AURORA PUBLIC SCHOOLS
OFFICE OF MEDICAID SERVICES

REQUEST FOR MEDICAID FUNDS FOR UNINSURED STUDENT HEALTH NEEDS
(for children who are uninsured and have a financial need)

DATE ________________________

STUDENT NAME _________________________ DOB _______________________

STUDENT ID# ____________________________ SCHOOL ___________________

PARENT NAME ___________________________

ADDRESS ________________________________

PHONE (HOME) _______________________ (WORK) ________________________

TYPE OF REQUEST

___Medication (one-time prescription)
Name of medication ____
Dose ____
___ Dental Care
___ Vision Care
___ Acute Health Care

Note: The family is responsible for providing transportation to the site of service.

INFORMATION REGARDING REQUEST
(Include a description of the student's health and ***financial needs***)

Signature of person making referral________________________ Date __________________

Telephone number and best time to be reached _____________________________________

Fax request to:
Medicaid Services Office
303-326-1813