Family PACT (Planning, Access, Care & Treatment) Eligibility

Introduction

Purpose

The purpose of this module is to provide participants with an overview of the administrative functions of the Family Planning, Access, Care and Treatment (Family PACT) Program.

Module Objectives

- Identify eligible Family PACT provider types
- Clarify Family PACT Program policies
- Review client eligibility criteria
- Explain the importance of the *Health Access Programs Family PACT Program Client Eligibility Certification (CEC)* form (DHCS 4461)
- Discuss the *Health Access Programs Family PACT Program Retroactive Eligibility Certification (REC)* form (DHCS 4001)
- Highlight Health Access Program (HAP) cards and activation options

Acronyms

A list of current acronyms is in the *Appendix* section of each complete workbook.

Family PACT Overview

The Family PACT Program is designed to assist individuals who have a medical necessity for family planning services. The overall goal of the Family PACT Program is to ensure that low-income women and men have access to health information, counseling and family planning services to reduce the likelihood of unintended pregnancies and to allow clients to establish the number and spacing of their children, as well as maintain optimal reproductive health.

The Office of Family Planning (OFP) administers the Family PACT Program. Family PACT is a comprehensive program because it includes family planning and family planning-related services together with client-centered health education and counseling. Family PACT serves approximately 1 million eligible women and men through both public and private providers.

NOTES

Family PACT Program

Provider Enrollment

Eligible providers are licensed/certified medical personnel with family planning skills, competency and knowledge who provide the full range of services covered by the program, as long as these services are within the provider's scope of licensure and practice. Clinical providers electing to participate in the Family PACT Program must be enrolled Medi-Cal providers in good standing. Eligible providers applying for enrollment must provide the scope of comprehensive family planning services, either directly or by referral, consistent with Family PACT Standards. In addition, providers agree to abide by program policies and administrative practices.

Solo providers, group providers or primary care clinics are eligible to apply for enrollment in the Family PACT Program if they currently have a National Provider Identifier (NPI) and are enrolled in Medi-Cal in good standing. An Affiliate Primary Care Clinic's (APCC) enrollment in the Family PACT Program is dictated by *Welfare and Institutions Code* (W&I Code), Section 24005(t) (1) and (2). Intermittent clinics and mobile clinics must apply for enrollment in the Family PACT Program using their organization NPI. The organizational NPI must be enrolled in Medi-Cal in good standing.

Anesthesiologists, laboratories, pharmacies and radiologists who are enrolled as Medi-Cal providers are not required to enroll in the Family PACT Program.

Providers electing to enroll into the Family PACT Program must submit a completed *Family PACT Provider Application* (DHCS 4468) application to the Office of Family Planning. This is the first form in the application process. Providers will receive additional forms after approval of the DHCS 4468. The complete Family PACT program application packet contains the following forms:

- *Family PACT Provider Application* (DHCS 4468)
- *Family PACT Program Provider Agreement* (DHCS 4469)
- *Family PACT Program Practitioner Participation Agreement* (DHCS 4470)

The DHCS 4468 is available for download on the Family PACT website at *www.familypact.org* or the DHCS Forms, Laws & Publications web page at *www.dhcs.ca.gov/formsandpubs/Pages/default.aspx*.

Non-Physician Medical Practitioners (NMPs) employed by a Medi-Cal provider who is applying to enroll in the Family PACT Program and will be delivering Family PACT services, must be identified on the DHCS 4468 form and complete a DHCS 4470 form. The DHCS 4470 is not required to be completed by an APCC, nonprofit community clinic or Primary Care Clinics (PCC), Federally Qualified Health Center (FQHC), Rural Health Clinic (RHC), or Indian Health Services Memorandum of Agreement (IHS-MOA) 638, Clinics. NMPs eligible to participate in the Family PACT Program include Nurse Practitioners (NPs), Physician Assistants (PAs) and Certified Nurse Midwives (CNMs).

All forms must be completed, signed and returned to the program before enrollment is approved.

Provisional Enrollment

New Family PACT provider applicants and/or new provider locations will be provisionally certified for enrollment in the Family PACT Program until an eligible representative completes a legislatively mandated Provider Orientation as determined by DHCS. Provider Orientation must be completed within six months of the date of provisional Family PACT enrollment for the provisional certification to be lifted. Failure to complete the Provider Orientation within six months will result in disenrollment. A provider who has been previously disenrolled for this reason may re-enroll in the Family PACT Program, but will not be granted provisional enrollment.

Each provider location is required to be certified for enrollment in the Family PACT Program. Each provider location must designate one eligible representative to be the site certifier. The site certifier cannot certify multiple sites. The Medical Director (MD), Certified Nurse Practitioner (CNP) or CNM responsible for overseeing the family planning services rendered at the location to be enrolled is eligible to certify the site.

