Providers must keep this original form in your medical record.

1 Armenian

6 Morean

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.

Code areas are for Provider use only. (See PPBI, Client Eligibility Certification Form Completion Section for code determinations.) □ No Do you currently receive Medi-Cal benefits or services? ☐ Yes 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 Yes ☐ No Maintenance Organization (HMO), Managed Care Plan, Student Health Insurance, etc.) Have you had out of pocket expenses for family planning/reproductive health services ☐ Yes ☐ No covered by the Family PACT program in the 3 months immediately preceding enrollment in the Family PACT program? Provider Use Do we need to keep your family planning services confidential from your partner, spouse, or Only—CODE ☐ Yes □No parent? How may we contact you if we need to talk to you about something? Confidentiality First name Middle name Last name Suffix (Jr., Sr.) ☐ Yes □ No Is your current name the same as your name at birth? If no, print your name at birth below. Suffix (Jr., Sr.) First name at birth Middle name at birth Last name at birth Number of live births County of residence Provider Use Nine-digit ZIP code Only-CODE Gender Provider Use Social security number Mother's first name Only-CODE ☐ Male ☐ Female Date of birth (mm/dd/yyyy) Provider Use Provider Use Provider Use State (if not California) Country (if not USA) Only—CODE Only-CODE Only—CODE Race/ethnicity 2 ☐ Black 3 Filipino 4 Hispanic 1 ☐ Asian 6 Pacific Islander 7 White 0 Other 5 Native American **Primary Language**

Privacy Statement (Civil Code Section 1798 et seq.)

2 Cantonese

7 Tagalog

4 Hmong

9 Vietnamese

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.

3 English

8 Spanish

5 Khmer/Cambodian

0 Other

employment, self-employment, tips, commissions, pensions, social security, child and/or spousal support, ongoing insurance payments, disability, Veterans Affairs, unemployment benefits, etc. **Gross Monthly Income** Relationship to You Name Age Source of 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 Signature of witness to mark or interpreter FOR PROVIDER USE ONLY ☐ Eligible for Family PACT Program Provider certification: ☐ 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 Date Reason code (see Provider Annual Certification: If client is decertified (no longer eligible)

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

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

DHCS 4461 (3-14)