SAS Database Input Offline Form

Applicant Information	
First Name:	
CIN (If Applicable):	
Date of Birth:	
City of Birth:	
Mother's First Name:	

Additional Applicant Information	
Last Name:	
Middle Initial:	
Email Address:	
Street Address:	
Apt. #:	
City:	
Zip Code:	
Phone No.:	
Language:	
Ethnicity:	
Is Applicant Pregnant?:	☐ YES ☐ NO

Beneficiary Information		
First Name:		
Last Name:		
Date of Birth:		
Gender:		
Relationship to Applicant:		

FAX

TO:	FROM:
Rodrigo Vazquez	
COMPANY:	**DATE:**
Community Health Initiative of Kern County	
FAX NUMBER:	**SENDER'S FAX:**
818-409-5392	
PHONE NUMBER:	**SENDER'S PHONE:**
661-632-5743	
RE:	**NO. OF PAGES INCLUDING COVER:**
Successful Application Stipend Program	

DOCUMENTS BEING FAXED:

- ☐ SAS confirmation page
- ☐ SAS consent form
- ☐ Other

_____

_____

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Successful Application Stipend (SAS)
Medi-Cal/Covered California Application or Renewal Assistance
Permission to Share Information

Case Name: _____ SS#: _____ Date: _____

DSH Worker: _____ Caseload #: _____ Phone #: _____

Permission to share information:

MEDI-CAL
I give permission to the Department of Human Services to share information concerning my application or annual eligibility renewal with Mercy Hospitals, the Certified Enrollment Counselor (CEC), the Certified Enrollment Entity (CEE) identified, and the Kern County Department of Public Health. This permission will end in one year. I certify that I had help completing this application/renewal by the listed CEC. This CEC help was free of charge to me.

COVERED CA
I give permission to the Certified Enrollment Counselor (CEC) and the Certified Enrollment Entity (CEE) identified to share information concerning my Covered California application or annual eligibility renewal with Mercy Hospitals and Kern County Department of Public Health. This permission will end in one year. I certify that I had help completing this application/renewal by the listed CEC. This CEC help was free of charge to me.

Name (Please Print): _____ DOB: _____

Signature: _____ Date: _____

Certified Enrollment Counselor Information:

(Reimbursement is subject to budget appropriations. Reimbursement will not be issued unless this section is completely filled out at the time this form is submitted.)

CEC#: _____ CEE# _____ Site: _____

CEC's Signature: _____ Phone#: _____

Email Address: _____ Fax#: _____

SAS APPLICATION ID#: _____