

## Information about California Children's Services

### What is the California Children's Services program?

CCS is a statewide program that treats children with certain physical limitations and chronic health conditions or diseases. CCS can authorize and pay for specific medical services and equipment provided by CCS-approved specialists. The California Department of Health Care Services (DHCS) manages the CCS program. Larger counties operate their own CCS programs, while smaller counties share the operation of their program with DHCS. The program is funded with state, county, and federal tax monies, along with some fees paid by parents.

### What does CCS offer children?

If you or your child's doctor think that your child might have a CCS-eligible medical condition, CCS may pay for or provide a medical evaluation to find out if your child's condition is covered.

If your child is eligible, CCS may pay for or provide:

- Treatment, such as doctor services, hospital and surgical care, physical therapy and occupational therapy, laboratory tests, X-rays, orthopedic appliances, and medical equipment.
- Medical case management to help get special doctors and care for your child when medically necessary, and referral to other agencies, including public health nursing and regional centers; or a
- Medical Therapy Program (MTP), which can provide physical therapy and/or occupational therapy in public schools for children who are medically eligible.

### Who qualifies for CCS?

The program is open to anyone who:

- is under 21 years old;
- has or may have a medical condition that is covered by CCS;
- is a resident of California; and
- has a family income of less than \$40,000 as reported on the adjusted gross income on the state tax form, or whose out-of-pocket medical expenses for a child who qualifies are expected to be more than 20 percent of the family income.

Family income is not a factor for children who:

- need diagnostic services to confirm a CCS eligible medical condition; or
- were adopted with a known CCS eligible medical condition; or
- are applying only for services through the Medical Therapy Program; or
- have Medi-Cal full scope, no share of cost.

### What medical conditions does CCS cover?

Only certain conditions are covered by CCS. In general, CCS covers medical conditions that are physically disabling or require medical, surgical, or rehabilitative services. There also may be certain criteria that determine if your child's medical condition is eligible. Listed below are categories of medical conditions that may be covered and some examples of each:

- Conditions involving the heart (congenital heart disease)
- Neoplasms (cancers, tumors)
- Disorders of the blood (hemophilia, sickle cell anemia)
- Endocrine, nutritional, and metabolic diseases (thyroid problems, PKU, diabetes)
- Disorders of the genitourinary system (serious chronic kidney problems)
- Disorders of the gastrointestinal system (chronic inflammatory disease, diseases of the liver)
- Serious birth defects (cleft lip/palate, spina bifida)
- Disorders of the sense organs (hearing loss, glaucoma, cataracts)
- Disorders of the nervous system (cerebral palsy, uncontrolled seizures)
- Disorders of the musculoskeletal system and connective tissues (rheumatoid arthritis, muscular dystrophy)
- Severe disorders of the immune system (HIV infection)
- Disabling conditions or poisonings requiring intensive care or rehabilitation (severe head, brain, or spinal cord injuries, severe burns)
- Complications of premature birth requiring an intensive level of care
- Disorders of the skin and subcutaneous tissue (severe hemangioma)
- Medically handicapping malocclusion (severely crooked teeth)

Ask your county CCS office if you have questions.

### **What must the applicant or family do to qualify?**

Families (or the applicant if age 18 or older, or an emancipated minor) must:

- complete the application form beginning on page 4 and return it to their local county CCS office;
- give CCS all of the information requested so CCS can determine if the family qualifies;
- apply to Medi-Cal if CCS believes that a family's income qualifies them for the Medi-Cal program. (If a family qualifies for Medi-Cal, the child is also covered by CCS. CCS approves the services; payment is made through Medi-Cal.)

### **How is my privacy protected?**

California law requires that families applying for services be given information on how CCS protects their privacy.<sup>1</sup>

To protect your privacy:

- CCS must keep this information confidential.<sup>2</sup>
- CCS may share information on the form with authorized staff from other health and welfare programs only when you have signed a consent form.

