CFS 906-4
Rev 2/2008

Illinois Department Of Children and Family Services

SPECIAL SERVICE FEE AND PAYMENT EXTENSION FORM

☐ SPECIAL SERVICE FEE ☐ PAYMENT EXTENSION

Client Name _____ ID _____

Provider Name _____ ID _____

Agency Name _____

Placement Date ____/____/____

Start Date ____/____/____

Stop Date ____/____/____

SSF Amount _____

Reason for SSF _____

Caseworker Name _____ ID _____

Caseworker Signature _____ Date ____/____/____

Supervisor Name _____

Supervisor Signature _____ Date ____/____/____

Regional Administrator Name_____

Regional Administrator Signature _____ Date ____/____/____

NARRATIVE _____

DCFS is an equal opportunity employer, and prohibits unlawful discrimination in all of its programs and/or services.