Aging and Disability Services Division
Office for Consumer Health Assistance

Request for Assistance

Consumer/Patient Information	
Name (Last, First, Middle):	Date of Birth:
Age:	Minor: ☐ Yes ☐ No
Parent/Guardian First and Last Name (If Minor):	
Mailing Address:	
Phone Number:	Other Phone Number:
Consumer/Patient Email Address:	
Employment Status:	Name of Employer:
Veteran: ☐ Yes ☐ No	Marital Status:
Primary Language:	Education/Schooling Level:

Race/Ethnicity:

☐ American Indian/ Alaskan Native
☐ Asian
☐ Bi-racial/multi-racial
☐ Black/African American
☐ Caucasian/White
☐ Filipino
☐ Hispanic/Latino
☐ Middle Eastern/North African
☐ Native Hawaiian/ Pacific Islander
☐ Other
☐ I choose not to answer
☐ Unknown

OCHA asks the questions below to learn about your community. Your answers help OCHA improve services but are optional.

Sex Assigned at birth:	Gender Identity:	Sexual Orientation:
☐ Male ☐ Female ☐ Prefer not to disclose	☐ Male ☐ Female ☐ Transgender Male ☐ Transgender Female ☐ Genderqueer/gender non-conforming ☐ Other (Specify): ☐ Prefer not to disclose	☐ Heterosexual ☐ Homosexual ☐ Bisexual ☐ Other (Specify): ☐ Prefer not to disclose

Clear Form

Aging and Disability Services Division
Office for Consumer Health Assistance

Request for Assistance

How did you hear about our office?
If you were referred by a state or federal agency, which agency?
Please describe the reason you need assistance:
How would you like to see this resolved?

Complete the section that is the best fit for you

Workers' Compensation	
Date of Injury:	Injured Body Part:
Workers Compensation Insurance/Third Party Administrator:	
Phone Number:	Claim Number:
Name of Employer at Time of Injury:	

Medicare/Medicaid	
Medicare ID Number:	Medicaid ID Number:
Insurance Phone Number:	
Do you have a Medicare Advantage Plan? (Ex: Aetna, AARP, Humana) ☐ Yes ☐ No	
Name of Medicare Advantage Plan:	
Medicare Advantage Plan ID Number:	
Medicare Advantage Plan Group Number:	

Aging and Disability Services Division
Office for Consumer Health Assistance

Request for Assistance

Health Insurance	
Insurance Company Name:	Phone Number:
Policy Holder Name:	
Policy Holder Date of Birth:	
Policy (Member ID) Number:	Policy Group Number:
Have you contacted the insurance company? ☐ Yes ☐ No	
Insurance Contact Name:	

Physician or Other Professional Billing
Name of physician/provider of healthcare services:
Phone Number:

Hospital Billing
Name of hospital:
Phone Number: