## How do we apply?

Fill out a CCS application and return it to your county CCS office. You can get an application from your county CCS office or download from:
**www.dhs.ca.gov/ccs**

Fill out your application carefully so CCS will have all the information they need to see if you qualify.

## Can a child apply for CCS?

If your child is 18 or older, or an emancipated minor they can apply on their own.

## What if I need more information about CCS?

For more information, or help in filling out your application, contact your county CCS office. Find their address and phone number in the government section of your phone book. Look under *California Children's Services* or *County Health Department*.

Or, look for your CCS local office at:
**www.dhs.ca.gov/ccs**

Edmund G. Brown, Jr.
Governor, State of California

PUB 4 May 2003 English

# California Children's Services

## Caring for Children with Special Medical Needs

## What is California Children's Services (CCS)?

CCS is a state program that helps children with certain diseases, physical limitations, or chronic health problems.


## Can our child get CCS?

If you or your child's doctor think that your child has a medical problem that CCS covers, CCS can pay for an exam to see if CCS can cover your child's problem.

If CCS covers your child's problem, CCS pays for or provides services like:

- Doctor visits
- Hospital stays
- Surgery
- Physical and occupational therapy
- Lab tests and X-rays
- Orthopedic appliances and medical equipment.

## What else can CCS do for our child?

CCS can manage your child's medical care. This means CCS can get the special doctors and care your child needs.

Sometimes, CCS refers you to other agencies, like public health nursing and regional centers so you can get the services your child needs.

CCS also has a Medical Therapy Program (MTP). MTPs are in public schools and give physical and occupational therapy to eligible children.

## Are there other requirements?

To get CCS, your child must:

- Be under 21 years old; and
- Have or may have a medical problem that CCS covers; and
- Be a resident of California; and
- Have a family income under $40,000 (your adjusted gross income on the state tax form).

## What if my family's income is more than $40,000?

You can still get CCS if:

- You have Medi-Cal (full scope, no cost);
- You have Healthy Families insurance;
- Your out-of-pocket medical expenses for your child's care is more than 20% of your family income;
- You only want MTP services;
- You need to see a doctor to see if your child is eligible for CCS; or
- You adopted your child with a known medical problem that made them eligible for CCS.

## What medical problems does CCS cover?

CCS doesn't cover all problems. CCS covers most problems that are physically disabling or that need to be treated with medicines, surgery, or rehabilitation. There are other factors, too.

CCS covers children with problems like:

- congenital heart disease
- cancers, tumors
- hemophilia, sickle cell anemia
- thyroid problems, diabetes
- serious chronic kidney problems
- liver or intestine diseases
- cleft lip/palate, spina bifida
- hearing loss, cataracts
- cerebral palsy, uncontrolled seizures
- rheumatoid arthritis, muscular dystrophy
- AIDS
- severe head, brain, or spinal cord injuries, severe burns
- problems caused by premature birth
- severely crooked teeth
- broken bones

## Can we use any doctor or provider we want?

No. CCS must approve the provider, services and equipment *first.*

## ¿Cómo solicitamos?

Llene una solicitud CCS y envíela a la oficina CCS de su condado. Puede obtener una solicitud en la oficina CCS de su condado o bajarla de:
**www.dhs.ca.gov/ccs**

Llene su solicitud con cuidado, para que CCS tenga toda la información que necesite para ver si su hijo califica.

## ¿Puede un niño solicitar CCS?

Si su hijo tiene 18 años de edad o más, o es menor de edad emancipado, puede presentar su propia solicitud.

## ¿Cómo obtengo más información sobre CCS?

Para más información o ayuda para llenar su solicitud, póngase en contacto con la oficina CCS de su condado. Busque la dirección y el número de teléfono en la sección de gobierno de su directorio telefónico. Busque bajo *California Children's Services* o *County Health Department*.

