**County of Orange Health Care Agency**
**CALIFORNIA CHILDREN'S SERVICES**
200 W. Santa Ana Blvd., Suite 100, Santa Ana, CA 92701-4134
PHONE: (714) 347-0300 • FAX: (714) 347-0301
http://ochealthinfo.com/phs/about/ccs

# 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. Please type or print clearly in black or blue ink.

## 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 | 6. Race/Ethnicity | 7. Social security number *(optional)* |
|---|---|---|
| ○ Male ○ Female | | |

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) | Mother's 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 completed signed form to CCS, 200 W. Santa Ana Blvd., Suite 100, Santa Ana, CA 92701.*



TRADUCCIÓN EN ESPAÑOL AL REVERSO

# INSTRUCTIONS FOR COMPLETING THE CALIFORNIA CHILDREN'S SERVICES APPLICATION FORM

Please print clearly so your application can be processed as quickly as possible.

Please fill out each section completely. If you do not provide all the information, CCS will not be able to proceed with your application. If you need help filling out this form, please contact CCS at (714) 347-0300.

Once the application is completed, signed and dated, mail it to: CCS, 200 W. Santa Ana Blvd., Suite 100, Santa Ana, CA 92701.

**Section A: Applicant Information** ("Applicant" means the child, individual age 18 or older, or emancipated minor for whom the services are being requested.)

1. **Applicant's name:** Print the applicant's last, first, and middle name. In the next box, print the applicant's full name as it appears on his/her birth certificate if different from his/her name. If the applicant is known by any other name, please include that name in the last box.
2. **Applicant's date of birth:** Print the month, day, and year of the applicant's birth.
3. **Place of birth:** Print the county and state where applicant was born. Include the country if the applicant was born outside the U.S.
4. **Address:** Print the street number, street name, apartment number, city, county, and ZIP code of the applicant's current residence in this space. Do not use a P.O. box.
5. **Applicant's gender:** Place a ✓ or an X in the correct gender box (male or female).
6. **Race/Ethnicity:** Please enter the category from the following list which best describes the applicant's primary race/ethnicity:

   - Alaskan Native
   - Amerasian
   - American Indian
   - Asian
   - Asian Indian
   - Black/African American
   - Cambodian
   - Chinese
   - Filipino
   - Guamanian
   - Hawaiian
   - Hispanic/Latino
   - Japanese
   - Korean
   - Laotian
   - Samoan
   - Vietnamese
   - White
   - Other

7. **Applicant's social security number (optional):** Print the applicant's nine-digit social security number.
8. **Suspected CCS condition or disability:** Print the applicant's disability or special health care need that would be treated by CCS. If you don't know, ask the applicant's doctor or leave the space blank. CCS will follow up with the applicant's physician if more information is needed.
9. **Name of applicant's physician:** Print the name of the applicant's physician.
10. **Physician's phone number:** Print the phone number for the physician listed in number 9.

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

11. **Parent/guardian name(s):** Print the name(s) of the applicant's parent(s) or the name(s) of the applicant's legal guardian(s).
12. **Mother's first name and maiden name:** Print the applicant's mother's first name and maiden name.
13. **Address:** Print the street number, street name, apartment number, city, county, and ZIP code of your current residence. Do not use a P.O. box.
14. **Mailing address:** If this address is different from number 13, print the street number, street name, city, and ZIP code.

**Section B:** *(continued)*

15. **Daytime phone number:** Please print the phone number where you can be reached during the day.
16. **Evening phone number:** Please print the phone number where you can be reached during the evening.
17. **Message phone number:** Please print your message phone number if applicable.
18. **Language(s) spoken:** Print the language you speak at home.

## Section C: Health Insurance Information

If CCS thinks you may qualify, they will ask you to apply for Medi-Cal if you are not currently receiving Medi-Cal health care benefits.

19. If the applicant does not receive Medi-Cal, check “No” and go to number 20. If the applicant receives Medi-Cal, check “Yes” and fill in the applicant’s Medi-Cal number. If you pay a portion of the cost of your Medi-Cal insurance, check “Yes” and fill in the amount of your shared cost.
20. If the applicant receives health insurance from the Healthy Families program please check “Yes” and fill in the name of the plan. If the applicant does not, check “No.” Healthy Families is a special health insurance program for moderate to low income families. If you think you might qualify, you can ask CCS how to apply for the Healthy Families program.
21. If the applicant does not have other health insurance, check “No” and go to number 22. If the applicant has health insurance, check “Yes” and fill in the name of the insurance plan or company. Then check the appropriate box depending upon what type of insurance it is. Your insurance forms will tell you what type of health insurance you have. If you are not sure, you can call your health insurance company and ask them.
22. If the applicant has dental insurance, check “Yes.” If the applicant does not have dental insurance, check “No.”
23. If the applicant has vision insurance, check “Yes.” If the applicant does not have vision insurance, check “No.”

## Section D: Certification

Be sure to sign and date in black or blue ink. If signature is signed with a mark, please have a witness sign his or her signature and fill in the date.

Under “Relationship to the applicant,” enter father, mother, legal guardian, or self (in the case of individuals age 18 or older, or emancipated minors).

## Submitting Your Application

Mail or deliver your signed and dated application to: CCS, 200 W. Santa Ana Blvd., Suite 100, Santa Ana, CA 92701.