



Provider Site User Guide Magellan of Wyoming

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Introduction

Begin by logging on to www.MagellanProvider.com and selecting *Referral/Care Management* within the *My Wyoming* section of the My Practice menu.

My Practice

- ▶ **My Wyoming**
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 - Administrator Setup
 - Display/Edit Practice Information

Welcome Magellan Provider

You are viewing information for:
123456789 PROVIDER, MAGELLAN (111111000)

[Edit My Profile](#)

Please be advised that maintenance is performed every Thursday from 5:00 - 5:30 a.m. Central Time. During this time, the site may be briefly unavailable. Data that has not been saved may be lost.

My Messages ::

Listed are your most recent messages.
You have a total of **0 new messages** in your Inbox.

From	Subject	Date
You have no messages.		

[Inbox](#) | [Compose New Message](#) | [Complaints](#) | [Compliments](#) | [Suggestions](#)

My Claims ::

Listed are the most recent claims received for this TIN (Taxpayer Identification Number).

Date Received	Status	Total Billed	Total Paid	
09/09/2015	Paid	\$1,133.00	\$837.00	Details
09/09/2015	Paid	\$1,077.50	\$837.00	Details
09/09/2015	Paid	\$1,207.00	\$837.00	Details
09/09/2015	Paid	\$1,000.00	\$837.00	Details

My Practice ::

MyPractice information is currently not available
[Display/Edit All Practice Information](#)
[Display/Edit Roster](#)

My Status ::

MyStatus information is currently not available
[Check Contract Status](#)

News Headlines ::

[Provider Focus Newsletter](#)
[National Provider](#)

When the member has been referred, but there is not an application yet, from the right box, upload the application and accompanying documents

The screenshot shows the 'Wyoming Referral/Care Management' application. On the left is a 'My Practice' sidebar with a tree view containing categories like 'My Wyoming', 'My Contact List', 'My Authorizations', 'My Status', 'My Practice', 'My Forms', and 'My Profile'. The main content area is titled 'Wyoming Referral/Care Management' and includes a 'Welcome' message. It features a 'Search for a Member' section with a list of actions: 'Search for a Member', 'View Member Details', 'Enter Member Assessment Details', and 'Enter Member Clinical Details'. To the right, there are sections for 'New Member Information (for Medicaid members only)', 'New Referral' (with a link to 'Upload Referral Information'), 'Choice of Providers Update' (with a link to 'Upload Choice of Providers Information'), 'Annual Evaluation Update' (with a link to 'Upload Scanned CASII/ECSII Information'), and 'Additional FCC Reports' (with links to 'Upload Return to Community Report', 'Upload Out-of-Home Status Report', and 'Upload Critical Incident Report'). A 'Return to MyPractice Page' link is at the bottom.

Once in the application, to find the appropriate enrolled member. Search by first name, last name, and member number.

This screenshot shows the 'Eligibility Search' section of the application. It begins with a header 'Wyoming Referral/Care Management :: Eligibility Search' and a 'Help?' link. A descriptive text states: 'This application allows you to determine if a member is eligible for Services.' Below this is a 'Search for a Member' section. It explains that search results are limited to one record and lists recommended search parameters: Member Name, Date of Birth, and State. It also notes that at a minimum, the user must enter the State and either the Member Name or Member Number. The search form includes input fields for 'Last Name:', 'First Name:', 'Date of Birth: (mm/dd/yyyy)', 'State/Province/Territory:' (a dropdown menu currently showing 'Wyoming'), 'Member Number:', and 'Zip Code:'. Each input field has a small purple square icon with a white question mark next to it. At the bottom, there are buttons for 'Search' and 'Cancel'.

When located, the member's details and plan information will display. Select either the *Assessments* or *Clinical Plans* button.

Wyoming Referral/Care Management ::**Member Details** **Help?**

Please be advised that the use of this tool for review of eligibility or benefits does not guarantee claim payment. Payment of benefits is subject to the member's eligibility on the date service is rendered and any other contractual provisions of the plan. To assure compliance with state mandates, please follow the pre-authorization instructions on the member's health insurance card.

Member Information

Member: JOHN DOE

Member DOB: 01/01/2002

Gender: M

Relationship: Subscriber

Address: 1234 MAIN STREET

Magellan Member No.: WYC0101

City, State, ZIP: CHEYENNE, WY 82001

Member Benefit Card No.: 234212454

Plan Benefits Information

Client Name:

Type of Plan	Coverage Start	Coverage End	Status
WYCME PSEUDO ID-NO BENEFITS	05/01/2015	12/31/2069	Active

Youth Assignment

Youth Assignment

Assessment Information

Assessments

Clinical Information

Clinical Plans

Search Again

[Return to MyPractice Page](#)

Assessments

The Assessments Summary page provides links to add Strength, Needs and Culture Discovery (SNCD). If previous assessments were submitted for the member, those submissions display on this page as well. The Family Empowerment Tool and the California Healthy Kids Assessments are no longer used and the CANS Assessment can now be found under *Manage Outcomes* on the left-hand menu.

Wyoming Referral/Care Management		Assessment Summary	
Member Information:			
Name:	JAMES DOE	DOB:	05/01/2009
Gender:	Male	Member Number:	WYC03
Strengths, Needs and Culture Discovery (SNCD) Assessment			
No SNCD Assessments found.			
Add SNCD Assessment			
Child and Adolescent Needs and Strengths (CANS)			
No CANS Assessments found.			
Add CANS Assessment			
Family Empowerment Tool (FET)			
No FET Assessments found.			
Add FET Information			
California Healthy Kids Survey (CHKS)			
No CHKS Assessments found.			
Add CHKS Information			
Return to Member Details Return to MyPractice			

Strength, Needs and Culture Discovery (SNCD) Assessments

The SNCD page requires completion of multiple sections:

- Member Information
- SNCD Assessment Information
- Family Information
- Vision/Needs Information
- Life Domain Information
- Child and Family Team Information
- Signature

SNCDNew Form

Strengths, Needs and Culture Discovery (SNCD) information may be completed immediately or saved for completion at a later date. To save an "Incomplete" plan, click the Save for Later button on the section you wish to exit. To return and finish the assessment, search for the member, click the Assessment button and select the assessment which is marked "Incomplete". Sections which were not previously completed will be marked with a red exclamation while completed sections will be marked with a green checkmark.