The site certifier must complete all required Provider Orientation trainings as determined by DHCS. The site certifier must ensure that all clinical personnel rendering services on behalf of the Family PACT program have completed OFP required trainings.

Provider Orientation

Medi-Cal providers applying to become a Family PACT provider are required to attend a Provider Orientation per W&I Code, section (§) 24005(k). The Provider Orientation training is delivered online and in person. The training includes information on comprehensive family planning, family planning-related services, program benefits and services, client eligibility, provider responsibilities and compliance.

New site certifiers and/or rendering providers administering the Family PACT Program must complete the Provider Orientation trainings within 60 days of hire.

Provider Orientation details and registration information is posted on the Family PACT Learning Management System (LMS) at www.ofpregistration.org or contact Family PACT at (916) 650-0414.

Please contact the OFP by phone at (916) 650-0414 or by email at ProviderServices@dhcs.ca.gov if you have any questions regarding the orientation process.

Provider Responsibility for Client Eligibility Determination

Through the Family PACT provider enrollment process, the Family PACT provider accepts the responsibility for appropriate onsite determination of eligible clients according to program guidelines and administrative practices. Only enrolled Family PACT Program providers may determine client eligibility and enroll Family PACT clients. Medi-Cal pharmacies and laboratories may not perform eligibility determination or enroll clients.

Eligibility Period

Family PACT Program eligibility begins the date the client is certified by the Family PACT provider as meeting the eligibility requirements and the Health Access Programs (HAP) card is activated. Family PACT clients are certified for the program for a maximum of 12 months or until the client's eligibility status changes. Certification for 12 months represents 365 days. A new *Health Access Programs Client Eligibility Certification* (CEC) form (DHCS 4461) must be completed in person on an annual basis for the client to continue to be enrolled if the client continues to meet all eligibility criteria.

Affirming Eligibility Each Visit

The provider or designee must affirm client eligibility at each visit. A client's income, family size and health insurance status must be reaffirmed. If there is a change in any information listed on the CEC form (DHCS 4461), the provider must make the updates in the HAP system. Whenever a client is determined to be no longer eligible for Family PACT, providers must deactivate the HAP card and advise the client of ineligibility.

Eligibility Requirements for BCCTP Applicants

Breast and Cervical Cancer Treatment Program (BCCTP) applicants must be denied full-scope Medi-Cal prior to the final BCCTP eligibility determination. Applying for Medi-Cal is a BCCTP eligibility requirement. Every Woman Counts (EWC) and Family PACT beneficiaries found to have a qualifying diagnosis, who have not applied to Medi-Cal within the last 30 days, should be instructed to apply for Medi-Cal.

Applicants eligible for Medi-Cal will not be enrolled into BCCTP. This requirement includes applicants who may not otherwise be eligible for full-scope Medi-Cal, such as undocumented individuals. Providers can continue to enroll qualified beneficiaries into BCCTP; they will remain in the BCCTP initial aid code until the Medi-Cal eligibility decision is completed by the county.

NOTE
Family PACT clients found to have a qualifying diagnosis, which have not applied to Medi-Cal within the last 30 days, should be instructed to apply for Medi-Cal. Family PACT Providers are required to give insurance affordability information and must providers must comply with W&I Code, section 24005(u), which requires Family PACT providers or the enrolling entity to provide applicants and

clients with information about applying to insurance affordability programs. The CEC form has been updated to include an acknowledgement line for the applicant to confirm that they received information about insurance affordability programs.

Client Eligibility Determination

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

1. California Resident

The client must be a resident of California.

2. Total Taxable Family Income

The client must have a total taxable family income at or below 200 percent of the federal poverty guidelines. The client's self-declaration must be accepted without further verification.

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.

Adults 18 years of age or older, other than spouses, residing together are considered a separate family. This applies to the parents of an adult client, adults living with their parents, unless the parents claim the adult child as a tax dependent. If this is the case and the client, an applicant is claimed as a tax dependent by the client's applicant's spouse or parents, the client's applicant's basic family unit includes the client, applicant's spouse if living together, the tax filer and the tax filer's other tax dependents.

More information regarding the determination of family size can be found in the *Client Eligibility* section of the *Family PACT Policies, Procedures and Billing Instructions* (PPBI) provider manual.

The federal poverty guidelines are updated annually by the federal government. Providers are notified of annual changes in the *Family PACT Update Bulletin*.

NOTE

The state of California recognizes "common-law" marriages established in other states (where common-law marriages are legally recognized), but does not recognize common law marriages occurring in California.

3. No Other Health Coverage

The client must have no other source of health care coverage for family planning services, or meet the criteria specified below for eligibility with Other Health Coverage (OHC).

