ABLE ADVOCATES

Application to Determine Program Eligibility

APPLICANT INFORMATION												
Last Name		First		M.I.		DOB						
Gender (Circle One)	Male ☐ Female ☐	Height		Weight		Race/Ethnicity						
Primary Physician's Name		Primary Physician's Phone Number										
Diagnosis												
School District		School Name		Grade								

PARENT/GUARDIAN INFORMATION						
Last Name		First				
Address		City		State		
Mailing Address (If different)						
Day Phone		Night Phone				
Family Income		Family Size				

HEALTH INSURANCE INFORMATION					
Does the applicant have Medi-Cal?	YES ☐	NO ☐	If yes, what is the Medi-Cal number?		
Is the applicant enrolled in the Healthy Families Program?	YES ☐	NO ☐	If yes, what is the name of the plan?		
Does the applicant have other health insurance?	YES ☐	NO ☐	If yes, what is the name of the insurance plan or company?		
Type of insurance plan or company	Preferred Provider (PPO) ☐		Health Maintenance Organization (HMO) ☐		Other ☐
If other, please describe			Policy Number		

ADDITIONAL RESOURCES
Please list all other agencies or programs that you have applied for

SERVICE OR EQUIPMENT
Describe what service is denied or not provided

Please list all services or equipment already obtained
NARRATIVE
Describe your child and why you are a good candidate

How did you hear about us?			
Signature		Date	