Transaction No.: 7

Member Information	!
SNCD Assessment Information	!
Family Information	!
Vision/Needs Information	!
Life Domain Information	!
Child and Family team Information	!
Signature	!

[Return to Assessment Summary](#) [Return to My Practice](#)

SNCD Assessment – Member Information

Be sure to complete all required fields. When finished, click *Save and Continue*. The red exclamation icon indicates this section is not complete.

Member Information 

** Required*


Member Name:	DOE, JOHN	Date of Birth:	01/01/2002
Gender:	MALE	Member ID:	WY000000000
Address:	123 MAIN STREET ANYTOWN, WY 75555		
County: *	-- SELECT --	Home Phone No.: *	
Cell Phone No.:			
Email:			
Preferred Language: *			
<input type="checkbox"/> English		<input type="checkbox"/> Spanish	
<input type="checkbox"/> Other			
Race *(Check all that apply)			
<input type="checkbox"/> American Indian or Alaska Native		<input type="checkbox"/> Asian	
<input type="checkbox"/> Black/African American		<input type="checkbox"/> Native Hawaiian/Pacific Islander	
<input type="checkbox"/> White/Caucasian		<input type="checkbox"/> Not Reported/Unknown	
<input type="checkbox"/> Other			
Ethnicity (Check all that apply)			
<input type="checkbox"/> Arapahoe		<input type="checkbox"/> Hispanic/Latino	
<input type="checkbox"/> Puerto Rican		<input type="checkbox"/> Shoshone	
<input type="checkbox"/> Not Reported/Unknown		<input type="checkbox"/> Other	
Does member have a disability?*			
Deaf/Hard of hearing		<input type="radio"/> Yes <input type="radio"/> No	
Blind		<input type="radio"/> Yes <input type="radio"/> No	


Save and Continue **Save for Later**

SNCD Assessment – SNCD Assessment Information

The next section you need to complete is *SNCD Assessment Information*. Note that *Member Information* now displays a green checkmark because that section is complete.

Transaction No.: 7

Member Information 

SNCD Assessment Information 

** Required*

Date Completed with Family:


Reason for Referral to Wraparound Process:*


^


v


You have 5000 characters remaining. [Clear](#)


Save and Continue **Save for Later**

Family Information 

Vision/Needs Information 

Life Domain Information 


Child and Family team Information 

Signature 

[Return to Assessment Summary](#) [Return to My Practice](#)

SNCD Assessment – Family Information

Family Information is the next section. Click the plus sign icon to add more family contacts. You can add up to 15 contacts.


Family Information 

** Required*

Family Contact Information:


1. **Name:**

Relation:

Phone No.: 


2. **Name:**

Relation:

Phone No.: 


3. **Name:**

Relation:

Phone No.: 


4. **Name:**


Relation:

Phone No.: 



5. **Name:**

Relation:

Phone No.: 

Click  to add Family Contact Information. You may add up to 15 Family Contacts.

Introduction to Family:

You have 5000 characters remaining. [Clear](#)

Save and Continue

Save for Later

SNCD Assessment – Vision/Needs Information

Vision/Needs Information is the next section.

Member Information ✓

SNCD Assessment Information ✓

Family Information ✓

Vision/Needs Information !

** Required*

Family Vision:*(Family's hopes and dreams for future)

You have 5000 characters remaining. [Clear](#)


Priority Needs and Concerns:*

You have 5000 characters remaining. [Clear](#)

[Save and Continue](#) [Save for Later](#)

SNCD Assessment – Life Domain Information

The next section is *Life Domain Information*.

Life Domain Information 

** Required*

Residence:*

You have 5000 characters remaining. [Clear](#)

Employment:*

You have 5000 characters remaining. [Clear](#)

Family/Extended Family:*

You have 5000 characters remaining. [Clear](#)

School:*

You have 5000 characters remaining. [Clear](#)

Friends:*

You have 5000 characters remaining. [Clear](#)

SNCD Assessment – Life Domain

Information *continued*

Click the plus sign icon to add more Life Domains. You can add up to five more.

Religious Background:*

You have 5000 characters remaining. [Clear](#)

Physical Health:*

You have 5000 characters remaining. [Clear](#)

Primary Care Physician Name:*

Mental Health:*

You have 5000 characters remaining. [Clear](#)


Safety:*

You have 5000 characters remaining. [Clear](#)

Legal:*

You have 5000 characters remaining. [Clear](#)


Additional Life Domain Information:

Click  to add a Life Domain. You may add upto 5 additional Life Domains.

[Save and Continue](#) [Save for Later](#)

SNCD Assessment – Child and Family Team Information

The next section is *Child and Family Team Information*. Click the plus sign to add additional CFT Contacts. You can add up to 15 contacts.


Child and Family team Information 

** Required*

CFT Contact Information:


1. Name:

Relation:

Phone No.: 


2. Name:

Relation:

Phone No.: 


3. Name:

Relation:

Phone No.: 


4. Name:


Relation:

Phone No.: 

5. Name:

Relation:

Phone No.: 


Click  to add Child and cft Team (CFT) Contact Information. You may add up to 15 CFT Contacts.

