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.)

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)			
	SELF			

Family size: 1

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.

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)	Date	Reason code Provider Use Only CODE