ACES$ WYOMING FMS REFERRAL FORM

Revision Date: 6-1-18

Referral Date:

PARTICIPANT INFORMATION

Name: *First* *Last* *MI*

Date of Birth: Social Security Number:

Physical Address: City, State, Zip:

Mailing Address: City, State, Zip:

Phone: Gender: Waiver: CCW: DD/Comp: DD/Supports:

Email: Medicaid #:

Employer of Record Information

Employer of Record different than Participant? Yes No ***If Yes, please complete the following information***

Does this person serve as the Authorized Representative? Yes No

Name: Relationship to Participant:

Complete Address: SSN:

☎ Phone:

Email: ☎ Alt:

Worker Information

1. Name: Relationship to Participant:

Complete Address: POA or AR of Participant? Yes No

Phone:

2. Name: Relationship to Participant:

Complete Address: POA or AR of Participant? Yes No

Phone:

Case Manager Information

Case Manager Name: Agency:

Email: ☎ Direct Phone:

Comments:

Form Submission

Fax: 1 (877) 226-8836

Email: secureWY@mycil.org

www.mycil.com

ACES$ Wyoming

2515 Warren Ave.* Suite 503 *Cheyenne, WY 82001

Questions?

CUSTOMER CARE HOTLINE: 1 (844) 500-3815

EMAIL: supportWY@mycil.org