State of California—Health and Human Services Agency

Department of Health Care Services
Children's Medical Services Branch

CHILD HEALTH AND DISABILITY PREVENTION (CHDP) PROGRAM
PRE-ENROLLMENT APPLICATION

Instructions to the Parent or Patient:

- In order to receive a health examination today at no charge, you must provide the information required on this form. The information you give is confidential. This is a voluntary program.

  Is the patient less than 19 years of age? ☐ Yes ☐ No

  How many people are in your family? _____

  How much money does your family make before taxes? $_____ (Monthly) Or $_____ (Yearly)

- You or your child may be eligible for continued health care coverage through Medi-Cal or premium assistance programs under Covered California.

  I want to apply for continuing coverage through Medi-Cal or premium assistance programs under Covered California. ☐ Yes ☐ No

  If you answered *yes* to this question, an application will be mailed to you in a few days. Please return it promptly. If you answered *no* to this question (or if you answered *yes* but do not return the application), the patient's coverage for health, dental, and vision benefits will stop at the end of next month unless the county Department of Social Services notifies you otherwise.

Patient Information

Does the patient have a State of California Benefits Identification Card (BIC) or Medi-Cal card? ☐ Yes ☐ No

If yes, what is the identification number on the BIC card (if available)? _____

Patient's name—Last | First | Middle initial

Date of birth (month/day/year) | Gender ☐ Male ☐ Female | Patient's social security number (SSN) *(optional)*

☐ If you are homeless, check here. Enter the general location in the "Home address" section and complete the "Mailing address" section.

Home address | Apartment number | City | State | ZIP code

County of residence

Mailing address (if different from home address) | Apartment number | City | State | ZIP code

Mother's name—Last | First | Middle initial

For patients under one year of age, please complete this section.

Mother's date of birth (month/day/year) | Mother's BIC or Medi-Cal card number or social security number

Parent/Legal Guardian Information

Name of parent/legal guardian or emancipated minor patient—Last | First | Middle initial

Home telephone number ( ) | Work telephone number ( ) | Message telephone number ( )

What language do you speak at home? | What language do you read best?

Certification

I am requesting a CHDP health examination today. I certify that I have read and understand this form. ~~I declare~~ that the information I have provided is true, correct, and complete.

Signature of parent/guardian or emancipated minor | Relationship to patient | Date

An individual has a right to review records containing his/her personal information. The official entity responsible for keeping the information is the Department of Health Care Services, MS 8100, P.O. Box 997413, Sacramento, CA 95899-7413. A copy of this information may be shared with the county Department of Social Services in the county in which you reside and will be kept with your child's medical record by your child's CHDP provider.