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:

Psychological Evaluation:	☐	Respite:	☐
Intensive Family Services:	☐	Counseling:	☐
Adoption Home Study:	☐	Individual:	☐
Adoption Home Study Update:	☐	Group:	☐
Adoption Child Summary:	☐	Family:	☐
Adoption Child Summary Update:	☐	In-Home:	☐
Home Study:	☐		
Drug Assessments: (Must have Central Office Approval)	☐	Drug Treatment:	☐

Client's Name: _____ Marital Status:_____ DOB: _____ Gender: ____

Client Address: _____ Phone #: _____ Ethnicity:_____

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

Insurance Carrier: _____ 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: _____

CFS-0015 (02/2018)