Children's Presumptive Eligibility Pre-Enrollment Worksheet

Instructions to the Parent or Applicant:
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.
Questions with an asterisk (*) are required.

How many people are in the child's family?* _____

- Family refers to immediate family living in the child's home. Please include the child, the child's parents, the child's siblings and the child's spouse . If a family member is pregnant, include the number of expected babies. Do not include other relatives or friends, even if they live with the child.

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 fill it out and return it promptly.
- If you answered *no* to this question (or if you answered *yes* but do not return the application), the applicant'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.

Attention: Medi-Cal applications can be submitted online, by mail, over the phone or in person. Applicants can sign an application over the phone using a telephonic signature by calling their county Medi-Cal office.

- County contact information can be found at: https://www.dhcs.ca.gov/services/medi-cal/Pages/CountyOffices.aspx
- Information on ways to apply can be found at: https://www.dhcs.ca.gov/services/medi-cal/pages/applyformedi-cal.aspx
- The outcome of the Children's Presumptive Eligibility (CPE) application does not impact you or your family's ability to apply for Medi-Cal. You can apply for Medi-Cal at any time.

Applicant Information

Does the applicant 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)? _____

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Applicant's name—Last*	First*	Middle Name

Date of Birth (MM/DD/YYYY)*	Gender* ☐ Male ☐ Female	Applicant's Social Security Number (SSN)

If you are homeless, check here ☐

Home address	Apartment number	City	State	ZIP Code

County of Residence* Living in California?* ☐ Yes ☐ No

Mailing address (if different)	Apartment number	City	State	ZIP Code

Mother's name—Last	First	Middle Initial

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

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?

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*

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.