Important information about the Child Health & Disability Prevention (CHDP) Gateway To Health Coverage

Welcome to the improved CHDP program! If your child is eligible, he or she will get a CHDP well-child check-up today. The information that you give on the CHDP Pre-enrollment Application is confidential and will be used to:

- Determine your child's eligibility for today's CHDP exam
- Determine your child's eligibility for temporary health care coverage through Medi-Cal
- Include your child in the California Department of Health Services confidential record system

Temporary Medi-Cal at no cost to you!

If your child is eligible today for temporary Medi-Cal, he or she can get health care services paid for by Medi-Cal until the end of next month. Services include dental, vision, prescriptions, doctor visits, and more. A Benefits Identification Card ("BIC" or Medi-Cal card) will be mailed to you if your child does not already have one.

How can my child continue to have health coverage?

Your child may be able to continue no- or low-cost health care coverage with Medi-Cal or Healthy Families. Apply for Medi-Cal or Healthy Families to continue the health coverage. Mark "yes" on the CHDP Pre-enrollment Application, and an application for Medi-Cal/Healthy Families will be mailed to you.

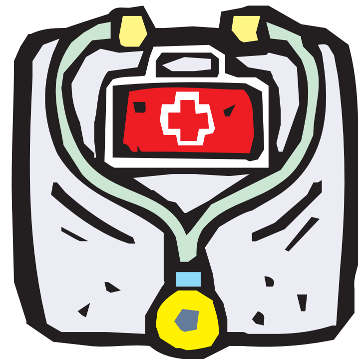
- Using CHDP or temporary Medi-Cal health coverage cannot prevent you or your child from getting a green card by making you a "public charge" and cannot prevent you or your child from becoming a U.S. citizen.

What if my child is not eligible for Medi-Cal or Healthy Families?

Your child may still be eligible for CHDP well-child check-ups and temporary Medi-Cal.

If your child is not eligible for a CHDP exam today, he or she may still be eligible for other health programs. Contact the CHDP Program in your local health department for more information.

With health insurance, you can get the health care your child needs when sick, and the care he or she needs to stay healthy.



05/19/03

CHILD HEALTH AND DISABILITY PREVENTION (CHDP) PROGRAM PRE-ENROLLMENT APPLICATION

Instructions to the Parent or Patient:

- 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.

  Is the patient less than 19 years of age? ☐ Yes ☐ No

  How many people are in your family? __________

  How much money does your family make before taxes? $____________________ Monthly Or $____________________ Yearly

- You or your child may be eligible for continued health care coverage through Medi-Cal or premium assistance programs under Covered California.

  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 return it promptly. If you answered *no* to this question (or if you answered *yes* but do not return the application), the patient'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.

Patient Information

Does the patient 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)? ______________________

Patient's name—Last	First	Middle initial

Date of birth (month/day/year)	Gender ☐ Male ☐ Female	Patient's social security number (SSN) ***(optional)***

☐ If you are homeless, check here. Enter the general location in the "Home address" section and complete the "Mailing address" section.

Home address	Apartment number	City	State	ZIP code

County of residence

Mailing address (if different from home address)	Apartment number	City	State	ZIP code

Mother's name—Last	First	Middle initial

For patients under one year of age, please complete this section.

Mother's date of birth (month/day/year)	Mother's BIC or Medi-Cal card number or social security number

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 a CHDP health examination today. I certify that I have read and understand this form. I declare that the information I have provided is true, correct, and complete.

Signature of parent/guardian or emancipated minor	Relationship to patient	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 CHDP provider.

Vaccines for Children (VFC) Program
Patient Eligibility Screening Record

Private Sector

Please Print or Type	Date:
Child Name Last: ______ First: ______ MI: ______	
Date of Birth: ____/____/____ Mth Day Yr	
Parent/Guardian Last: ______ First: ______ MI: ______	
Provider Name:	

☐ **The child named above qualifies for immunization through the VFC Program because he/she, or his/her parent/guardian states the child is 18 years of age or younger and:**

Choose only one of the following. (Note: If a child meets two or more of the eligibility qualifications, choose the first one that applies.)

_____1. Is Child Health and Disability Prevention (CHDP) Program or Medi-Cal eligible; or

_____2. Does not have private health insurance; or

_____3. Is an American Indian or Alaskan Native.

☐ **The child named above does not qualify for immunization through the VFC Program.** (This includes children who have health insurance, whether or not it pays for vaccines and **Healthy Families Program subscribers.**)

Notes

1. This form documents the VFC-eligibility status of the child named above.
2. This same form may be used for all of the child's subsequent visits provided the child's eligibility status does not change.
3. The health care provider must keep this record for the VFC-eligible child for no less than three (3) years and make it available to state or federal officials for inspection upon request. If this form is used for subsequent immunizations with VFC Program vaccines, the three year period begins on the date the child received his or her last VFC Program-provided vaccine. Retention of this record for a child not eligible for the VFC Program is optional.
4. This record may be completed by the patient (if he or she is an emancipated minor or 18 years of age), his or her parent or guardian or by the health care provider.
5. Verification of responses is not required.

CONSENT FORM
California Child Health & Disability Prevention Program

I hereby give my consent for ______________________________
(NAME OF PATIENT)

to receive the health screening tests and immunizations recommended by the CHDP Program. I hereby authorize release of information concerning the results of these screening tests to CHDP Program personnel. I also authorize release of the information to the locations checked below. I understand that information provided to CHDP Program personnel will be strictly confidential and will be used only to make the provision of health services easier and to permit statistical reporting on the results of screening.

(Check box)

☐ School ______________________________
NAME

____
ADDRESS

____

☐ Health Care Provider ______________________________
NAME

Santa Lucia Medical Group
1336 Natividad Rd
Salinas, CA 93906
PH# (831) 754-4444

____
ADDRESS

____

☐ Other ______________________________
NAME

____
ADDRESS

______________________________ ______________________________
SIGNATURE OF PARENT, GUARDIAN, OR EMANCIPATED MINOR DATE

____
NAME OF PARENT, GUARDIAN, OR EMANCIPATED MINOR

Screening Provider: This form signed by parent, guardian, or emancipated minor must be retained in patient's file.

Parent Questionnaire
Lead Exposure Risk Assessment

Question		
Does your child eat Tamarind candy or lick candy wrappers?	Yes	No
¿Come su niño(a) dulce de tamarindo o chupa la cubierta?	Si	No
Does your child eat foods or candies with Chile spice?	Yes	No
¿Come su niño(a) comidas o dulces con especias de chile?	Si	No
Does your child eat dried grasshoppers?	Yes	No
¿Come su niño(a) chapulines?	Si	No
Do you use pottery containers to prepare or store your food?	Yes	No
¿Usa usted vajillas de cerámica para preparar o guardar su comida?	Si	No
Does your child wear toy metal necklaces, rings, bracelets, or Medallions?	Yes	No
¿Usa su niño(a) collares, anillos, brazaletes o medallas de metal para jugar?	Si	No
Do you give your child any home remedies such as "Greta" or"Azarcón"?	Yes	No
¿Le da usted a su niño(a) remedios caseros como Greta o Azarcón?	Si	No
Did you (mom) chew on pottery or clay or other non-foods while pregnant?	Yes	No
¿Usted (la madre) masticaba la cerámica o algo que no es comida mientras estaba embarazada?	Si	No
Do you live in a place built before 1978 or that has chipped paint peelings?	Yes	No
¿Vive usted en una casa que fue construida antes de 1978 o tiene pintura que esta escarapelada o astillada?	Si	No