- OHC does not cover <u>any</u> family planning contraceptive methods.

- 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.
- OHC requires an annual deductible that the client is unable to meet on the date of service.
- Clients with barrier to access. 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.
- Client has a Medi-Cal unmet Share of Cost (SOC) on the date of service.
- Client has limited scope Medi-Cal that does not cover family planning

4. Medical Necessity

The client must have a medical necessity for family planning services.

Clients Enrolled in Medi-Cal Managed Care

Medi-Cal Managed Care enrolled members seeking family planning care outside of a designated health plan, the health plans are required to reimburse out-of-plan providers for covered clinical, laboratory and pharmacy services. 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.

Income Eligibility Guidelines

The federal poverty guidelines are published annually by the federal government. Providers are to use the following income eligibility guidelines when determining client eligibility. Providers are notified of annual changes in the *Family PACT Update Bulletin*. Providers should disregard all previous income eligibility guideline charts.

Family PACT Income Eligibility Guidelines 200 Percent of the 2020 Federal Poverty Guidelines Effective April 1, 2020		
Number of Persons in Family	**Monthly Income**	**Annual Income**
1	$2,127	$25,520
2	$2,873	$34,480
3	$3,620	$43,440
4	$4,367	$52,400
5	$5,113	$61,360
6	$5,860	$70,320
7	$6,607	$79,280
8	$7,353	$88,240
For each additional member, add	$747	$8,960

Clients with Benefits Identification Cards (BICs)

If a 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 client has met any required Share of Cost (SOC). Clients who have met their SOC and have no barrier to access, the client should not be enrolled into Family PACT.

NOTE
Both BIC cards are valid.

Sample: BIC cards

Client Eligibility Guide

The following table assists providers in determining client eligibility. For more information, refer to the *Client Eligibility* (client elig) section in the PPBI.

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 an unmet SOC and requests confidentiality because 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, including Medi-Cal fee-for-service and Medi-Cal managed care (covers contraceptive methods), without deductible, but 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 fee-for-service to plan

*See “Eligible Client s with Other Health Coverage (OHC)” section for more information.

Family PACT Program Standards

Program Standards are the program framework and parameters for expected provider performance, service delivery and quality improvement. The standards are subdivided by the following service areas of the program including:

Informed Consent

Informed consent shall include client participation in the process of eligibility determination as well as onsite enrollment in the Family PACT program. 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 based on their need for these services, without parental consent, according to *California Family Code*, Section 6925, subd. (a). 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 and/or treatment of sexually transmitted infections (STIs) according to *California Family Code*, Section 6926.

Confidentiality

All information about personal facts obtained by the provider shall be treated as privileged communications, shall be held confidential, and shall not be disclosed without the client's written consent, except as required by law or if necessary to provide emergency services to the client or by the Department of Health Care Services (DHCS) to administer the Family PACT program.

Cultural and Linguistic Competency

All services shall be provided in a culturally sensitive manner and communicated in a language understood by the client.

Access to Care

All services shall be provided to eligible clients without bias based upon gender, sexual orientation, age (except for sterilization), race, marital status, parity or disability.

A barrier to access is when a client's OHC does not ensure provision of services to a client without his or her parent, partner or spouse 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.

Availability of Covered Services

Only licensed personnel with family planning skills, knowledge and competency may provide the full range of family planning medical services covered under Family PACT in accordance with W&I Code, Section 24005(b). Clinical providers electing to participate in the Family PACT program shall provide the full scope of family planning, education, counseling and medical services specified by Family PACT, either directly or by referral.

Clinical and Preventive Services

Clinicians providing care to Family PACT clients shall practice evidence-based medicine using nationally recognized clinical practice guidelines. The Family PACT program provides family planning and family planning-related services to eligible women and men when the care is provided coincident to a visit for the management of a family planning method.

Family Planning Services:

- Contraceptive services for women and men
- Limited fertility services
- Specified reproductive health screening tests

Family Planning-Related Services:

- Cervical Cancer Screening
- Management of STIs
- Management of Urinary Tract Infections (UTI)
- Management of Cervical Abnormalities and Pre-invasive Cervical Lesions

Education and Counseling Services

Client-centered health education and counseling is considered integral to Family PACT and must be incorporated throughout the family planning visit. Regardless of the type of visit, provision of reproductive health education and counseling is required for all Family PACT clients including:

- A practice setting that is appropriate for discussion of sensitive topics
- Ongoing individualized client assessment and focused communication
- Topics and behaviors that promote personal choice, risk reduction and optimal reproductive health practices

NOTE

For additional information on Program Standards, refer to the *Program Standards* (prog stand) section of the PPBI.

