



Application

Aplicación

MEDICAL, DENTAL, VISION AND BEHAVIORAL HEALTH
COBERTURA MÉDICA, DENTAL, VISIÓN Y COMPORTAMIENTO

CaliforniaKids Application Form

Please print or type ALL information

THIS IS NOT A TEMPORARY IDENTIFICATION CARD

SECTION 1 LIST ALL ELIGIBLE CHILDREN IN THE FAMILY. If selected in the CaliforniaKids Program, each person listed below must receive all medical care through the Medical Group or Independent Practice Association (IPA) selected, must be between the ages of 2 through 18, and must live within 30 miles of the group selected. Please see your CaliforniaKids Directory when selecting a Medical Group or IPA. IF YOU SELECT AN IPA, YOU MUST SELECT A PRIMARY CARE PHYSICIAN FROM WITHIN THAT IPA and indicate the physician code below. If you need assistance, contact 1 (818) 755-9700.

Children	Last Name	First Name	Middle Initial	Age	Date of Birth	Name of School enrolled in	Social Security No.	Child is a U.S. Citizen or legal resident	Medical Group or IPA Office	IPA Primary Care Physician Code
<input type="checkbox"/> Male <input type="checkbox"/> Female					MONTH DATE YEAR			<input type="checkbox"/> Yes <input type="checkbox"/> No		0
<input type="checkbox"/> Male <input type="checkbox"/> Female					MONTH DATE YEAR			<input type="checkbox"/> Yes <input type="checkbox"/> No		0
<input type="checkbox"/> Male <input type="checkbox"/> Female					MONTH DATE YEAR			<input type="checkbox"/> Yes <input type="checkbox"/> No		0
<input type="checkbox"/> Male <input type="checkbox"/> Female					MONTH DATE YEAR			<input type="checkbox"/> Yes <input type="checkbox"/> No		0
<input type="checkbox"/> Male <input type="checkbox"/> Female					MONTH DATE YEAR			<input type="checkbox"/> Yes <input type="checkbox"/> No		0

SECTION 2 ARE ANY OF THE ABOVE CHILDREN ELIGIBLE FOR MEDICAL, EMERGENCY MEDICAL, HEALTHY FAMILIES OR CCS? IF YES, PLEASE LIST ELIGIBLE CHILD(REN) AND PROGRAMS

Name: Medi-Cal Emergency Medi-Cal Healthy Families CCS Explain: _____
 Name: Medi-Cal Emergency Medi-Cal Healthy Families CCS Explain: _____
 Name: Medi-Cal Emergency Medi-Cal Healthy Families CCS Explain: _____

SECTION 3 PARENT / GUARDIAN / STEPPARENT / OR OTHER / LIVING WITH CHILD(REN) INFORMATION (Check one) Single Married Widowed Divorced Separated

Mother's Last Name: _____ First Name: _____ Home Phone: () _____ Employer: _____ Work Phone: () _____
 Father's Last Name: _____ First Name: _____ Home Phone: () _____ Employer: _____ Work Phone: () _____

Home address: _____ City: _____ State _____ Zip _____

SECTION 4 Total monthly income of household before taxes: \$ _____ + other income: \$ _____ = \$ _____ total monthly income.

Total family size _____

SECTION 5 I. AUTHORIZATION TO OBTAIN OR RELEASE MEDICAL INFORMATION EXPLANATION. Blue Cross is authorized to obtain and release medical information in compliance with the Insurance and Privacy Protection Act, Section 791 et seq. of the California Insurance Code. I hereby authorize any physician, health care practitioner, hospital, clinic, or other medical or medically related facility to furnish an agent, designee, or representative of Blue Cross of California any and all records pertaining to medical history, services rendered, or treatment given to anyone enrolled hereunder or added hereafter for purposes of review, investigation, or evaluation of an application or a claim. I also authorize Blue Cross of California, or its agents, designees or representatives to disclose to a hospital or health care service plan, self-insurer, or insurer any such medical information obtained if such disclosure is necessary to allow the processing of any claim. If my coverage is under a Group Master Agreement held by my employer, an association, trust fund, union or similar entity, this authorization also permits disclosure to them for purposes of utilization review or financial audit. The effective date of coverage is subject to Blue Cross of California approval. This authorization shall become effective immediately and shall remain in effect as long as is necessary to enable Blue Cross of California to process claims. A photocopy of this authorization shall be as valid as the original. **II. ARBITRATION AGREEMENT** I understand that any dispute or controversy which may arise under the agreement between myself (and or any enrolled family member) and Blue Cross of California, or any participating medical office must be submitted to binding arbitration in lieu of a jury or court that if the amount in dispute exceeds the jurisdictional limits of small claims court. If any such dispute is within the jurisdictional limits of small claims court, the matter will be resolved in small claims court. **III. I (we) certify that all information listed above on this application form is truthful, complete and accurate. I (we) understand that any false statements or any misrepresentation of facts is grounds for termination from this program.** **IV. I (we) understand that our child(ren) will be covered as long as live make our monthly premium payment.**

YOU ARE ENTITLED TO A COPY OF THIS SIGNED AUTHORIZATION FOR YOUR FILES IF REQUESTED

SIGNATURE OF PARENT/LEGAL GUARDIAN: _____ DATE: _____

PLEASE SUBMIT A MONEY ORDER, CASHIERS CHECK OR PERSONAL CHECK MADE PAYABLE TO CALIFORNIAKIDS FOR THE FIRST TWO MONTHS OF PREMIUM.

