APPLICATION TO DETERMINE CCS PROGRAM ELIGIBILITY

This application is to be completed by the parent, legal guardian, or applicant (if age 18 or older, or an emancipated minor) in order to determine if the applicant is eligible for CCS services/benefits. The term **"applicant"** means the child, individual age 18 or older, or emancipated minor for whom the services are being requested. For instructions on completing this form, please see page 4. Please type or print clearly.

A. Applicant Information

1. Name of applicant (last) (first) (middle) | Name on birth certificate (if different) | Any other name the applicant is known by

2. Date of birth (month, day, year)

3. Place of birth—county and state | Country, if born outside the U.S.

4. Applicant's residence address (number, street) (do not use a P.O. box) | City | County | ZIP code

5. Gender ☐ Male ☐ Female

6. Race/ Ethnicity

7. Social security number (optional)

8. What is the applicant's suspected eligible CCS condition or disability?

9. Name of applicant's physician

10. Physician's phone number ( )

B. Parent/Legal Guardian Information (Applicants age 18 or older, or emancipated minors skip items 11 and 13.)

11. Name(s) of parent or legal guardian

12. Mother's first name (if not identified in 11) | Maiden name

13. Residence address (number, street) (do not use a P.O. box) | City | County | ZIP code

14. Mailing address (if different from 13) | City | ZIP code

15. Day phone number ( )

16. Evening phone number ( )

17. Message phone number ( )

18. What language do you speak at home?

C. Health Insurance Information

19. Does the applicant have Medi-Cal? ☐ Yes ☐ No | If yes, what is the applicant's Medi-Cal number? | Is there a share-of-cost? ☐ Yes ☐ No | If yes, what amount do you pay per month? $

20. Is the applicant enrolled in the Healthy Families program? ☐ Yes ☐ No | If yes, what is the name of the plan?

21. Does the applicant have other health insurance? ☐ Yes ☐ No | If yes, what is the name of the insurance plan or company?

Type of insurance plan or company
☐ Preferred Provider (PPO) ☐ Health Maintenance Organization (HMO) ☐ Other:__________

22. Does the applicant have dental insurance? ☐ Yes ☐ No

23. Does the applicant have vision insurance? ☐ Yes ☐ No

D. Certification (Initial and sign below. Your signature authorizes the CCS program to proceed with this application.)

___ I am applying to the CCS program in order to determine eligibility for services/benefits. I understand that the completion of this application does not assure acceptance of the applicant by the CCS program.

___ I give my permission to verify my residence, health information, or other circumstances required to determine eligibility for CCS services/benefits.

___ I certify that I have read and understand the information or have had it read to me.

___ I also certify that the information I have given on this form is true and correct.

Signature of person completing the application	Relationship to the applicant	Date
Signature of witness (only if the person signed with a mark)		Date

Mail this form to your county CCS office.