APPLICATION TO DETERMINE CCS PROGRAM ELIGIBILITY

This application is to be completed by the parent, legal guardian, or applicant (if age 18 or older, or an emancipated minor) in order to determine if the applicant is eligible for CCS services/benefits. The term **"applicant"** means the child, individual age 18 or older, or emancipated minor for whom the services are being requested. For instructions on completing this form, please see page 4. Please type or print clearly.

A. Applicant Information

1. Name of applicant (last) (first) (middle)	Name on birth certificate (if different)	Any other name the applicant is known by	
2. Date of birth ________ / ________ / ________	3. Place of birth—county and state	Country, if born outside the U.S.	
4. Applicant's residence address (number, street) (do not use a P.O. box)	City	County	ZIP code
5. Gender ☐ Male ☐ Female	6. Race/ Ethnicity	7. Social security number ___ ___ ___ - ___ ___ - ___ ___ ___ ___	
8. What is the applicant's suspected eligible CCS condition or disability?			
9. Name of applicant's physician		10. Physician's phone number ( )	

B. Parent/Legal Guardian Information (Applicants age 18 or older, or emancipated minors skip items 11 and 13.)

11. Name(s) of parent or legal guardian	12. Mother's first name (if not identified in 11)	Maiden name	
13. Residence address (number, street) (do not use a P.O. box)	City	County	ZIP code
14. Mailing address (if not listed in 13)		City	ZIP code
15. Day phone number ( )	16. Evening phone number ( )	17. Message phone number ( )	18. What language do you speak best?

C. Health Insurance Information

19. Does the applicant have Medi-Cal? ☐ Yes ☐ No	If yes, what is the applicant's Medi-Cal number?	Is there a share-of-cost? ☐ Yes ☐ No	If yes, what amount do you pay per month? $
20. Is the applicant enrolled in the Healthy Families program? ☐ Yes ☐ No	If yes, what is the name of the plan?		
21 Does the applicant have other health insurance? ☐ Yes ☐ No	If yes, what is the name of the insurance plan or company?		
Type of insurance plan or company ☐ Preferred Provider (PPO) ☐ Health Maintenance Organization (HMO) ☐ Other:________________			
22. Does the applicant have dental insurance? ☐ Yes ☐ No	23. Does the applicant have vision insurance? ☐ Yes ☐ No		

D. Certification (Your signature below authorizes the CCS program to proceed with this application.)

I am applying to the CCS program in order to determine eligibility for services/benefits. I understand that the completion of this application does not assure acceptance of the applicant by the CCS program. I give my permission to verify my residence, health information, or other circumstances required to determine eligibility for CCS services/benefits.

I certify that I have read and understand the information or have had it read to me. I also certify that the information I have given on this form is true and correct.

Signature of person completing the application	Relationship to the applicant	Date
Signature of witness (only if the person signed with a mark)		Date

Mail this form to : Yolo County CCS, 825 East Street Suite #302, Woodland, CA 95776

INSTRUCTIONS FOR COMPLETING THE CALIFORNIA CHILDREN'S SERVICES APPLICATION FORM (DHS 4480)

Please print clearly so your application can be processed as quickly as possible.

Please fill out each section completely. If you do not provide all the information, CCS will not be able to proceed with your application. If you need help filling out this form, please contact your county CCS office.

Once the application is completed, mail it to your county CCS office (see page 6). Remember to sign and date the form.

Section A: Applicant Information ("Applicant" means the child, individual age 18 or older, or emancipated minor for whom the services are being requested.)

1. **Applicant's name:** Fill in the applicant's last, first, and middle name. In the next box, write the applicant's full name as it appears on his/her birth certificate if different from his/her name. If the applicant is known by any other name, please include that name in the last box.
2. Applicant's date of birth: Write the month, day, and year of the applicant's birth.
3. Place of birth: Write the county and state where applicant was born. Include the country if the applicant was born outside the U.S.
4. Address: Write the street number, street name, apartment number, city, county, and ZIP code of the applicant's current residence in this space. Please do not use a P.O. box.
5. Applicant's gender: Place a checkmark or an X in the correct gender box (male or female).
6. Race/Ethnicity: Please enter the category from the following list which best describes the applicant's primary race/ethnicity:
   - Alaskan Native
   - Amerasian
   - American Indian
   - Asian
   - Asian Indian
   - Black/African American
   - Cambodian
   - Chinese
   - Filipino
   - Guamanian
   - Hawaiian
   - Hispanic/Latino
   - Japanese
   - Korean
   - Laotian
   - Samoan
   - Vietnamese
   - White
   - Other
   - Unknown
7. **Applicant's social security number:** Please write the applicant's nine-digit social security number.
8. **Suspected CCS condition or disability:** Write down the applicant's disability or special health care need that would be treated by CCS. The enclosed description of CCS eligible conditions may help you (see "What medical conditions does CCS cover" on page 1). If you don't know, ask the applicant's doctor or leave the space blank. CCS will follow up with the applicant's physician if more information is needed.
9. **Name of applicant's physician:** Write the name of the applicant's physician.
10. **Physician's phone number:** Write the phone number for the physician listed in number 9.

Section B: Parent/Legal Guardian Information (Applicants age 18 or older, or emancipated minors skip items 11 and 13.)

11. **Parent/guardian name(s):** Write the name(s) of the applicant's parent(s) or the name(s) of the applicant's legal guardian(s).
12. **Mother's first name and maiden name:** Write the applicant's mother's first name and maiden name.
13. **Address:** Write the street number, street name, apartment number, city, county, and ZIP code of your current residence. Please do not use a P.O. box.
14. **Mailing address:** If this address is different from number 13, please write the street number, street name, city, and ZIP code.
15. **Daytime phone number:** Please write the phone number where you can be reached during the day.
16. **Evening phone number:** Please write the phone number where you can be reached during the evening.
17. **Message phone number:** Please write your message phone number if applicable.
18. **Language(s) spoken:** Write down the language you speak **best**.

Section C: Health Insurance Information

If CCS thinks you may qualify, they will ask you to apply for Medi-Cal if you are not currently receiving Medi-Cal health care benefits.

19. If the applicant does not receive Medi-Cal, check “No” and go to number 20. If the applicant receives Medi-Cal, check “Yes” and fill in the applicant’s Medi-Cal number. If you pay a portion of the cost of your Medi-Cal insurance, check “Yes” and fill in the amount of your shared cost. If you don’t, check “No” and go to number 20.
20. If the applicant receives health insurance from the Healthy Families program please check “Yes” and fill in the name of the plan. If the applicant does not, check “No.” Healthy Families is a special health insurance program for moderate to low income families. If you think you might qualify, you can ask your county CCS program about how to apply for the Healthy Families program.
21. If the applicant does not have other health insurance, check “No” and go to number 22. If the applicant has health insurance, check “Yes” and fill in the name of the insurance plan or company. Then check the appropriate box depending upon what type of insurance it is. Your insurance forms will tell you what type of health insurance you have. If you are not sure, you can call your health insurance company and ask them.
22. If the applicant has dental insurance, check “Yes.” If the applicant does not have dental insurance, check “No.”
23. If the applicant has vision insurance, check “Yes.” If the applicant does not have vision insurance, check “No.”

Section D: Certification

Be sure to sign and date in ink. If signature is signed with a mark, please have a witness sign his or her signature and fill in the date.

Under “Relationship to the applicant,” enter father, mother, legal guardian, or self (in the case of individuals age 18 or older, or emancipated minors).