



GASTON COUNTY DEPARTMENT OF HEALTH & HUMAN SERVICES

330 North Marietta Street • Gastonia, North Carolina 28052
Phone 704-862-7530 FAX 704-862-7898

Name of Child (Use separate request for each child): _____

Parent Name(s) and contact information: _____

Name of Professional recommending services/activity/items: _____

Special training, licensure, or credential of the individual: _____

Type of service for which vendor payment will be utilized (use separate request for each service request):

Diagnosis/Special Need/Condition child has: _____

How does the service requested relate to the condition of the child? How will it be beneficial: _____

For medical related request, specify if the service is not covered by Medicaid or private insurance and why it is a need: _____

Specify about the service:

Service goals: _____

Duration of service: _____

Monthly cost of service: _____

Projected total cost of service: _____

What other services have been explored and utilized as resources other than vendor payments?

Signature of Parent(s): _____ Date: _____

Signature of Professional: _____ Date: _____