O busque su oficina local de CCS en:
**www.dhs.ca.gov/ccs**

Arnold Schwarzenegger
Governor, State of California

PUB 135 May 2003 Spanish

# Servicios para los niños de California

## Atendiendo a niños con necesidades médicas especiales

## ¿Qué son Servicios para los niños de California (CCS)?

CCS es un programa del estado que ayuda a niños con ciertas enfermedades, limitaciones físicas o problemas de salud crónicos.


## ¿Puede nuestro hijo obtener CCS?

Si usted o el médico de su hijo creen que su hijo tiene un problema médico que cubre CCS, CCS puede pagar un examen para ver si CCS puede cubrir el problema de su hijo.

Si CCS cubre el problema de su hijo, CCS paga o presta servicios como:

- visitas al médico
- estadías en el hospital
- operaciones
- fisioterapia y terapia ocupacional
- pruebas de laboratorio y radiografías
- aparatos ortopédicos y equipo médico.

## ¿Qué más puede hacer CCS por nuestro hijo?

CCS puede manejar la atención médica de su hijo. Esto significa que CCS puede obtener los médicos y los cuidados especiales que necesite su hijo.

A veces CCS remite a su hijo a otras agencias, como enfermería de salud pública y centros regionales, para que pueda obtener los servicios que necesite su hijo.

CCS también tiene un Programa de Terapia Médica (MTP). Los MTP están en las escuelas públicas y dan fisioterapia y terapia ocupacional a niños calificados.

## ¿Hay otros requisitos?

Para obtener CCS, su hijo tiene que:

- ser menor de 21 años de edad; y
- tener o poder tener un problema médico que cubre CCS; y
- ser residente de California; y
- tener un ingreso familiar de menos de $40,000 (su ingreso bruto ajustado en la declaración de impuestos del estado).

## ¿Qué pasa si el ingreso de mi familia es de más de $40,000?

Igual puede obtener CCS si:

- tiene Medi-Cal (completo, sin costo);
- tiene el seguro Healthy Families;
- sus gastos médicos de su bolsillo para el cuidado de su hijo son más del 20% de su ingreso familiar;
- sólo desea servicios MTP;
- necesita ver a un médico para saber si su hijo califica para CCS; o,
- adoptó a un niño con un problema médico conocido que lo hace elegible para CCS.

## ¿Qué problemas médicos cubre CCS?

CCS no cubre todos los problemas. CCS cubre la mayoría de los problemas que causan impedimentos físicos o que hay que tratar con medicamentos, operaciones o rehabilitación. También hay otros factores.

CCS cubre a niños con problemas como:

- enfermedad congénita del corazón
- cánceres, tumores
- hemofilia, anemia de células falciformes
- problemas de tiroides, diabetes
- problemas crónicos serios de los riñones
- enfermedades del hígado o del intestino
- labio leporino, hendidura palatina, espina bífida
- pérdida de audición, cataratas
- parálisis cerebral, ataques no controlados
- artritis reumatoide, distrofia muscular
- SIDA
- lesiones serias de la cabeza, el cerebro o la médula espinal, quemaduras graves
- problemas causados por el nacimiento prematuro
- dientes muy torcidos
- huesos rotos

## ¿Podemos usar cualquier médico o proveedor que elijamos?

No. CCS debe aprobar *primero* el proveedor, los servicios y los equipos.

# "STAYING HEALTHY" ASSESSMENT
## Children, 0–3 years of age

**Patient Stamp**

Patient Number _____ Plan Name/Number _____

*If patient stamp not used, write in Patient and Plan Name/Number*

| Child's name (first, last) | Date of birth | Sex | Today's date | *For Clinical Use* |
|---|---|---|---|---|
| | | ☐ Male ☐ Female | | **Assistance needed:** **Reading:** ☐ Yes ☐ No **Interpreter:** ☐ Yes ☐ No |
| Your name | Relationship to child ☐ Parent ☐ Relative ☐ Guardian ☐ Friend ☐ Other | | | |

