HAP Identification Number

Family Planning, Access, Care, and Treatment (Family PACT) Program Client Eligibility Certification (CEC) Application

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

This program provides confidential, no-cost family planning and reproductive health services to eligible individuals.

Step 1 Tell Us About Yourself

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

Date of birth (MM/DD/YYYY)	**Social Security Number (SSN)** (optional)
	Not having a SSN does not impact your ability to receive services.

DHCS will not send mail to this address without your consent.

Street address ☐ Home (default) ☐ Mailing	**Apartment/Suite number**

City	**State**	**Zip code**	**County of residence**

Preferred contact method
☐ Phone ☐ Text ☐ Email ☐ Mail Number/Email:

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
☐ Asian Indian
☐ Cambodian
☐ Chinese
☐ Filipino
☐ Hmong
☐ Japanese
☐ Korean
☐ Laotian
☐ Vietnamese
☐ Guamanian or Chamorro
☐ Samoan
☐ Other:
☐ I decline to answer

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

If yes, what is your origin?
☐ Mexican, Mexican American, or Chicano
☐ Salvadoran ☐ Guatemalan
☐ Cuban ☐ Puerto Rican
☐ Other origin

Primary language (check only one)

☐ English	☐ Chinese	☐ Japanese	☐ Punjabi	☐ Thai
☐ Arabic	☐ Farsi	☐ Korean	☐ Russian	☐ Ukrainian
☐ Armenian	☐ Hindi	☐ Laotian	☐ Spanish	☐ Vietnamese
☐ Cambodian	☐ Hmong	☐ Mien	☐ Tagalog	☐ Other:
				☐ I decline to answer

What is your sex? (required)

☐ Female ☐ Male ☐ Transgender: male to female ☐ 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 sex was listed on your original birth certificate?

☐ Female ☐ Male ☐ I decline to answer

What is your gender identity?
(Select the option that best describes your current gender identity.)

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

What is your sexual orientation?

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

Step 2 Health Coverage

A provider must affirm client eligibility, which includes income, household/family size, and health coverage status at each visit.

1. **Do you currently receive Medi-Cal benefits?** ☐ Yes ☐ No – *Skip to Question 4.*
   If Yes, provide your Medi-Cal Card or Beneficiary Identification Card (BIC) number and issue date.
   Medi-Cal card number: Issue Date (MM/DD/YYYY):
   Check box, if you do not know your Medi-Cal card number or issue date. ☐

2. **Do you have Restricted Scope Medi-Cal that does not cover contraceptive methods?**
   ☐ Yes – *Skip to Question 4.* ☐ No

3. **Have you met your Share of Cost (SOC) for Medi-Cal?**
   ☐ Not applicable. My Medi-Cal does not have Share of Cost. *Skip to Question 6.*
   ☐ Yes, I have met my Share of Cost. *Skip to Question 6.*
   ☐ No, I have an unmet Share of Cost.
   Share of Cost (SOC) is similar to a private insurance plan's out-of-pocket deductible. It is a monthly dollar amount that some Medi-Cal recipients must pay toward their medical expenses.

4. Do you have other health coverage that covers contraceptive methods?

☐ Yes, I have private health insurance, such as a commercial health plan or student health plan.

☐ No, I don't have other health coverage for family planning services. *Skip to Step 3*.

☐ I do not know. *Skip to Step 3*.

Examples of commercial health plans include Kaiser, Blue Cross, Health Net, etc.

5. Has your deductible been met for your other health coverage?

☐ Yes

☐ No – *Skip to Step 3*.

☐ I do not know. – *Skip to Step 3*.

The deductible is the amount that you owe for health care services that your health insurance plan covers before your health care plan begins to pay.

6. Are you unable to use your other health coverage due to a barrier to access?

☐ Yes ☐ No

A barrier to access means that you cannot use your health coverage because you are concerned a spouse, partner, parent, or guardian may be notified or informed of your family planning office visit.

Step 3 Family Size and Income

If you are a tax filer, list yourself and your family members (spouse and dependents) who live with you in your household, and the taxable monthly income sources for each person. Enter "0" in the last column, under Taxable Monthly Income, if you or your family member do not have a taxable monthly income.

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

A minor's application is considered a household/family size of one and only the minor's monthly taxable income is considered. If you are 17 years of age or younger, your parents' or guardians' taxable monthly income is excluded.

If you need assistance to determine your tax filing status, household/family size, income source, and taxable monthly income which is used to determine eligibility for Family PACT Program benefits, please talk with a Family PACT Program provider staff or call the Office of Family Planning at (916) 650-0414.

You may add additional pages to detail your household/family size and taxable monthly income.

First Name and Last Name	Relationship to You	Age	Income Source	Taxable Monthly Income
	(Self)			
Family/household size:		**Total taxable monthly income:**		

Step 4 Health Insurance Affordability Programs and Retroactive Eligibility

California Health Insurance Eligibility

I received information on how to apply and enroll for insurance affordability programs, information about the open enrollment periods for Covered California, and the continuous enrollment aspect of the Medi-Cal program.

