CATHOLIC CHARITIES
SAN BERNARDINO & RIVERSIDE COUNTIES
SERVICE REFERRAL FAX FORM

Revised 01/21

Date of Referral: _____

To:

____ **S.B. Regional Center**
Phone: (909) 880-3625
Fax: (909) 880-9847

____ **West End Regional Center**
Phone: (909) 906-5980
Fax: (909) 391-1400

____ **High Desert Regional Center**
Phone: (760) 243-1100
Fax: (760) 243-5335

____ **Counseling Intake**
Phone: (909) 763-4970 or (760) 449-7877
Fax: (909) 763-4977
referral@ccsbriv.org

____ **Center of Hope, Riverside**
Phone: (951) 689-1803
Fax: (951) 689-6953

____ **Coachella Valley Regional Center**
Phone: (760) 342-0157
Fax: (760) 342-0341

____ **Immigration/Citizenship**
Phone: (909) 388-1239
Fax: (909) 383-0448

From:

Name: _____ Phone: _____

Agency & Location: _____

CLIENT NAME: _____

ADDRESS: _____

TELEPHONE: _____ Best Time to Call: _____

LANGUAGE: _____ DATE OF BIRTH: _____

FAMILY COMPOSITION: Adults: _____ Children: _____

Referral for (Services Needed): _____

_____

_____

Other Information:

- PLEASE FAX THIS FORM TO THE APPROPRIATE CATHOLIC CHARITIES' OFFICE.
- PLEASE PROVIDE PERSON REQUESTING SERVICES WITH A COPY OF THIS FORM.
- CATHOLIC CHARITIES' STAFF WILL CONTACT DIRECTLY THE PERSON WHO WAS REFERRED BY THIS FORM.

It is important for all to understand that this is only a referral and not any guarantee of service.
Some counseling and immigration services may require a fee for service.
All services are provided at multiple locations throughout two-county area.

Signature of Person Requesting Services: _____