Tulare County California Children Services (CCS) Program

1062 S. K. St. Tulare, CA 93274
Phone: (559) 685-5800 Fax: (559) 749-9793
Email: CCSProgram@tularecounty.ca.gov

This form is to be completed by the person who is requesting authorization for a medical service (including hospital inpatient stays) from the CCS program for an infant/child/adolescent who may have a CCS medically eligible condition. The form is to be completed for an initial request for services, which constitutes a referral to the program.

Please print and fill out as completely as possible

CCS Case Number (if known):_____ BIC or CIN Number: _____Referral date: _____

Patient's Birth Certificate Name: _____Child's DOB: _____Male ( ) Female ( )

Patients Social Socurity #: _____ Place of Birth: _____

Parent (s) or Legal Guardian (s) Name: _____

Address: _____ (P.O. Box) _____

Home Phone: _____ Cell Phone: _____Message Phone:_____

Name of referring Party, Address, Phone:

_____

_____

_____

Referred By: Hospital ☐ Parent ☐
Regional ☐ School ☐
Medical Clinic ☐ Other ☐

Relationship to CCS Patient: _____ Medi-Cal? Yes ☐ No ☐ Applying ☐

Medi-Cal Number:_____ Carrier or Policy Number (If available):_____

Plan: Blue Cross ☐ HealthNet ☐ Private Insurance? Yes ☐ No ☐ HMO ☐

Healthy Families? Yes ☐ No ☐

Child also receiving Social Security? Yes ☐ No ☐

☐ White ☐ American Indian
☐ Black ☐ Filipino
☐ Asian ☐ Laotian
☐ Hispanic ☐ Other

Mother's Maiden Name & Birthdate: _____ Language Spoken: _____

Suspected Medical Condition (s): _____

Services requested: _____

Primary Diagnosis (If known): _____

Local Physician: _____ Location: _____ Phone #: _____

Specialist (s) being seen? _____ Location: _____

Requested Provider/Specialist: _____

Completed by: _____ Title: _____Today's Date: _____