HEALTH ACCESS PROGRAMS
FAMILY PACT PROGRAM
CLIENT ELIGIBILITY CERTIFICATION (CEC)

Client identification number

This form is the property of the State of California, Department of Health Care Services, Office of Family Planning, and cannot be changed or altered.

Please ***print*** answers to all questions. The questions about your family size, income, and health care insurance are to determine if you are eligible for Family PACT Program services.

- Providers must keep this original form in your medical record.
- ***Code areas are for Provider use only*.**
  (See PPBI, Client Eligibility Certification Form Completion Section for code determinations.)

Do you currently receive Medi-Cal benefits or services? ☐ Yes ☐ No

Do you have a Medi-Cal Benefits Identification Card (BIC)? ☐ Yes ☐ No

BIC number	Issue date

Do you have health care insurance for family planning services? (Private insurance, Health Maintenance Organization (HMO), Managed Care Plan, Student Health Insurance, etc.) ☐ Yes ☐ No

Have you had out of pocket expenses for family planning/reproductive health services covered by the Family PACT program in the 3 months immediately preceding enrollment in the Family PACT program? ☐ Yes ☐ No

Do we need to keep your family planning services confidential from your partner, spouse, or parent? How may we contact you if we need to talk to you about something? ☐ Yes ☐ No *Confidentiality*

***Provider Use Only*—CODE**

First name	Middle name	Last name	Suffix (Jr., Sr.)

Is your current name the same as your name at birth? If no, print your name at birth below. ☐ Yes ☐ No

First name at birth	Middle name at birth	Last name at birth	Suffix (Jr., Sr.)

Number of live births	County of residence	***Provider Use Only*—CODE**	Nine-digit ZIP code

Gender ☐ Male ☐ Female	***Provider Use Only*—CODE**	Social security number ___ ___ ___ / ___ ___ / ___ ___ ___ ___	Mother's first name

Date of birth (mm/dd/yyyy) / /_ _ _ _	Place of birth (county, if California)	***Provider Use Only*—CODE**	State (if not California)	***Provider Use Only*—CODE**	Country (if not USA)	***Provider Use Only*—CODE**

Race/ethnicity

1 ☐ Asian 2 ☐ Black 3 ☐ Filipino 4 ☐ Hispanic

5 ☐ Native American 6 ☐ Pacific Islander 7 ☐ White 0 ☐ Other

Primary Language

3 ☐ English 1 ☐ Armenian 2 ☐ Cantonese 4 ☐ Hmong 5 ☐ Khmer/Cambodian

8 ☐ Spanish 6 ☐ Korean 7 ☐ Tagalog 9 ☐ Vietnamese 0 ☐ Other

Privacy Statement (Civil Code Section 1798 et seq.)

This information will be used to see if you are enrolled in any state health program. Information will also be used to monitor health outcomes and for program evaluation purposes. Your name will not be shared. Each individual has the right to review personal information maintained by the provider unless exempt under Article 8 of the Information Practices Act.

Complete eligibility information on reverse side.

Eligibility Determination: Please list all family members (self, spouse, and children) living in your household and supported by the family income. List the source of any earned or unearned income and the amount of income, including income from employment, self-employment, tips, commissions, pensions, social security, child and/or spousal support, ongoing insurance payments, disability, Veterans Affairs, unemployment benefits, etc.

Name	Relationship to You	Age	Source of Income	Gross Monthly Income (Before taxes or deductions.)
	(Self)			
Family size:			Total family income	$

I declare under penalty of perjury under the laws of the state of California that the foregoing information on this form is true and correct. I understand that the giving of false information may make me ineligible for this program.

Signature (or mark) of applicant	Date	Signature of witness to mark or interpreter	Date

FOR PROVIDER USE ONLY

Provider certification: ☐ Eligible for Family PACT Program

☐ Ineligible for Family PACT Program (Give applicant Fair Hearing Rights.)

Medi-Cal client eligible for Family PACT verified: ☐ Limited scope ☐ Unmet share-of-cost

Based upon the information provided by the applicant and according to state and federal requirements, I certify that the applicant identified on this Client Eligibility Certification is eligible to receive family planning services under the Family PACT Program. If ineligible, the client has received a copy of this form which includes the Fair Hearing Rights. I also certify that the client has received the Notice of Privacy Practices.

Print name	Signature	Date

Annual Certification: If client is decertified (no longer eligible)	Date	Reason code (see Provider Manual)

Fair Hearing Rights

Any applicant for, or recipient of, services under the Family PACT Program shall have a right to a hearing regarding eligibility or receipt of services. An applicant or recipient does not have a right to contest changes made to the eligibility standards or benefits of the Family PACT Program.

First level review: If you wish to appeal either your denial of eligibility or receipt of services, please send your name, telephone number, address, and reason why you are requesting a First Level Review to the address below. A request for a first level review must be postmarked within 20 working days of the denial of eligibility or services. The Office of Family Planning may request additional information by telephone or in writing from the provider or the applicant before issuing a decision.

Formal Hearing: You may request a formal hearing within 90 days from the day you were notified that you were not eligible or the services you wanted will not be provided or have been discontinued. If you have good cause as to why you were not able to file for a hearing within the 90 days, you may still file for a hearing. If you provide *good cause*, your request may still be scheduled. Provide all requested information such as your full name, telephone number, address, and the reason for the Formal Hearing and mail it to the Formal Hearing address below. If you wish, you may attach a letter as well and explain why you believe the action taken is not correct. You may also call the Public Inquiry and Response number below. If you have trouble understanding English, be sure to state your language so arrangements can be made to have language assistance at the hearing. If you have chosen an authorized representative, be sure to state his/her name, phone number and address. Keep a copy of your hearing request for your records. You may submit your formal hearing request in one of two ways:

First Level Review
Department of Health Care Services
Office of Family Planning
P.O. Box 997413, Mail Station 8400
Sacramento, CA 95899-7413

Formal Hearing
California Department of Social Services
State Hearings Division
P.O. Box 944243, Mail Station 9-17-37
Sacramento, CA 94244-2430

or Toll-Free Call
Department of Social Services
State Hearings Division
Public Inquiry and Response
1-800-952-5253 or 1-800-743-8525
TDD 1-800-952-8349
Fax: (916) 651-5210