CaliforniaKids is:

A charitable, non-profit organization. CaliforniaKids is supported by contributions from businesses, community organizations, and individuals. Through these partnerships, the cost of the program is subsidized.

Who is Eligible for the Program?

To qualify for the CaliforniaKids program a child must:

- Be age 2 through 18
- Not be married
- Not be eligible for Medi-Cal or the Healthy Families program
- Not be enrolled under any private health care contract
- Must meet the income requirement
- Reside full time with applying parent/guardian
- If school age, be enrolled and attending school

How much will it cost?

The monthly premium is \$10 dollars per child up to 3 children. For families with 3 or more children enrolled, a maximum fee of \$30 dollars per month will be charged.

Do I have to Pay a Deductible?

A minimal co-payment is required for office visits, prescription drugs, dental and vision care.

What Health Care Services are Covered?

The CaliforniaKids program provides access to affordable basic preventive and primary health care services designed to meet the typical needs of children. If your child has a chronic medical need or will require specialty or inpatient care, CaliforniaKids is not the program for your child.

The CaliforniaKids benefits package includes:

- Preventive care, to include routine physical examinations and immunizations
- Office visits when a child is sick or injured
- X-ray and laboratory tests
- Limited emergency care
- Limited outpatient, same-day surgery
- Preventive dental care
- Standard eye examination, glasses and/or contact lenses
- Prescription drugs
- Behavioral health benefits
- 24-hour personal health advisor

You will select your child's primary care physician from the CaliforniaKids Health Care Provider Directory. Your child's primary care physician will be responsible for all of their medical health care needs, including authorizations for emergency care or referrals to a specialist. All medical services must be obtained through or delivered by a participating CaliforniaKids health care physician.

The CaliforniaKids program does not cover inpatient hospital or surgical care.

How to Complete the Application Form?

If you are interested in coverage for your child(ren), please complete all sections of the CaliforniaKids application. Your application form will not be processed unless it is complete and readable.

Section 1

- List all eligible children in your family. Print clearly, last name, then first name.
- List each child's correct age followed by its date of birth and Social Security number. If your child(ren) does not have a Social Security number, please leave blank.
- If your child is enrolled in school, fill in the name of the school in the space provided.
- Please indicate if your child is a U.S. citizen or a legal resident.

- Please select a Medical Group or IPA physician from the CaliforniaKids Health Care Provider Directory and indicate by placing the Medical Group (3-digit code) or IPA physician (6-digit code) in the box provided. You must live within 30 miles of the selected group.

Section 2

- Please indicate if your child is enrolled in Medi-Cal or the Healthy Families program. (If your child has emergency Medi-Cal only, please indicate).

Section 3

For each parent or legal guardian living in the household:

- Please fill in your last name and first name, and indicate your marital status.
- Please clearly print your current address and your home and work telephone numbers. (If you live in an apartment, please include the number).
- Please complete the employer information requested.

Section 4

- Please indicate in the space provided your total monthly household income.

Section 5

- Please read the authorization section and sign and date at the bottom of the application form. All information provided is private and will be held in strict confidence and used solely to determine eligibility for the CaliforniaKids program.

Very Important

Before mailing your application form you must attach the following information:

- A money order, cashiers check or personal check for the 1st payment of \$20 dollars per child. (This payment covers the first two months of coverage. You will be billed \$10 dollars per child thereafter).
- Copy of your child's birth certificate.
- Two current paycheck stubs from each working member or, a copy of your Federal income tax 1040 form for the previous calendar year or, a written verification of your monthly household income.

A pre-addressed return envelope is included for your convenience. For questions about the program or assistance in completing the application form, please call a customer service representative at (818) 755-9700.

Our mailing address is: **CaliforniaKids Healthcare Foundation**
PO Box 260
North Hollywood, CA 91603

Completed application forms will be processed in the order in which they are received. If your child(ren) qualifies you will receive a CaliforniaKids Identification Card to be used when visiting your doctor.

Completing the application form does not constitute coverage. You can only receive health care services under the CaliforniaKids program when your child(ren) receives their Identification Card. Please call (818) 755-9700 to verify the effective date of coverage.

Duration of Coverage

Once enrolled, each child will be covered in the CaliforniaKids Program unless a child's status changes, failure to pay the shared-premium or if the program is canceled.

CaliforniaKids Checklist

- ✓ A money order, cashiers check or personal check payable to CaliforniaKids Healthcare Foundation for the 1st payment of \$20 dollars per child. (This payment covers the first two months of coverage. You will be billed \$10 dollars per child thereafter)
- ✓ Copy of your child's birth certificate
- ✓ Two current paycheck stubs from each working member or, a copy of your Federal income tax 1040 form for the previous calendar year or, a written verification of your monthly household income
- ✓ Selection of a participating health care provider for your child(ren)
- ✓ Please use correct postage

If any of the above items are incomplete or not enclosed, your application form will not be processed.

The CaliforniaKids Program does not cover inpatient hospital or surgical care.

If a child has a chronic medical need or will require specialty or inpatient care, CaliforniaKids is not the program for that child.

If your child(ren) are eligible and approved, a CaliforniaKids identification card and information package will be mailed.

If your child(ren) are not eligible, CaliforniaKids will return you application along with your payment.