Client Eligibility

Page updated: April 2023

‹‹The following section contains the administrative practices of the enrolled Family Planning, Access, Care and Treatment (Family PACT) provider for determining client eligibility and certifying clients for the Family PACT Program.

Provider Responsibility for Eligibility Determination

A Family PACT Program provider, through the Family PACT provider enrollment process, accepts the responsibility for appropriate onsite, synchronous video, or audio-only synchronous determination of eligible clients according to program guidelines and administrative practices. Eligibility determination via any asynchronous modality is not allowed. Only enrolled Family PACT providers may determine client eligibility and enroll Family PACT clients. Eligibility determination is a provider administrative function that is not reimbursable under the Family PACT Program. Time spent enrolling or recertifying clients into the Family PACT Program is not a billable service, regardless of the modality used. Any provider who includes time spent on eligibility determination in the CPT® and HCPCS codes billed to Family PACT for Evaluation and Management (E&M) and Education and Counseling (E&C) office visits will be subject to disenrollment. Medi-Cal pharmacies and laboratories may not perform eligibility determination or enroll clients. Information reported by the client about health care coverage, family size and income are used by the provider to determine eligibility. The client must meet all of the eligibility criteria outlined in this section.

A Family PACT provider is prohibited from exchanging, and/or offering to exchange, anything of value in an effort to induce or reward the referral of, or application to, the Family PACT Program. Failure to adhere to this policy will result in disenrollment from Family PACT.

Remote Eligibility Determination

A Family PACT provider may enroll and recertify clients through synchronous video or audio-only synchronous telehealth modalities. For purposes of this section, “synchronous” means a real-time interaction between the client and a provider located at a distant site, in accordance with Section 2290.5(a)(5) of the Business and Professions Code.

The following apply when utilizing synchronous modalities:

- A provider may complete the Client Eligibility Certification (CEC) form (DHCS 4461) and Retroactive Eligibility Certification (REC) form (DHCS 4001), if applicable, on behalf of the applicant/client.
- The provider is required to complete each field on the CEC form (DHCS 4461) and REC form (DHCS 4001) on behalf of the client based on the applicant/client’s responses. The CEC form (DHCS 4461) or REC form (DHCS 4001) must not be prepopulated.››

- ‹‹Providers have the following options to obtain an applicant/client's signature when the individual is not in-person:

  1. Recorded oral signature: Providers must ensure that they are able to collect an audio or video recording that can be stored in the client's medical record and retrieved upon request. Providers may use either of the following two options for audio or video-recorded signatures.

     a. Recording only the signature portion of the audio or video synchronous interaction. When recording only the signature portion of the interaction, providers must record the portion of the interaction where the applicant/client acknowledges and confirms that all information provided is true and correct under penalty of perjury, where the applicant/client providers their understanding that the oral signature holds the same weight as a written signature, and where the applicant/client provides their oral signature; or

     b. Recording the entire audio or video synchronous interaction with the oral signature included.

Regardless of the option providers choose, providers must obtain consent and inform the applicant/client which portion of the audio/video synchronous interaction is being recorded, and ensure they are able to store and easily access audio or video-recorded signatures in the client's medical record or securely store a recorded oral signature and document its location in the client's medical record.

2. Electronic signature: Providers may obtain an electronic signature. Consistent with the Uniform Electronic Transactions Act, California Civil Code Section 1633.2, an "electronic signature" is an electronic sound, symbol, or process attached to or logically associated with an electronic record and executed or adopted by a person with the intent to sign the electronic record. An electronic signature includes a "digital signature," defined in subdivision (d) of Section 16.5 of the Government Code, to mean an electronic identifier, created by computer, intended by the party using it to have the same force and effect as the use of a manual signature.

Regardless of the type of electronic signature collected, providers must ensure that they are able to store and/or easily access documentation of the electronic signature in the client's medical record.››

- ‹‹Regardless of the method used to obtain the signature on the CEC form (DHCS 4461) or REC form (DHCS 4001), providers must recite the Privacy Statement and ensure the applicant/client was:
  1. Informed of the California health insurance affordability programs through Covered California.
  2. Offered a copy of the Notice of Privacy Practices. Providers must document the date the Notice was received or declined in the client's medical record.
  3. Offered a copy of the Nondiscrimination Policy. Providers must document the date the Policy was received or declined in the client's medical record.
  4. If applicable, provide the original REC form (DHCS 4001).

