

## Appendix 5

# Uninsured Student Referral Form

The Lynwood Unified School District in Lynwood, California designed a one page Uninsured Student Referral Form to be used by the student services department that oversees outreach and enrollment activities.

Its goal is to keep a student's health insurance status and any outreach and referral tracking information documented in one place. The Uninsured Student Referral Form gives both the school district and the enrollment partner important information with the ability to update as needed.

The form includes key student information that can then be entered into the student database for future reference and includes the following elements:

- Student contact and background information
- Additional family members' information
- Parental consent information
- Uninsured status/reason
- Students' health insurance program plan, if applicable
- Health insurance renewal date and status, if applicable
- Medical needs of student
- Results, date(s) and contact attempts by community clinic partner(s)
- Results, date(s) and contact attempts by the school district
- Whether the student/family obtained health insurance, what kind, and the renewal date

**Lynwood Unified School District**  
EDUCATIONAL SERVICES DIVISION/STUDENT SERVICES  
11327 Buja Rd., Lynwood, California 90262  
Phone: (310) 936-1428

**UNINSURED HEALTH REFERRAL** SCAN and EMAIL TO: [care@lynwood.org](mailto:care@lynwood.org)

School: \_\_\_\_\_ Student: \_\_\_\_\_ Student ID# \_\_\_\_\_  
Grade: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Ethnicity: \_\_\_\_\_ Gender: \_\_\_\_\_  
Parent/Guardian: \_\_\_\_\_ Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Best Time to Call: \_\_\_\_\_  
Non-English Speaking Parent? Yes \_\_\_ No \_\_\_ Number of Family Members in this home: \_\_\_\_\_  
Student is in need of: \_\_\_\_\_  
\_\_\_\_\_ Classes \_\_\_\_\_ Health \_\_\_\_\_ Immunizations \_\_\_\_\_ Medical Care \_\_\_\_\_ Medication \_\_\_\_\_ Preventive Care \_\_\_\_\_  
Reason for uninsured status: \_\_\_\_\_ Loss of Job \_\_\_\_\_ Income \_\_\_\_\_ ex. Medical \_\_\_\_\_ Other please explain \_\_\_\_\_  
I hereby authorize permission for the information I have provided above, to be release to any of the health agency partners in through LISDC. I understand this information will only be used to allow me to receive information on health care coverage and services.  
Yo autorizo que la informacion que he proporcionado anteriormente, sea liberada a cualquier agencia de salud que este en asociacion con el distrito escolar. Yo entiendo que esta informacion sera solamente usada para permitirme recibir informacion acerca de cobertura y servicios de seguro médicos.  
Client/Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
STUDENT SERVICE Use Only:  Blue Shield of CA CARE1™  MyLife  LA Care  Allia Med  Anthem Blue Cross  Elmer Medical Center  
 St. Francis  SSMCH  Other \_\_\_\_\_ Date: \_\_\_\_\_ District Signature: \_\_\_\_\_

**AGENCY Use Only:** Results of Parent Contact

Attempt #	Date	Results
1		
2		
3		

Did student/Family obtain Health Care Coverage: Yes \_\_\_ No \_\_\_

Results	Family Member	Coverage Plan	Renewal Date
1	Student	Medical <input type="checkbox"/> Covered CA <input type="checkbox"/> Care <input type="checkbox"/> Healthy Kids <input type="checkbox"/> Kaiser <input type="checkbox"/> CCS <input type="checkbox"/> Sky Health LA	
2			
3			
4			
5			
6			

Student/family was unable to get coverage due to (reason) and they were referred to: \_\_\_\_\_  
\_\_\_\_\_

I/We Lynwood Unified School District-Student Services was notified re: Student Obtaining Health Care Coverage: \_\_\_\_\_  
FAX to 310-995-4884 or EMAIL to [care@lynwood.org](mailto:care@lynwood.org)