

Children's Presumptive Eligibility Pre-Enrollment Worksheet

Applicant's name—Last	First	Middle Name
Date of Birth (MM/DD/YYYY)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Applicant's Social Security Number (SSN) (optional)

If you are homeless, check here

Home address	Apartment number	City	State	ZIP Code
County of Residence		Living in California? <input type="checkbox"/> Yes <input type="checkbox"/> No		

Mailing address (if different)	Apartment number	City	State	ZIP Code
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Mother's name—Last	First	Middle Initial
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For Applicants Under One Year of Age, Please Complete this Section.

Mother's Date of Birth (MM/DD/YYYY)	Mother's BIC or Medi-Cal Card Number or SSN
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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

What language do you speak at home?	What language do you read best?
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Certification

I am requesting Children's Presumptive Eligibility 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 Applicant	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 CPE provider.