Family PACT providers must arrange for the client to receive the Notice of Privacy Practices, Nondiscrimination Policy, and REC form (DHCS 4001), if applicable. Options include, but are not limited to, in-person pick up, sending via electronic mail, mailing to the client's home or mailing address, or any other HIPAA-compliant manner (e.g., patient portal). If a client elects to receive the Notice of Privacy Practices, Nondiscrimination Policy, or REC form (DHCS 4001) through the mail, the provider must receive and document the express consent of the client to mail it and must ensure that the address is verified as a valid address.

- The provider or designee must sign the CEC form (DHCS 4461) or REC form (DHCS 4001).
- The original CEC form (DHCS 4461) and a copy of the REC form (DHCS 4001) must be maintained in the client's medical record.
- Family PACT providers must provide the client with their HAP card number and arrange for the client to receive their HAP card to ensure a client has continued access to pharmacy, laboratory services, and other Family PACT covered benefits. Options include, but are not limited to, in-person pick up or mailing to the client's home or mailing address. If the HAP card is mailed, the provider must receive and document the express consent of the client to mail it and must ensure that the address is verified as a valid address.
- If the applicant/client is deemed ineligible for Family PACT, the applicant/client must receive a copy of the CEC form (DHCS 4461), which includes the Fair Hearing Rights. Options include, but are not limited to, in-person pick up, sending via electronic mail, or mailing to the client's home or mailing address. If mailed, the provider must receive and document the express consent of the client to mail it and must ensure that the address is verified as a valid address.

All administrative practices for determining client eligibility as noted in this section, including how to certify clients as eligible for the Family PACT Program, also apply to remote eligibility determination unless otherwise stated.››

Eligible Clients

To be eligible for Family PACT benefits, clients must meet all of the following criteria:

- The client must be a resident of California.
- The client must have a total taxable family income at or below 200 percent of the federal poverty guidelines.
- The client must have no other source of health care coverage for family planning services, or meet the criteria specified for eligibility with Other Health Coverage (OHC). For more information, refer to “Eligible Clients with Other Health Coverage” on a following page.
- The client must have a medical necessity for family planning services.

‹‹Ineligible Individuals

An individual is not eligible for Family PACT benefits for any of the following reasons:

- The individual is not a California resident.
- The individual has a total taxable family income that is more than 200 percent of the federal poverty guidelines.
- The individual has full-scope Medi-Cal.
- The individual has Medi-Cal with a Share of Cost (SOC) that is met on the date of services.
- The individual is enrolled in a Medi-Cal managed care health plan.
- The individual has OHC, including Medi-Cal for family planning services and a barrier to access their OHC does not exist. For more information, refer to “Eligible Clients with Other Health Coverage (OHC),” outlined in this section.
- The individual does not have a medical necessity for family planning services.
- The individual is an inmate of public institution, including prison, jail or juvenile detention center. For more information, refer to the *Eligibility: Special Groups* section in the Part 1 Medi-Cal manual.
- The individual does not meet the condition in “Affirming Eligibility Each Visit” stated on a following page.

A provider or designee must affirm the individual’s eligibility at each visit (this does not require a new *Health Access Programs Family PACT Program Client Eligibility Certification (CEC*) form (DHCS 4461). If an individual previously determined ineligible returns to a Family PACT provider, a new *Health Access Programs Family PACT Program Client Eligibility Certification (CEC*) form (DHCS 4461) must be completed to determine eligibility.››

Eligibility Period

‹‹The period of eligibility begins on the day the client is certified by the Family PACT provider as meeting the eligibility requirements and the Health Access Programs (HAP) card is activated for the Family PACT Program. Family PACT clients are certified for the program for a maximum of 12 months or until the client's eligibility status changes, whichever comes first. Twelve months represents 365 days (for example, February 4, 2007, through February 3, 2008). A new *Health Access Programs Family PACT Program Client Eligibility Certification (CEC)* form (DHCS 4461) must be completed on an annual basis for the client to continue to be enrolled if the client continues to meet all eligibility criteria. Family PACT must not be billed for services provided prior to the date of a client's certification for program enrollment.››

Retroactive Eligibility

Once a new client is certified eligible for Family PACT, the provider asks the client if he or she received Family PACT covered family planning and/or reproductive health services during the three-month period prior to the month that the client was enrolled in the Family PACT Program. If the client responds affirmatively, the Family PACT provider will give the client retroactive eligibility information and a *Health Access Programs Family PACT Program Retroactive Eligibility Certification (REC)* form (DHCS 4001) for completion.