☐ Yes ☐ No

Retroactive Eligibility

Have you had out-of-pocket expenses for family planning services in the last 90 calendar days that could be covered by the Family PACT Program?

☐ Yes ☐ No

Retroactive eligibility allows a client, who has paid for family planning services in the last 90 calendar days prior to enrollment, to apply for reimbursement of those costs.

Step 5 Please Read and Sign Application

I declare under penalty of perjury under the laws of the State of California that the foregoing information on this application is true and correct. I understand that giving false information may make me ineligible for this program. I declare that I have been informed of my rights and responsibilities. If an authorized representative signs for you, they must include their name, signature, date, relationship to the applicant, and phone number.

Applicant

Signature of applicant	Date

Authorized Representative, if applicable

Print name of authorized representative	
Signature of authorized representative	Date
Relationship of applicant	Phone number

Provider Certification

1. Select the enrollment method used to determine certification of applicant or recertification of client:
   ☐ In-Person ☐ Phone (Audio-only) ☐ Video (Audio/Visual)
2. Is the applicant or client eligible for the Family PACT Program?
   ☐ Yes ☐ No, select reason for ineligibility:
   - ☐ Not a California resident
   - ☐ Total taxable monthly income above 200% annual federal poverty guidelines
   - ☐ Has Medi-Cal or other health coverage without an eligibility criteria exception
   - ☐ No medical necessity for family planning services
3. Is the applicant or client currently enrolled in Medi-Cal (check Medi-Cal Eligibility Verification System)?
   ☐ Yes ☐ No ☐ N/A (evidence of non-Medi-Cal other health coverage)
4. If the applicant or client has Medi-Cal, select the reason for Family PACT eligibility:
   ☐ Restricted scope ☐ Unmet share of cost ☐ Barrier to Access
5. Provide the following client notification and recordkeeping compliance.
   a. Did the applicant or client decline receipt of any hard copy document in the declaration below?
      ☐ Yes ☐ No
   b. For telehealth eligibility determination, applicant's or client's signature was obtained via:
      ☐ Electronic signature ☐ Recorded oral signature
   c. Documents or HAP ID number delivery method:
      ☐ In-Person ☐ Mail ☐ HIPAA compliant method

DECLARATION

I certify that the applicant or client was:

1) Informed of California health insurance eligibility programs through Covered California;
2) Offered a copy of the Family Planning Patient Rights at https://familypact.org/clinical-resources/ or informed that they could view a copy posted at the service location;
3) Offered and received (or declined) a copy of the Notice of Privacy Practices and Nondiscrimination Policy;
4) Provided a Retroactive Eligibility Certification Application (DHCS 4001), if applicable; and
5) Informed of the Fair Hearing Rights.

My signature attests that, based on the information provided by the applicant or client and in accordance with the requirements of the *Family PACT Policies, Procedures, and Billing Instructions (PPBI) Manual*, I certify that the individual identified on this application is eligible to receive Family PACT Program services. If the individual is not eligible, I certify that I have provided a copy of this application, which includes information on Fair Hearing Rights. I declare under penalty of perjury under the laws of the State of California that the foregoing information is true, accurate, and complete to the best of my knowledge and belief.

Print Name	Signature	Date

This form must be retained for a period of at least three years in accordance with Welfare and Institutions Code section 24005(p).

Rights and Responsibilities

Privacy Statement (Civil Code § 1798, et seq.)

This application will be used to determine your eligibility for the Family, Planning, Access, and Treatment (Family PACT) Program. Information will also be used to monitor health outcomes and for program evaluation purposes. The information is being requested by DHCS' Office of Family Planning under Welfare and Institutions Code §§ 14132(aa) and 14501(k). Information you provide is protected by the Information Practices Act of 1977 (California Civ. Code, § 1798, et seq.), and may be protected by other laws, such as the Health Insurance Portability and Accountability Act of 1996 (45 C.F.R. Parts 160, 164).

The information requested in this application is required unless it is marked, "optional." If you do not provide the information requested, we will not be able to determine your eligibility. DHCS may share the information with: (1) other state agencies to perform their legal duties where the use is compatible with a purpose for which it was requested; (2) government entities if required by state or federal law; and (3) other entities, as permitted by state or federal law, as outlined in DHCS' Notice of Privacy Practices. Please do not provide any personal or medical information other than what is specifically requested.

In most cases, individuals have a right to access their own information within state records. For more information or access to the information requested on this application, contact:

Department of Health Care Services
Office of Family Planning
P.O. Box 997413, MS 8400
Sacramento, CA 95899-7413
Phone: 916-650-0414
Email: familypact@dhcs.ca.gov

DHCS' Notice of Privacy Practices is available at:
https://www.dhcs.ca.gov/formsandpubs/laws/priv/Pages/NoticeofPrivacyPractices.aspx.

The Privacy Policy Statement is available at: https://www.dhcs.ca.gov/pages/privacy.aspx.

The privacy notice is required by California Civil Code section 1798.17.

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 client does not have a right to contest changes made to the eligibility standards or benefits of the Family PACT Program.

