COUNTY OF LOS ANGELES

CALIFORNIA CHILDREN'S SERVICES

APPLICATION FOR SERVICES

9320 Telstar Avenue, Suite 226, El Monte, CA 91731
Telephone (800) 288-4584

This application is to be completed by the parent, legal guardian or applicant. The term "applicant" means the child for whom the services are being requested.

APPLICATION INFORMATION (please print)

1. _____ 2. _____ 3. Sex: M [ ] F [ ]
   Name of Applicant (Last) (First) (Middle) Date of Birth

4. _____
   Applicant's Street Address City State Zip Code

5. (_____) _____ 6. _____ - _____ - _____ 7. _____
   Area Code Telephone Number Social Security Number (Optional) CCS No.

PARENT/LEGAL GUARDIAN INFORMATION

8. _____ 9. _____ 10. (____) _____
   Name of Parent or legal Guardian Mother's Date of Birth Area Code Telephone Number

11. _____ 12. _____
   Street Address City State Zip Code How Long at This Address

13. If you have not been referred by a physician or other health care professional and are initiating this request, please provide your child's diagnosis or describe the services you are requesting from CCS.

_____

_____

_____

14. **MEDICAL INSURANCE INFORMATION**

A. Medi-Cal [ ] No [ ] Yes, Child's Medi-Cal Number _____

Share of Cost? [ ] No [ ] Yes, Amount $ _____

B. Medical Insurance [ ] No [ ] Yes, If Yes, Name of Insurance Company

_____

(Please Check One)

[ ] Preferred Provider (PPO)
[ ] Health Maintenance Organization (HMO)
[ ] Major Medical

15. I am applying for CCS and certify that the information I have provided is true and correct to the best of my knowledge. I understand that the filling out of this application does not assure acceptance of the applicant by CCS. I give my permission to verify my residence, medical information or other information required for application to CCS.

Your signature below authorizes CCS to proceed with this application.

_____

Signature of Parent/Legal Guardian/Applicant Relationship to Child Date

Sign and Return Form to CCS (address located above)