Note: Only the client is responsible for claim submission.

Retroactive eligibility is determined separately for each of the three calendar months preceding the month of certification. Eligibility is for the entire month. For example, if retroactive eligibility is determined for a client on April 15, 2011, the client may be eligible back to January 1, 2011.

Notice of Eligibility Determination

All applicants for Family PACT services must be verbally informed of their eligibility or ineligibility at the time of the certification or recertification. Clients who are ineligible must be offered a copy of the completed CEC form (DHCS 4461) and the original REC form (DHCS 4001), if applicable, which includes a "Fair Hearing Rights" notification. The client must be informed of the fair hearing request process both verbally as well as in writing.

Client Notification

At the time the client presents for family planning services, the provider must verbally advise the client of the following:

- The Family PACT eligibility requirements.
- The Family PACT scope of benefits: The Family PACT Program is limited to family planning and family planning-related reproductive health services. It is not a primary care program.
- The confidential nature of the information received, including the fact that parents, spouse or partner will not be contacted without the client's consent, if requested.
- The right to request a fair hearing. Refer to the "Fair Hearing Rights" on the *Health Access Programs Family PACT Program Client Eligibility Certification (CEC)* form (DHCS 4461), and

  California health insurance affordability programs through Covered California: Per *Welfare and Institutions Code* (W&I Code), Section 24005(u), providers or the enrolling entity shall make available to all applicants, prior to or concurrent with enrollment, information on the manner in which to apply for insurance affordability programs. This includes, but is not limited to, the Family PACT provider providing a paper copy of the single application for Covered California or Medi-Cal coverage upon the client's request. Family PACT providers are not required to provide applicants with assistance in completing the single form application. If the applicant requests assistance, providers may direct them to:
- Online: (www.coveredca.com)
- Phone: 1-800-300-1506 (TTY 1-888-889-4500)
- Covered California Customer Service Center
- In person: A listing of trained Certified Enrollment Counselors, Certified Insurance Agents and local county social services offices can be found at www.coveredca.com or by calling 1-800-300-1506

Affirming Eligibility Each Visit

A provider or designee must affirm client eligibility at each visit. A client's income, family size and health insurance status must be reaffirmed. The client must be asked to present evidence of OHC, such as health program ID cards. If there is a change in any information contained on the CEC form (DHCS 4461), the provider must update the HAP system. ‹‹Whenever a client is determined to be no longer eligible for Family PACT, providers must deactivate the HAP card and verbally advise the client of their ineligibility.››

Confidentiality Requirements

Names and all information concerning the condition or circumstance of any person(s) from whom or about whom information is obtained are to be kept confidential. All information about personal facts and circumstances obtained by the provider shall be treated as privileged communications, shall be held confidential and shall not be divulged without the individual's written consent, except as required by law or as may be necessary to provide emergency services to the individual, or as required by the Department of Health Care Services (DHCS) to administer the Family PACT Program.

Information may be disclosed in summary, statistical or other forms that do not identify particular individuals. The applicant, client, their attorney or other authorized representative may inspect the client's certification records maintained by the provider.

Consent of Parents or Others Not Required

Notwithstanding any other provision of law, the provision of family planning services does not require the consent of anyone other than the person who is to receive services. In determining eligibility for minors, the State will exclude parental income. Minors may apply for family planning services on the basis of their need for these services, without parental consent, according to *California Family Code* Section 6925, subd. (a), *Welfare and Institutions Code* (W&I Code), Section 24003, subd. (b). If a client is 17 years of age or younger, the client is considered a minor. A minor who is 12 years of age or older may consent to medical care related to the diagnosis, treatment and/or prevention of sexually transmitted infections (STIs) according to *California Family Code* Section 6926, et seq.

