State of California
Health and Human Services Agency

Department of Health Care Services

Client HAP number

HEALTH ACCESS PROGRAM
FAMILY PACT PROGRAM
CLIENT ELIGIBILITY CERTIFICATION

This Client Eligibility Certification (CEC) form is the property of the State of California, Department of Health Care Services, Office of Family Planning.
This form cannot be changed, altered, or prepopulated.

Step 1: Tell Us About Yourself

First name	Middle name	Last name	Suffix (Sr., Jr., III, IV etc.)

The Department of Health Care Services does not send mail to the address provided

Address ☐ Home ☐ Mailing			Apartment number
City	**State**	**Zip code**	**County of residence**

Date of birth (mm/dd/yyyy)	Social Security Number (SSN) Not having a SSN does not impact your ability to receive services.	Provider Use Only CODE

Marital status (optional)
☐ Single ☐ Never married ☐ Married ☐ Divorced
☐ Widowed ☐ Registered domestic partner ☐ I decline to answer

Race/Ethnicity (optional; check all that apply)
☐ White
☐ Black or African American
☐ American Indian or Alaska Native
☐ Native Hawaiian
☐ Other
☐ Asian Indian
☐ Cambodian
☐ Chinese
☐ Filipino
☐ Hmong
☐ Japanese
☐ I decline to answer
☐ Korean
☐ Laotian
☐ Vietnamese
☐ Guamanian or Chamorro
☐ Samoan

Are you of Hispanic, Latino, or Spanish origin? (optional)
☐ Yes ☐ No

If yes, check which ones:
☐ Mexican, Mexican American, or Chicano
☐ Salvadoran ☐ Guatemalan
☐ Cuban ☐ Puerto Rican
☐ Other origin

Primary language (check only one)
☐ English ☐ Armenian ☐ Cantonese ☐ Hmong ☐ Khmer/Cambodian ☐ Spanish
☐ Korean ☐ Tagalog ☐ Vietnamese ☐ Punjabi ☐ Hindi ☐ Ukrainian
☐ I decline to answer ☐ Other

Best way to contact you if we need to talk to you
☐ Phone ☐ Text ☐ Email ☐ Mail Message Number/Email

What is your sex? (required)

☐ Female ☐ Transgender: Male to Female
☐ Male ☐ Transgender: Female to Male

Sexual orientation and gender identity

The following information is optional and confidential.
It will not be used to determine eligibility.

What is your gender?
(check box that best describes your current gender identity)

☐ Female
☐ Male
☐ Transgender: male to female
☐ Transgender: female to male
☐ Non-binary (neither male or female)
☐ Another gender identity
☐ I decline to answer

Do you think of yourself as:

☐ Straight or heterosexual
☐ Gay or lesbian
☐ Bisexual
☐ Queer
☐ Another sexual orientation
☐ Unknown
☐ I decline to answer

What sex was listed on your original birth certificate?

☐ Female ☐ Male ☐ I decline to answer

Step 2: Other Health Coverage

I have had out of pocket expenses for family planning/reproductive health services covered by the Family PACT Program in the three months immediately preceding enrollment in the Family PACT Program.	☐ YES ☐ NO
I currently receive Medi-Cal benefits. If you know your Medi-Cal card number, write the number and date issued in the boxes. If you do not know, write UNKNOWN in the box. Medi-Cal Card Number _____ Issue Date _____	☐ YES ☐ NO
I have Medi-Cal with an unmet Share of Cost.	☐ YES ☐ NO
I have restricted Medi-Cal (such as “Emergency Medi-Cal”) that does not cover contraceptive methods.	☐ YES ☐ NO
I have Other Health Coverage that covers contraceptive methods. Other Health Coverage may include Medi-Cal Managed Care plans, Commercial Health Plans (Kaiser, BlueCross, Health Net) or student health insurance.	☐ YES ☐ NO
I do not know if I have other health coverage (check box if you do not know).	☐
I have health insurance through Medi-Cal or Other Health Coverage on my date of service, but I cannot use my insurance because I am concerned that my spouse, partner or parent(s) may be notified or informed of my family planning visit (this is called a barrier to access).	☐ YES ☐ NO Provider Use Only CODE _____

Taxable Income

List yourself and your family members (spouse and children) who live with you, and the taxable income sources for each person.

If someone claims you on their taxes, list everyone claimed on that person's tax form. Sources of income includes employment, self-employment, social security (even if not taxable), tips, spousal support received, unemployment benefits, etc. Request additional pages as needed.

If you are 17 years of age or younger, your parents income is excluded. A provider can talk with you more and help you find out your family size.

