HEALTH INSURANCE INTEREST/REFERRAL FORM

Information for client interested or being referred:

Referral Date: ____

Referral submitted by: ____

Name of referred client: ____

Preferred Language: ____

Mailing Address: ____

City/Zip: ____

Phone: ____

I would like more information regarding the following program: (Please check all that applies)

☐ Covered California ☐ Medicare ☐ Private ☐ Medi-Cal ☐ Other

Additional Information:

Please Email to:
Community Health Initiative
info@calchi.org