



Family PACT

Client Eligibility Certification (CEC)

and Enrollment

Self-Study Module

Presented by
Office of Family Planning
California Department of Public Health





Accompanying Documents for this Module

- All documents referenced in this module, including the module evaluation form are available for you to download from the www.familypact.org website.
- Prior to beginning the module, you can print the documents by clicking on the list located just below the actual module link.
- You can also access documents via the links as indicated within this module.





Navigation Tips

- **Click links to view documents at the end of the narration for each slide.**
- **Close document with ‘Back’ arrow to return to the module.**
- **Close all other Internet windows and applications before starting the module.**
- **Use arrow keys on keyboard to manually advance or reverse slides.**





Purpose of this Module

- **Family PACT providers are required to correctly document client eligibility.**
- **Correct CEC forms provide important client demographic data.**
- **This module can help staff avoid common mistakes.**





Objectives

- 1. Identify how to protect client confidentiality during enrollment.**
- 2. Determine who is eligible to enroll as a Family PACT client.**
- 3. Understand the difference between confidentiality as an enrollment criterion vs. confidential services in the practice setting.**
- 4. Identify how to accurately complete the CEC form.**





Confidentiality





Family PACT Standards

**Standard - B. Confidentiality,
Item #1 states:**

“All services including the eligibility determination process shall be provided in a manner that respects the privacy and dignity of the individual client.”





Maintaining Confidentiality

- **Ask reason for visit away from others.**
- **Place partitions between clients at the front desk.**
- **Have others wait at least 4 ft from desk behind a line on the floor.**
- **Review personal, family, and income information in a confidential area.**
 - back office area
 - counseling room
 - exam room





Determining Client Eligibility





Determining Client Eligibility

- **Family PACT eligibility is based on client self-report.**
- **Clients do not provide any supporting documentation.**
- **Clients consent for services in Family PACT.**
- **There are both financial and clinical determinations of eligibility.**





Who is Eligible?

- **California residents**
- **200% Federal Poverty Level (determined by family size and income)**
- **At risk of pregnancy or causing pregnancy**
- **Women (through age 55), Men (through age 60)**
- **No other source of health care for family planning services**





Who is NOT Eligible? (1 of 2)

- **Has other insurance coverage or full-scope Medi-Cal**
- **Is NOT a California resident**
- **Gross family Income more than 200 percent federal poverty level**
- **Is NOT at risk of pregnancy or causing pregnancy**





Who is NOT Eligible? (2 of 2)

- **Older than age 55 (females) or 60 (males)**
- **Inmate in prison, jail, or juvenile detention center**
- **Eligibility status change since last visit**
- **Has Medi-Cal Managed Care**





More about Medi-Cal Managed Care Clients

- **Medi-Cal Managed Care clients may seek family planning services outside of their designated plan**
- **Family PACT providers should serve these clients, but do not enroll them into Family PACT**
- **Family PACT providers must bill the managed care health plan for services**
- **Plans must reimburse any qualified out-of-plan family planning provider who provides services to a plan member**





Other Eligibility Issues

- **Sample Questions to assess other coverage:**
 1. “How did you pay for family planning services in the past? Can you use that coverage now? Why not?”
 2. “Have you used Medi-Cal in the past to pay for family planning services? Do you have a BIC card? Can you use it now?”
- **Regarding residency: those whose permanent address is outside of CA or those in CA on vacation are not eligible.**
- **Federal Poverty Level income guidelines published in the PPBI.**





Completing the CEC Form



Completing the CEC Form

State of California—Health and Human Services Agency

California Department of Public Health

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 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 907420
 Sacramento, CA 95899-7420

Formal Hearing

California Department of Public Health
 Office of Regulations and Hearings
 MS 0507
 P.O. Box 907377
 Sacramento, CA 95899-7377

Completing the CEC Form Side One

- **Other health coverage**
- **“Barriers to access”**
- **Contact information**
- **Social Security Number**





Side One



Other Health Care Coverage

State of California—Health and Human Services Agency

California Department of Public Health

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- **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

Other Health Care Coverage

Provider Use Only—CODE



Other Health Care Coverage (OHC)

Clients with OHC may be eligible if:

- The OHC does not cover any method
- The client cannot meet the OHC annual deductible on date of service
- The client cannot meet the Medi-Cal Share-of-Cost on date of service
- A student with only student health services has no health coverage for contraceptive methods
- The client has limited-scope Medi-Cal that does not cover family planning, for example,
 - Emergency-only Medi-Cal
 - County Medical Service Program (CMSP)
 - Pregnancy-only Medi-Cal



Side One

Other Health Care Coverage

Note: Seeking a specific method not offered by OHC even though it offers *some* form of contraceptive is not a criterion for Family PACT eligibility.