Name	Relationship To You	Age	Source of Income	Taxable Monthly Income
	(Self)			

Family size: Total taxable family income:

Step 3: Please Read And Sign Application

California Health Insurance Eligibility

I received information on how to apply and enroll for insurance affordability programs. ☐ YES ☐ NO
Please visit www.CoveredCA.com or call 1-800-300-1506 for assistance with completing the application for these programs.

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 giving false information may make me ineligible for this program.

Applicant Signature (or mark)	Date Signed

Privacy Statement (Civil Code § 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.

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

Nondiscrimination Policy

Section 1557 of Patient Protection and Affordable Care Act (ACA) prohibits discrimination on the basis of race, color, national origin, sex, age or disability in certain health programs or activities. In effect since 2010, section 1557 builds on long-standing federal civil rights laws: Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972, section 504 of the Rehabilitation Act of 1973 and the Age Discrimination Act of 1975.

Effective July 18, 2016, the Health and Human Services (HHS) Office for Civil Rights issued its final rule implementing section 1557 at Title 45 Code of Federal Regulations (CFR) Part 92. The rule applies to any health program or activity, any part of which receives federal financial assistance, an entity established under Title I of the ACA that administers a health program or activity, and HHS. In addition to other requirements, Title 45 CFR Part 92.201, requires:

- **Language assistance services requirements:** Language assistance services required under paragraph (a) of Part 92.201 must be accurate, timely and provided free of charge, and protect the privacy and independence of the individual with limited English proficiency.
- **Specific requirements for interpreter and translation services:** Subject to paragraph (a) of Part 92.201.
    - A covered entity shall offer a qualified interpreter to an individual with limited English proficiency when oral interpretation is a reasonable step to provide meaningful access for that individual with limited English proficiency.
    - A covered entity shall use a qualified translator when translating written content in paper or electronic form.

For more information about the application and requirements of the final rule implementing section 1557, providers should contact their representative professional organizations. They may also visit the section 1557 of the Patient Protection and Affordable Care Act page of the HHS website to find sample materials and other resources.

Language Services Notice

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 541-800-55551 (رقم هاتف الصم والبكم: 711 TTY.[Arabic]

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-541-5555 TTY：711 [Chinese]

ध्यान द□: य□द आप □हदी बोलते ह □तो आपके ि◌लए मुफ्त म□ भाषा सहायता सेवाएं उपलब्ध ह।□ 1-800-541-5555 TTY: 711 पर कॉल कर□। [Hindi]

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-541-5555 TTY: 711 [Hmong]

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-541-5555 TTY: 711 お電話にてご連絡ください。[Japanese]

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-541-5555 TTY: 711 번으로 전화해 주십시오.[Korean]

ប្រយ័ត្ន៖ ទេបើសិន□អ□កនិ□យ □□ែខ□រ, ទេស□ជំនួយផ□ក□□ ទេ□យមិនគិតឈ□□ល គឺ□ច□ននំ□ប់បំទេ□អ□ក។ ចូរ ទូរស័ព□ 1-800-541-5555 TTY: 711 [Cambodian]។

ਿਧਆਨ ਿਦਓ: ਜੇ ਤੁਸ□ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤ□ ਭਾਸ਼ਾ ਿਵੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-800-541-5555 TTY: 711 [Punjabi] 'ਤੇ ਕਾਲ ਕਰੋ।

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-541-5555 телетайп: 711 [Russian]

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-541-5555 TTY: 711 [Tagalog]

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-541-5555 TTY: 711 [Thai]

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-541-5555 TTY: 711 [Vietnamese]

Step 4:	PROVIDER USE ONLY

Provider certification:

- ☐ Eligible for Family PACT Program
- ☐ Ineligible for Family PACT Program (Give Fair Hearing Rights)

Why client is ineligible: _____

Medi-Cal client eligible for Family PACT verified:

☐ Limited scope ☐ Unmet share-of cost ☐ Barrier to Access

DECLARATION

My signature attests that based upon the information provided by the applicant and according to state and federal requirements, I certify that the applicant identified on this form is eligible to receive family planning services under the Family PACT Program. If ineligible, the client has received a copy of the CEC form which includes the Fair Hearing Rights. I also certify that the client was 1) informed of California health insurance eligibility programs through Covered California, 2) offered and received (or declined) a copy of the Notice of Privacy Practices, Nondiscrimination Policy and 3) if applicable, provided a Retroactive Eligibility Certification Form (DHCS 4001).

Print name	Signature	Date
Deactivation: If client is deactivated (no longer eligible)	Deactivation Date	Reason code Provider Use Only CODE