Children of Migrant Workers Outreach

SECTION 1

Name of Children 1._____DOB_____2._____DOB_____3._____DOB_____

4._____DOB_____

Current Address: _____ City:_____ State: _____ Zip:_____ Ph: (_____) _____

Homebase Address: _____ City: _____ State: _____ Zip: _____ Ph: (_____) _____

SECTION 2

Do you or any members of your family have Medicaid with Driscoll Children's Health Plan? YES ☐ NO ☐

******* IF YES, CONTINUE ON TO SECTION 3*******
******* IF NO, STOP HERE. DO NOT PROCEED FURTHER*******

SECTION 3

Has your family made a qualifying move from_____(City/State/Country) to the worksite at_____(City/State/Country)

☐On or ☐ About _____(Date M/D/Y/) to enable the worker to ☐ Obtain or ☐ Seek (Mark one) ☐ Temporary or ☐ Seasonal Employment In (Mark one)

(Mark one) ☐ Agriculture or ☐ Fishing _____(Qualifying activity)

******CONTINUE TO SECTION 4******

SECTION 4

Driscoll Children's Health Plan has many services to offer children of migrant farm workers. We offer help with:

- Getting your family checkups with your doctor before migrating to another area
- Transportation to your doctor's office for your THSteps exams
- Finding a doctor
- Finding a dentist
- Providing cell phones for pregnant women

CALL US TOLL FREE FOR ASSISTANCE: MEMBER SERVICES 1-877-220-6376
PLEASE FAX THIS FORM TO: DRISCOLL CHILDREN'S HEALTH PLAN AT FAX (361)882-4520!

*Information contained within this facsimile transmission is **CONFIDENTIAL.** If you receive this facsimile in error please contact us as (361) 694-4487*