Save and Continue **Save for Later**

SNCD Assessment – Signature

The last section is *Signature*. Complete the required fields and then click *Print Signature PDF*. Once you sign the printed signature page, scan the signed page.

Please note: The parent/guardian and youth (when appropriate) will be required to sign the signature page.

Signature 

Please identify the names and credentials of the Child and Family Team members below who have reviewed and agreed to the Strengths, Needs and Cultural Discovery and will execute the signature page of this assessment.

Printed name information will print with designated signature areas.

*** Required**

Printed Name of Member:	MEMBER, TEST
Printed Name of Parent/Guardian/Custodian: *	<input type="text"/>
Printed Name of Parent/Guardian/Custodian 2:	<input type="text"/>
Printed Name of Submitting Provider:	GROUP, TEST
Submit Date: *	<input type="text"/>

Print Signature PDF **Save for Later**

SNCD Assessment - Signature Page



Member:	DOE, JOHN
Source Member ID:	WYC0101
Gender:	Male
Signature:	<hr/>
Date:	<hr/>
Parent/Guardian	JANE SMITH
Signature:	<hr/>
Date:	<hr/>
Parent/Guardian	N/A
Signature:	<hr/>
Date:	<hr/>



SNCD Assessment – Attachment

Once you sign and scan the signature page, you must upload it to Magellan through the *Attachment* section. Click *Browse* to locate the scanned document and then click *Upload Document*.

Attachment 

You must upload a Signature page for this SNCD in order to submit.

If the Signature page is not ready to upload, you will be able to return to this page to upload the document and submit your assessment at a later date.


When ready to upload the Signature page, Search for the member and on the Assessment Summary page click the Edit icon associated with the assessment marked Incomplete.

To upload the Signature Page browse to the file on your computer, click Open and then click Upload Document.

Document Upload: **Browse...**

Upload Document



Confirmation will be given once the upload is complete. Click *Submit*.

Attachment 

If the Signature page is not ready to upload, you will be able to return to this page to upload the document and submit your assessment at a later date.

When ready to upload the Signature page, Search for the member and on the Assessment Summary page click the Edit icon associated with the assessment marked Incomplete.

To upload the Signature Page browse to the file on your computer, click Open and then click Upload Document.

You have successfully uploaded the Signature PDF.  

By submitting this Strength, Needs and Cultural Diversity (SNCD) Assessment I attest that all members listed on the Signature Page have reviewed and approved this Assessment.

Submit


of Health

SNCD Assessment – Submission Confirmation

Once submitted, confirmation will be provided, along with a reference number. Click *Return to Assessment Summary*.

Plan of Care**Submission Confirmation**

You have successfully completed the Strengths, Needs and Cultural Diversity (SNCD) Assessment. The SNCD ID for your reference is: 7



Click  to print a copy of the Plan of Care for your records.
You may also print or save a copy of this plan of care from the Assessment Summary page.

This Strengths Needs and Culture Discovery (SNCD) Assessment will automatically be made available to the custodian when identified on the Plan of Care. If you do not want this information to go to this contact, update the Plan of Care and mark the question 'Does this contact have permission to view the Plan of Care?' to 'No'. Notifications are sent daily. If you do not want this information to be shared, you must make the change in the Plan of care immediately.

[Return to Assessment Summary](#) [Return to My Practice](#)

SNCD Assessment – Completed Submissions

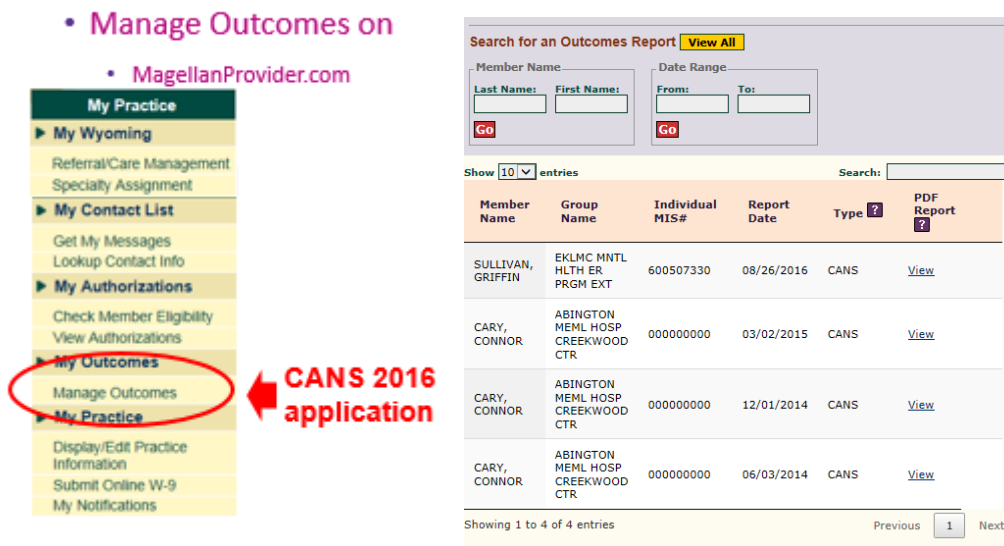
Previous submissions will display on the Assessment Summary page and can be viewed by clicking the magnifying glass icon, or updated by clicking the green arrow icon. Once the first SNCD has been submitted the red *Add SNCD Assessment* button will no longer show. You will add SNCDs by clicking the green arrow icon and updating the last SNCD.

