Wyoming Department of Health

Medicaid Supports Waiver Application

Applicable Program - Submit this form to the Benefits and Eligibility Specialist (BES) in your area

I am currently on a Medicaid Waiver: ☐ Yes ☐ No Waiver Name: _____

If yes, your case manager's name:_____ Case manager's phone number: _____

I am interested in receiving information on institutional placement ☐ Yes ☐ No

I have an acquired brain injury (ABI) ☐ Yes ☐ No Age the ABI occurred: _____

Applicant Contact Information

Applicant Name:_____ Phone Number: _____

Physical Address:_____ Mailing Address: _____

City, State, Zip: _____ City, State, Zip:_____

County of Residence: _____ E-mail Address:_____

Social Security Number: _____ - ___ - _____ DOB:_____/_____/_____ Age:_____

☐ Male ☐ Female Ethnicity: _____ Medicaid #: ____ - _____

City/County where I will receive services:_____

I am a qualifying dependent of an active military service member: ☐ Yes ☐ No

As the applicant's legally authorized representative, I certify that I intend to reside in Wyoming within eighteen (18) months after retiring or separating from military service. ☐ Yes ☐ No ☐ N/A

Legally Authorized Representative Contact Information

Please complete the following section if the applicant is under 18 years of age or has a court-appointed legally authorized representative (full or limited).

Name of Parent(s)/legally authorized representative(s): _____

Physical Address: _____ Phone Number: _____

City, State, Zip: _____ E-mail Address: _____

Is this person a court-appointed legally authorized representative (full or limited)? ☐ Yes ☐ No

Emergency Contact Information

Please include emergency contact information.

Name: _____ Relationship to Participant:_____

Physical Address: _____ Phone Number: _____

City, State, Zip: _____ E-mail Address: _____

Signatures

_____

Signature of Applicant or Legally Authorized Representative Date ___/___/_____

Signature of Witness_____ Date ___/___/_____

(required if signature is marked with an "X")

Wyoming Department of Health

Case Management Selection Form

Applicant Information - Submit this form to the Benefits and Eligibility Specialist (BES) in your area

Applicant: _____ Legally Authorized Representative: _____

Acknowledgement of Choice of Providers and Case Manager Conflict of Interest Disclosure

Please initial each line to verify services available through this Waiver Program have been explained to you.

____ I understand that I have the ability to make decisions regarding which services will be provided to me and which providers I will work with as a waiver participant.

____ I understand that I have the right to request an informal dispute resolution or an administrative hearing if I am not given the choice of providers.

____ I understand that I must choose a case manager who is not related to me or affiliated with any of my other services, so a conflict of interest will not exist.

____ I understand that it is my responsibility to notify my case manager of any changes to my address or phone number. If, during the application process or while on the waiting list for services, my case manager is unable to contact me, I understand that my case may be closed.

Case Manager Selection

A list of certified case managers (https://health.wyo.gov/healthcarefin/hcbs/) who are available in my region was provided to me and I have completed my case manager interviews. I have chosen the following individual to serve as my case manager, assist me in gathering the necessary information to determine my clinical eligibility and, if I am eligible for services, develop and submit my individualized plan of care.

Case Manager Name: _____ Organization: _____

Phone Number: _____ Email address:_____

If you are changing your case manager, who is your current case manager? _____

Phone Number: _____ Requested date change to new case manager: ___/___/_____

Email address:: _____

____ My current case manager will have access to my case for up to seven calendar days after my new case manager begins, in order to complete required duties from the previous month of service. (Please initial if you understand and agree.)

Consent for Information Release

Please initial each line to verify that you understand and agree to the following information:

____ I agree to participate in assessments and screenings to determine my clinical eligibility and need for waiver services.

____ I authorize the release of my information by my physician, hospital, community mental health center, other social service providers, school, health service providers, and family members to and among Wyoming state agencies, and their agents, as it relates to my medical condition and ability, in order to determine appropriate waiver services. I understand I may revoke this release of information in writing at any time.

Signatures

_____	___/___/____	_____	___/___/____
Applicant or Legally Authorized Representative Signature	Date	Witness Signature (required if signature is marked with an "X")	Date
_____	___/___/____	_____	___/___/____
New or Current Case Manager Signature	Date	New Selected Case Manager Signature	Date