

CareTrust Health Alliance

Individual & Family Care Inquiry Form

Help us understand your needs so we can guide you to affordable, high-quality care options.

Personal Information

Full Name: _____

Email Address: _____

Phone Number: _____

City/State: _____

Household Information

Are you inquiring for: Individual Family

Number of Household Members: _____

Current Coverage (if any)

Do you currently have health insurance? Yes No Not Sure

Type of Coverage (if yes): _____

Care Needs (check all that apply)

- Routine & preventive care
- Primary care access
- Specialty care services
- Diagnostic services
- Guidance on affordable care options

Goals

- Lower healthcare costs
- Better access to care
- Simpler healthcare experience
- Long-term care affordability

Additional Information

Please share anything specific you'd like us to know:

Next Step

Would you like a CareTrust advisor to contact you? Yes Just send information