Wyoming Referral/Care Management		Assessment Summary	
Member Information			
Member:	MEMBER, TEST	DOB:	06/24/1997
Gender:	Female	Member Number:	WYC000000001
Strengths, Needs and Culture Discovery (SNCD) Assessment			
Assessment Date	Transaction Number	Status	Action
07/01/2015	7	Submitted	 
Child and Adolescent Needs and Strengths (CANS)			
No CANS Assessments found.			
Add CANS Assessment			

Child and Adolescent Needs and Strengths (CANS) Assessments

The CANS Assessment can be found under Manage Outcomes in the yellow tool bar to the far Left side of the page. Then utilize the List and Search Functions

- Manage Outcomes on MagellanProvider.com



Search for an Outcomes Report [View All](#)

Member Name: Last Name: First Name: From: To: Go Go

Show 10 entries Search:

Member Name	Group Name	Individual MIS#	Report Date	Type	PDF Report
SULLIVAN, GRIFFIN	EKLHC MNTL HLTH ER PRGM EXT	600507330	08/26/2016	CANS	View
CARY, CONNOR	ABINGTON MEML HOSP CREEKWOOD CTR	000000000	03/02/2015	CANS	View
CARY, CONNOR	ABINGTON MEML HOSP CREEKWOOD CTR	000000000	12/01/2014	CANS	View
CARY, CONNOR	ABINGTON MEML HOSP CREEKWOOD CTR	000000000	06/03/2014	CANS	View

Showing 1 to 4 of 4 entries Previous 1 Next

Start the Assessment Process

Manage Outcomes Reports ::

Member

Start Self Assessment Process

Click Continue to:

- Select a member and launch Outcomes360 assessments
- Print fax assessment forms
- Check-In for IBC members

Continue

Select the CANS Application

Manage Outcomes:: **Select Assessment**

Select and Launch Outcomes Assessment

Non-Medicaid	Select this assessment if your member is enrolled in a health plan or employer sponsored program, including Medicare.
or	
Medicaid	Select this assessment if your member is enrolled in Medicaid and/or other Public Sector program.
or	
CANS	Select this assessment for members who are between the ages of 3-20 years. It can be used as a decision support tool, a quality improvement tool, or as an outcomes monitoring tool. (Child & Adolescent Needs & Strengths - CANS-MH)

Manage Outcomes **Assessment**

The CANS-MH assessment tool is designed to give a profile of the needs and strengths of the child and family. It is an item level tool and the terms might have a direct impact on the service planning process. The levels of each item translate immediately into action levels. Action levels are different for needs and strengths.

Member Information:

Member Name
Address here
Location here

Provider Information:

Group:
Individual:
None Selected

Assessment Information:

* Required Field
Assessment Type: *
Initial Assessment
Assessment Date: *
12/05/2016

Begin **Cancel**

If the FCC works for one agency with multiple locations, the FCC may see more than one "group" or location/site. The FCC should select the correct "group."

If the FCC works for more than one agency, the FCC will have more than one account on MagellanProvider.com. The FCC needs to make sure the CANS is entered under the correct account and agency. This box is a double check you are in the correct account.

The FCC should select his/her own individual name.

Manage Outcomes **Assessment**

The CANS-MH assessment tool is designed to give a profile of the needs and strengths of the child and family. It is an item level tool and the terms might have a direct impact on the service planning process. The levels of each item translate immediately into action levels. Action levels are different for needs and strengths.

Member Information:

Member Name: _____ Member DOB: 04/04/1998
 Address here: _____ Gender: Male

Provider Information:

Group:
 Individual:

Assessment Information:

* Required Field
 Assessment Type: *
 Initial Assessment
 Assessment Date: 12/05/2016
 Primary Diagnosis: *
 Service Type: *
 Select
 Community
 Residential
 Intensive Residential

Assessment Type: *
 Initial Assessment
 Reassessment
 Transition/Discharge

Calendar: December 2016
 Sun Mon Tue Wed Thu Fri Sat
 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31
 Today is: December 5, 2016

Default date today but can be dated earlier.

Have the ICD-10 diagnosis code from LOC before you start the CANS

The "Initial" is the First CANS. The "Discharge/Transition" is the Last CANS. The rest are "Reassessments."

- ✓ Each Domain title will expand when clicked
- ✓ Each Item has a 0-3 rating with a brief anchor text with "more" for additional text to improve reliability
- ✓ Please use the Magellan CANS 2016 Manual for complete anchor definitions

Life Domain Functioning

Select a rating for each item listed. All items are required. Please select the Save button once completed.

Family: 0 1 2 3
 Child is doing adequately in relationships with family mem... more

Living Situation: 0 1 2 3

School: 0 1 2 3

Social Functioning: 0 1 2 3

Answer Explanation
 Child is doing adequately in relationships with family members although some problems may exist. For example, some family members may have some problems in their relationships with child.

CANS Assessment – Submission Confirmation

Once submitted, confirmation will be provided, along with a reference number. Click *Return to Assessment Summary*.

WY CANS Assessment	Submission Confirmation
<p>You have successfully completed the WY CANS Assessment. The WY CANS Assessment ID for your reference is 73.</p> <p>Click here to print a copy of this submission for your records. You may also view, print or save a copy of this assessment from the Assessment Summary Page.</p> <p>Return to Assessment Summary Page Return to MyPractice Page</p>	


Clinical Plans

The Clinical Summary page provides links to add Plan of Care/Crisis Plans and Progress Notes. If you entered previous submissions for the member, those submissions would display on this page as well.


Wyoming Referral/Care Management		Clinical Summary	
Member Information			
Member:	DOE, JOHN	DOB:	01/01/2002
Gender:	MALE	Member Number:	WY000000000
Plans of Care/Crisis Plans			
No Plans of Care/Crisis Plans found.			
Add Plan of Care/Crisis Plan			
Progress Notes			
No Progress Notes found.			
Add Progress Notes			
Return to Member Details Return to MyPractice			

Plan of Care/Crisis Plan – Member Information

Be sure to complete all required fields. When finished, click *Save and Continue*. The red exclamation icon indicates this section is not complete.

