

## GBIO Healthcare Outreach and Enrollment Session Notes

Date: \_\_\_\_\_ Institution: \_\_\_\_\_ Notetaker: \_\_\_\_\_

Leader: \_\_\_\_\_ Number in Attendance: \_\_\_\_\_

Name	Insurance status	Story	Follow-Up:
	<b>Insured:</b> <input type="checkbox"/> Com. Care <input type="checkbox"/> Com. Choice <input type="checkbox"/> Employer <input type="checkbox"/> Mass Health <input type="checkbox"/> Medicare <input type="checkbox"/> Other _____ <input type="checkbox"/> <b>Uninsured</b>		<b>Team Member:</b>  <b>Phone#:</b>
	<b>Insured:</b> <input type="checkbox"/> Com. Care <input type="checkbox"/> Com. Choice <input type="checkbox"/> Employer <input type="checkbox"/> Mass Health <input type="checkbox"/> Medicare <input type="checkbox"/> Other _____ <input type="checkbox"/> <b>Uninsured</b>		<b>Team Member:</b>  <b>Phone#:</b>
	<b>Insured:</b> <input type="checkbox"/> Com. Care <input type="checkbox"/> Com. Choice <input type="checkbox"/> Employer <input type="checkbox"/> Mass Health <input type="checkbox"/> Medicare <input type="checkbox"/> Other _____ <input type="checkbox"/> <b>Uninsured</b>		<b>Team Member:</b>  <b>Phone#:</b>
	<b>Insured:</b> <input type="checkbox"/> Com. Care <input type="checkbox"/> Com. Choice <input type="checkbox"/> Employer <input type="checkbox"/> Mass Health <input type="checkbox"/> Medicare <input type="checkbox"/> Other _____ <input type="checkbox"/> <b>Uninsured</b>		<b>Team Member:</b>  <b>Phone#:</b>

Please return copies of (1) this form, (2) your blue commitment cards, and (3) your session sign in sheet to:  
 Lisa Vinikoor at GBIO, 594 Columbia Road, Suite 402· Dorchester, MA 02125· P: 617 825-5600· F: 617 825-5400

Name	Insurance status	Story	Follow-Up:
	<b>Insured:</b> <input type="checkbox"/> Com. Care <input type="checkbox"/> Com. Choice <input type="checkbox"/> Employer <input type="checkbox"/> Mass Health <input type="checkbox"/> Medicare <input type="checkbox"/> Other _____ <input type="checkbox"/> <b>Uninsured</b>		<b>Team Member:</b>  <b>Phone#:</b>
	<b>Insured:</b> <input type="checkbox"/> Com. Care <input type="checkbox"/> Com. Choice <input type="checkbox"/> Employer <input type="checkbox"/> Mass Health <input type="checkbox"/> Medicare <input type="checkbox"/> Other _____ <input type="checkbox"/> <b>Uninsured</b>		<b>Team Member:</b>  <b>Phone#:</b>
	<b>Insured:</b> <input type="checkbox"/> Com. Care <input type="checkbox"/> Com. Choice <input type="checkbox"/> Employer <input type="checkbox"/> Mass Health <input type="checkbox"/> Medicare <input type="checkbox"/> Other _____ <input type="checkbox"/> <b>Uninsured</b>		<b>Team Member:</b>  <b>Phone#:</b>
	<b>Insured:</b> <input type="checkbox"/> Com. Care <input type="checkbox"/> Com. Choice <input type="checkbox"/> Employer <input type="checkbox"/> Mass Health <input type="checkbox"/> Medicare <input type="checkbox"/> Other _____ <input type="checkbox"/> <b>Uninsured</b>		<b>Team Member:</b>  <b>Phone#:</b>

Number of people with insurance: \_\_\_\_\_    Number of people without insurance: \_\_\_\_\_  
 Number of people eligible for Commonwealth Care: \_\_\_\_\_    Number of people eligible for Commonwealth Choice: \_\_\_\_\_  
 Number of people who plan to apply for a waiver: \_\_\_\_\_

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