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 ◯ BroomfieldCounty ◯ Other _____

Primary Contact Person: _____
Phone: _____
Email: _____
Household Language: ◯ English ◯ Spanish ◯ Other _____

Referral Source: _____
(Name of the person making the referral. If the referral is being made by a SVVSD 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:

Click Here to Submit Form by Email

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!