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

Client identification number

This form is the property of the State of California, California Department of Public Health, 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 a copy of this form in the client's medical record. (See PPBI, Client Eligibility Certification Form Completion Section for code determinations.)
- ***Code areas are for Provider use only***.

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

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

1 ☐ Armenian 2 ☐ Cantonese 3 ☐ English 4 ☐ Hmong 5 ☐ Khmer/Cambodian
6 ☐ Korean 7 ☐ Tagalog 8 ☐ Spanish 9 ☐ Vietnamese 0 ☐ Other

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 that the information I have given on this form is true, correct, and complete. 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.

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 has a right to a hearing conducted by the California Department of Public Health 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 review to the **First Level Review 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 appeal the decision of the first level review within five working days of your receipt of the decision of the first level review by sending your name, telephone number, address, and reason for the appeal to the **Formal Hearing address** below. At the hearing, you may be represented by a friend, relative, lawyer, or other person of your choice. A representative of the provider will be present to explain the reasons for denying eligibility. If you want an interpreter provided at the hearing, please specify the language in your letter requesting a hearing.

First Level Review

California Department of Public Health
Office of Family Planning
MS 8400
P.O. Box 997420
Sacramento, CA 95899-7420

Formal Hearing

California Department of Public Health
Office of Regulations and Hearings
MS 0507
P.O. Box 997377
Sacramento, CA 95899-7377