

Arkansas Department of Human Services
 Division of Developmental Disabilities Services
 ACS Waiver Services
 Change Form for Minimum Wage

Individual's Name _____

Medicaid Number _____

If increase causes person's cost to move from Limited/Extensive to Pervasive service level, all the documentation required is required to request Pervasive Level of Service.

PA Number	Service	Begin Date of Revision	End Date of Revision	Current Total Approved Amount	Amount of Increase	Revised Total Amount Requested	Current Daily Rate	Days Left in Plan Year	Current Amount for Days Left	Amount of Increase	Revised Amount for Days Left	Revised Daily Rate
A	B	C	D	E	F	G = E + F	H	I	J = H x I	K = F	L = J + K	M = L / I
	H2016											
	S5151											

I certify that this individual receives Limited/Extensive Level of Care and the maximum daily rate is not exceeded for the Supported Living Array of Services.

I certify that this individual receives Pervasive Level of Care and the maximum daily rate is not exceeded for the Supported Living Array of Services.

Provider Name _____

Provider Designee/Agency Signature _____

Date _____

FROM HERE DOWN; FOR DDS USE ONLY

DDS Changes

PA Number	Service	Begin Date of Revision	End Date of Revision	Current Total Approved Amount	Amount of Increase	Revised Total Amount Requested	Current Daily Rate	Days Left in Plan Year	Current Amount for Days Left	Amount of Increase	Revised Amount for Days Left	Revised Daily Rate
A	B	C	D	E	F	G = E + F	H	I	J = H x I	K = F	L = J + K	M = L / I
	H2016											
	S5151											

DDS approval of revision as requested.

DDS approval of revision with the above DDS Changes.

DDS Approval Signature _____

Date _____