Member Information 

** Required*


Member Name:	DOE, JOHN	Date of Birth:	01/01/2002
Gender:	MALE	Member ID:	WY000000000
Address:	123 MAIN STREET ANYTOWN, WY 75555		
County: *	-- SELECT -- 	Home Phone No.: *	<input type="text"/>
Cell Phone No.:	<input type="text"/>		
Email: *	<input type="text"/>		
Preferred Language: *			
<input type="checkbox"/> English		<input type="checkbox"/> Spanish	
<input type="checkbox"/> Other <input type="text"/>			
Race: *(Check all that apply)			
<input type="checkbox"/> American Indian or Alaska Native		<input type="checkbox"/> Asian	
<input type="checkbox"/> Black/African American		<input type="checkbox"/> Native Hawaiian/Pacific Islander	
<input type="checkbox"/> White/Caucasian		<input type="checkbox"/> Not Reported/Unknown	
<input type="checkbox"/> Other			
Ethnicity: (Check all that apply)			
<input type="checkbox"/> Arapahoe		<input type="checkbox"/> Hispanic/Latino	
<input type="checkbox"/> Puerto Rican		<input type="checkbox"/> Shoshone	
<input type="checkbox"/> Not Reported/Unknown		<input type="checkbox"/> Other	
Does member have a disability?*			
Deaf/Hard of Hearing: *		<input type="radio"/> Yes <input type="radio"/> No	
Blind: *		<input type="radio"/> Yes <input type="radio"/> No	
Save and Continue		Save for Later	


Plan of Care/Crisis Plan – Plan of Care Information

The next section to complete is *Plan of Care Information*.

Please note: If you wish to be able to update the submission, please select “Initial” or “Initial – Correction” as the Type of Transaction.

Transaction No.: 1098

Member Information 

Plan of Care Information 

** Required*

Type of Transaction:*

Plan Date:* Referral Date to HFWA Agency/Provider:*

Primary Care Physician Name:

Due Date for Next Assessment:*

Was member recently or currently in a PRTF?* ☐ Yes ☐ No

Was member recently hospitalized in a psychiatric hospital?* ☐ Yes ☐ No


Does this Plan of Care involve a Crisis? * ☐ Yes ☐ No

Was the SNCD Assessment reviewed as part of establishing this Plan of Care? * ☐ Yes ☐ No


Save and Continue **Save for Later**

Plan of Care/Crisis Plan – Current Living Situation Information

The next section to complete is *Current Living Situation Information*.

Current Living Situation Information 


** Required*


Member's Current Living Situation:* -- SELECT -- 

Name of Agency/Location/Person where Member is residing:*

MIS:

Address:*

City:* **State:*** -- 

County:* -- SELECT --  **ZIP Code:***

Home Phone No.:* **Cell Phone No.:**

Other Phone No.: **Fax:**


Email:*

Other Contact/Relationship:* **Other Contact/Relationship Phone No.:***

Save and Continue **Save for Later**


Plan of Care/Crisis Plan – Custodial Information

The next section to complete is *Custodial Information*.

Custodial Information 

** Required*


Parent/Legal Guardian Last Name: *	<input type="text"/>	Parent/Legal Guardian First Name: *	<input type="text"/>
Address: *	<input type="text"/> <input type="text"/>		
City: *	<input type="text"/>	State: *	-- <input type="button" value="v"/>
County: *	-- SELECT -- <input type="button" value="v"/>		
ZIP Code: *	<input type="text"/> - <input type="text"/>		
Home Phone No.: *	<input type="text"/>	Cell Phone No.:	<input type="text"/>
Other Phone No.:	<input type="text"/>	Child & Family Team (CFT) Date: *	<input type="text"/>
Email: *	<input type="text"/>		

Does this contact have permission to view the Plan of Care? *  ☐ Yes ☐ No

Save and Continue **Save for Later**

Plan of Care/Crisis Plan – Medical Information

The next section to complete is *Medical Information*.

Medical Information 

** Required*

Primary Care Physician Name:*

Address:

City: **State:** **ZIP Code:**

County: **Phone No.:**

Cell Phone No.: **Fax:**

Email:

Primary Medical Issues or Health Concerns:*

You have 5000 characters remaining. [Clear](#)

Medications:


Physical:

Psychiatric:

Save and Continue **Save for Later**

Plan of Care/Crisis Plan – Vision/Mission/Strength Information

The next section to complete is *Vision/Mission/Strength Information*.

Vision/Mission/Strength Information 

** Required*

Family Vision:* (Family's hopes and dreams for future)

You have 5000 characters remaining. [Clear](#)

Child and Family Team Mission:*

You have 5000 characters remaining. [Clear](#)

Strengths:*

You have 5000 characters remaining. [Clear](#)

Save and Continue **Save for Later**

Plan of Care/Crisis Plan – Life Domain Information

The next section to complete is *Life Domain Information*. Click the plus sign icon to begin adding. You can add up to eight domains.

Life Domain Information

* Required

Primary Diagnosis

Click  to add a Life Domain. You may add up to 8 Life Domains.

Save and Continue

Save for Later

Plan of Care/Crisis Plan – Life Domain Information *continued*

The first tab to complete in the Life Domain section is *Life Domain Information*. There are three additional tabs that also must be completed – *Objectives*, *Strategies* and *Barriers*.

Please note: Be sure to click the *Save* button after completing each section.

Add Life Domain - 1

Life Domain Information

Objectives

Strategies

Barriers

* Required

Required information must be completed on all tabs before any data will be saved to our system.

