MEDICAID /CHILD HEALTH PLAN PLUS DEPARTMENT

DATE _____

Yes! I Want Information on Health Insurance for my Children.

School: _____

Parent(s) Name: _____

Children(s) Name and DOB:

1. _____ 2. _____
3. _____ 4. _____

Address: _____

_____

Home Phone: _____ **Work Phone:** _____
(If you would like us to call you at work)

APS employee making referral: _____

Good time to call: _____

Please Sign: _____

I give my permission to the above referring school to release this information to the Medicaid/Child Health Plan Plus Outreach Department.

Signature of APS employee affirming verbal consent by parent(s):

_____

Please Fax Requests To: 303-326-1813

2009-10