You have the right to see your application and CCS records concerning you or your child. If you wish to see these records contact your local county CCS office. By law, the information you give CCS is kept by the program.<sup>3</sup>

### **Do I have a right to appeal a decision?**

You have the right to disagree with decisions made by CCS.<sup>4</sup> This is called an appeal. The appeal process gives the parent/legal guardian or applicant a way to work with the CCS program to find solutions to disagreements. For information on the appeal process, contact your local county CCS office.

**Where can I get more information about CCS?**

For more information about CCS, please visit the CCS home page on the DHCS website here: <https://www.dhcs.ca.gov/services/ccs/Pages/default.aspx>.

For help in filling out this application, please contact your local county CCS office. To find your county CCS office, go to: <https://www.dhcs.ca.gov/services/ccs/Pages/CountyOffices.aspx>, or look in the government section of your local telephone directory under “California Children’s Services” or “county health department.”

**Notes**

1. Civil Code, Section 1798.17  
[https://leginfo.legislature.ca.gov/faces/codes\\_displaySection.xhtml?sectionNum=1798.17.&lawCode=CIV](https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=1798.17.&lawCode=CIV)
2. In accordance with Section 41670, Title 22, California Code of Regulations and the California Public Records Act (Government Code, Sections 6250–6255)  
[https://leginfo.legislature.ca.gov/faces/codes\\_displayText.xhtml?division=7.&chapter=3.5.&lawCode=GOV&title=1.&article=1](https://leginfo.legislature.ca.gov/faces/codes_displayText.xhtml?division=7.&chapter=3.5.&lawCode=GOV&title=1.&article=1)
3. Section 123800 et. seq. of the California Health and Safety Code  
[https://leginfo.legislature.ca.gov/faces/codes\\_displayText.xhtml?lawCode=HSC&division=106.&title=&part=2.&chapter=3.&article=5](https://leginfo.legislature.ca.gov/faces/codes_displayText.xhtml?lawCode=HSC&division=106.&title=&part=2.&chapter=3.&article=5).
4. California Code of Regulations, Title 22, Chapter 13, Sections 42702–42703  
[https://govt.westlaw.com/calregs/Document/13EB90F40D4B811DE8879F88E8B0DAAAE?viewType=FullText&originationContext=documenttoc&transitionType=CategoryPageItem&contextData=\(sc.Default\)](https://govt.westlaw.com/calregs/Document/13EB90F40D4B811DE8879F88E8B0DAAAE?viewType=FullText&originationContext=documenttoc&transitionType=CategoryPageItem&contextData=(sc.Default))

### Application to Determine California Children Services Program Eligibility

This application is to be completed by the parent, legal guardian, or applicant (if age 18 or older, or an emancipated minor) in order to determine if the applicant is eligible for CCS services/benefits. The term "applicant" means the child, individual age 18 or older, or emancipated minor for whom the services are being requested. Please type or print clearly.

#### A. Applicant Information

1. Name of Applicant  
 (Last) (First) (Middle)

Name on birth certificate (if different) Any other name the applicant is known by

2. Date of birth (month, day, year) 3. Place of birth – county and state  
 Country, if born outside of the U.S.

4. Applicant’s residence address (number, street) (do not use a P.O. Box)

City County Zip Code

5. Sex  
 Female Male

6. Sexual Orientation and Gender Identity (Optional):  
*If the applicant would like to tell us more about their gender, gender identity, gender expression or sexual orientation, please fill in items a, b, and c below. Section 6 is optional, but is required for DHCS to ask with the passage of Assembly Bill 959 (2015 - 2016).*

a. What is the applicant’s gender (check the box that best describes your current gender identity)?  
 Female Male Transgender: Male to Female Transgender: Female to Male  
 Non-binary (neither male nor female) Another gender identity

b. What sex was listed on the applicant’s original birth certificate?  
 Female Male

c. Does the applicant think of them self as:  
 Straight / heterosexual Gay / lesbian Bisexual Queer  
 Another sexual orientation Unknown

7. Race / Ethnicity	8. Social Security Number (optional)
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9. What is the applicant's suspected eligible CCS condition or disability?

