

*Do NOT copy  
for students!*




**EL Civics Assessment Packet  
Answer Key  
Spring 2026**

Intermediate High

**Health: COAAP 26.3**

## Task 1 Assessment (4 pages) (14 points possible)

Directions: Look at the flyers. Fill in the chart on the next page with the correct information. Be sure to write neatly.


<p><b>#1</b></p> <p><b>UCI Health Family Health Center Santa Ana</b></p> <p><i>Bringing health to our community one patient, one family at a time.</i></p>  <p><b>Office Information</b> 800 N. Main St. Santa Ana, CA 92701 Office Phone: 657-282-6355</p> <p><b>Required: Picture ID</b></p> <p><b>Hours</b></p> <ul style="list-style-type: none"> <li>Monday thru Friday — 7:30 a.m. to 8:00 p.m.</li> <li>Saturday — 8:00 a.m. to 5:00 p.m.</li> </ul> <p><b>Services</b> Primary care, prenatal care, pediatrics, X-ray services</p>	<p><b>#2</b></p>  <p><b>Lestonnac Free Clinic</b></p> <p><b>1215 East Chapman Avenue Orange, CA 92866</b> Phone: (714) 633-4600 <a href="mailto:info@lestonnacfreeclinic.org">info@lestonnacfreeclinic.org</a></p> <p><b>Office Hours</b></p> <ul style="list-style-type: none"> <li><b>Monday – Saturday</b> <b>9:00 a.m. – 12:00 p.m.</b> <b>1:00 p.m. – 5:00 p.m.</b></li> </ul> <p><b>Services</b> <b>Primary care, physical therapy, dental care, vision care</b></p> <p><i>The mission of <b>Lestonnac Free Clinic</b> is to provide free health care services to low-income and uninsured residents in Southern California, through the support of generous volunteers and donors.</i></p> <p>Documentation Needed: Picture ID</p>	<p><b>#3</b></p> <p><b>Mariposa Women &amp; Family Center</b></p>  <p>1845 W. Orangewood Ave., Suite 300 Orange, CA 92868 Tel: (714) 547-6494 Fax: (714) 547-7940 <a href="mailto:info@mariposacenter.org">info@mariposacenter.org</a></p> <p><b>Hours</b> Mon – Fri 9:00am-7:00pm</p> <p><b>Services</b> Mental health services, substance abuse counseling, online counseling</p> <p>Please bring your picture ID to the Center.</p> <p><i>40+ Years Empowering Women and Families to Make Positive Changes in their Lives</i></p>
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## Task 1 Assessment (cont.)

	#1	#2	#3
<b>Name</b>	UCI Health Family Health Center Santa Ana	Lestonnac Free Clinic	Mariposa Women & Family Center
<b>Address</b>	800 N. Main St. Santa Ana, CA 92701	1215 East Chapman Avenue Orange, CA 92866	1845 W. Orangewood Ave., Suite 300 Orange, CA 92868
<b>Phone Number</b>	657-282-6355	(714) 633-4600	(714) 547-6494
<b>Hours</b>	Monday thru Friday — 7:30 a.m. to 8:00 p.m. Saturday —8:00 a.m. to 5:00 p.m.	Monday – Saturday 9:00 a.m. – 12:00 p.m. 1:00 p.m. – 5:00 p.m.	Mon – Fri 9:00am-7:00pm
<b>Documentation Needed</b>	Picture ID	Picture ID	Picture ID
<b>Services Provided</b>	Primary care, prenatal care, pediatrics, X-ray services	Primary care, physical therapy, dental care, vision care	Mental health services, substance abuse counseling, online counseling

**Task 1 Assessment (cont.)**

Directions: Look at the flyers. Fill in the chart on the next page with the correct information. Be sure to write neatly.

