

Arkansas Department of Human Services  
Division of Developmental Disabilities Services  
ACS Waiver Services

**SOCIAL HISTORY**

Date: \_\_\_\_\_

Applicant: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ Age: \_\_\_\_\_

\_\_\_\_\_ Phone Number: \_\_\_\_\_ Ext: \_\_\_\_\_

DDS Representative: \_\_\_\_\_

**1. Physical Description:**

Marital Status: \_\_\_\_\_ Hair Color: \_\_\_\_\_

Height: \_\_\_\_\_ Eye Color: \_\_\_\_\_

Weight: \_\_\_\_\_ Race: \_\_\_\_\_

**2. Diagnosis: (Check and complete appropriate blanks)**

Developmental Delay

At risk for delay due to medical condition (Identify condition) \_\_\_\_\_

Intellectual Disability (level, if known) \_\_\_\_\_

Epilepsy \_\_\_\_\_

Seizures (type/frequency) \_\_\_\_\_

Cerebral Palsy (functioning level, if known) \_\_\_\_\_

Autism (functioning level, if known) \_\_\_\_\_

Other, please explain \_\_\_\_\_

Age at which diagnosis was made or condition was noticed? \_\_\_\_\_

**3. Services Requested and Current Situation:**

A. What assistance is needed, and why? \_\_\_\_\_

\_\_\_\_\_

B. Does individual presently reside with family? Yes  No

If no, please explain. \_\_\_\_\_

Arkansas Department of Human Services  
Division of Developmental Disabilities Services  
ACS Waiver Services

C. Is present living situation satisfactory? Yes  No

If not, what is needed? \_\_\_\_\_

**Please list current service providers:**

A. List agencies, schools, programs, etc., presently assisting applicant, and services provided. \_\_\_\_\_

\_\_\_\_\_

School presently attending: \_\_\_\_\_

School previously attended if no longer in school: \_\_\_\_\_

Year Graduated: \_\_\_\_\_

Was applicant in Special Education Classes? Yes  No  If yes, what years? \_\_\_\_\_

\_\_\_\_\_

Pediatrician \_\_\_\_\_

Family Doctor \_\_\_\_\_

Dentist \_\_\_\_\_

Nurse \_\_\_\_\_

Orthopedist \_\_\_\_\_

Ear, Nose, and Throat Specialist \_\_\_\_\_

Ophthalmologist \_\_\_\_\_

Psychiatrist/Psychologist \_\_\_\_\_

Audiologist \_\_\_\_\_

Speech Therapist \_\_\_\_\_

Occupational Therapist \_\_\_\_\_

Physical Therapist \_\_\_\_\_

Social Worker \_\_\_\_\_

Dietician \_\_\_\_\_

Others (please specify) \_\_\_\_\_

Arkansas Department of Human Services  
Division of Developmental Disabilities Services  
ACS Waiver Services

B. List other agencies, schools, training facilities, and programs that have assisted applicant in the past including services they provided and the outcomes: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

C. Any past services requested from DDS or other agencies including whether or not services were received and if not received, why? \_\_\_\_\_  
\_\_\_\_\_

**Family Information:**

List guardian/custodian name, address and phone number: \_\_\_\_\_  
\_\_\_\_\_

**Father**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_ Ext: \_\_\_\_\_  
\_\_\_\_\_  
Employer's Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Ext: \_\_\_\_\_  
Deceased  Retired  Disabled  Military (Active)  (Retired)   
Branch: \_\_\_\_\_ Salary Estimate: \_\_\_\_\_

**Mother**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_ Ext: \_\_\_\_\_  
\_\_\_\_\_  
Employer's Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Ext: \_\_\_\_\_  
Deceased  Retired  Disabled  Military (Active)  (Retired)   
Branch: \_\_\_\_\_ Salary Estimate: \_\_\_\_\_

**Step Parents:** List name, address, and telephone number: \_\_\_\_\_

Arkansas Department of Human Services  
Division of Developmental Disabilities Services  
ACS Waiver Services

---

---

**4. Developmental/Behavioral Profile:**

Answer appropriately:

Sat alone	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Age _____	Toilet Trained	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Age _____
Crawled	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Age _____	Bowel	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Age _____
Walked alone	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Age _____	Bladder	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Age _____
Made sound/babble	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Age _____	Dry at night	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Age _____
Single word	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Age _____	Pronounced clear	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Age _____
Phrases/Sentences	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Age _____	Understood by mom	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Age _____
Said words correctly	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Age _____	Understood by others	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Age _____

Areas of concern: (Check all areas that are of concern to you about applicant.)

