OHAAT BEDS FOR KIDS

Reimbursement Program Pre-Referral Form

A Note to Referral Partner Representatives:

This form is NOT a referral and should only be used as a tool for collecting information. All referrals must be submitted online at www.bedsforkidsprogram.org.

A Note to Potential Recipients:

Assistance is NOT guaranteed. If your referral is approved, someone from the Beds for Kids program will call you within 7 days to schedule a delivery.

Client Full's Name (Head of Household): _____

Primary Phone Number: _____ Alternate Phone Number: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Household Members in Need of Beds:

First Name: _____ Age: _____ Gender: _____ Race: _____

First Name: _____ Age: _____ Gender: _____ Race: _____

First Name: _____ Age: _____ Gender: _____ Race: _____

First Name: _____ Age: _____ Gender: _____ Race: _____

First Name: _____ Age: _____ Gender: _____ Race: _____

First Name: _____ Age: _____ Gender: _____ Race: _____

First Name: _____ Age: _____ Gender: _____ Race: _____

First Name: _____ Age: _____ Gender: _____ Race: _____

Please provide pertinent details regarding this referral, such as the client's expected move-in date or delivery address if it's different than the address listed above.

_____

_____

_____

_____

This form contains confidential information. If it is found, please return to:

Referral Partner Representative: _____ Phone Number: _____