STATE OF WYOMING
Department of Health
Division on Aging
6101 Yellowstone Road, Suite 259B
Cheyenne, WY 82002

HCBS-200a (Rev. 1/00)
LTC WAIVER PLAN OF CARE

PLAN PARTICIPANTS (PLEASE LIST)

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OTHER SERVICES USED:

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Client Needs Codes and Desired outcome codes are listed on the back of the form.

Diagnosis codes are located on list provided by the Aging Division.

Care Coordinator Provider Number	Fax No.	Six-Month Period From:	To:	YOU MUST ATTACH CURRENT LT101 AND CLIENT CHOICE OF SERVICE WITH NEW AND
Care Coordinator Name	Phone No.	Recipient Medicaid ID#:	Recipient SSN:	Amendment to existing Plan of Care? Y N
Agency Name (client)	County	Recipient Last Name	First	Date of LT101: LT101 Points

Client needs Code	Desired Outcome Code	Service Start Date	Procedure Code	Procedure Description	Medicaid Provider #	Unit Charge	Units Month 1	Units Month 2	Units Month 3	Units Month 4	Units Month 5	Units Month 6	Diagnosis Code
			W-6012	Care Coordinator									
			W-6002	Self Help Assistant (Certified)									
			W-6004	Self Help Assistant (Non-Certified)									
						DOLLAR TOTALS							

AN APPROVAL OF THIS PLAN OF CARE IS NOT A GUARANTEE OF ELIGIBILITY OR PAYMENT. COVERAGE OF SERVICES UNDER THE APPROVED PLAN OF CARE IS CONTINGENT UPON THE CLIENT'S ONGOING MEDICAID ELIGIBILITY.

Signature of Client (or Client Designee) _____ Date

Signature of Care Coordinator _____ Date

Office Use: Faxed _____ (date) Mailed _____ (date) TC _____ (date)

DoA-WHITE COPY PROVIDER-YELLOW CLIENT-PINK