15400 Grand River 2nd. Floor Detroit MI, 48227

pops1org@gmail.com 248-974-7417

POP SOLUTIONS CHW COVER SHEET

☐ Mr. ☐ Ms. ☐ Youth ☐ Senior ☐ Veteran ☐ Returning Citizen

First Name: Last Name:

Address: City:

State: Zip Code:

Phone Number: Email Address:

Social Services Requested

☐ Food ☐ Medical Insurance ☐ Medical ☐ Mental Health ☐ Water ☐ Lights/Gas ☐ Housing Assistance ☐ Eviction

☐ Workforce Development / Education ☐ Work/Jobs

Other Notes:

Does the client have insurance?

☐ Yes ☐ No ☐ Not Sure

Insurance Information

Name of Primary Health Insurance Co: Group Name:

Insured's ID: Group #:

Insurance Co. Address Group Address:

City: City:

State: State:

Zip: Zip:

Insurance Co. Phone Number: Group Phone Number:

☐ All information is assumed to be true to the best knowledge of the Community Health Worker. The CHW has seen the participants Valid ID and Insurance Card that match the name and address as verification. Or if the participant does not have health insurance all legal and valid documents have been physically reviewed.

CHW Name or ID#: