

**ARKANSAS DEPARTMENT OF HUMAN SERVICES
DIVISION OF DEVELOPMENTAL DISABILITIES SERVICES**

ACS WAIVER FACE SHEET

REFERRAL SOURCE: ICF/MR Nursing Home ASH
 Admission to Group Home/Apt DCFS APS Regular Request List

WAIVER CONSUMER INFORMATION:

Individual's Name (Last, First Middle)

Medicaid #

Date of Birth

Social Security #

Street Address

City, State, Zip Code

Mailing Address

City, State, Zip Code

() - _____
Home Phone

County

CONTACT INFORMATION:

Guardianship: Self Power of Attorney (Explain Below) Other (Explain Below)
(Power of Attorney which conveys same rights as guardianship)

Contact's/ Guardian's/Power of Attorney's Name

Relationship

Contact's/ Guardian's/Power of Attorney's
County

Contact's/ Guardian's/Power of Attorney's Street Address

City, State, Zip Code

Contact's/ Guardian's/Power of Attorney's Mailing Address

City, State, Zip Code

() - _____
Contact's/ Guardian's/Power of
Attorney's Home Phone

() - _____
Contact's/ Guardian's/Power of Attorney's
Work Phone and Extension

() - _____
Contact's/ Guardian's/Power of
Attorney's Cell Phone

Contact's/ Guardian's/Power of Attorney's E-Mail Address

FOR USE ONLY AFTER RELEASE:

Case Management Provider: _____

Supportive Living Provider: _____

COMMENTS: (i.e. driving directions or additional information) _____

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