

Read and check off assurances prior to signing application form.
If affiliated with an agency, must include signature from an individual authorized to sign for the agency. Unsigned applications will be returned.

☐ Applicant assures that, if approved, he/she and agency affiliate (if applicable) will maintain compliance with all applicable state and federal statutes, regulations, licensure, and certification requirements for the approved service(s).

☐ Applicant and agency affiliate (if applicable) assures that, if approved, he/she and agency affiliate will provide only those Medicaid home and community-based services for which the provider has been approved; services which have been identified and authorized in the child's service plan; and in accordance with the Medicaid Enrolled Provider Agreement.

Signature of Applicant:

Print Name:

Authorized Signature of Agency (if applicable):

Date:

Mail to:
Children's Mental Health Waiver Program
WDH Mental Health/Substance Abuse Services Division
6101 Yellowstone Road Suite 220
Cheyenne, WY 82002

Direct Application questions to:
Children's Mental Health Waiver Program
Phone: (307) 777-5061