

## 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.

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.

## Children's Presumptive Eligibility Pre-Enrollment Worksheet

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>

## Children's Presumptive Eligibility Pre-Enrollment Worksheet

- 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)? \_\_\_\_\_

State of California-Health and Human Services Agency  
Department of Health Care Services

**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) <i>(optional)</i>
-------------------------------	--	--

---

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

---

**Children’s Presumptive Eligibility  
Pre-Enrollment Worksheet**

**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.

State of California-Health and Human Services Agency  
Department of Health Care Services

**Children’s Presumptive Eligibility  
Pre-Enrollment Worksheet**

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.