West Virginia Department of Health & Human Resources
Bureau for Public Health

OFFICE OF MATERNAL, CHILD AND FAMILY HEALTH
RIGHT FROM THE START PROGRAM
REFERRAL OF INFANTS/PRENATALS TO RFTS

right start

Infant Name: _____ (Last / First / MI)

SSN: _____

Hospital of Delivery: _____

Date of Birth: ___/___/___ Sex: ☐ Female ☐ Male

Mother/Guardian Name: _____

Address: _____

_____

Mother/Guardian SSN: _____

Mother/Guardian DOB: ___/___/___

County: _____

Telephone: _____

Medicaid #: _____

Effective Date: ___/___/___

☐ Child ☐ Mother/Guardian

MCO Plan: _____

MCO #: _____

Effective Date: ___/___/___

Name & Address of Physician:

_____

_____

_____

Telephone: _____

Concerns: _____

_____

_____

Prenatal Name: _____ (Last / First / MI)

SSN: _____

Address: _____

_____

Telephone: _____

DOB: ___/___/___

EDC: ___/___/___

County: _____

☐ RFTS Maternity Services ☐ Medicaid ☐ Insurance

RFTS/Medicaid #: _____

Effective Date: ___/___/___

MCO Plan: _____

MCO #: _____

Effective Date: ___/___/___

Name & Address of Physician:

_____

_____

_____

Telephone: _____

Concerns: _____

_____

_____

_____

_____

_____

_____

Child Protective Services Referral: _____

Case Worker: _____ Telephone: _____

Referred to RFTS by: _____ Date: ___/___/___

Site: _____ Telephone: _____

Date Received: _____ Date of Approval: ___/___/___

Referred to (DCC Agency): _____

Recommendations: _____

Signature: _____ Date: ___/___/___
(Regional Care Coordinator)

*SEPARATE FORMS FOR MULTIPLE BIRTHS
WVDHHR/BPH/OMCFH/DPWH/PP/RFTS-R019
Revised: 08/2016

White:RCC
Yellow:DCC
Pink:HMO
Goldenrod:RCC