

**IF YOU DON'T HAVE HEALTH INSURANCE,
BE SURE TO BRING THIS COMPLETED FORM TO YOUR SPORTS
PHYSICAL APPT. @
THE HEALTH CTR.**

**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 (Title 17, California Code of Regulations, Sections 6802 and 6832).
- Filling out and signing this form may provide you or your child with a complete health exam today and may provide dental, vision, mental, and other health services at no cost for this month and next month.

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. If you answer NO to this question, the patient's coverage for health, dental, and vision benefits will stop the end of next month. You will still be eligible for CHDP preventive services.

I want to apply for continuing coverage through Medi-Cal or Healthy Families. Yes No

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

Date of birth (month/day/year) Gender
 Male Female

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

Patient's social security number (optional) Mother's name—Last First

Parent/Legal Guardian Information

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

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

What language do you speak at home? 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 responsible for keeping this information is the Department of Health Services, P.O. Box 942732, Sacramento, CA 94234-7320. A copy of this information will also be kept with your child's medical record.