Barrier to Access- Confidentiality Concerns

State of California—Health and Human Services Agency

California Department of Public Health

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Do you currently receive Medi-Cal benefits or services? Yes No

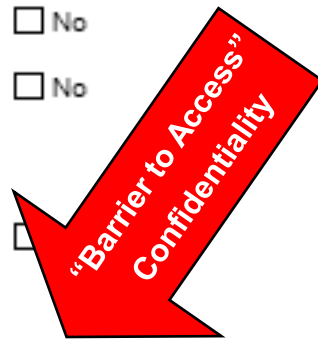
Do you have a Medi-Cal Benefits Identification Card (BIC)? Yes No

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



Side One

Residency & Other Information



Client Information

		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. <input type="checkbox"/> Yes <input type="checkbox"/> 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	Provider Use Only—CODE	Social security number		Mother's first name		
<input type="checkbox"/> Male <input type="checkbox"/> Female						
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 <input type="checkbox"/> Asian	2 <input type="checkbox"/> Black	3 <input type="checkbox"/> Filipino	4 <input type="checkbox"/> Hispanic			
5 <input type="checkbox"/> Native American	6 <input type="checkbox"/> Pacific Islander	7 <input type="checkbox"/> White	0 <input type="checkbox"/> Other			
Primary Language						
1 <input type="checkbox"/> Armenian	2 <input type="checkbox"/> Cantonese	3 <input type="checkbox"/> English	4 <input type="checkbox"/> Hmong	5 <input type="checkbox"/> Khmer/Cambodian		
6 <input type="checkbox"/> Korean	7 <input type="checkbox"/> Tagalog	8 <input type="checkbox"/> Spanish	9 <input type="checkbox"/> Vietnamese	0 <input type="checkbox"/> 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.

Side One

Social Security Number

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. <input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/> Male <input type="checkbox"/> Female	Provider Use Only—CODE	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 <input type="checkbox"/> Asian	2 <input type="checkbox"/> Black	3 <input type="checkbox"/> Filipino	4 <input type="checkbox"/> Hispanic	5 <input type="checkbox"/> Native American	6 <input type="checkbox"/> Pacific Islander	7 <input type="checkbox"/> White	0 <input type="checkbox"/> Other
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Complete eligibility information on reverse side.

Completing the CEC Form Side Two

- **Family size**
- **Total family Income**
- **Client certification**
- **Provider certification**
- **Fair hearing rights**



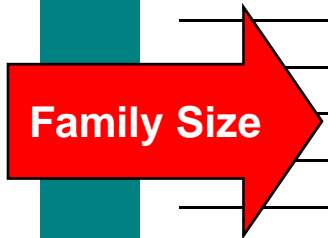


Side Two

Determining Family Size

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



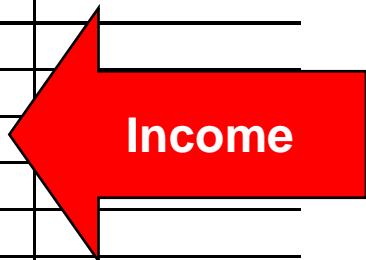


Side Two

Client Income

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	\$



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Income Guidelines

**Federal Income Guidelines
 200 Percent of Poverty by Family Size
 Effective for dates of service on or after May, 1 2008**

Number of Persons	Monthly Income	Annual Income
1	\$ 1,734	\$ 20,800
2	\$ 2,334	\$ 28,000
3	\$ 2,934	\$ 35,200
4	\$ 3,534	\$ 42,400
5	\$ 4,134	\$ 49,600
6	\$ 4,734	\$ 56,800
7	\$ 5,334	\$ 64,000
8	\$ 5,934	\$ 71,200
9	\$ 6,534	\$ 78,400
10	\$ 7,134	\$ 85,600
For each additional member, add	\$ 600	\$ 7,200





Enrolling Adolescents

When determining eligibility, consider that adolescents:

- **By law, can consent for family planning without parental consent**
- **Can consent for STI treatment at age 12**
- **Are considered a family size of one**
- **Should consider allowance as income**
- **Have no income requirement if under age 14**





Side Two

Client Certification

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.

