Home and Community Based (HCBS) Waiver Request

Department of HUMAN SERVICES

Applicant Information

First Name, Middle Name, Last Name			
Home Address			Phone Number
City	State	Zip Code	County
Birth Date		Social Security Number	
Case Number	State ID	Worker ID/Name	

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

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

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

CONTACT INFORMATION

First Name, Last Name	
Worker Address	Phone Number

Des Moines Service Area
Imaging Center 5 PO Box 41130
Des Moines, IA, 50311