FLORIDA DECIDES HEALTHCARE

Medicaid Expansion

Petition Intake Cover Sheet

Please return this cover sheet along with all completed petitions

YOUR name	
YOUR phone number	
YOUR e-mail address	
YOUR organization or congregation (if applicable)	
How many petitions are you submitting?	
Date of petition submission	
County (one cover sheet needed per county)	
Approximately how much time did you spend collecting petitions?	

Please check that each petition has all of the required information

▢ The voter's name (as it appears on their voter registration card)
▢ The voter's address (including city, zip and county)
▢ The voter's date of birth OR voter registration number (only need one)
▢ The date the voter signed the petition, as recorded by the voter

Please return this cover sheet and your petitions as soon as possible to your local regional hub OR Florida Decides Healthcare, Inc., P.O. Box 10829, Tallahassee, FL 32302

HUB WILL FILL OUT THE FOLLOWING INFO:
Complete petitions _____
Incomplete petitions _____
County _____
▢ Followed up with a collector
Processed by (initials) _____