SAN BERNARDINO COUNTY DEPARTMENT OF PUBLIC HEALTH
CALIFORNIA CHILDREN SERVICES
Health Insurance Information

I. PATIENT INFORMATION

Patient's Name: Date of Birth: CCS Number:

II. PRIVATE/EMPLOYER SPONSORED INSURANCE ☐ Yes ☐ No **(If no, proceed to number III)**

Name of Policy Holder_____ Insurance Address_____

Employer of Policy Holder_____ Policy Holder Social Security # _____ /_____ _/_____

Name of Insurance_____ Insurance Company Telephone #_____

Policy Number_____ Group Number _____

Effective Date of Policy_____ Is CCS Condition Covered? _____

Type of coverage: ❒PPO/IPA ❒HMO ❒Major Medical ❒EPO ❒OTHER _____

If newborn, effective date of coverage _____

PATIENTS WITH PRIVATE HEALTH INSURANCE COVERAGE

1. **CCS DOES NOT PAY CO-PAYS. Co-pays are the responsibility of the patient/family.**
2. **"Co-insurances" may or may not be fully covered by the CCS program.**
3. **HMO Denial required for services.**

MUST ATTACH A COPY OF THE FRONT AND BACK OF YOUR INSURANCE CARD

I certify that this information is complete and correct to the best of my knowledge. I have read the Information Practices Act Statement on the reverse of this form.

Applicant, Parent, or Legal Guardian_____ **Date** _____

III. MEDI-CAL/MEDI-CARE

Does the patient have Medi-Cal? ❒Yes ❒No Does the patient have **HEALTHY FAMILIES**? ❒Yes ❒No

If yes, effective date_____ If yes, Plan Name _____

Medi-Cal Number_____

Type of Medi-Cal: ❒IEHP ❒Molina/Maxi care ❒Other

Is there a monthly share of cost? ❒Yes ❒No If yes, $_____Monthly

Does the child have Medi-Care? ❒Yes ❒No Medi-Care Health Insurance Claim Number _____

PLEASE TURN PAGE & COMPLETE SIDE 2, SECTION IV

Rev. March 18, 2015

IV. APPLICATION SCREENING CHECK LIST

(Please check all of the lines that apply to your family)

A. MEDI-CAL

1. _____ We will apply for Medi-Cal benefits if requested by the CCS Program and understand that if we do not complete the application process, we will not be eligible for benefits through CCS.
2. _____ We applied for Medi-Cal benefits on _____ (Date) but have not been interviewed by an eligibility worker.
3. _____ We have completed the Medi-Cal application process:
   _____ Determination has not been made.
   _____ Medi-Cal eligibility was denied (Please provide a copy of Notice of Action).
4. _____ We refuse to apply for Medi-Cal benefits and understand that refusal to apply will result in CCS Program eligibility denial or termination. Family has the right to appeal the Program's decision.

B. SUPPLEMENTAL SECURITY INCOME (SSI)

1. _____ We understand we may be referred for SSI Benefits if indicated, and agree to complete the application for benefits, if requested.
2. _____ We applied for SSI Benefits on _____(Date).
   _____ Determination has not been made.
   _____ SSI Eligibility was denied (Please provide a copy of Denial Notice).

_____ _____

Signature of Applicant, Parent or Legal Guardian completing form Date

INFORMATION PRACTICE ACT STATEMENT

The County and State California Children's Services (CCS) as part of your application for assistance require the information on this form, as CCS cannot pay for that portion of expenses, which are a benefit of your insurance resource. The information is maintained pursuant to Section 123800 et seq. of the California Health and Safety Code. You are required to provide the information on this form. If you do not provide this information, eligibility for services may be denied. The County and State CCS offices, the State Department of Health Services and providers of services may use any information, which you provide. You have a right to review records maintained by CCS concerning you. If you wish to review these records, contact the person responsible for your records in your county CCS office. After reviewing your records you may request in writing that they be corrected or amended to make them accurate, relevant and complete. Appeals may be directed to: Ken Adams, Program Manager at San Bernardino County California Children Services – 150 E. Holt Blvd, 3rd Floor, Ontario, CA 91762 (909) 458-1637