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Family size:			Total family income	\$

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Signature of applicant	Date	Signature of witness to mark or interpreter	Date
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Side Two

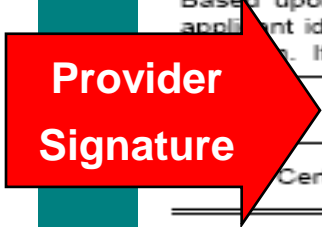
Provider Certification

FOR PROVIDER USE ONLY

Provider certification: Eligible for Family PACT Program
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Medi-Cal client eligible for Family PACT verified: Limited scope Unmet share-of-cost

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	Signature	Date
Certification: If client is decertified (no longer eligible)	Date	Reason code (see Provider Manual)

Fair Hearing Rights

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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.

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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
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 MS 0507
 P.O. Box 997377
 Sacramento, CA 95899-7377

Side Two

Fair Hearing Rights

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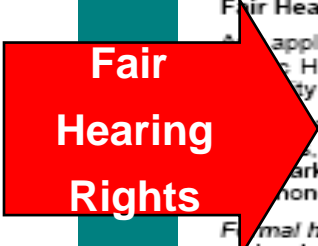
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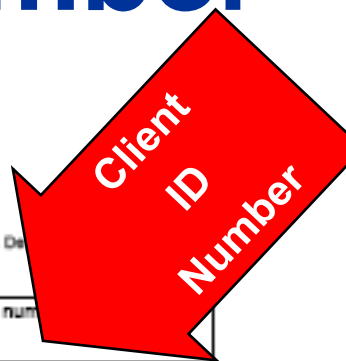
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 MS 8400
 P.O. Box 997420
 Sacramento, CA 95899-7420

Formal Hearing

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Client Identification Number (CIN)



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California Department of Public Health

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BIC number	Issue date
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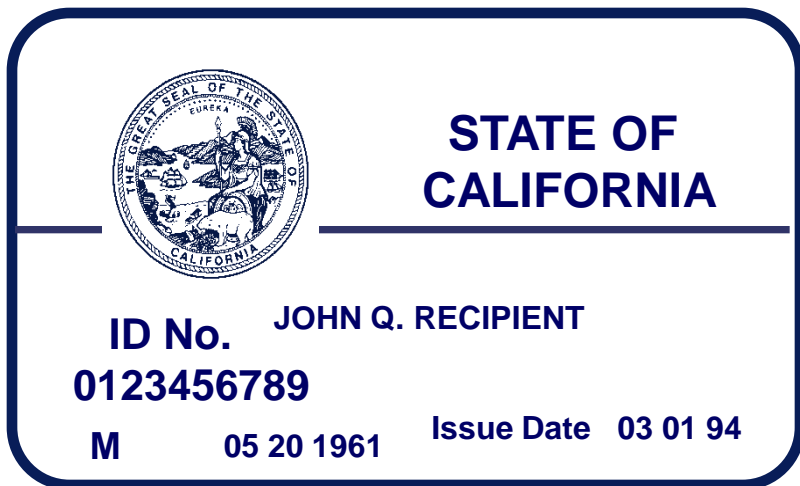
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Confidentiality