Client Eligibility Forms

Providers must use the CEC form (DHCS 4461) and REC form (DHCS 4001), if applicable, to certify a client as eligible for Family PACT benefits. The CEC form (DHCS 4461) and REC form (DHCS 4001) are legal documents of eligibility determination and must be completed correctly, as described in this section, in order for Family PACT to reimburse benefits.

English and Spanish versions of the CEC form (DHCS 4461) and REC form (DHCS 4001) are included with the original shipment of HAP cards from the California MMIS Fiscal Intermediary. These are official state forms and must be reproduced without alteration. No other forms are acceptable in substitution for CEC form (DHCS 4461) and REC form (DHCS 4001). It is the responsibility of the provider to make copies of these forms for subsequent use. The current forms may be obtained in these ways:

- ‹‹The Department of Health Care Services (DHCS) website at *www.dhcs.ca.gov* – "Forms" (by Program) link on the "Forms and Publications" web page
- The Family PACT website at *www.familypact.org* – "Forms" link under "the Providers tab.››

‹‹Clients must independently complete the CEC form (DHCS 4461) and REC form (DHCS 4001), if applicable. Providers may not complete the forms on behalf of the client unless eligibility is being determined through an audio or video synchronous modality (refer to *Remote Eligibility Determination* in this section).›› The CEC form (DHCS 4461) or REC form (DHCS 4001) must not be prepopulated by the provider. However, providers are permitted to provide assistance or accommodations for clients who need help completing the forms, either due to language barriers or mental, developmental or physical disabilities. This includes difficulty of any kind reading or understanding what is being asked of them. Clients may ask questions for clarification purposes only. Providers must proactively assess if the client understands the form and that all questions have been answered appropriately. Clients must complete all fields of CEC form (DHCS 4461) and REC form (DHCS 4001). If the client does not have an income, it should be noted as a “zero” or “0” on the CEC form (DHCS 4461) and REC form (DHCS 4001).

Automated Eligibility System Guidelines

Providers with automated systems for determining eligibility for multiple recipient programs must obtain approval from the Office of Family Planning (OFP) to ensure that all required information is obtained to verify eligibility for Family PACT, including confirmation that the client has been provided all of the information and notices that are included on the CEC form (DHCS 4461) and REC form (DHCS 4001) if applicable. Requests must be made on provider or clinic letterhead and must include the NPI, the service site address and the provider owner’s signature. Mail to:

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

Signatures Required

‹‹For in-person client eligibility determination, the client must complete and sign the CEC form (DHCS 4461) and the REC form (DHCS 4001), if applicable, and the provider or designee must sign the form. *California Government Code* Section 16.5 allows for signatures to be captured electronically. Providers opting to capture signatures electronically when the individual is not in-person (refer to *Remote Eligibility Determination* in this section) should assure that they are in full compliance with GC Section 16.5 and with *California Code of Regulations* (CCR) Title 2, Division 7, Chapter 10.››

Social Security Number

Family PACT providers are required to ask for a client's Social Security Number (SSN). If the client does not provide the SSN, the client's stated reason why it is not available must be documented on the CEC form (DHCS 4461) in the *Social Security Number* box. Providers shall not deny access to family planning services if the client is unable or unwilling to provide an SSN.

Client Responsibilities

Each person seeking family planning services from Family PACT must:

- ‹‹Complete a CEC form (DHCS 4461). Eligibility is based on the client's self-declaration of total taxable monthly income, family size, other source of health care coverage and California residency, signed under penalty of perjury. CEC form (DHCS 4461) completion is required during the initial eligibility session and annually thereafter.››
- Sign the CEC form (DHCS 4461), certifying the accuracy of information provided.
- Report on the CEC form (DHCS 4461) all of the facts that are pertinent to the determination of eligibility and certification for services.
- Report at each family planning visit any changes in the facts pertinent to their eligibility determination (family size, total taxable family income, California residence, and medical necessity for family planning services) and any changes in the client's demographic information.
- Report any entitlement to other health care coverage for family planning benefits to the provider at the time of application, recertification or at any time the health care coverage changes.
- Complete and sign a REC form (DHCS 4001), if applicable.
- Submit REC form (DHCS 4001) within one year of receipt of services or within 90 days after certification of retroactive eligibility, whichever is longer. To file the claim, the client must call or write Medi-Cal at:

