SPECIAL NEEDS REQUEST FORM

SUBMIT REQUEST TO:

Contra Costa Health Department
597 Center Avenue, Suite 200
Martinez, CA 94553
Phone: (925) 313-6771
Fax: (925) 313-6798
Attn: Natalie / Christine / Anita

TODAY'S DATE_________**CASE MANAGER**_______________**CARE ID**___________

AMOUNT REQUESTED $_____________**CLIENT**_____________________________

TYPE OF ASSISTANCE NEEDED *Dental Services other than Dr Low or Dr Tanner, please list provider name, address, phone and FAX number and attach W9.*

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Please explain why the client needs this assistance (what special circumstances?)

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Issue check to: ______________________________________W9 form (Attach)_______

Address____

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Please explain what sources you have tried to access (Medi-Cal, ADAP, substance abuse programs, DEA services, etc.) and why those sources are not available:

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Last Medical Visit ____________________________ Itemized Bill Attached_____________

family members living with client_________ % Federal Poverty Level_______________

Care Plan Updated____________Last Case Conference/Supervisor check_______________

Insurance source and date_____________________

For office use only: prior use date__________________

Date received______________approved by_____________Cost Center_________________

ARIES check: Demographic____Insurance_____HIV Eligibility____Financial Eligibility____MD Visit_____

Services____S/NS____case notes_____W9?________Other_______________________________________

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June 2, 2014