

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? \$ _____ Or \$ _____
Monthly Yearly

- You or your child may be eligible for continued health care coverage through Medi-Cal or Healthy Families.

I want to apply for continuing coverage through Medi-Cal or Healthy Families. 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 <input type="checkbox"/> Male <input type="checkbox"/> Female	Patient's social security number (SSN) (<i>optional</i>)
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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
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County of residence _____

Mailing address (if different from home address)	Apartment number	City	State	ZIP code
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Mother's name—Last _____ First _____ Middle initial _____

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

If less than one year of age, did the infant live with the mother in the month of birth? Yes No

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