Arkansas Department of Human Services
Division of Children and Family Services
REQUEST FOR SERVICE / ENCUMBRANCE

Case Worker's Name: _____ Phone #: _____

Email Address: _____ Fax #: _____

Supervisor's Name/Email: _____ Phone # _____

Requesting County:_____ County of Client's Current Residence _____

Contractor's Name: _____ Today's Date: _____

Service:

- Adoption Home Study ☐
- Adoption Home Study Update ☐
- Adoption Child Summary ☐
- Adoption Child Summary Update ☐
- Drug Assessment ☐
- Residential Drug Treatment ☐
  (must have Central Office approval)
- Outpatient Drug Treatment ☐
- Home Study ☐
- Psychological Evaluation ☐
- Respite ☐

Counseling ☐ *If yes, also select type of counseling):*

- Group ☐
- Family ☐
- Individual ☐
- In-Home ☐

- Intensive Family Services ☐
- Intensive In-Home Services ☐
- Triple P (Positive Parenting Program ☐

Client's Name: _____ DOB: _____ Gender: _____

Client Address: _____ Phone #: _____

CHRIS Client ID/CHRIS #: _____ SSN #:_____ Ethnicity _____

Does client have Medicaid? ☐ Yes ☐ No If yes, Medicaid #:_____

Insurance Carrier Other than Medicaid: _____ Policy #: _____

Is this service court ordered? ☐ Yes ☐ No Date of Court Order: _____

Next Court Date: _____

Comments/Additional Information:

Unit Supervisor Approval: _____ Date: _____

County Supervisor Approval: _____ Date: _____

Financial Coordinator: _____Units Keyed _____ Date: _____