



Arkansas Department of Human Services
Division of Children and Family Services

TRUST ACCOUNT INVOICE

Vendor Name:
Address:
City:
State / Zip

GOODS, SERVICES AND/OR ASSISTANCE PROVIDED:

Table with 2 columns: Description, Amount. Includes a Total Payment row and a note about using another form for more lines.

Signature Client/Provider/Vendor:
Official Title:
DHS Authorized Signature:
Official Title:
Date:
Date:

Required Supporting Documents and Submission Instructions:

Mail this completed form and the required documents to:

Department of Human Services
General Operations Section, Purchase Orders
P.O. Box 8068, Slot W406
Little Rock, AR 72203-8068