

Date: _____
Phone: (707)644-4491
Fax: (707) 644-1318
Revised 8/08



Full-Service Vendor # HN0208
Service Code: 862
G-Tube/Epi-pen/Inhaler:
USE SHC Referral

Referral for In-Home Respite FULL-SERVICE (Agency)

UCI/ID#: _____ D.O.B.: _____ Monolingual Spanish? Yes No

Client's Name: _____

Address: _____ Apt. _____

City: _____ Zip: _____ Email: _____

Phone: _____ Cell: _____

Parent(s) or contact person's name(s): _____

Regional Center client sibling(s) with Full-Service referrals or current POS/authorization:

Name(s): _____

Please note: each sibling needs a separate referral

Case Manager's Name: _____ Reg. Ctr. Office: _____

Phone: _____ Email: _____

CPC has made Home Visit? YES NO

Diagnosed Disabilities: _____

Seizures? Yes- average duration _____ No

Please Note: BRC workers CANNOT administer any type of rectal seizure medication/enemas

G-tube/ Epi-Pen/Inhaler/ Nebulizer? **If Yes- send Specialized Healthcare Referral**

Call a Program Coordinator at 707/644-4491 to get a SHC referral or go online at www.bayrespitecare.org

Is this a returning Full-Service(Agency) respite client? Yes No

Client is switching from: Family Voucher BRC Self-Service(EOR) Other New to Respite

Please note: If switching from BRC SSR, please send pos cancellation to SSR program

Any known dangerous propensities exhibited by client or family situation? Yes No

If Yes, describe: _____

Client requires lifting: YES, Weight _____ lbs. No

Please note: BRC policy states our workers cannot lift over 50lbs (unassisted)- NO EXCEPTIONS

Amount of Respite: Basic: _____ Hours/Per _____

From: _____ To _____

Please Fax to: (707) 644-1318 or email to: Sue@BayRespiteCare.org