Room Request Form

Please complete form prior to submission. Incomplete forms will delay placement on the waiting list.

To: Family Services Manager

Fax #: (314) 773.2053 Park Avenue

(314) 569.8932 West County

Date: _____

Time: _____

First Date of Need: _____

Est. Length Stay: # of days_____ ☐1-2 months ☐2+

Guests Staying (max of 4): _____

Does the family have transportation?: ☐Yes ☐No

Patient Information:

Name: _____ Date of Birth: _____ Gender: _____

Address: (Min. of 50 miles)

_____

_____

Phone Numbers:

Main Contact: _____

Secondary Contact: _____

Contact: ☐Family Directly ☐Social Worker

Hospital: _____

Social Worker: _____

Phone Number: _____

Child's Department: _____

Diagnosis: _____

Does child have Missouri Medicaid? ☐Yes ☐No

Other Lodging Reimbursement: _____

Guest Information: *No one under the age of 18 may stay at the House without a parent/guardian

Name: _____ DOB: _____ Relation to Patient: _____

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Special Needs: Elevator: ☐____ Pack N' Play: ☐____ Other: _____

By signing or typing my name below, I accept responsibility for confirming that this family meets the requirements for lodging at the RMHC. All requests will be placed on the Waiting List in the order received. When a room becomes available, the preferred contact will be notified. **A family has one hour to accept or decline the room before RMHC will move on to the next family on the waitlist.** If a family declines a room or they never call back, they will be removed from the waitlist. **Requests are taken no earlier than 3 working days in advance of first day of need**, which includes the first day of need. If you have not heard about your room request by 4:00 pm, plan to make alternate lodging arrangements.

Social Worker: _____

Click Here to Submit Form to RMHC