



**Division of Children and Family Services**

P.O. Box 1437, Slot S560 · Little Rock, AR 72203-1437  
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**DDS MEDICAID WAIVER CLIENT REFERRAL FORM**

Intake Date: \_\_\_\_\_ CLIENT PHONE # \_\_\_\_\_

CLIENT NAME: \_\_\_\_\_ ( ) MALE ( ) FEMALE

DOB: \_\_\_\_\_ CHRIS CASE #- \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

COUNTY OF RESIDENCE: \_\_\_\_\_

CURRENT PLACEMENT: ( ) FOSTER HOME ( ) HOSPITAL ( ) OTHER: \_\_\_\_\_

MEDICAID #- \_\_\_\_\_

PRIMARY FAMILY SERVICE WORKER: \_\_\_\_\_ CONTACT #- \_\_\_\_\_

SECONDARY FAMILY SERVICE WORKER: \_\_\_\_\_ CONTACT #- \_\_\_\_\_

DCFS COUNTY SUPERVISOR: \_\_\_\_\_ CONTACT #- \_\_\_\_\_

DCFS HEALTH SERVICES WORKER: \_\_\_\_\_ CONTACT #- \_\_\_\_\_

PHYSICIAN: \_\_\_\_\_ CONTACT #- \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ ZIP: \_\_\_\_\_

UAMS "PACE EVALUATION" ( ) YES ( ) NO DATE: \_\_\_\_\_ IQ SCORE: \_\_\_\_\_

**DIAGNOSIS:**

[Empty box for diagnosis]

**ADDITIONAL PERTINENT INFORMATION / SPECIAL NEEDS:**

[Empty box for additional information]