Provider Use Only—CODE



HAP

Family PACT ID card



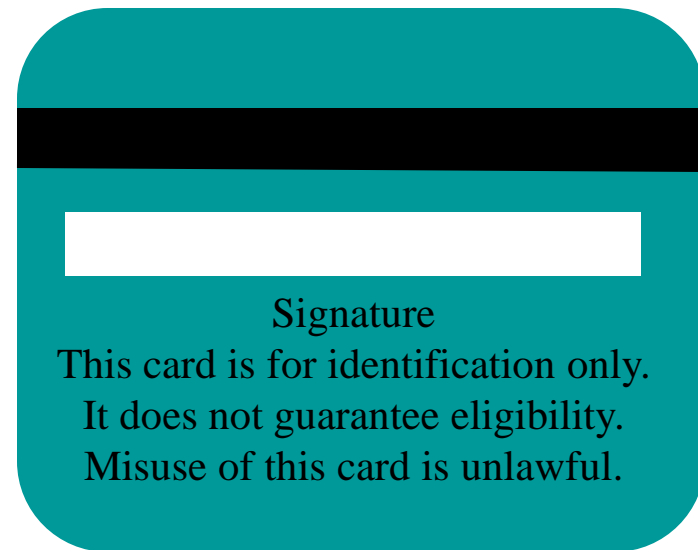
BIC

check Medi-Cal first

Order additional cards at 1-800-541-5555

HAP Replacement Card

- HAP Card



Health Access Programs (HAP) Replacement Card



HAP Card – Key Points

- **HAP Card must be activated immediately once client is certified**
- **Have client sign back of card**
- **Clients must have their card to access services when and where they choose**
- **Clients need only one HAP Card and number**
- **Attempt to deactivate lost or stolen cards**
- **Explain clearly the services clients can access with the HAP Card**





Eligibility Transactions

- 1. Activation**
- 2. Recertification**
- 3. Inquiry**
- 4. Update**
- 5. Deactivation**

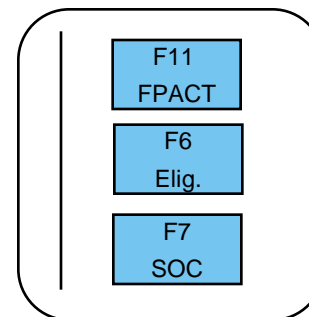




Methods to Perform Eligibility Transactions

POS/T7 Device

- Point of Service (POS) Device

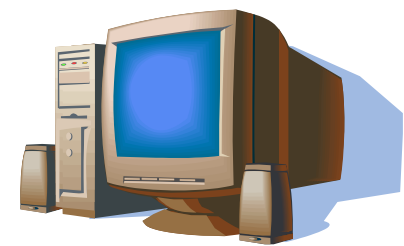




Methods to Perform Eligibility Transactions

Internet

- Internet
 - www.medi-cal.ca.gov





Methods to Perform Eligibility Transactions

AEVS

- Automated Eligibility Verification System (AEVS)





Eligibility Confirmation

- **All Family PACT-eligible clients will have an aid code of 8H.**
- **Providers will receive the aid code 8H message unless client has been deactivated**
- **Deactivation may be due to client ineligibility**
- **For more information regarding client deactivation, see PPBI, client elig cert section**
- **Period of eligibility – one year (365 days)**





Client Recertification

- **Check client eligibility information for accuracy at each visit.**
- **Questions you can ask:**
 1. **Has your income changed since your last visit?**
 2. **Has the number of people living with you changed since your last visit?**
 3. **Have you or your spouse started a new job with health benefits since your last visit?**
- **Clients must be recertified every year.**
- **Fill out a new CEC form each year, client keeps same HAP card number**





In Summary

- **Every client must have a completed CEC form on file in their chart**
- **Clients must be recertified by completing a new CEC form every 365 days**
- **HAP card must be activated and recertified by POS device, Internet or AEVS**
- **Eligibility must be confirmed at every visit**
- **If client is no longer eligible deactivate card**
- **If client may return to the program, file card for future use**



Provider Support Services



**Telephone Service Center (TSC)
1-800-541-5555**

- **TSC Operator Assistance**
- **HAP card orders**
- **EDS Field Representative**





Provider Support Services

- **1- 877- FAMPACT**
Toll-free Provider Resource Line
- **916-650-0414**
Office of Family Planning
- **www.familypact.org**
Program information, trainings, online modules





Provider Support Services

- **Family PACT E-News**

Web-based update emailed to providers on the latest in Family PACT. To sign up, email familypact@cfhc.org.

- **www.medi-cal.ca.gov**

Medi-Cal policy and information.

Revised Family PACT Manual- Policies, Procedures and Billing Instructions (PPBI).





Upon exiting this module, if you have not already done so, please download the Evaluation Form for this module by clicking the link below and email the completed form to:

familypact@cfhc.org

**Or fax the completed form to:
(213) 368-4428**

Thank you!