  Department of Health Care Services
  Beneficiary Services Center
  P.O. Box 138008
  Sacramento, CA 95813-8008
  (916) 403-2007
  TDD: (916) 635-6491

Determination of Client Eligibility

The steps for determining client eligibility are as follows:

- Determine if the client is a Medi-Cal recipient with full-scope family planning coverage, or if the client has OHC for family planning services. At each visit, a client with a Medi-Cal Benefits Identification Card (BIC) must be screened for eligibility and the provider must bill the Medi-Cal program if the client is Medi-Cal eligible for family planning benefits and has met all SOC on the date of service. Medi-Cal payment sources should always be billed, if applicable.
- Determine the age of the client. If the client is 17 years of age or younger, the client is considered a minor. If the client is 18 years of age or older, the client is considered an adult. In determining eligibility for minors, the State will exclude parental income.
- Determine the family size. The “basic family unit” must be taken into account when determining family size. The “basic family unit” consists of the applicant, spouse (including common-law) and minor children, if any, related by blood, marriage, or adoption, and residing in the same household.
- If an applicant intends to file taxes and is not claimed as a tax dependent, the applicant’s basic family unit includes the applicant, spouse if living together and the applicant’s tax dependents. When adults, other than spouses, reside together, each person shall be considered a separate family. This also applies to adults living with their parents, unless the parents claim the adult child as a tax dependent. If an applicant is claimed as a tax dependent by the applicant’s spouse or parents, the applicant’s basic family unit include the applicant, spouse if living together, the tax filer and the tax filer’s other tax dependents.

  Note: California recognizes “common-law” marriages established in other states (where common-law marriages are legally recognized); it does not recognize common-law marriages occurring in California.
- Determine the client’s total taxable family income. The client’s self-declaration must be accepted without further verification.
- Find the client’s declared family size and total taxable income in “Income Eligibility Guidelines” in this section. If the client’s income is at or below the maximum for their declared family size, the client is eligible for Family PACT benefits when all the other criteria are met.

- Once a new client has been certified eligible for Family PACT, the provider asks the client if he or she has received Family PACT-covered family planning and/or reproductive health services during the three-month period prior to the month that the client was enrolled in the Family PACT Program. If the client has received services, the Family PACT provider will give the client the retroactive eligibility information and the REC form (DHCS 4001) for completion.
- ‹‹The provider accepts responsibility for determination of retroactive eligibility. A copy of the retroactive eligibility information and the completed REC form must be given to the client for client claim processing.››

Income Eligibility Guidelines

The federal poverty guidelines are updated annually by the federal government. Providers are notified in the *Family PACT Update* bulletin. The income eligibility guidelines for the Family PACT Program reflect the federal poverty guidelines as published, effective April 1, 2023.

Family PACT Income Eligibility Guidelines

200 Percent of the 2023 Federal Poverty Guidelines Effective April 1, 2023

Number of Persons in Family/Household	Monthly Income (in dollars)	Annual Income (in dollars)
1	2,430	29,160
2	3,287	39,440
3	4,143	49,720
4	5,000	60,000
5	5,857	70,280
6	6,713	80,560
7	7,570	90,840
8	8,427	101,120
For each additional member, add	857	10,280

Family Size and Income

The following are instructions for completing the family size and income *Eligibility Determination* component on the CEC form (DHCS 4461) and/or REC form (DHCS 4001), if applicable.

- The client designates himself/herself as "self" and lists all "basic family unit" members who live with him/her and are supported by the family income. For the definition of "basic family unit," refer to "Determination of Client Eligibility" on a previous page.
- The client fills in the source of income for each family member with earned or unearned income. If the client does not work for one easily identifiable employer (that is, a company), a general descriptive phrase will suffice as a response. For example, if the client is a migrant farm worker, the place of employment could be "local farms."
- The client determines the total family size and the total gross monthly income. For minors, the State will exclude parental income.

