

- HSA
- Golden Valley
- Oakdale CHC
- Riverbank CHC
- Online



Healthy Cubs

Please **print** answers to all questions. The questions about your family size, income, and health care insurance are to determine if you or your child is eligible for the Healthy Cubs Program. The Healthy Cubs program is for children under the ages of 6 and for pregnant women. Once completed, you may either turn the application into the HSA Eligibility Department or mail to Healthy Cubs, P.O. Box 3007, Modesto, CA 95353-3007.

FAMILY INFORMATION:

Patient Last Name	First Name	Middle	Date of Birth (Mo/Day/Yr)	Age	Social Security Number	Sex	Eligible? (County Use Only)
(Child 1 UNDER THE AGE OF 6)							
(Child 2 UNDER THE AGE OF 6)							
(Child 3 UNDER THE AGE OF 6)							
(Child 4 UNDER THE AGE OF 6)							
MOTHER'S NAME:			DATE OF BIRTH:		SOCIAL SECURITY #:		
Contact Person (If different from above) NAME			Home Phone Number		Alternate Phone Number		
Home Address (number and Street) DO NOT USE P.O. BOX			City		Zip		Home Phone Number
Mailing Address (if different from above) or P.O. BOX			City		Zip		Work Phone Number
How did you hear about this program?			<input type="checkbox"/> Newspaper <input type="checkbox"/> Friend/Family Member <input type="checkbox"/> Outreach Worker		<input type="checkbox"/> Television <input type="checkbox"/> Doctor's Office <input type="checkbox"/> Radio		Message Phone

PATIENT INFORMATION

	Yes	No
1. Is the patient:		
a. Pregnant? (If Yes, attach doctor verification)	<input type="checkbox"/>	<input type="checkbox"/>
b. On Medi-Cal now?	<input type="checkbox"/>	<input type="checkbox"/>
If Yes, what type of Medi-Cal?		
<input type="checkbox"/> Full Scope? <input type="checkbox"/> Share of Cost? <input type="checkbox"/> Restricted? <input type="checkbox"/> Pending?		
c. On Healthy Families or other insurance now?	<input type="checkbox"/>	<input type="checkbox"/>
2. How many people are in your family?		
3. How much money does your family earn before taxes? \$ _____ per month		
4. What county do you live in? _____		
5. Primary Language Spoken _____ Read _____		

NOTE: The Healthy Cubs health access program is not a health plan. You will be contacted by a Health Services Agency representative to assist you in applying for either Medi-Cal or Healthy Families. Failure to comply with application to these programs will affect continued eligibility under Healthy Cubs.

I authorize the Indigent Health Care Program to forward this information to Medi-Cal or Healthy Families	Yes	No
	<input type="checkbox"/>	<input type="checkbox"/>

I declare under penalty of perjury that the foregoing is true and correct. I understand that perjury is a criminal offense punishable by imprisonment in the state prison and that I may be prosecuted for deliberately providing false or misleading information.

Signature of Parent/Guardian or Emancipated Minor

Date

Relationship to patient

Application taken by Phone #

PLEASE CHECK YOUR ETHNIC ORIGIN:

- (1) White (2) Black (3) Hispanic (4) Native American/Eskimo/Aleutian (5) Asian/Pacific Islander (6) Other (Specify) _____