WEST VIRGINIA DEPARTMENT OF HUMAN SERVICES

Bureau for Behavioral Health

SAMHSA Funded SOR Childcare Referral

Agency: Child Care Resource & Referral

Participant Name: _____

Address: _____

_____

Phone: _____

Date of Birth: _____

Last 4 of Social: _____

Referring Provider: _____

Address: _____

Phone: _____

☐ Participating in Treatment Date:

☐ Completed Treatment Date:

Recovery sessions location and number of sessions weekly: _____

_____

Referral: Please assist _____ with the childcare eligibility process
They are a participant in OUD or OUD/Polysubstance Treatment effective _____
Please find enclosed a copy of their childcare coupon. Please feel free to contact the referring provider above with any questions or concerns.

Providers: Individuals participating in treatment and/or recovery services are eligible for 3 months of childcare assistance per referral form. By signing this form, you are providing verification that the participant is compliant with current treatment. This form must be renewed every 90 days for continued assistance. If the participant has recently completed treatment, childcare assistance is limited to 60 days post discharge.

_____ _____

Provider Signature Date

_____ _____

Participant Signature Date