10. Primary Care Physician	11. Physician's phone number
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**B. Parent/Legal Guardian/Family Information**

(Applicants age 18 or older, or emancipated minors skip items 12 and 14 below).

12. Name(s) of parent or legal guardian	13. Mother's first name (if not identified in 12)	Maiden name
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14. Residence address (number, street) (do not use a P.O. Box)

City	County	Zip Code
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15. Mailing address (if different from 14)

City	County	Zip Code
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16. Home phone number	17. Cell phone number	18. Work phone number
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19. What language do you speak at home?	20. Email address
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21. Number of persons in family unit	22. Other Parent Name if not living with the applicant
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Street Address of Other Parent	City	Zip Code
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**C. Health Insurance Information**

23. Does the applicant have Medi-Cal? Yes                      No	24. If yes, what is the applicant's Medi-Cal number?
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25. Is there a share of cost? Yes                      No	26. If yes, what is the amount you pay per month?
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27a. Does the applicant have other health insurance? Yes                      No	27b. If yes, what is the name of the insurance plan or company?
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27c. Policy or Plan Number

28. Type of insurance plan or company

Preferred Provider Organization (PPO)      Health Maintenance Organization (HMO)      Other:

29. Does the applicant have dental insurance?

Yes                      No

30. Does the applicant have vision insurance?

Yes                      No

**D. Certification**

(Initial and sign below. Your signature authorizes the CCS program to proceed with this application).

I am applying to the CCS program in order to determine eligibility for services/benefits. I understand that the completion of this application does not assure acceptance of applicant by the CCS program.

I give my permission to verify my residence, health information, or other circumstances required to determine eligibility for CCS services/benefits.

I certify that I have read and understand the information or have had it read to me.

I also certify that the information I have given on this form is true and correct.

Signature of person completing the application	Relationship to the applicant	Date
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Signature of witness (only if the person signed with a mark)	Date
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**\*See instructions on the next page.**

**INSTRUCTIONS FOR COMPLETING THE  
CALIFORNIA CHILDREN'S SERVICES APPLICATION (DHCS 4480)**

Print clearly so your application can be processed as quickly as possible.

Fill out each section completely. If you do not provide all the information, CCS will not be able to proceed with your application. If you need help filling out this form, contact your local county CCS office.

Once the application is completed, mail it to your local county CCS office. Remember to sign and date the form.

**Section A: Applicant Information** ("Applicant" means the child, individual age 18 or older, or emancipated minor for whom the services are being requested).

1. **Applicant's name:** Fill in the applicant's last, first, and middle name. In the next Box, write the applicant's full name as it appears on their birth certificate if different from their name. If the applicant is known by any other name, include that name in the last box.
2. **Applicant's date of birth:** Write the month, day, and year of the applicant's birth.
3. **Place of birth:** Write the county and state where the applicant was born. Include the country if the applicant was born outside the U.S.
4. **Address:** Write the street number, street name, apartment number, city, county, and ZIP code of the applicant's current residence in this space. Do not use a P.O. Box.
5. **Applicant's sex:** Mark the correct sex box for the applicant (male or female).
6. **Sexual Orientation and Gender Identity (Optional):** If the applicant would like to tell us more about their gender, gender identity, gender expression or sexual orientation, please fill in items a, b, and c. Section 6 is optional, but is required for DHCS to ask with the passage of [Assembly Bill 959](#) (2015 - 2016).
  - 6a. Check the box that best describes the applicant's current gender identity.
  - 6b. Mark the option of the sex listed on the applicant's original birth certificate.
  - 6c. Check the box that best describes the applicant's sexual orientation.
7. **Race/Ethnicity:** Enter the category from the following list which best describes the applicant's primary race/ethnicity:

