WEST VIRGINIA Department of Health & Human Resources
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