



**ARKANSAS REHABILITATION SERVICES  
REQUEST FOR MEDIATION**

Name \_\_\_\_\_

**SSN** (Last 4 digits only): \_\_\_\_\_

Counselor \_\_\_\_\_

Please list the decision(s) you want resolved:

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I have been advised that I can seek assistance from the Client Assistance Program.

Disability Rights Center  
1100 N. University, Suite 201  
Little Rock, AR 72207  
Telephone: (501) 296-1775  
1-800-482-1174

\_\_\_\_\_  
Applicant/Client

\_\_\_\_\_  
Date

