



Health Coverage Screening Referral Sheet



Sacramento
Children's
Health Initiative

Client/Family Information

First Name _____ M. _____ Last Name _____

Address _____ City _____ Zip _____

Telephone _____ Email _____ 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. If no, when did the coverage end? _____

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)

3. Is anyone in the home currently pregnant? Yes No

4. # of parents in the home _____

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

6. Are there any outstanding medical bills within the last 3 months from services received while being uninsured? _____

Notes _____

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

Parent/Guardian Signature _____ Date _____

Referral Information

Organization _____ Date Referred _____

Contact Name _____ Phone _____

To refer family: Fax form to (916) 369-0318
or call (916) 369-3335 or email nicole.ullrich@childaction.org