

# Children's Health Initiative of San Luis Obispo County

REFERRAL AND RELEASE OF INFORMATION FOR DETERMINATION OF ELIGIBILITY TO HEALTH COVERAGE PROGRAMS: MEDI-CAL, HEALTHY FAMILIES, and HEALTHY KIDS\*

Primary Language: \_\_\_\_\_

**Please provide the following information:**

Parent/Guardian:	DOB:	SSN: (if available)
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Home Address / city / zip:	Phone#:
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Mailing Address /city /zip: \_\_\_\_\_

Child's name:	DOB:	SSN:
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Child's name:	DOB:	SSN:
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Child's name:	DOB:	SSN:
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Child's name:	DOB:	SSN:
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Currently, who is your primary care physician? \_\_\_\_\_

My children currently receive Healthy Kids benefits:  Yes  No

I would like assistance in completing my application/annual renewal packet:  Yes  No

**SERVICE PROVIDER/AGENCY MAKING THIS REFERRAL:**

Service Provider: CHISLO - website  
Address: PO Box 1737, San Luis Obispo, CA 93406  
Contact Person: Ofélia Montoya  
Phone: 805-540-5177

**AUTHORIZATION FOR RELEASE OF INFORMATION**

I hereby authorize Children's Health Initiative of San Luis Obispo, Department of Social Services and the agency or service provider named above, to share the above information about my family and me with the purpose to determine health care coverage eligibility. I have the right to revoke this authorization at any time. Unless revoked sooner, this authorization shall remain in effect for 12 months.

CHISLO partners with DSS to determine eligibility for Medi-Cal, Healthy Families, & Healthy Kids. If you are eligible for Medi-Cal or Healthy Families, you will not be eligible for Healthy Kids.

\_\_\_\_\_  
Parent/Guardian's Signature

\_\_\_\_\_  
Date

Please Mail or Fax completed form to:  
The Children's Health Initiative  
PO Box 1737  
San Luis Obispo, CA 93406  
Fax: (805) 540-5178



FRN: