

**Kern County Department of Public Health
Child Health & Disability Prevention (CHDP) – Kern Access to Children’s Health**

This project is sponsored by



Funded by Proposition 10

REQUEST FOR FREE AND LOW-COST HEALTHCARE INSURANCE INFORMATION

By completing this form, you can request that the KCDPH contact you by phone to give you information about free and low-cost healthcare insurance programs for your child and family.

THIS FORM IS NOT AN APPLICATION FOR HEALTHCARE INSURANCE

Complete this form if your child **does not** have healthcare insurance or has Medi-Cal share-of-cost.

AUTHORIZATION – REFFERAL

I authorize _____ to share information that I provide on this form with

(Name of Agency)

the Kern County Department of Public Health, CHDP – Kern Access to Children’s Health Project.

Signature of Parent or Legal Guardian

Date

Note to Referring Agency: Please provide us with the following information so that we may be able to follow up with you:

Referring Person: _____ Contact #: _____

PLEASE PRINT

Child’s First, Last Name

Date of Birth

Child’s First, Last Name

Date of Birth

Child’s First, Last Name

Date of Birth

Child’s First, Last Name

Date of Birth

Print Parent’s or Legal Guardian’s First and Last Name

Address

City

Zip Code

Best Time of Day to Call _____

Home Phone Number

Other Phone Number

Mark language you prefer (X) English Spanish Other _____

If you have any questions, please call the KCDPH Monday through Friday at (661) 868-0588 or 1(800) 974-2717 ext. 80588

Please return this form to: Kern County Department of Public Health, 1800 Mt. Vernon Avenue, 2nd Floor, Bakersfield, CA 93306 or FAX to (661) 868-0493