



HEALTH COVERAGE SCREENING SHEET

Client/Family Information:

First Name: _____ M: _____ Last Name: _____

Address: _____ City: _____ Zip: _____

Telephone: _____ Language: _____

1. How many children are you applying for? # of children: _____ Children's ages: _____

2. Do any of your children have health coverage? Yes No

If yes, please check the type of insurance and the number of children currently on it:

Healthy Families _____ Private Insurance _____ Employer-sponsored insurance _____
(Purchased) (Through work)

No-cost Medi-Cal _____ Share-of-cost Medi-Cal _____ Restricted Medi-Cal _____
(Emergency services only)

Health Plan chosen: _____
(If other children are enrolling in Medi-Cal or Healthy Families)

3. Is anyone in the home currently pregnant: yes no

4. # of parents in the home: _____

5. Earned Household Gross Monthly Income (before taxes): \$ _____

Notes:

By providing this information you give permission to be contacted by a Certified Application Assistant from Cover the Kids.

Parent/Guardian Signature: _____ Date: _____

REFERRAL INFORMATION

Organization: _____

Contact Name: _____ Phone #: _____

TO REFER FAMILY: FAX FORM TO **916-808-6155**
or call **916-808-3838** or Toll-free at **1-866-850-4321**