***You and your child's health care team can work together towards better health. Please answer these questions as best you can. You may check (✔) "Skip" if you do not know an answer or do not wish to answer. You may talk with your provider about any questions. Your answers will be protected as part of your child's medical record.***

**Annual Review Date/Initials**

| | | | | | |
|---|---|---|---|---|---|
| *Sample Question and Answer: Does your child go to preschool?* | ✔ | No | Skip | Interventions Code/Date/Initials |
| | **Does Your Home Have:** | | | | |
| 1. | A working smoke detector? | Yes | No | Skip | |
| 2. | Water that comes from the faucet hot enough to burn your child? | No | Yes | Skip | |
| 3. | Window guards and stair gates above the first floor? | Yes | No | Skip | |
| 4. | Cleaning supplies, medicines, and matches in a locked cabinet? | Yes | No | Skip | |
| 5. | The phone number for the poison control center posted by your telephone? | Yes | No | Skip | |
| | **Do You:** | | | | |
| 6. | Always put your child to sleep on his/her back, if younger than 12 months of age? | Yes | No | Skip | |
| 7. | Ever put your child to sleep with a bottle of juice, milk, or soda? | No | Yes | Skip | |
| 8. | Make sure your child's teeth are brushed every day? | Yes | No | Skip | |
| 9. | Always stay with your child when she/he is in the bathtub? | Yes | No | Skip | |
| 10. | Always put your child in a car seat and seat belt in the back seat of a car? | Yes | No | Skip | |
| 11. | Always walk around your car to check for children before backing out? | Yes | No | Skip | |

*For Clinical Use*

**Intervention Codes:** **C: Counseling** **EM: Educational Materials** **R: Referral** **F: Follow-up Needed** **SPN: See Progress Notes**

| | | | | | For Clinical Use<br>Interventions Code/Date/Initials |
|---|---|---|---|---|---|
| | **Does Your Child:** | | | | |
| 12. | Receive health care from anyone besides a medical doctor (such as an acupuncturist, herbalist, curandero, or other healer)? | No | Yes | Skip | |
| 13. | Breastfeed? | No | Yes | Skip | |
| 14. | Drink formula, milk, or eat yogurt at least 2 times each day? | Yes | No | Skip | |
| 15. | Eat fruits and vegetables every day? | Yes | No | Skip | |
| 16. | Eat foods that may cause choking such as nuts, popcorn, hotdogs, whole grapes, or hard candy? | No | Yes | Skip | |
| 17. | Spend time at a house or apartment complex with a swimming pool or hot tub? | No | Yes | Skip | |
| 18. | Spend time in a home where a gun is kept? | No | Yes | Skip | |
| 19. | Spend time in a home with anyone who smokes? | No | Yes | Skip | |
| 20. | Often spend time outdoors without sunscreen or other protection such as a hat or shirt? | No | Yes | Skip | |
| 21. | Has your child ever witnessed or been a victim of abuse or violence? | No | Yes | Skip | |
| 22. | **Do you have other questions or concerns about your child's health?**<br>(Please identify) _____<br>_____<br>_____<br>_____ | No | Yes | Skip | |

*For Clinical Use*

**Intervention Codes:** **C: Counseling** **EM: Educational Materials** **R: Referral** **F: Follow-up Needed** **SPN: See Progress Notes**

**Privacy Statement**

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# "STAYING HEALTHY" ASSESSMENT
## Children, 4–8 years of age

**Patient Stamp**

Patient Number _____ Plan Name/Number _____

*If patient stamp not used, write in Patient and Plan Name/Number*

| Child's name (first, last) | Date of birth | Sex | Today's date |
|---|---|---|---|
| | | ☐ Male ☐ Female | |
| Your name | Relationship to child ☐ Parent ☐ Guardian ☐ Relative ☐ Friend ☐ Other | | |