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

California Department of Health Care Services
Office of Family Planning
P.O. Box 997413, MS 8400
Sacramento, CA 95899-7413

Formal Hearing: You may request a formal hearing within 90 calendar 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 could not file for a hearing within the 90 calendar days, you may still file for a hearing. If you provide good cause, your request may still be scheduled.

Provide the requested information such as your full name, phone number, address, and the reason for the Formal Hearing and mail it to the 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 to request a formal hearing. If you have trouble understanding English, be sure to state your language so arrangements can be made to have language assistance at the formal hearing. If you have an authorized representative, be sure to state their name, phone number, and address. Keep a copy of your formal hearing request for your records.

Mailing Address
California Department of
Social Services
State Hearings Division
P.O. Box 944243, MS 9-17-37
Sacramento, CA 94244-2430

Call Toll-Free
California 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

The Department of Health Care Services (DHCS) complies with applicable State and Federal civil rights laws. DHCS does not unlawfully discriminate against, exclude, or treat people differently on the basis of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation.

DHCS:

- Provides free aids and services in a timely manner to people with disabilities to communicate effectively with DHCS, such as:
  - Qualified sign language interpreters
  - Written information in other formats, such as large print, braille, audio, or written information in other formats, such as large print, or accessible electronic formats such as braille, audio, or digital text conforming with accessibility standards including TXT, PDF, MS Word, and HTML.
- Provides free language services in a timely manner to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call the Office of Civil Rights at **1-916-440-7370**, 711 (California State Relay) or email CivilRights@dhcs.ca.gov. Upon request, this document can be made available to you in braille, large print, audio, or other accessible electronic format.

If you believe DHCS has failed to provide these services, or you have been discriminated against in another way on the basis of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation, you can file a grievance with the Office of Civil Rights.

Department of Health Care Services
Office of Civil Rights
P.O. Box 997413, MS 0009
Sacramento, CA 95899-7413
(916) 440-7370, 711 (California State Relay)
Email: CivilRights@dhcs.ca.gov

If you need help filing a grievance, the Office of Civil Rights can help you. Complaint forms are available at: https://www.dhcs.ca.gov/discrimination-grievance-procedures.

If you believe that you have been discriminated against on the basis of race, color, national origin, age, disability, or sex, you can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights. You can file electronically through the Office for Civil Rights Complaint Portal at: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or you can file by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue
S.W. Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, TTY 1-800-537-7697

Complaint forms are available at: http://www.hhs.gov/ocr/office/file/index.html.

Language Services Notice

شعار: إذا كنت تتحدث العربية، يمكنك الحصول على خدمات المساعدة اللغوية مجانًا. يرجي الاتصال بالرقم
.[Arabic] 1-800-541-5555 TTY: 711

注意: 如果您會說中文、您可以免費獲得語言協助服務。致電

1-800-541-5555 TTY:711 [Chinese]

सूचना: अगर आप हिंदी बोलते हैं, तो आप निःशुल्क भाषा सहायता सेवाएँ प्राप्त कर सकते हैं। कृपया 1-800-541-5555 TTY: 711 पर कॉल करें [Hindi]

CEEB TOOM: Yog tias koj hais Lus Hmoob, koj tuaj yeem tau txais cov kev pab cuam txhais lus pub dawb xwb. Hu rau 1-800-541-5555 TTY: 711 [Hmong]

注意: 日本語を話せる方には、無料言語支援サービスがございます。電話
1-800-541-5555 TTY: 711 [Japanese]

참고 사항: 한국어를 하는 있는 경우 무료로 언어 지원 서비스를 받을 수 있습니다.
1-800-541-5555 TTY: 711 로 문의하십시오. [Korean]

សម្គាល់៖ ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ អ្នកអាចទទួលបានសេវាជំនួយផ្នែកភាសាដោយឥតគិតថ្លៃ។ សូមទូរសព្ទទៅលេខ 1-800-541-5555 TTY: 711 [Cambodian]

ਨੋਟਿਸ: ਜੇਕਰ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਤੁਸੀਂ ਮੁਫਤ ਵਿੱਚ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਹਾਸਲ ਕਰ ਸਕਦੇ ਹੋ। ਕਾਲ ਕਰੋ 1-800-541-5555 TTY: 711 [Punjabi]

УВЕДОМЛЕНИЕ: Если Вы говорите по-русски, Вы можете получить услуги языковой помощи бесплатно. Звоните по номеру 1-800-541-5555 TTY: 711 [Russian]

PAUNAWA: Kung Tagalog ang gamit ninyo, maaari kang makatanggap ng mga tulong sa wikang mga serbisyo nang walang bayad. Tumawag sa 1-800-541-5555 TTY: 711 [Tagalog]

โปรดทราบ: ถ้าคุณพูดภาษาไทย คุณสามารถรับบริการความช่วยเหลือด้านภาษาโดยไม่เสียค่าใช้จ่ายได้ โทรไปที่

1-800-541-555 TTY: 711 [Thai]

THÔNG BÁO: Nếu bạn nói tiếng Việt, bạn có thể tiếp nhận các dịch vụ trợ giúp ngôn ngữ miễn phí. Hãy gọi đến số 1-800-541-5555 TTY: 711 [Vietnamese]