WEST VIRGINIA DEPARTMENT OF HEALTH & HUMAN RESOURCES

Pre-Employment Services Project Referral

Funded By: Bureau for Children & Families
Administered By: Bureau for Public Health

Referred Individual's Name: _____

Address: _____

Mailing Address (if different): _____

Phone: _____ Date of Birth: _____

SSN: _____ RAPIDS Case No. _____

I certify that the individual identified above is eligible to receive the following services as marked:

❒ Dental Services (Balance_____) ❒ Vision Services

_____ _____
Signature of Family Support Specialist Referral Date

Name of Family Support Specialist (Printed): _____

Office Address: _____

Phone: _____ Supervisor's Name (Printed): _____

PLEASE READ--IMPORTANT INFORMATION FOR REFERRED INDIVIDUAL

✔**Services must be completed within one year of the Referral Date above.**

✔**You must choose an eye doctor and/or dentist from the list provided.**

✔ **You must give at least a 24-hour notice if you must cancel a scheduled appointment.**

Address questions or concerns to: Pre-employment Services Project
Phone: 1-800-642-8522 or 304-558-5388

Distribution of Copies

White:	OMCFH
Pink::	Dental Services
Yellow:	Vision Services
Gold:	Local Office DHHR File
Mail to:	Pre-Employment Services 350 Capitol St., Room 427 Charleston, WV 25301-3714