

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

**NOTIFICATION OF CHANGE OF ADDRESS**

Name: \_\_\_\_\_

Medicaid Number: \_\_\_\_\_ - \_\_\_\_\_

New Mailing Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

New Residence Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Telephone Number: \_\_\_\_\_ ( ) \_\_\_\_\_ - \_\_\_\_\_

Guardian: \_\_\_\_\_

New Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Telephone Number: \_\_\_\_\_ ( ) \_\_\_\_\_ - \_\_\_\_\_

Parent(s) if different from Guardian:

Parent Name: \_\_\_\_\_

New Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Telephone Number: \_\_\_\_\_ ( ) \_\_\_\_\_ - \_\_\_\_\_

**Please send a copy of the completed form to:**

1) \_\_\_\_\_  
Medicaid Program Coordinator  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2) \_\_\_\_\_  
DDS Waiver Specialist  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_