ARKANSAS DEPARTMENT OF HUMAN SERVICES
PERSONAL CARE REFERRAL FORM

Email Completed Form to: Referrals@arkansas.gov

☐ New Referral ☐ PC Provider Change ☐ Request Change in Service Hrs

MEDICAID INFORMATION

Client Medicaid Number:

Date of last eligibility verification on the AR Medicaid Portal:

APPLICANT INFORMATION (this section to be completed by person making referral)

Social Security Number: Date of Birth:

First Name: Last Name:

Gender: Primary Language:

Address: Apt:

City: County: Zip:

Phone Number with area code:

GUARDIAN CONTACT INFORMATION

Full Name: Phone number:

REFERRING ORGANIZATION

Employee Name: Phone number:

Organization Name:

Full Address:

PERSONAL CARE PROVIDER INFORMATION (*PC ID ends in ...32)

Provider ID Number: Phone number:

Provider Name:

Mailing Address:

City: County: Zip:

PERSONAL CARE PROVIDER POINT OF CONTACT

Employee Name: Phone number:

Contact email:

DHS STAFF ONLY:

DHS RN Name:

Date of Independent Assessment:

PA Date: Units of Service: Teir:

Name and relationship of person who selected provider (*N/A if client or representitive signed the freedom of choice on the DMS-618):

Date: