**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)** |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

**8/17**