



PORTICO
Healthnet

Portico Healthnet
1600 University Ave W Suite 211
St. Paul, MN 55104
651-489-2273

Organization Name _____
Staff Name _____
Address _____
City, State Zip _____
Phone Number _____

Do you need health coverage?

Let us help!

If anyone in your household needs health coverage, complete this form, and Portico Healthnet will contact you.

I give permission to _____ and Portico Healthnet to share the information entered below to assist my family and me in establishing and/or maintaining enrollment in a health care program.

I understand that the information will be used for the sole purpose of assisting with establishing and/or maintaining enrollment in a health care program for my family and me. The information may not be shared with anyone else without my permission and the information will be kept secure and private.

This written permission will remain in effect for one year from the date of my signature. I understand that I may cancel this permission in writing at any time; however, it does not apply to information that may already have been shared.

Yes, I would like help in finding health care coverage:

Name of Client _____

Name of Parent/Guardian (if patient is under 18) _____

Address _____

City and Zip Code _____

Home phone _____ *Cell/Work phone* _____

Number of adults living in household _____

Number of children living in household _____

Primary Language _____ *Need interpreter?* Yes No

Signature _____ *Date* _____

Client has provided verbal consent

Fax to 651-603-5101

Or send via secure document upload system at porticohealthnet.sendsafely.com/dropzone/sendsafely