

## 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 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 <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.**

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 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.