☐ New Applicant
☐ Annual Redetermination
☐ Re-open Case

SAN BERNARDINO COUNTY DEPARTMENT OF PUBLIC HEALTH
CALIFORNIA CHILDREN SERVICES
Residential and Financial Eligibility Worksheet

Parent/Applicant: Only a parent or legal guardian may apply for services on behalf of an applicant. Applicants 18 – 20 years of age can file their own application and must complete an Adult Services Declaration form. Please print all information and return with required documentation.

CCS CASE #:_____

Patient/Child Information

Team: _____

Name: _____/_____/_____ Date of Birth_____/_____/_____ Gender: ☐ Male ☐ Female
Last First MI

SS#:_____/_____/_____ Place of Birth: _____ Adopted: ☐Yes ☐No If yes, date: _____
County, State or Country

Address: _____ How Long? _____
Street City/State Zip

Home Phone: (____) _____ Child resides with: ☐ Parent ☐ Parent/Stepparent ☐ Legal Guardian ☐ Foster Parent

Mailing Address: _____
Street/P. O. Box City/State Zip

Race/Ethnicity (Optional): ☐ White ☐ African American ☐ Asian/Pacific Islander ☐ Hispanic ☐ Native American ☐ Other: _____

Family Status and Size

Mother's Name: _____/_____/____ _____ SS#_____/_____/_____
Last First MI Maiden Name

Address: _____
Street/P. O. Box City/State Zip

Date of Birth _____/_____/_____ Home Phone: (____) _____ Work Phone: (____) _____

Father's Name: _____/_____/____ Date of Birth _____/_____/_____ SS#_____/_____/_____
Last First MI

Address: _____
Street/P. O. Box City/State Zip

Home Phone: (____) _____ Work Phone: (____) _____

If parents are divorced, who has legal custody: ☐ Mother ☐ Father ☐ Joint ☐ Other – Specify _____

If person applying for child is legal guardian, has a Letter of Guardianship been issued? ☐ Yes ☐ No
IF YES, PLEASE SUBMIT A COPY OF LETTER OF GUARDIANSHIP WITH THIS FORM.

Is child a ward of the court? ☐ Yes ☐ No If yes, in what County? _____

If child was placed by an agency, please indicate the name, county and phone number:

_____ _____ Phone #: (____) _____
Agency County

Indicate the number of people in the immediate family supported by family income: _____ Adults _____ Children

Please list family members residing together and specify relationship to child:

NAME	RELATIONSHIP	PREVIOUS OR CURRENT CCS #	NAME	RELATIONSHIP	PREVIOUS OR CURRENT CCS #

Parent/Child Residential Information

Previous Address:_____
Street City/State Zip

Length of time at previous address? _____ In what state did you file last year's taxes? _____

Registered to vote? ☐ Yes ☐ No If yes, in what County? _____

Active Military only: State of Designation? _____

Please submit a copy of two (2) of the following items, if available:

- Rent Receipt, Lease Agreement or Mortgage Statement for the current address
- Utility Bill
- Proof of Employment in California
- Proof of Cash Aid in California
- California Driver's License, California ID, or California Vehicle Registration

Services Requested and CCS History

Has the child had CCS coverage before? ☐ Yes ☐ No In what County? _____ CCS #:_____

Is the child known to the Inland Regional Center? ☐ Yes ☐ No

Current Physician: _____ (_____) _____
Name Phone Number

Does child see a pediatrician for regular check-ups? ☐ Yes ☐ No If no, would you like to be referred to a pediatrician? ☐ Yes ☐ No

Please indicate what services you are requesting from CCS: _____

_____

Signature of Applicant, Parent or Legal Guardian completing this form is required:

_____ _____ _____
Signature Relationship to Child Date

********WORKSHEET IS NOT COMPLETE UNLESS SIGNED********

For CCS Office Use Only

Medi-Cal Eligibility

Income < 200% poverty ☐ Yes ☐ No
Referred to Medi-Cal ☐ Yes ☐ No
If referred, date referral sent _____/_____/_____

Income

AGI (20 ____) $_____
Source: ☐ 540 ☐ 1040 ☐ Other_____
Income> $40,000 ☐ Yes ☐ No
20% of AGI = $_____
Estimated Cost of Care = $_____
Estimated Out of Pocket = $_____

Enrollment Fee

Total Gross Income: $_____
Source: ☐ 1040 ☐ Other_____
Family Size: _____
Fee: ☐ Exempt, < 200% poverty
☐ Exempt, other _____
☐ No fee, based on family size & income
☐ Annual enrollment fee $_____

Assessment Fee ☐ Yes ☐ No

Eligibility Determination

Residentially Eligible ☐ Yes ☐ No
Financially Eligible ☐ Yes ☐ No
Unable to determine eligibility ☐ Yes ☐ No
Reason: _____

_____ _____/_____/_____
COMPLETED BY DATE