Total Taxable Family Income

"Total Taxable Family Income" means the monthly sum of taxable income received by an individual and the individual's basic family unit identified by the Internal Revenue Service (IRS) as taxable. Monthly taxable income for migrant farm workers and other seasonally employed persons may be computed by averaging total taxable income received during the previous 12 months.

The following are types of taxable income identified by the IRS:

- Wages or salary
- Net income (profit) from farm and non-farm self-employment
- Social Security (even if not taxable)
- Dividends, interest (on savings or bonds), income from estates or trusts, net rental income or royalties
- Pension and annuities
- Unemployment compensation/disability insurance
- Veterans' pension (if taxable)
- Alimony received

Exclusions From Computation of Monthly Taxable Income

The following are not considered sources of monthly taxable income according to the IRS:

- Public Assistance or welfare payments
- Workers' compensation
- Child support
- Alimony paid
- Money received from sale of property, such as stocks, bonds, a house or a car (unless the person was engaged in the business of selling such property, in which case the net proceeds would be counted as income from self-employment)
- Withdrawals of bank deposits, money borrowed, tax refunds, gifts or capital gains
- Lump-sum inheritances or insurance payment
- Loans and grants, such as scholarships, obtained and used under conditions that preclude their use for current living costs
- Any grant or loan to any undergraduate student for educational purposes made or insured under any program administered by the Commissioner of Education under the Higher Education Act
- The value of the food stamp coupon allotment in excess of the amount paid for the coupons
- The value of USDA-donated foods
- The value of supplemental food assistance under the Child Nutrition Act of 1966 and the special food program under the National School Lunch Act
- Earnings of a child if less than the threshold for being required to file taxes
- Per capita payments to or funds held in trust for any individual in satisfaction of a judgment of the Indian Claims Commission or Court of Claims
- Payments made pursuant to the Alaska Native Claims Settlement Act to the extent such payments are exempt from taxation under Section 21(a) of the Act
- Any payment received under the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970
- Home produce utilized for household consumption
- Payments received under the Energy Crisis Assistance Program or the Low Income Energy Assistance Program

Certification of Client Eligibility

Providers shall use the HAP onsite client enrollment system for certifying clients as eligible and for activating the client's HAP card. The HAP system also allows providers to inquire, update, recertify and deactivate client eligibility. For more information, refer to the *Health Access Programs (HAP)* Cards section of this manual.

Providers or their designees certify clients as eligible for the Family PACT Program by checking the *Eligible for Family PACT Program* box and signing and dating the *Health Access Programs Family PACT Program Client Eligibility Certification (CEC)* form (DHCS 4461) and *Health Access Programs Family PACT Program Retroactive Eligibility Certification (REC)* form (DHCS 4001), if applicable, affirming that:

- The CEC form (DHCS 4461) and REC form (DHCS 4001), if applicable, are complete.
- The client's county of residence is within California.
- The client's eligibility is based upon medical necessity for family planning services.
- The client's family size and income place them at or below 200 percent of federal poverty guidelines.
- The client has no other source of health care coverage for family planning services.
- ‹‹The client has signed and dated the CEC form (DHCS 4461) and REC form (DHCS 4001), if applicable or the provider has obtained an applicant/client's signature when the individual is not in-person (refer to *Remote Eligibility Determination* in this section).››

When clients do not meet these requirements, providers or their designees certify ineligibility by checking the *Ineligible for Family PACT Program* box, dating and signing the CEC form (DHCS 4461) and/or the REC form (DHCS 4001), if applicable. Failure to adequately certify the client or to sign and date the CEC form (DHCS 4461) may result in the disenrollment of the provider from the Family PACT Program.

Note: Clinic staff who are eligible and wish to enroll in the Family PACT Program may not certify their own eligibility or enroll themselves as clients in the program.

Providers must maintain the completed CEC form (DHCS 4461), whether the client is eligible or ineligible, and a copy of the REC form (DHCS 4001) if applicable, in the client's medical record for a period of at least three years in accordance with *Welfare and Institutions Code* (W&I Code), Section 14124.1. The CEC form (DHCS 4461), and REC form (DHCS 4001), if applicable, may be maintained electronically, in compliance with all aspects of *Health & Safety Code*, Section 123149.