**For Clinical Use**

**Assistance needed:**
**Reading:** ☐ Yes ☐ No
**Interpreter:** ☐ Yes ☐ No

***You and your child's health care team can work together towards better health. Please answer these questions as best you can. You may check (✔) "Skip" if you do not know an answer or do not wish to answer. You may talk with your provider about any questions. Your answers will be protected as part of your child's medical record.***

| *Sample Question and Answer: Does your child play sports?* | ✔ Yes | No | Skip | Interventions Code/Date/Initials |
|---|---|---|---|---|
| **Does Your Home Have:** | | | | |
| 1. A working smoke detector? | Yes | No | Skip | |
| 2. Water that comes from the faucet hot enough to burn your child? | No | Yes | Skip | |
| 3. Window guards above the first floor? | Yes | No | Skip | |
| 4. Cleaning supplies, medicines, and matches in a locked cabinet? | Yes | No | Skip | |
| 5. The phone number for the poison control center posted by your telephone? | Yes | No | Skip | |
| **Does Your Child:** | | | | |
| 6. Receive health care from anyone besides a medical doctor (such as an acupuncturist, herbalist, curandero, or other healer)? | No | Yes | Skip | |
| 7. See the dentist at least once a year? | Yes | No | Skip | |
| 8. Drink milk or eat yogurt or cheese at least 2 times each day? | Yes | No | Skip | |
| 9. Eat fruits and vegetables every day? | Yes | No | Skip | |
| 10. Eat only a limited amount of fried or fast foods? | Yes | No | Skip | |

**Annual Review Date/Initials**

*For Clinical Use*

**Intervention Codes:** **C: Counseling** **EM: Educational Materials** **R: Referral** **F: Follow-up Needed** **SPN: See Progress Notes**

| | | | | | For Clinical Use: Interventions Code/Date/Initials |
|---|---|---|---|---|---|
| | **Does Your Child:** | | | | |
| 11. | Play actively 5 days a week? | Yes | No | Skip | |
| 12. | Need to lose or gain weight? | No | Yes | Skip | |
| 13. | Ever play in the street or unsupervised in the front yard? | No | Yes | Skip | |
| 14. | Always use a booster seat and seat belt when riding in a car? | Yes | No | Skip | |
| 15. | Always wear a helmet when riding a bike or skateboard? | Yes | No | Skip | |
| 16. | Spend time at a house or apartment complex with a swimming pool or hot tub? | No | Yes | Skip | |
| 17. | Spend time in a home where a gun is kept? | No | Yes | Skip | |
| 18. | Spend time in a home with anyone who smokes? | No | Yes | Skip | |
| 19. | Often spend time outdoors without sunscreen or other protection such as a hat or shirt? | No | Yes | Skip | |
| | **Has Your Child:** | | | | |
| 20. | Ever witnessed or been a victim of abuse or violence? | No | Yes | Skip | |
| 21. | Had any problems at home or school? | No | Yes | Skip | |
| 22. | **Do you have other questions or concerns about your child's health?** (Please identify) _____ _____ _____ _____ | No | Yes | Skip | |

*For Clinical Use*

**Intervention Codes:** **C: Counseling** **EM: Educational Materials** **R: Referral** **F: Follow-up Needed** **SPN: See Progress Notes**

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# "STAYING HEALTHY" ASSESSMENT
## Pre-adolescents, 9–11 years of age

**Patient Stamp**

Patient Number _____ Plan Name/Number _____

*If patient stamp not used, write in Patient and Plan Name/Number*

| Child's name (first, last) | Date of birth | Sex | Today's date | *For Clinical Use* |
|---|---|---|---|---|
| | | ☐ Male ☐ Female | | **Assistance needed:** |
| Your name | Relationship to child | | | **Reading:** ☐ Yes ☐ No |
| | ☐ Parent ☐ Guardian | | | **Interpreter:** ☐ Yes ☐ No |
| | ☐ Relative ☐ Friend | ☐ Other | | |

***You and your child's health care team can work together towards better health. Please answer these questions as best you can. You may check (✔) "Skip" if you do not know an answer or do not wish to answer. You may talk with your provider about any questions. Your answers will be protected as part of your child's medical record.***

