



Arkansas Department of Human Services
Division of Children and Family Services

Close Out/Overpayment Notification

MEMORANDUM

TO: , Accountant, Office of Finance & Administration, DHS
FROM: , Trust Fund Coordinator, IV-E & Medicaid Eligibility Unit
DATE:

Child's Name: Client ID #:
Custody Begin Date: Custody End Date:

REQUESTED ACTION:

- Close out Account (Please return funds after paying any outstanding invoice(s).)
Overpayment Request for Funds: SSA Case Number

(NOTE: A CFS-334 FORM MUST BE COMPLETED TO GENERATE A CHECK FOR AN OVERPAYMENT)

Return Account Balance To: SSA OCSE Parent/Guardian Child
Relationship To Child:
Name:
Address:
City, State, Zip:

Statement of Accounting Period From: To:

Special Instructions:

- 458 (Treasury) 458 (Savings) \$
Regular Request Emergency Shelter Emergency Medical Emergency Travel
Priority Request

PROGRAM SUPPORT USE ONLY:

Date Received
Date Processed
Initials

cc: Trust Resolution Coordinator - IV-E/Medicaid Eligibility Unit / SLOT S571