Client Eligibility Certification Codes

The Family PACT Program Client Eligibility Certification Codes table is used to complete specific items on the CEC form (DHCS 4461). Accurately entering the corresponding code is necessary when activating eligibility, updating HAP records or recertifying client eligibility.

Family PACT Program
Client Eligibility Certification Codes Table

County of Residence

County	Code
Alameda	01
Alpine	02
Amador	03
Butte	04
Calaveras	05
Colusa	06
Contra Costa	07
Del Norte	08
El Dorado	09
Fresno	10
Glenn	11
Humboldt	12
Imperial	13
Inyo	14
Kern	15
Kings	16
Lake	17
Lassen	18
Los Angeles	19
Madera	20
Marin	21
Mariposa	22
Mendocino	23
Merced	24
Modoc	25
Mono	26
Monterey	27
Napa	28
Nevada	29
Orange	30

County of Residence

County	Code
Placer	31
Plumas	32
Riverside	33
Sacramento	34
San Benito	35
San Bernardino	36
San Diego	37
San Francisco	38
San Joaquin	39
San Luis Obispo	40
San Mateo	41
Santa Barbara	42
Santa Clara	43
Santa Cruz	44
Shasta	45
Sierra	46
Siskiyou	47
Solano	48
Sonoma	49
Stanislaus	50
Sutter	51
Tehama	52
Trinity	53
Tulare	54
Tuolumne	55
Ventura	56
Yolo	57
Yuba	58
Unknown	99

Social Security Number Not Provided

Definition	Code
Client does not know SSN	01
Client does not have SSN	02
Client declined to answer	03

Other Health Coverage Codes

Definition	Code
Yes	01
No	02

Family PACT Program
Client Eligibility Certification Codes Table (continued):
Deactivation Codes

Code	Definition
01	Not resident of California
02	Over 200 percent of the federal poverty level
03	Sterilized, no longer contracepting
04	Health insurance coverage for family planning services
05	Full-scope Medi-Cal (does not have an unmet Share of Cost)
06	Permanent deactivation of HAP card (lost/stolen)

Third-Party Payment Sources

Clients with third-party payment sources are those who present with coverage from other sources of payment for family planning services, including Medi-Cal, prepaid health plans, military or private health insurance. If coverage is intermittent, status at the time of certification determines eligibility. The status of the client's enrollment in a third-party payment source must be updated at each visit to determine continued eligibility in Family PACT.

‹‹Chart Documentation Requirements

Providers must document in the client's record if the person requesting family planning services has financial coverage for such services under any third-party payment source. If so, that source of funding must be billed for the family planning services and the billing must be documented in the client's file.››

Clients with Benefits Identification Cards

If the client has a Benefits Identification Card (BIC), the provider must determine if the client is eligible for Medi-Cal family planning benefits on the date of service and if the recipient has met any required Share of Cost (SOC). For more information, refer to “Ineligible Clients” on a previous page. See the following sample BICs. Any of the three card types are valid. Providers should accept all three BIC designs and must continue to verify eligibility accordingly.