<input type="checkbox"/> Walk	<input type="checkbox"/> Dress self	<input type="checkbox"/> Use telephone
<input type="checkbox"/> Talk	<input type="checkbox"/> Write/print	<input type="checkbox"/> Prepares own meals
<input type="checkbox"/> See	<input type="checkbox"/> Tell time	<input type="checkbox"/> Bathe/groom self
<input type="checkbox"/> Hear	<input type="checkbox"/> Use toilet	<input type="checkbox"/> Travel alone
<input type="checkbox"/> Read	<input type="checkbox"/> Feed self	<input type="checkbox"/> Work independently
<input type="checkbox"/> Recognize money/make change		<input type="checkbox"/> Wash clothes
<input type="checkbox"/> Communicate		<input type="checkbox"/> Self-medicates

**Behavioral Profile:**

Does applicant have challenging behavior/temper tantrums? Yes  No

Please describe: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Describe applicant's typical behavior with regard to:**

Activity level: \_\_\_\_\_

Aggressive or passive: \_\_\_\_\_

Reactions to others: \_\_\_\_\_

**Describe any unusual/extreme behavior of applicant (and frequency) with regard to:**

Reaction to authority: \_\_\_\_\_

Non-Compliant/oppositional behaviors: (if yes, explain/describe) \_\_\_\_\_

Arkansas Department of Human Services  
Division of Developmental Disabilities Services  
ACS Waiver Services

---

Any self-stimulatory behaviors: (describe) \_\_\_\_\_

---

Legal issues/pending charges/arrests: \_\_\_\_\_

---

**List alternate placement options and efforts: (Give dates)** \_\_\_\_\_

---

**5. Medical History:**

A. Birth Information:

Problems during pregnancy: (explain) \_\_\_\_\_

---

Complications with birth: (explain) \_\_\_\_\_

---

B. Individual's Information:

History of Diagnosis and Treatment: \_\_\_\_\_

---

Current Medications/Dosages: \_\_\_\_\_

Arkansas Department of Human Services  
Division of Developmental Disabilities Services  
ACS Waiver Services

---

---

---

History of any significant injuries and dates: \_\_\_\_\_

---

---

---

Allergies: \_\_\_\_\_

Special Precautions/Instructions/Diet: \_\_\_\_\_

---

---

---

Has the applicant been tested for vision? Yes  No  If yes, when? \_\_\_\_\_

Where? \_\_\_\_\_ What were you told? \_\_\_\_\_

Hearing? Yes  No  If yes, when? \_\_\_\_\_

Where? \_\_\_\_\_ What were you told? \_\_\_\_\_

Dental? Yes  No  If yes, when? \_\_\_\_\_

Where? \_\_\_\_\_ What were you told? \_\_\_\_\_

Does applicant have any income? Yes  No  If yes, how much and what type? \_\_\_\_\_

Please list AFDC, VA, SSI, SSA, Child Support, Trusts and Payee:

Type	Amount	Individual	Payee
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Arkansas Department of Human Services  
Division of Developmental Disabilities Services  
ACS Waiver Services

---

---

---

**For Adults Only:**

A. List all past living arrangements: (i.e. with parents, group home, apartment, HDC, own home, etc.) \_\_\_\_\_

---

---

---

---

---

---

---

---

---

---

B. List all past jobs: \_\_\_\_\_

---

---

---

---

---

---

---

---

---

---

**Informant's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Relationship to applicant:** \_\_\_\_\_