Life Domain Area of Need:*

☐ Residence

☐ Religious Background

☐ Employment

☐ Physical Health

☐ Family/Extended Family

☐ Mental Health

☐ School

☐ Safety

☐ Friends

☐ Legal

Primary Diagnosis:*

Need:*

You have 5000 characters remaining. [Clear](#)

Start Date:*


Target Date:*


Drop Date:

Save

Cancel

Magellan
HEALTHCARESM

 Wyoming
Department
of Health

 WYO MEDICAID
DIVISION OF
HEALTHCARE FINANCING

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Plan of Care/Crisis Plan – Life Domain Information *continued*

The second tab in the Life Domain section is *Objectives*.

Add Life Domain - 1

Life Domain Information

Objectives

Strategies

Barriers

* Required

Please use this section to add Objectives to this life domain. You can add up to 4 objectives. If none, please enter N/A.

Objective - 1 *

You have 5000 characters remaining.

Clear

Start Date: *Target Date: *Drop Date:

Objective - 2

You have 5000 characters remaining.

Clear

Start Date:Target Date:Drop Date:

Objective - 3

You have 5000 characters remaining.

Clear

Start Date:Target Date:Drop Date:

Objective - 4

You have 5000 characters remaining.

Clear

Start Date:Target Date:Drop Date:

Save

Cancel

Department
of Health

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Plan of Care/Crisis Plan – Life Domain

Information *continued*

The third tab in the Life Domain section is *Strategies*. You can add up to 15 strategies.

Add Life Domain - 1

Life Domain Information

Objectives

Strategies

Barriers

* Required

Please use this section to add Strategies/Assigned Tasks to this life domain. You can add up to 15 strategies. If none, please enter N/A.

Strategy /Assigned Task - 1 *

You have 5000 characters remaining.

Clear

Frequency: * x -- SELECT -- -- SELECT --

Start Date: * Responsible Member: *

Since the last POC, have the strategies implemented improved the CASII, ESCII or CANS identified area of need? * ☐ Yes ☐ No

Strategy /Assigned Task - 2

You have 5000 characters remaining.

Clear


Frequency: x -- SELECT -- -- SELECT --


Start Date: Responsible Member:

Since the last POC, have the strategies implemented improved the CASII, ESCII or CANS identified area of need? ☐ Yes ☐ No

Strategy /Assigned Task - 3

Magellan
HEALTHCARESM

 Wyoming
Department
of Health

 WYO MEDICAID
DIVISION OF
HEALTHCARE FINANCING

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Plan of Care/Crisis Plan – Life Domain

Information *continued*

The fourth and final tab in the Life Domain section is *Barriers*. You can add up to four barriers. When this tab is complete, click *Save*.

Add Life Domain - 1

Life Domain Information

Objectives

Strategies

Barriers

* Required

Please use this section to add Barriers to this life domain. You can add up to 4 barriers. If none, please enter N/A.

Barrier - 1 *

Clear

You have 5000 characters remaining.

Barrier - 2

Clear

You have 5000 characters remaining.

Barrier - 3

Clear

You have 5000 characters remaining.

Barrier - 4

Clear

You have 5000 characters remaining.

Save

Cancel

of Health



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Plan of Care/Crisis Plan – Life Domain Information *continued*

The *Life Domain Information* section now shows one completed Life Domain. If more are needed, click the plus sign icon. You can view the completed domain by clicking the pencil icon, or delete it by clicking the red X icon. When all domains have been added, click *Save and Continue* to proceed to the next section.

Life Domain Information ✓

* Required


	Primary Diagnosis	
Life Domain -1	300.02	 

Click  to add a Life Domain. You may add up to 8 Life Domains.

Save and Continue **Save for Later**

Plan of Care/Crisis Plan – Recommend Service Information

The *Recommended Service Information* section contains many fields. At least one service is required to proceed to the next section. Please add the requested units to this section for each HFWA role.

Recommended Service Information 

** Required*

Family Care Coordination

Organization Name: MIS:

Contact Name:

Family Support

Organization Name: MIS:

Contact Name:

Has the member declined this service? ☐ Yes ☐ No

Youth Support

Organization Name: MIS:

Contact Name:

Has the member declined this service? ☐ Yes ☐ No

Youth and Family Training

Organization Name: MIS:

Contact Name: No. of Units Requested:

Has the member declined this service? ☐ Yes ☐ No

Short Term Respite

Organization Name: MIS:

Contact Name: No. of Units Requested:

Has the member declined this service? ☐ Yes ☐ No

Flex Funds

Organization Name: MIS:

Contact Name:

Has the member declined this service? ☐ Yes ☐ No

Plan of Care/Crisis Plan – Recommend Service Information *continued*

Medicaid Services

Independent Living Skills Building

Organization Name: MIS:
Contact Name:

Crisis Stabilization

Organization Name: MIS:
Contact Name:

Community Psychiatric Support & Training (CPST)

Organization Name: MIS:
Contact Name:

Psychosocial Rehabilitation(PSR)

Organization Name: MIS:
Contact Name:

Crisis Intervention

Organization Name: MIS:
Contact Name:

Individual Counseling

Organization Name: MIS:
Contact Name:

Medication Management


Organization Name: MIS:
Contact Name:

Plan of Care/Crisis Plan – Recommend Service Information *continued*

Others			
Organization Name:	<input type="text"/>	MIS:	<input type="text"/>
Contact Name:	<input type="text"/>		
<hr/>			
Other Services - 1			
Organization Name:	<input type="text"/>	MIS:	<input type="text"/>
Contact Name:	<input type="text"/>		
<hr/>			
Other Services - 2			
Organization Name:	<input type="text"/>	MIS:	<input type="text"/>
Contact Name:	<input type="text"/>		
<hr/>			
Other Services - 3			
Organization Name:	<input type="text"/>	MIS:	<input type="text"/>
Contact Name:	<input type="text"/>		
<hr/>			
Other Services - 4			
Organization Name:	<input type="text"/>	MIS:	<input type="text"/>
Contact Name:	<input type="text"/>		
<hr/>			
Other Services - 5			
Organization Name:	<input type="text"/>	MIS:	<input type="text"/>
Contact Name:	<input type="text"/>		
Save and Continue		Save for Later	


Plan of Care/Crisis Plan – Natural/Informal Information

The *Natural/Informal Information* section is next. Click the plus sign icon to add supports. You can add up to five supports.