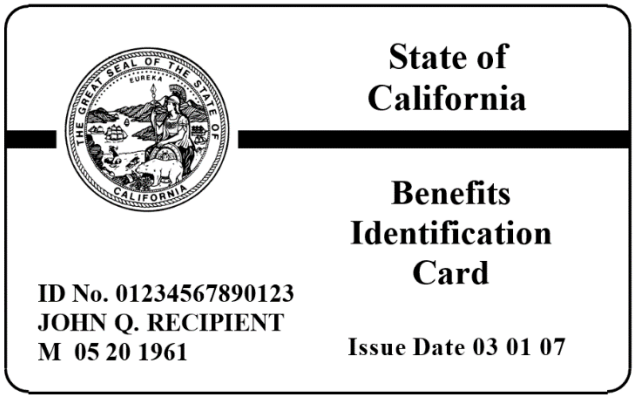

Figure 1: Front of BIC printed in blue with sex indicator

Figure 2: Front of BIC printed in full color with sex indicator

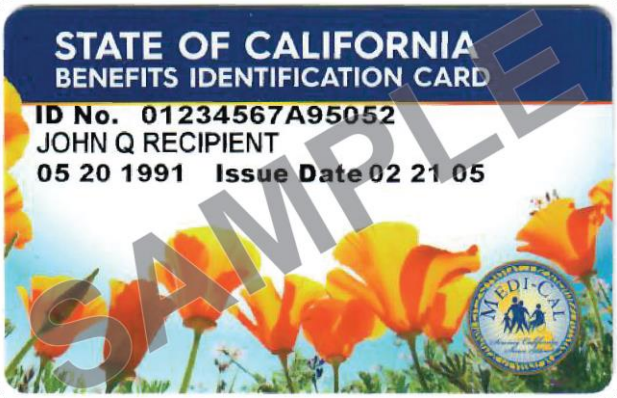

Figure 3: Front of BIC printed in full color without sex indicator

Eligible Clients with Other Health Coverage (OHC)

Clients who have Other Health Coverage (OHC), including Medi-Cal fee-for-service and managed care, can be eligible for Family PACT benefits. Clients must meet all Family PACT eligibility criteria described under "Eligible Clients" on a previous page, including any of the following:

- The OHC does not cover any contraceptive methods. Seeking a specific method or brand of birth control not offered by OHC is not a criterion for Family PACT eligibility.
- The client is a student who has no health care coverage for any contraceptive methods. Seeking a specific method or brand of birth control not offered by OHC is not a criterion for Family PACT eligibility.
- The OHC requires an annual deductible that the client is unable to meet on the date of service.

  Note: If the OHC is health insurance with an insurance copayment per visit, the client is not eligible for Family PACT benefits. The provider should collect the copayment, render services and bill the third party insurance.
- A barrier to access exists. A barrier to access is when a client's OHC does not ensure provision of family planning services to a client without his or her spouse, partner or parents being notified or informed. For clients who indicate on the CEC form (DHCS 4461) that their concern of a partner, spouse, or parent learning about their family planning appointment may keep them from using their OHC, there is a barrier to access, and the clients are eligible for Family PACT benefits if they meet all other eligibility criteria. This applies to all clients regardless of age or marital status.
- The client has a Medi-Cal unmet SOC on the date of service.
- The client has limited-scope Medi-Cal that does not cover family planning.

Clients Enrolled in Medi-Cal Managed Care

When Medi-Cal managed care enrolled members seek family planning care outside of a designated health plan, the health plans are required to reimburse qualified out-of-plan family planning providers for family planning services as well as laboratory and pharmacy services related to family planning. Family PACT providers should serve Medi-Cal managed care clients and then bill the managed care health plan rather than enrolling clients into Family PACT. Seeking a specific method of birth control not covered by their health plan of enrollment is not a criterion for eligibility in Family PACT. Providers may obtain more detailed plan enrollment information for Medi-Cal managed care clients through the Medi-Cal Point of Service (POS) network or online eligibility verification systems. ‹‹Information about managed care plans and copies of the policy letters cited in this section are available on the DHCS Medi-Cal Managed Care Letters website.››

Client Eligibility Determination Table

The following table assists providers in determining client eligibility.

Client Information	Family PACT Eligibility	Action Taken
Client has full-scope Medi-Cal with no Share of Cost (SOC)	No	No activation. Bill to Medi-Cal
Client has Medi-Cal with an unmet SOC	Yes	Issue and activate HAP card
‹‹Client has Medi-Cal with no SOC but client indicates a barrier to access exists*››	Yes	Issue and activate HAP card
Client has restricted services Medi-Cal (no coverage of contraceptive methods).	Yes	Issue and activate HAP card
Client has OHC (covers contraceptive methods) with no deductible.	No	No activation. Bill insurance
‹‹Client has OHC (Medi-Cal managed care with no deductible and OHC covers contraceptive methods, but client indicates a barrier to access exists.*››	Yes	Issue and activate HAP card
Client has OHC (covers contraceptive methods) with an unmet deductible.	Yes	Issue and activate HAP card
Client has no health care coverage.	Yes	Issue and activate HAP card
Client is enrolled in Medi-Cal managed care but requests out-of-plan family planning services.	No	No activation. Provide services, bill for service to plan

Legend

Symbols used in the document above are explained in the following table.

Symbol	Description
‹‹	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
››	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.
*	See “Eligible Clients with Other Health Coverage” on a previous page.