

CaliforniaKids is a charitable, non-profit organization that provides uninsured children access to comprehensive preventive and primary health care services.

Who is eligible for the program?

- All children between 2-18 years of age
- Reside in areas where CaliforniaKids providers are available
- If school age, be enrolled and attending school

How much will it cost?

The monthly premium is \$75 per child.

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. A minimal co-payment is required for office visits, prescription drugs, emergency room care, and outpatient same-day surgery.

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
- Prescription drugs
- Behavioral health benefits
- 24-hour nurse advisor

You will select your child's primary care physician from the CaliforniaKids Healthcare 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.

IMPORTANT

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 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 legible.

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 select a Medical Group or IPA physician from the CaliforniaKids Healthcare 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

- Optional

Section 5

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

Cost per Child

The monthly cost is \$75 per child. CaliforniaKids requires that you pay the first and second month of medical coverage in advance and a one-time application processing fee of \$10.

Please see the table below for premium payment amount to be included with your application:

Number of children	Two-months premium	Application processing fee	Total Amount
1	\$150	\$10	\$160
2	\$300	\$10	\$310
3	\$450	\$10	\$460

You will be billed \$75 per child each month thereafter.

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.

Completed application forms will be processed in the order in which they are received. Completing the application form does not constitute coverage. Your child 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:

- The child turns 19 years of age
- Failure to pay the monthly premium
- If the program is cancelled

CaliforniaKids Checklist

- ✓ A money order, cashiers check or personal check payable to CaliforniaKids Healthcare Foundation for the correct premium payment amount (Please refer to the table below for premium payment amounts)

Number of children	Two-months premium	Application processing fee	Total Amount
1	\$150	\$10	\$160
2	\$300	\$10	\$310
3	\$450	\$10	\$460

Your payment covers the first two months of medical coverage. You will be billed \$75 per child each month thereafter)

- ✓ Selection of a participating health care provider for your child(ren)
- ✓ Correct postage

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

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

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

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

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

Our mailing address is: **CaliforniaKids Healthcare Foundation
PO Box 680
North Hollywood, CA 91603**

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 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: _____ Program: Medi-Cal Emergency Medi-Cal Healthy Families CCS Explain: _____
 Name: _____ Program: Medi-Cal Emergency Medi-Cal Healthy Families CCS Explain: _____
 Name: _____ Program: 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 reevaluation 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 trial 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 I/we 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: _____