Natural/Informal Support Information 

** Required*

Name	Task
------	------

Click here to add a Support Information. You can add up to 5 Supports. 

Has member been linked to appropriate adult services and programs?* ☐ Yes ☐ No

For members 15 or older, what are their transition needs?*

You have 5000 characters remaining. [Clear](#)

Save and Continue **Save for Later**

Plan of Care/Crisis Plan – Natural/Informal Information *continued*

After you complete all required fields, click *Save*.

Add Support Information - 1

Support Information

*** Required**

Please identify services projected to be needed over the next 12 months.

Support Name: *

Task: *

>

<

[Clear](#)

You have 5000 characters remaining.

Frequency: *

X

-- SELECT --

-- SELECT --

Contact Name: *


Contact Phone:

Save

Cancel


Plan of Care/Crisis Plan – Crisis Plan Information

Crisis Plan Information is the next section. Click the plus sign icon to add action supports. You can add up to 15 supports. Use the magnifying glass icon to search for the appropriate Primary Diagnosis code. Use the *Print Crisis Information* button to print a draft of the crisis plan. Please refer to the Crisis Plan Training Tool for the information required in each field.

Crisis Plan Information 

*** Required**

Crisis Plan Date:*

Primary Diagnosis:* 

Current Medications:*

You have 5000 characters remaining. [Clear](#)

Brief History:*

You have 5000 characters remaining. [Clear](#)


Triggers:*

You have 5000 characters remaining. [Clear](#)

Potential Crisis:*

You have 5000 characters remaining. [Clear](#)

Action Steps:*

Action Steps	Person Responsible
Click here to add an Action Support. You can add up to 15 Action Supports. 	

[Save and Continue](#) [Save for Later](#) [Print Crisis Information](#)

Plan of Care/Crisis Plan – Crisis Plan Information *continued*

After completing all required fields, click *Save*.

Add Action Support - 1

* Required

Action Steps/Assigned Tasks:*

You have 5000 characters remaining. [Clear](#)

Person Responsible:*

Contact Name:*

Contact Phone No:*

Save

Cancel

Plan of Care/Crisis Plan – Transition and Discharge Information Sections

The next section is *Transition Information* and then *Discharge Information*. All fields are required. Please refer to the Training Tools for the information required in each field.

Discharge Information

!

* Required

Natural/Informal Supports and Formal Services to Continue:*

^

v

You have 5000 characters remaining. [Clear](#)

Further Recommendations for Natural/Informal Supports and Formal Supports:*

What needs to happen for member to remain successful.

^

v

You have 5000 characters remaining. [Clear](#)

Triggers:*

^

v

You have 5000 characters remaining. [Clear](#)

Potential Crisis:*

^

v

You have 5000 characters remaining. [Clear](#)

Action Steps for Home and School:*

^

v

You have 5000 characters remaining. [Clear](#)

Person Responsible:*

Contact Name:*

Contact Phone:*


Save and Continue

Save for Later

Plan of Care/Crisis Plan – Signature

The last section is *Signature*. Complete the required fields and then click *Print Signature PDF*. Once the printed signature page has been signed, scan the signed page.

Please note: The parent/guardian and youth (when appropriate) will be required to sign the signature page.


Signature 


Please identify the Team Member names (Family, Support and Others, and Agencies involved in plan development) and credentials below who will execute the Signature Page of this Plan of Care. Individuals listed below collaborated in the creation of the Plan of Care.

Printed name information will print with designated signature areas.

*** Required**

Printed Name of Member:	MEMBER, TEST
Printed Name of Parent/Legal Guardian:	Doe, John
Printed Name of School Representative:*	<input type="text"/>
Submitting Provider:*	GROUP, TEST
Signature Date:*	<input type="text"/>

Contact Information: 

Printed Name of Agency Representative	Title
1. <input type="text"/>	<input type="text"/> 

Print Signature Page **Save for Later**

Plan of Care - Signature Page




Member:	MEMBER, TEST		
Source Member ID:	WYC000000001	Gender:	Female
Signature:	<hr/>		
Date:	<hr/>		
Parent/Guardian	DOE, JOHN		
Signature:	<hr/>		
Date:	<hr/>		



Plan of Care/Crisis Plan – Attachment

Once you sign and scan the signature page, you must upload it through the *Attachment* section. Click *Browse* to locate the scanned document and then click *Upload Document*.

Attachment 

You must upload a Signature page for this plan of care in order to submit.

If the Signature page is not ready to upload, you will be able to return to this page to upload the document and submit your plan at a later date.

When ready to upload the Signature page, Search for the member and on the Clinical Summary page click the Edit icon associated with the plan marked Incomplete.

To upload the Signature Page browse to the file on your computer, click Open and then click Upload Document.


Document Upload:

Browse...

Upload Document

Plan of Care/Crisis Plan – Attachment *continued*



Confirmation will be given once the upload is complete. Click *Submit*.

Attachment 

If the Signature page is not ready to upload, you will be able to return to this page to upload the document and submit your plan at a later date.

