CommUnityCare HEALTH CENTERS | CAROUSEL PEDIATRICS

Healthcare Assistance Application
Additional Children Form

Child

Full Name (First, Middle, Last) ____

Date of Birth: _________________ Social Security Number: _____________________ Gender: ☐ Male ☐ Female

Check box next child's legal status:

☐ US Citizen ☐ Legal Permanent Resident ☐ Certificate of Naturalization ☐ Other, list:_______________

Has child received payments from any of the following within the last 30 days? ☐ No ☐ Yes, check applicable box(s)

☐ Social Security ☐ Disability ☐ Survivors

Is this person listed pregnant or have children of their own living in the house? ☐ No ☐ Yes

Does child have any of the following healthcare benefits? ☐ No ☐ Yes, check applicable box:

☐ Medicaid ☐ CHIP ☐ Private Health Insurance ☐ Other, list: ____________________

Child

Full Name (First, Middle, Last) ____

Date of Birth: _________________ Social Security Number: _____________________ Gender: ☐ Male ☐ Female

Check box next child's legal status:

☐ US Citizen ☐ Legal Permanent Resident ☐ Certificate of Naturalization ☐ Other, list:_______________

Has child received payments from any of the following within the last 30 days? ☐ No ☐ Yes, check applicable box(s)

☐ Social Security ☐ Disability ☐ Survivors

Is this person listed pregnant or have children of their own living in the house? ☐ No ☐ Yes

Does child have any of the following healthcare benefits? ☐ No ☐ Yes, check applicable box:

☐ Medicaid ☐ CHIP ☐ Private Health Insurance ☐ Other, list: ____________________

Child

Full Name (First, Middle, Last) ____

Date of Birth: _________________ Social Security Number: _____________________ Gender: ☐ Male ☐ Female

Check box next child's legal status:

☐ US Citizen ☐ Legal Permanent Resident ☐ Certificate of Naturalization ☐ Other, list:_______________

Has child received payments from any of the following within the last 30 days? ☐ No ☐ Yes, check applicable box(s)

☐ Social Security ☐ Disability ☐ Survivors

Is this person listed pregnant or have children of their own living in the house? ☐ No ☐ Yes

Does child have any of the following healthcare benefits? ☐ No ☐ Yes, check applicable box:

☐ Medicaid ☐ CHIP ☐ Private Health Insurance ☐ Other, list: ____________________