

CALIFORNIA CHILDREN'S SERVICES FACE SHEET

County of residence		Birthplace (county, other state, or country)		Medi-Cal number (attach copy of card if available)		Effective date		California Children's Services number	
Legal name (last, first, middle)			Nickname		Social Security number — —		Birth date (month, day, year)		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown
Address (number, street)			City		ZIP code		Telephone ()		Cross street or landmark
Mother				Maiden name		Social Security number — —		Birth date (month, day, year)	
Address (number, street)					City		ZIP code		Telephone ()
Employer		Address (number, street)			City		ZIP code		Telephone ()
Health insurance company		Address (number, street)			City		ZIP code		Policy/group number
Father						Social Security number — —		Birth date (month, day, year)	
Address (number, street)					City		ZIP code		Telephone ()
Employer		Address (number, street)			City		ZIP code		Telephone ()
Health insurance company		Address (number, street)			City		ZIP code		Policy/group number
Legal guardian		Address (number, street)			City		ZIP code		Telephone ()
Foster parent/relationship		Address (number, street)			City		ZIP code		Telephone ()
School					Grade	Telephone ()			Nurse
Address (number, street)					City		ZIP code		Telephone ()
Physician						Telephone ()		Send reports <input type="checkbox"/> Yes <input type="checkbox"/> No	
Address (number, street)					City		ZIP code		Telephone ()
Specialist requested			Specialty		City			Telephone ()	
Specialist requested			Specialty		City			Telephone ()	

Reason for referral: Describe nature of physical handicap, significant associated conditions, dates of onset, date/types of treatment, and where care was received.

Factors that will assist CCS in planning care, e.g., transportation, language, social, housing, other agencies involved, previous CCS coverage Presumptive CCS eligible diagnosis (CCS Use Only)	Others in home (check CCS patients)			
	CCS?	Name	Birth Year	Relationship to Patient
	<input type="checkbox"/>			
	<input type="checkbox"/>			

Race: <input type="checkbox"/> White <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Filipino <input type="checkbox"/> Asian <input type="checkbox"/> American-Indian <input type="checkbox"/> Black <input type="checkbox"/> Other nonwhite <input type="checkbox"/> No response <input type="checkbox"/> Unknown				Referral source: <input type="checkbox"/> Parent <input type="checkbox"/> Physician <input type="checkbox"/> CCS case finding <input type="checkbox"/> Other provider <input type="checkbox"/> CHDP—EPSDT <input type="checkbox"/> School <input type="checkbox"/> Hospital <input type="checkbox"/> DD regional center <input type="checkbox"/> Other _____					
Referred by: Name		Title		Agency		Telephone ()		Date	
Face sheet completed by: Name		Title		Agency		Telephone ()		Date	