Department of HUMAN SERVICES

HOME AND COMMUNITY BASED (HCBS) WAIVER REQUEST
(for current Medicaid recipients only!)

APPLICANT INFORMATION

First Name, Middle Name, Last Name			
Home Address			**Phone Number**
City	**State**	**Zip Code**	**County**
Birth Date		**Social Security Number**	

Please check the waiver(s) you would like to apply for:

- ☐ AIDS / HIV Waiver
- ☐ Brain Injury (BI) Waiver
- ☐ Elderly Waiver (EW)
- ☐ Health & Disability (HD) Waiver
- ☐ Intellectual Disability (ID) Wavier
- ☐ Physical Disability (PD) Waiver
- ☐ Children's Mental Health (CMH) Waiver

Signature of Applicant or Contact (e.g. Parent, POA, Guardian) **Date**

CONTACT INFORMATION

First Name, Middle Name, Last Name			
Address			**Phone Number**
City	**State**	**Zip Code**	**County**

For Office Use Only- DHS State ID # _____

Iowa DHS / Western Iowa Service Area (WISA)
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