**Annual Review Date/Initials**

| *Sample Question and Answer: Does your child go to school?* | Yes ✔ | No | Skip | Interventions Code/Date/Initials |
|---|---|---|---|---|

**Does Your Child:**

| | | | | | |
|---|---|---|---|---|---|
| 1. | Receive health care from anyone besides a medical doctor (such as an acupuncturist, herbalist, curandero, or other healer)? | No | Yes | Skip | |
| 2. | See the dentist at least once a year? | Yes | No | Skip | |
| 3. | Drink milk or eat yogurt or cheese at least 3 times each day? | Yes | No | Skip | |
| 4. | Eat fruits and vegetables every day? | Yes | No | Skip | |
| 5. | Eat only a limited amount of fried or fast foods? | Yes | No | Skip | |
| 6. | Play actively 5 days a week? | Yes | No | Skip | |
| 7. | Need to lose or gain weight? | No | Yes | Skip | |
| 8. | Often feel sad or depressed? | No | Yes | Skip | |
| 9. | Always wear a helmet when riding a bike or skateboard? | Yes | No | Skip | |
| 10. | Always wear a seatbelt when riding in a car? | Yes | No | Skip | |
| 11. | Spend time in a home where a gun is kept? | No | Yes | Skip | |

*For Clinical Use*

**Intervention Codes:** **C: Counseling** **EM: Educational Materials** **R: Referral** **F: Follow-up Needed** **SPN: See Progress Notes**

| | | | For Clinical Use |
|---|---|---|---|
| | | | Interventions Code/Date/Initials |
| | **Does Your Child:** | | |
| 12. | Spend time with any friends who carry a gun, knife, club, or other weapon? | No Yes Skip | |
| 13. | Spend time in a home with anyone who smokes? | No Yes Skip | |
| 14. | Often spend time outdoors without sunscreen or other protection such as a hat or shirt? | No Yes Skip | |
| | **Has Your Child:** | | |
| 15. | Ever smoked cigarettes or chewed tobacco? | No Yes Skip | |
| 16. | Ever had alcohol such as beer, wine, wine coolers, or liquor? | No Yes Skip | |
| 17. | Ever smoked marijuana, sniffed glue, or used street drugs? | No Yes Skip | |
| 18. | Had friends or family members who had a problem with drugs or alcohol? | No Yes Skip | |
| 19. | Started dating or "going with" boyfriends/girlfriends? | No Yes Skip | |
| 20. | Become sexually active? | No Yes Skip | |
| 21. | Ever been molested or sexually abused? | No Yes Skip | |
| 22. | Ever witnessed or been a victim of physical abuse or violence? | No Yes Skip | |
| 23. | Had problems at home or school? | No Yes Skip | |
| 24. | **Do you have other questions or concerns about your child's health?** (Please identify) _____ | No Yes Skip | |

*For Clinical Use*

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# "STAYING HEALTHY" ASSESSMENT
## Adolescents, 12–17 years of age

**Patient Stamp**

Patient Number _____ Plan Name/Number _____

*If patient stamp not used, write in Patient and Plan Name/Number*

| Patient's name (first, last) | Date of birth | Sex ☐ Male ☐ Female | Today's date |
|---|---|---|---|
| Name of person completing form (if other than patient) | Relationship ☐ Parent ☐ Relative ☐ Guardian ☐ Friend ☐ Other | | |

***For Clinical Use***

**Assistance needed:**
**Reading:** ☐ Yes ☐ No
**Interpreter:** ☐ Yes ☐ No

***You and your health care team can work together towards better health. Please answer these questions as best you can. You may check (✔) "Skip" if you do not know an answer or do not wish to answer. You may talk with your provider about any questions. Your answers will be protected as part of your medical record.***