- |                          |                   |              |
|--------------------------|-------------------|--------------|
| • Alaskan Native         | • Chinese         | • Laotian    |
| • Amerasian              | • Filipino        | • Samoan     |
| • American Indian        | • Guamanian       | • Vietnamese |
| • Asian                  | • Hawaiian        | • White      |
| • Asian Indian           | • Hispanic/Latino | • Other      |
| • Black/African American | • Japanese        |              |
| • Cambodian              | • Korean          |              |

8. **Applicant's social security number (optional):** Write the applicant's nine-digit social security number.
9. **Suspected CCS condition or disability:** Write the applicant's disability or special health care need that would be treated by CCS. The enclosed description of CCS eligible conditions may help you (see "What medical conditions does CCS cover" on pages 1 and 2). If you don't know, ask the applicant's doctor or leave the space blank. CCS will follow up with the applicant's physician if more information is needed.
10. **Name of applicant's primary care physician:** Write the name of the applicant's physician.
11. **Physician's phone number:** Write the phone number of the physician listed in number 10.

**Section B: Parent/Legal Guardian Information** (Applicants age 18 or older, or emancipated minors skip items 12 and 14).

12. **Parent/guardian name(s):** Write the name(s) of the applicant's parent(s) or the name(s) of the applicant's legal guardian(s).
13. **Mother's first name and maiden name:** Write the applicant's mother's first name and identify the mother's maiden name in the next box.
14. **Address:** Write the street number, street name, apartment number, city, county, and ZIP code of your current residence. Do not use a P.O. Box.
15. **Mailing address:** If this address is different from number 14, write the street number, street name, city, and ZIP code.
16. **Home phone number:** Write the home phone number where you can be reached.
17. **Cell phone number:** Write the cell phone number where you can be reached.
18. **Work phone number:** Write the work phone number where you can be reached.
19. **Language(s) spoken:** Write the language you speak at home.
20. **Email address:** Write the email address for the parent or legal guardian.
21. **Number of persons in family unit:** Write the number of persons living in the same household.
22. **Other Parent Name and Address if not living with the applicant:** Write the name and address for a second contact person.

**Section C: Health Insurance Information**

If CCS thinks you may qualify, they will ask you to apply for Medi-Cal if you are not currently receiving Medi-Cal health care benefits.

23. If the applicant does not receive Medi-Cal, mark "No" and go to number 27a. If the applicant receives Medi-Cal, mark "Yes" and fill in the applicant's Medi-Cal number.
24. If you the applicant has Medi-Cal, enter the 14 digit Medi-Cal number.
25. If you pay a portion of the cost of your Medi-Cal insurance, mark "Yes".
26. If you pay a portion of the share of cost, fill in the monthly amount paid.
- 27a. If the applicant does not have other health insurance, mark "No" and go to number 29.
- 27b. If the applicant has health insurance, fill in the name of the insurance plan or company.



- 27c. If the applicant has health insurance, fill in the policy or plan number.
28. If the applicant has health insurance, mark the appropriate box depending upon what type of insurance it is. Your insurance forms will tell you what type of health insurance you have. If you are not sure, call your health insurance company and ask them.
29. If the applicant has dental insurance, mark "Yes." If the applicant does not have dental insurance, mark "No."
30. If the applicant has vision insurance, mark "Yes." If the applicant does not have vision insurance, mark "No."

**Section D: Certification**

Be sure to sign and date in ink. If signature is signed with a mark, have a witness sign and fill in the date.

Under "Relationship to the applicant," enter father, mother, legal guardian, or self (in the case of individuals age 18 or older, or emancipated minors).

**Submitting Your Application**

Mail or deliver your application to your local county CCS office. To find your county CCS office, go to <https://www.dhcs.ca.gov/services/ccs/Pages/CountyOffices.aspx> or look in the government section of your local telephone directory under "California Children's Services" or "county health department."