<p><b>#4</b></p> <p><b>AltaMed Medical and Dental Group</b> <b>Santa Ana, Main</b></p> <p>1400 North Main St. Santa Ana, CA 92701 (888) 499-9303</p> <p><i>Services</i> Primary Care, Pediatrics, Senior Care, Women's Health, Dental Care</p> <p>Required Documentation: Picture ID and Insurance Card</p> <p><i>Medical Hours</i> M/W/F 8 am - 5 pm T/Th 9 am - 5 pm</p> <p><b>AltaMed</b> <b>Your Community Health Network</b></p>	<p><b>#5</b></p> <p><b>Friendly Center</b></p> <p>147 W. Rose Ave., Orange, CA 92867 (714) 771-5300 <a href="mailto:info@friendlycenter.org">info@friendlycenter.org</a></p> <p><i>Hours</i> Monday-Friday 8:30AM-5PM</p> <p><i>Services</i> Mental health services</p> <p>Required documentation: Picture ID</p> <p><i>Friendly Center is a non-profit in Orange County providing stability, opportunity, and hope to children and families in poverty. By providing wrap-around services to the whole family unit, in addition to essential basic needs, we elevate families to overcome crisis and the barriers of poverty. Join us in strengthening families.</i></p> 
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## Task 1 Assessment (cont.)

	#4	#5
<b>Name</b>	AltaMed Medical and Dental Group (Santa Ana, Main)	Friendly Center
<b>Address</b>	1400 North Main St. Santa Ana, CA 92701	147 W. Rose Ave. Orange, CA 92867
<b>Phone Number</b>	(888) 499-9303	(714) 771-5300
<b>Hours</b>	M/W/F 8 am – 5 pm T/Th 9 am - 5 pm	Monday-Friday 8:30AM-5PM
<b>Documentation Needed</b>	Picture ID and Insurance Card	Picture ID
<b>Services Provided</b>	Primary Care, Pediatrics, Senior Care, Women's Health, Dental Care	Mental health services

## Task 2 Assessment (3 pages) (16 points possible)

Directions: Using the information from the story below, fill out the application on this page and the next two pages. If you do not have any information about a particular section, leave it blank. There are **38** pieces of information you need to complete (including checkboxes). Be sure to write neatly.

### Scenario:

Leo Jose Sanchez lives at 2867 Main St. Apartment 18, Santa Ana, California, 92701. He lives in the county of Orange. He's married, and his date of birth is 12/15/1985. His mailing address is the same as his home address. His cell phone (preferred) number is (714) 823-6598, and his work phone is (714) 256-1183. His preferred method of contact is email, which is leosanchez@gmail.com. His Social Security number is 780-62-3177, and his primary language is English. He's applying for himself. His employer is Michael's Pizzeria, where he earns \$3500 per month. He doesn't have any dependents, and he is the primary tax filer. He files annually, and his status is "married filing jointly". He doesn't have health insurance, and he doesn't have either a disability or the need for long-term care services.

<b>Step 1: Tell us about the adult who will be our main contact for this application</b>				
<b>First name</b> Leo	<b>Middle name</b> Jose	<b>Last name</b> Sanchez	<b>Suffix (examples: Sr., Jr., III, IV)</b> N/A	
<b>Home Address</b> 2867 Main St.				<b>Apartment #</b> 18
<b>City (home address)</b> Santa Ana		<b>State</b> CA	<b>Zip Code</b> 92701	<b>County</b> Orange
<input type="checkbox"/> Check here if you do not have a home address. You must give us a mailing address below.				
<input checked="" type="checkbox"/> Check here if your mailing address is the same as your home address. <b>If it is not the same, you must give us your mailing address below:</b>				
<b>Mailing Address or P.O. Box (if different from home address)</b> N/A				<b>Apartment #</b>
<b>City (home address)</b>		<b>State</b>	<b>Zip Code</b>	<b>County</b>
<b>Best phone number to reach you</b> <input type="checkbox"/> Home <input checked="" type="checkbox"/> Cell <input type="checkbox"/> Work <b>Number: ( 714 ) 555 - 6598</b>			<b>Other phone number</b> <input type="checkbox"/> Home <input type="checkbox"/> Cell <input checked="" type="checkbox"/> Work <b>Number: ( 714 ) 555 - 1183</b>	
<b>What language should be write to you in?</b> English			<b>What language do you want us to speak to you in?</b> English	
<b>How would you like to get information about this application?</b> <input type="checkbox"/> Phone <input type="checkbox"/> Mail <input checked="" type="checkbox"/> Email <b>Email address: leosanchez@gmail.com</b>				

