



BVSD Student Medicaid and CHP+ Outreach Referral Form

Student First Name: _____

Student Last Name: _____

Student School: _____

Student Date of Birth: _____

Student ID#: _____

County of Residence: Boulder County Broomfield County Other _____

Primary Contact Person: _____

Phone: _____ Best time to be reached: 8 AM-12 PM 12 PM-5 PM 5 PM-7PM

Email: _____

Household Language: English Spanish Other _____

Referral Source: _____

(Name of the person making the referral. If the referral is being made by a BVSD employee, please include job title and school/building.)

Email or Phone Number for Referral Source: _____

Reason for contacting:

Medicaid or CHP+ Enrollment Assistance

Non-Citizen Health Insurance or Health Care Resources

Assistance in using current Medicaid/CHP+ benefits or connecting with providers/specialists

Other: _____

Additional Information or Comments:

Please email referral form to HKOutreach@bouldercounty.org or fax to 303-568-7859

*Healthy students have a better chance of improved learning outcomes, attendance, behavior, and test scores.
Help us keep students healthy!*