



- New Applicant
Annual Redetermination
Re-open Case

Residential and Financial Eligibility Worksheet

Parents/Applicant: Only the parents 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.

California Children's Services (CCS) CASE #: TEAM:

CLIENT INFORMATION

Name: Last First MI Date of Birth: / /

Gender: Male Female Non-Binary Not Known
Gender Identity: Male Female Transgender Male to Female Transgender Female to Male Decline to State Other
Sexual Orientation: Straight or Heterosexual Gay or Lesbian Bisexual Queer Decline to State Other

SS#: / / Place of Birth: County, State or Country

Preferred Language: English Spanish

Physical Address: Street City/State Zip

How Long? Home Phone: () Mobile Phone: ()

Mailing Address: Street/PO Box City/State Zip

Client resides with: Parent Parent/Stepparent Legal Guardian Foster Parent Independent Other

Race/Ethnicity: White African American Asian/Pacific Islander Hispanic Native American Other

FAMILY INFORMATION

Mother's Name: Last First MI Maiden Name

SS#: / / Date of Birth: / /

Address: Street/PO Box City/State Zip

Home Phone: () Mobile Phone: ()

Father's Name: Last First MI

SS#: / / Date of Birth: / /

Address: Street/PO Box City/State Zip

Home Phone: () Mobile Phone: ()

If parents are divorced, who has legal custody: Mother Father Joint Other-Specify:

If person applying for client is the legal guardian, has a Letter of Guardianship been issued? Yes No

IF YES PLEASE SUBMIT A COPY OF LEGAL GUARDIANSHIP DOCUMENTS WITH THIS FORM

Adopted: Yes No If yes, date: _____

IF YES, PLEASE SUBMIT A COPY OF ADOPTION DOCUMENTS WITH THIS FORM

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

If client was placed by an agency, please indicate the name of the agency, case worker's name and phone number:

_____ Phone #: (____) _____
Agency Case Worker's Name

Address: _____
Street/PO Box City/State Zip

FAMILY SIZE AND INCOME

What is your family Annual Gross Income? \$ _____

Does this income include stepparent's income? Yes No

How many people in the immediate family are supported by family income: _____ Adults _____ Children

Please list family members residing together and specify relationship to the CCS client:

NAME	RELATIONSHIP TO CLIENT	CCS CASE #

CLIENT RESIDENTIAL INFORMATION

Previous Address: _____
Street/PO Box City/State Zip

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

Please submit a copy of at least 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
- California Vehicle Registration

SERVICES REQUESTED AND CCS HISTORY

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

Is the client known to the Inland Regional Center? Yes No

Current Physician: _____ (____) _____
Physician's Name Phone Number

Please indicate what services you are requesting from CCS: _____

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

Signature Relationship to Client Date

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