## Task 2 Assessment (cont.)

<b>Person 1 Tell us about yourself</b>				
First name III, IV)	Middle name	Last name	Suffix (examples: Sr., Jr.,	Relationship to you
Leo	Jose	Sanchez	N/A	Self
Are you: <input checked="" type="checkbox"/> <b>Male</b> <input type="checkbox"/> Female		Are you: <input type="checkbox"/> Single <input type="checkbox"/> Never married <input checked="" type="checkbox"/> <b>Married</b> <input type="checkbox"/> Divorced <input type="checkbox"/> Registered domestic partner <input type="checkbox"/> Widowed		
Date of birth (month/day/year) <b>12/15/85 (or 12/15/1985)</b>		Are you pregnant? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> <b>No</b> <i>If yes, how many babies are expected? _____</i> What is the expected delivery date? _____		
<b>Applying for health insurance</b> <i>Even if you have insurance now, you might find better coverage or lower costs.</i>				
Are you applying for health insurance for yourself? <input checked="" type="checkbox"/> <b>Yes.</b> If yes, answer the questions below and complete pages 4 and 5. <input type="checkbox"/> No. If you are not applying for yourself, but are applying for a dependent, be sure to fill in page 5. <input type="checkbox"/> No. If you are not applying for yourself or a dependent, go to page 6.				
Social Security Number <b>780-62-3177</b>		If you do not have an SSN, what is the reason? <input type="checkbox"/> Adoption Taxpayer Identification Number (ATIN) _____ <input type="checkbox"/> Individual Taxpayer Identification Number (ATIN) _____ <input type="checkbox"/> Religious exemption <input type="checkbox"/> I do not qualify for an SSN		

<b>Tell us about your current job and how you get money</b> <i>Attach an extra page if you need more space</i>	
Do you work now? <input checked="" type="checkbox"/> <b>Yes</b> <i>if yes</i> , answer the questions below <input type="checkbox"/> <b>No</b> <i>if no</i> , go to other income on this page	
<b>Where do you work now?</b> <i>If you have more jobs, attach another sheet of paper</i>	
<b>JOB 1:</b> How do you get paid?	<input type="checkbox"/> Hourly: How many hours per week? _____ <input type="checkbox"/> Daily: How many days per week? _____ <input type="checkbox"/> Weekly <input type="checkbox"/> Every two weeks <input type="checkbox"/> Twice a month <input checked="" type="checkbox"/> <b>Monthly</b> <input type="checkbox"/> Quarterly <input type="checkbox"/> Every six months <input type="checkbox"/> Yearly <input type="checkbox"/> One-time payment
Employer name <b>Michael's Pizzeria</b>	How much do you get paid (before taxes)? <b>\$ 3500/mo</b>
<b>JOB 2:</b> How do you get paid?	<input type="checkbox"/> Hourly: How many hours per week? _____ <input type="checkbox"/> Daily: How many days per week? _____ <input type="checkbox"/> Weekly <input type="checkbox"/> Every two weeks <input type="checkbox"/> Twice a month <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Every six months <input type="checkbox"/> Yearly <input type="checkbox"/> One-time payment
Employer name	How much do you get paid (before taxes)? \$ _____

## Task 2 Assessment (cont.)

<b>Step 2: Person 1 (continued)</b>	
<b>Federal income tax information</b> <i>If you don't file taxes, you can still qualify for free or low-cost insurance through Medi-Cal. We will keep your information private. We will use your information only to decide if you qualify for health insurance.</i>	
Are you the primary tax filer (your name was the first on the tax return)? <input checked="" type="checkbox"/> <b>Yes</b> <input type="checkbox"/> No <i>Only one person on this application can be the primary tax filer.</i>	
Are you going to file taxes for the benefit year? <input checked="" type="checkbox"/> <b>Yes</b> <input type="checkbox"/> No If yes, how will you file? <input type="checkbox"/> Head of Household <input type="checkbox"/> Single <input checked="" type="checkbox"/> <b>Married filing jointly</b> <input type="checkbox"/> Married filing separately	Does anyone claim you as a dependent on their taxes? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> <b>No</b> If yes, who? <input type="checkbox"/> Person # _____ on this application <input type="checkbox"/> This person is a parent without custody. <input type="checkbox"/> This person is a parent without custody who is not listed on this application.
Do you have other health insurance or are you offered insurance through a job? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> <b>No</b>	
Do you have a physical, mental, emotional, or developmental disability? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> <b>No</b> <i>See FAQ #27 for more information on what it means to have a disability.</i>	Do you need help with long-term care or home and community-based services? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> <b>No</b>