**Annual Review Date/Initials**

| *Sample Question and Answer: Do you play sports?* | Yes ✔ | No | Skip | Interventions Code/Date/Initials |
|---|---|---|---|---|
| **Do you:** | | | | |
| 1. Live at home? | Yes | No | Skip | |
| 2. Go to school? | Yes | No | Skip | |
| 3. Receive health care from anyone besides a medical doctor (such as an acupuncturist, herbalist, curandero, or other healer)? | No | Yes | Skip | |
| 4. See the dentist at least once a year? | Yes | No | Skip | |
| 5. Drink milk or eat yogurt or cheese at least 3 times each day? | Yes | No | Skip | |
| 6. Eat fruits and vegetables every day? | Yes | No | Skip | |
| 7. Try to limit the amount of fried or fast foods that you eat? | Yes | No | Skip | |
| 8. Exercise or play an active sport 5 days a week? | Yes | No | Skip | |
| 9. Think you need to lose or gain weight? | No | Yes | Skip | |
| 10. Often feel sad, down, or hopeless? | No | Yes | Skip | |
| 11. Always wear a seat belt when riding in a car? | Yes | No | Skip | |
| 12. Always wear a helmet when riding a bike or skateboard? | Yes | No | Skip | |
| 13. Spend time in a home where a gun is kept? | No | Yes | Skip | |
| 14. Spend time in a home with anyone who smokes? | No | Yes | Skip | |
| 15. Often spend time outdoors without sunscreen or other protection such as a hat or shirt? | No | Yes | Skip | |

***For Clinical Use***

**Intervention Codes:** **C: Counseling** **EM: Educational Materials** **R: Referral** **F: Follow-up Needed** **SPN: See Progress Notes**

| **Your answers to questions about sex and family planning cannot be shared with anyone, including your parents, without your special written permission.** | | | | | *For Clinical Use*<br>Interventions Code/Date/Initials |
|---|---|---|---|---|---|
| | **Do you ever:** | | | | |
| 16. | Smoke cigarettes or cigars or chew tobacco? | No | Yes | Skip | |
| 17. | Drink alcohol such as beer, wine, wine coolers, or liquor? | No | Yes | Skip | |
| 18. | Drive a car after drinking or ride in a car driven by someone who has been drinking? | No | Yes | Skip | |
| 19. | Use drugs such as marijuana, cocaine, crack, crank, or ecstasy? | No | Yes | Skip | |
| 20. | **Have you ever had sex?**<br>*If "yes," continue to next question. If "no," go to question 26.* | No | Yes | Skip | |
| 21. | Do you think you or your partner could be pregnant? | No | Yes | Skip | |
| 22. | Have you had sex without using birth control in the last year? | No | Yes | Skip | |
| 23. | Do you think you or your partner could have a sexually transmitted disease? | No | Yes | Skip | |
| 24. | Have you or your partner(s) had sex with any other people in the past year? | No | Yes | Skip | |
| 25. | Did you or your partner use a condom the last time you had sex? | Yes | No | Skip | |
| | **Have you:** | | | | |
| 26. | Ever been forced or pressured to have sex? | No | Yes | Skip | |
| 27. | Ever been hit, slapped, kicked, or physically hurt by someone? | No | Yes | Skip | |
| 28. | Ever carried a gun, knife, club, or other weapon? | No | Yes | Skip | |
| 29. | **Do you have other questions or concerns about your health?**<br>(Please identify) _____<br>_____<br>_____<br>_____ | No | Yes | Skip | |

*For Clinical Use*

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# "STAYING HEALTHY" ASSESSMENT
## Adults, 18 years of age and older

**Patient Stamp**

Patient Number _____ Plan Name/Number _____

*If patient stamp not used, write in Patient and Plan Name/Number*

| Patient's name (first, last) | Date of birth | Sex ☐ Male ☐ Female | Today's date | *For Clinical Use* Assistance needed: Reading: ☐ Yes ☐ No Interpreter: ☐ Yes ☐ No |
|---|---|---|---|---|
| | | | | |

