**Case #**

 **Acct #**  (office use only)

****

**REFERRAL FORM**

**REST HAVEN CHILDREN’S HEALTH FUND**

**NAME OF CHILD:** Click here to enter text.

 Date of Birth: Click here to enter text.

 Parent(s) and/or Guardians(s): Click here to enter text.

 Address: (include zip code): Click here to enter text.

 Phone(s): Click here to enter text.

**MEDICAL DIAGNOSIS:** (if any): Click here to enter text.

**GENERAL CATEGORY of REQUEST:** (only check one)

[ ] Medication or Medical Services [ ] Glasses

[ ] Dental Treatment (must attach dental treatment plan) [ ] Therapy (speech, ot, pt, mental health, etc.)

[ ] Medical Equipment [ ] Adaptive Equipment or Conversions

[ ] Non-Medical Equipment (car seat, bed, mattress, etc.) [ ] Other Health Needs

[ ] Emergency Basic Needs (i.e. food, clothes, shoes, etc.) [ ] Funeral/Cremation Assistance

[ ] Emergency Family Services (gas, housing, utilities, etc.) [ ] Camping Scholarships

[ ] Special Diet

**SPECIFIC REQUEST:** (specific item, therapy, (s) & any other details needed to purchase, etc.)

Click here to enter text.

**REASON FOR REQUEST:** (family info including siblings/others living in home, family dynamics, employment & financial status, extenuating circumstances that lends support to request, other funding resources pursued, how request will impact child’s health and any other pertinent information to help in determination )

Click here to enter text.

**SUPPORTING DOCUMENTATION:** [ ] **yes** [ ] **no** Download File and Attach

**TOTAL AMOUNT REQUESTED:** (itemize tax & shipping, if applicable) Click here to enter text.

**VENDOR INFORMATION:**

Vendor:(where item/service can be purchased, website, etc.) Click here to enter text.

MailingAddress: Click here to enter text.

Contact Name: Click here to enter text.

Email: Click here to enter text. Phone: Click here to enter text.

**SERVICES RECEIVING:** (only check those that apply)

[ ] Medi Cal Type of Coverage: Click here to enter text.

[ ] Denti Cal Type of Coverage: Click here to enter text.

[ ] Private Medical Insurance Name of Coverage:Click here to enter text.

[ ] Private Dental Insurance Name of Coverage: Click here to enter text.

[ ] Other Health Coverage Name of Coverage: Click here to enter text.

[ ] California Children’s Services

[ ] San Diego Regional Center

[ ] In Home Supportive Services

**REFERRED BY:**

Name:Click here to enter text.

Title: Click here to enter text.

Agency: Click here to enter text.

MailingAddress: Click here to enter text.

Email: Click here to enter text. Phone(s): Click here to enter text.

(for office use only)

**DATE APPROVED:**

**DATE DENIED:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **TOTAL** | **DISCOUNT****(IF ANY)** | **PARENT** | **REST HAVEN****CHF** | **OTHER****(AGENCY, RELATIVE)** | **OTHER (AGENCY, RELATIVE)** |
|  |  |  |  |  |  |
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 **8/17**