



**ARKANSAS DEPARTMENT OF HUMAN SERVICES**  
**Division of Children and Family Services**  
**Special Adoption Subsidy Determination**

We (I) hereby give consent for the release of medical and/or social information concerning:

\_\_\_\_\_  
 Child's Name

For the purpose of determining eligibility for a special subsidy under the Arkansas Subsidized Adoption Program. It is requested that the information be forwarded to the following Adoption Specialist and address:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_  
 Name of Adoptive Parent 1                      Signature of Adoptive Parent 1                      Date

\_\_\_\_\_  
 Name of Adoptive Parent 2                      Signature of Adoptive Parent 2                      Date

**Provider should complete this section:**

Diagnosed Condition Covered by Subsidy:

\_\_\_\_\_

Current Treatment Plan:

\_\_\_\_\_

Anticipated Duration of Treatment:

\_\_\_\_\_

Projected Cost (up to twelve months):

\_\_\_\_\_

\_\_\_\_\_  
 Provider's Name    Title    Date

\_\_\_\_\_  
 Address    Telephone Number

\_\_\_\_\_  
 Provider's Signature