***You and your health care team can work together towards better health. Please answer these questions as best you can. You may check (✔) "Skip" if you do not know an answer or do not wish to answer. You may talk with your provider about any questions. Your answers will be protected as part of your medical record.***

| *Sample Question and Answer: Do you play sports?* | Yes ✔ | No | Skip | Annual Review Date/Initials / Interventions Code/Date/Initials |
|---|---|---|---|---|

**Do You:**

| | | | | | |
|---|---|---|---|---|---|
| 1. | Receive health care from anyone besides a medical doctor (such as an acupuncturist, herbalist, curandero, or other healer)? | No | Yes | Skip | |
| 2. | See the dentist at least once a year? | Yes | No | Skip | |
| 3. | Drink milk or eat yogurt or cheese at least 3 times each day? | Yes | No | Skip | |
| 4. | Eat fruits and vegetables every day? | Yes | No | Skip | |
| 5. | Try to limit the amount of fried or fast foods that you eat? | Yes | No | Skip | |
| 6. | Exercise or do moderate physical activity such as walking or gardening 5 days a week? | Yes | No | Skip | |
| 7. | Think you need to lose or gain weight? | No | Yes | Skip | |
| 8. | Often feel sad, down, or hopeless? | No | Yes | Skip | |
| 9. | Have friends or family members that smoke in your home? | No | Yes | Skip | |
| 10. | Often spend time outdoors without sunscreen or other protection such as a hat or shirt? | No | Yes | Skip | |

*For Clinical Use*

**Intervention Codes:** **C: Counseling** **EM: Educational Materials** **R: Referral** **F: Follow-up Needed** **SPN: See Progress Notes**

| *Your answers to questions about alcohol and drug use cannot be released to others without your special written permission.* | | | | | *For Clinical Use* Interventions Code/Date/Initials |
|---|---|---|---|---|---|
| | **Do You:** | | | | |
| 11. | Smoke cigarettes or cigars or use any other kinds of tobacco? | No | Yes | Skip | |
| 12. | Use any drugs or medicines to go to sleep, relax, calm down, feel better, or lose weight? | No | Yes | Skip | |
| 13. | Often have more than 2 drinks containing alcohol in one day? | No | Yes | Skip | |
| 14. | Think you or your partner could be pregnant? | No | Yes | Skip | |
| 15. | Think you or your partner could have a sexually transmitted disease? | No | Yes | Skip | |
| | **Have You:** | | | | |
| 16. | Or your partner(s) had sex without using birth control in the last year? | No | Yes | Skip | |
| 17. | Or your partner(s) had sex with other people in the past year? | No | Yes | Skip | |
| 18. | Or your partner(s) had sex without a condom in the past year? | No | Yes | Skip | |
| 19. | Ever been forced or pressured to have sex? | No | Yes | Skip | |
| 20. | Ever been hit, slapped, kicked, or physically hurt by someone? | No | Yes | Skip | |
| 21. | **Do you have other questions or concerns about your health?** (Please identify) _____ | No | Yes | Skip | |

*For Clinical Use*

**Intervention Codes:** **C: Counseling** **EM: Educational Materials** **R: Referral** **F: Follow-up Needed** **SPN: See Progress Notes**

**Privacy Statement**

The Information Practices Act of 1977 (California Civil Code 1798) and the Federal Privacy Act (5 USC 552a, Subdivision (E)(3)) require this notice to be provided when collecting personal information from individuals. The information on this form is requested by your health care provider, health plan, and the Department of Health Services for purposes of providing health education services. Furnishing the information requested on this form is optional for the patient. Failure to provide the information requested will not result in any negative consequence for the patient. Information collected on this form is to be maintained in the patient's medical record, and is subject to the same medical and legal protection as other information maintained in the patient's medical record. State law and regulation including reporting requirements and protection of patient confidentiality applies to all information identified on this form. Within the constraints of these laws and regulations, certain information collected on this form may be transferred to state and local governmental and regulating agencies, contracted health plans, and health care providers.