

**Arkansas Department of Human Services
Division of Developmental Disabilities Services
ACS Waiver Monthly Abeyance Report**

Name of participant whose case was placed in abeyance:

Medicaid Number:

Date Placed in Abeyance:

Reason Placed in Abeyance:

Where Person is Currently Placed?

Dates of Monitoring Contacts:

Who was Contacted and Relationship?

Who Performed Contact?

Was this Contact by DDS Staff or Provider

Narrative:

Identify Waiver Provider:

Who is responsible for ongoing monitoring?

Projected date of return to waiver or end of abeyance:

Current Status of participant:

This report is to be completed at the end of each month.

DDS ACS 116 (Effective: 03/01/10)