When ready to upload the Signature page, Search for the member and on the Clinical Summary page click the Edit icon associated with the plan marked Incomplete.

To upload the Signature Page browse to the file on your computer, click Open and then click Upload Document.

You have successfully uploaded the Signature PDF.  

By submitting this Plan of Care I attest that:


- All Child and Family Team members listed on the Signature Page have reviewed and approved this Plan of Care.
- I have taken appropriate steps to confirm that the Custodial Information contact is allowed to receive this info. The contact is either the parent, legal guardian or personal representative.
- The email address listed is secure. Parties that are not authorized to view information for this member do not have access to this email account.
- I understand that access will automatically be provided to this Plan of Care, as well as the SNCD.

If you do not want this information to be accessible to this contact, update the Plan of Care and answer 'No' to the question 'Does this contact have permission to view the Plan of Care?' Notifications are emailed daily. If you do not want this information to be sent, you must make the change in the Plan of Care immediately.

Submit

Plan of Care/Crisis Plan – Submission Confirmation

Once submitted, confirmation will be provided along with a reference number. Click [Return to Clinical Summary](#).

Plan of Care	Submission Confirmation
<p>You have successfully completed the Plan of Care. The Plan of Care ID for your reference is: 1098</p> <p>Click  to print a copy of the Plan of Care for your records.</p> <p>You may also print or save a copy of this plan of care from the Clinical Summary page.</p>	
<p>Access to this Plan of Care will automatically be provided to: Sipe, Momma at cjtodd@magellanhealth.com.</p> <p>Magellan will make this Plan of Care available to the custodian when identified. If you do not want this information to go to this contact, update the Plan of Care and answer 'No' to the question 'Does this contact have permission to view the Plan of Care?' Notifications are emailed daily. If you do not want this information to be shared, you must make the change in the Plan of Care immediately.</p> <p><i>Please note the following surveys and assessments are required with an initial and discharge Plan of Care:</i></p> <ul style="list-style-type: none">• Child and Adolescent Needs and Strengths (CANS)• California Healthy Kids Survey (CHKS)• Family Empowerment Tool (FET)	
Return to Clinical Summary	Return to MyPractice Page

Plan of Care/Crisis Plan – Completed Submissions

Previous submissions will display on the Clinical Summary page and can be:

- viewed by clicking the magnifying glass icon,
- corrected by clicking the wrench icon,
- updated by clicking the green arrow icon, or
- discharged by clicking the flag icon.

Wyoming Referral/Care Management

Clinical Summary

Member Information

Member:

MEMBER, TEST

Gender:

Female

DOB:

06/24/1997

Member Number:

WYC000000001

Plans of Care/Crisis Plans

Plan Date	Plan Type	Transaction No.	Status	Action
07/21/2015	Initial	1098	Submitted	   

Add Plan of Care/Crisis Plan

Progress Notes

No Progress Notes found.

Add Progress Notes

[Return to Member Details](#) | [Return to MyPractice](#)

Progress Notes – Add New Progress Note

Progress Notes consist of just one page. You must complete all required fields. You can upload additional documentation at the bottom of the page.

Progress Notes

Add New Progress Note

Please identify the Team Member names (Family, Support and Others, and Agencies involved in plan progress) who attended the meeting.

*** Required**

Select Provider TIN / MIS:*
GROUP, TEST 123456789 / 111111000

Member Information

Member:	MEMBER, TEST	Date of Birth:	06/24/1997
Gender:	Female	Member Number:	WYC000000001

Service Date:*

Service Type:*

-- SELECT --

Length of Contact/Meeting:*

-- SELECT --

Attendees:* (check all that apply)

Invited	Attended	Refused	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Parent/guardian(s)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Foster Parent(s)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Child/Youth
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	FSP
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	YSP
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	DFS
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Juvenile Justice
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Education
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	MH professional(s)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Natural supports
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	PCP
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Coaches
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other

Progress Notes – Add New Progress Note *continued*

When you complete all fields, click *Submit*.

Description of Support*
(check all that apply)

☐ Planned Contact

☐ CFT Team Meeting

☐ Update Crisis Plan

☐ Update POC

☐ Crisis Intervention

☐ Evaluation

☐ School/Education Coordination

☐ Court

☐ EPSDT Coordination

☐ Weekly Phone Contact

☐ Bi-monthly Face-to-Face

☐ Family Contact within 72 hours of referral

☐ Other

☐ YFT

☐ PCP Care Coordination

Description of Contact:*You have 5000 characters remaining. [Clear](#)**Description of Continued Support***
(check all that apply)

☐ Next planned Contact

☐ CFT Scheduled

☐ Evaluation

☐ Other

Submit

Cancel

[Return to Clinical Summary](#)

[Return to My Practice](#)

Progress Notes -Submission

The following confirmation will display.

Description of Contact:*

✕

Your progress note was successfully saved.

Transaction Number : 21

You will be redirected back to the summary page in a few seconds

Next planned Contact: 07/20/2015

Progress Notes – Clinical Summary

The completed note then displays on the Clinical Summary page. You can view previous submissions by clicking the magnifying glass icon.

Wyoming Referral/Care Management

Clinical Summary

Member Information

Member:

MEMBER, TEST

Gender:

Female

DOB:

06/24/1997

Member Number:

WYC000000001

Plans of Care/Crisis Plans

Plan Date	Plan Type	Transaction No.	Status	Action
07/21/2015	Initial	1098	Accepted	   

Add Plan of Care/Crisis Plan

Progress Notes

Service Date	Transaction No.	Description of Contact	Submitted By	Action
07/21/2015	21	type here	GROUP, TEST	

Add Progress Notes

[Return to Member Details](#) | [Return to MyPractice](#)