State of California
Health and Human Services Agency

Department of Health Care Services

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

Client HAP 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.

- Providers must keep this original form in your medical record.
- ***Code areas are for Provider use only.***
  (See PPBI, Client Eligibility Certification Form Completion Section for code determinations.)

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

Have you had out of pocket expenses for family planning/reproductive health services covered by the Family PACT program in the 3 months immediately preceding enrollment in the Family PACT program? ☐ Yes ☐ No

Does your concern that your partner, spouse, or parent learn about your family planning appointment keep you from using your health care insurance? ☐ Yes ☐ No

How may we contact you if we need to talk to you about something?

	Provider Use Only CODE

First name	Middle name	Last name	Suffix (Jr., Sr.)

Is your current name the same as your name at birth? ☐ Yes ☐ No
If no, print your name at birth below.

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	9-digit ZIP code

Gender ☐ Male ☐ Female Provider Use Only CODE	Mother's first name (optional)	Social security number

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

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

Eligibility Determination: Please list all family members (self, spouse, and children) and all taxable income sources. If someone else claims you on their taxes, list everyone claimed and all related taxable income sources. Reportable income includes but is not limited to: income from employment, self-employment, social security (even if not taxable), passive income (dividends, interest, etc.), pensions and annuities, tips, commissions, spousal support received, and unemployment benefits.

Name	Relationship to You	Age	Source of Income	Taxable Monthly Income
	(Self)			
Family size:			Total taxable family income $	

I received information on how to apply for insurance affordability programs ☐ Yes ☐ No
I understand that I can visit 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 the giving of false information may make me ineligible for this program.

Signature (or mark) of applicant	Signature of witness
Date	Date

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.