



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

Requester's Name: _____ Phone #: _____
Email Address: _____ Fax #: _____

Contractor's name: _____
Requesting County: _____

Service: _____ Today's Date: _____

Psychological Evaluation:	<input type="checkbox"/>	Respite:	<input type="checkbox"/>
Intensive Family Services:	<input type="checkbox"/>	Counseling:	<input type="checkbox"/>
Adoption Home Study:	<input type="checkbox"/>	Individual:	<input type="checkbox"/>
Adoption Home Study Update:	<input type="checkbox"/>	Group:	<input type="checkbox"/>
Adoption Child Summary:	<input type="checkbox"/>	Family:	<input type="checkbox"/>
Adoption Child Summary Update:	<input type="checkbox"/>	In-Home:	<input type="checkbox"/>
Home Study:	<input type="checkbox"/>		
Drug Assessments:	<input type="checkbox"/>		

(Must have Central Office Approval)

Client's Name: _____ Date of Birth: _____

CHRIS Client ID #: _____ SSN #: _____

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

Comments/Additional Info:

Unit Supervisor Approval: _____ Date: _____

County Supervisor Approval: _____ Date: _____