ACES$ WYOMING FMS
Referral Form

Revision Date: 7-21-2023

Referral Date: ☐

New Participant: ☐ Employer Change: ☐ Restart: ☐ Employee Packet Request: ☐

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 Information

Employer 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: ☐

Employee Information

1. Name: ☐ Relationship to Participant: ☐

Complete Address: ☐ POA or AR of Participant? ☐ Yes ☐ No

☐ Phone: ☐

Email: ☐

2. Name: ☐ Relationship to Participant: ☐

Complete Address: ☐ POA or AR of Participant? ☐ Yes ☐ No

☐ Phone: ☐

Email: ☐

Case Manager Information

Case Manager Name: ☐ Agency: ☐

Email: ☐ ☎ Direct Phone: ☐

Comments: ☐

Form Submission

Fax: 1 (877) 226-8836 **Email:** To securely email, please send a request to - secureWY@mycil.org

202 E. 18th Street Cheyenne, WY 82001 **Participant Care:** 1 (844) 500-3815 **Email:** supportWY@mycil.org