Arkansas Department of Human Services
Division of Children and Family Services
Authorization For Billing & Trust Account Action

I. Client Information:

Child's Name: _____ County: _____ DOB: _____

Race: _____ Sex: _____ Child's SSN: _____ Medicaid Number _____

CHRIS Case: _____ Client ID: _____ Date Sent: _____

II. Funding Source:

☐ SSA ☐ SSI ☐ Child Support ☐ Other: _____

Amount: $_____ Begin Date of Income Receipt: _____

III. Account Type: ☐ Regular Trust Account ☐ Dedicated Trust Account

IV. Authorized Services:

☐ Open Trust Account

☐ Contract Billing _____ _____
Authorized Signature Date

☐ Request To Hold Trust Account Funds -

Amount to be held: $_____ Purpose(s): _____

☐ Correct/Update Trust Account Information (Explain) - _____

☐ Close Trust Account -

Reason for Closure: _____ Closeout Date: _____
Forward Funds To: _____ Relationship: _____
Address: _____
City, State, Zip: _____

Prepared By:

_____ _____ _____ _____
DCFS Staff/Title Co.# Telephone Number Date

Authorized By:

_____ _____
DCFS County Supervisor Date

_____ _____
DCFS Area Director Date