Client Eligibility Certification Process

Client Eligibility Form

The *Health Access Programs Family PACT Program Client Eligibility Certification (CEC)* form (DHCS 4461) is a legal document that is used to certify a client as eligible for Family PACT.

The CEC form is available in both English and Spanish and can be downloaded from the Family PACT website *(www.familypact.org*) or the DHCS website (*www.dhcs.ca.gov*).

These are official State forms and must be reproduced without alteration and must not be pre-populated. The signed hard copy CEC form must be kept on file for three years.

These forms can be stored either electronically or by hard copy.

If a client was previously determined ineligible returns to a Family PACT provider, a new CEC form (DHCS 4461) must be completed to determine eligibility. If the client is eligible, the provider must update any changes in the HAP system using the prior HAP card number, if applicable.

Client Certification Form (DHCS 4461)

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

DHCS 4461 (11/16)

Page 1 of 4

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.

FOR PROVIDER USE ONLY

Provider certification: ☐ Eligible for Family PACT Program
☐ Ineligible for Family PACT Program (Give Fair Hearing Rights)

Why: _____

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. I also certify that the client has received the Notice of Privacy Practices.

Print name	Signature	Date
Deactivation: If client is deactivated (no longer eligible)	Date	Reason code (see Provider Manual)

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 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 First Level Review to the 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 request a formal hearing within 90 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 were not able to file for a hearing within the 90 days, you may still file for a hearing. If you provide *good cause*, your request may still be scheduled. Provide all requested information such as your full name, telephone number, address, and the reason for the Formal Hearing and mail it to the Formal Hearing 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. If you have trouble understanding English, be sure to state your language so arrangements can be made to have language assistance at the hearing. If you have chosen an authorized representative, be sure to state his/her name, phone number and address. Keep a copy of your hearing request for your records. You may submit your formal hearing request in one of two ways:

First Level Review
Department of Health Care Services
Office of Family Planning
P.O. Box 997413, Mail Station 8400
Sacramento, CA 95899-7413

Formal Hearing
California Department of
Social Services
State Hearings Division
P.O. Box 944243,
Mail Station 9-17-37
Sacramento, CA 94244-2430

or Toll-Free Call
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

Client Eligibility Certification Codes

CONFIDENTIALITY	
Yes	
No	

COUNTY OF RESIDENCE / COUNTY OF BIRTH, IF CA	
Alameda	0
Alpine	0
Amador	0
Butte	0
Calaveras	0
Colusa	0
Contra Costa	0
Del Norte	0
El Dorado	0
Fresno	1
Glenn	1
Humboldt	1
Imperial	1
Inyo	1
Kern	1
Kings	1
Lake	1
Lassen	1
Los Angeles	1
Madera	2
Marin	2
Mariposa	2
Mendocino	2
Merced	2
Modoc	2
Mono	2
Monterey	2
Napa	2
Nevada	2
Orange	3
Placer	3
Plumas	3
Riverside	3
Sacramento	3
San Benito	3
San Bernardino	3

COUNTY OF RESIDENCE / COUNTY OF BIRTH, IF CA (continued)	
San Diego	
San Francisco	
San Joaquin	
San Luis Obispo	
San Mateo	4
Santa Barbara	4
Santa Clara	4
Santa Cruz	4
Shasta	4
Sierra	4
Siskiyou	4
Solano	4
Sonoma	4
Stanislaus	5
Sutter	5
Tehama	5
Trinity	5
Tulare	5
Tuolumne	5
Ventura	5
Yolo	5
Yuba	5
Unknown	9

GENDER	
Male	M
Female	F

STATE OF BIRTH, IF NOT	
Alabama	0
Alaska	0
Arizona	0
Arkansas	0
California	0
Colorado	0
Connecticut	0
Delaware	0
Florida	0

STATE OF BIRTH, IF NOT CALIFORNIA (continued)
Georgia
Hawaii
Idaho
Illinois
Indiana
Iowa
Kansas
Kentucky
Louisiana
Maine
Maryland
Massachusetts
Michigan
Minnesota
Mississippi
Missouri
Montana
Nebraska
Nevada
New Hampshire
New Jersey
New Mexico
New York
North Carolina
North Dakota
Ohio
Oklahoma
Oregon
Pennsylvania
Rhode Island
South Carolina
South Dakota

STATE OF BIRTH, IF NOT CALIFORNIA (continued)	
Tennessee	42
Texas	43
Utah	44
Vermont	45
Virginia	46
Washington	
West Virginia	
Wisconsin	
Wyoming	
District of Columbia	
Unknown	

COUNTRY OF BIRTH, IF NOT USA	
Aleutian Islands	01
Argentina	02
Belize	03
Bolivia	04
Brazil	05
Cambodia	06
Canada	07
Chile	08
China	09
Columbia	10
Costa Rica	11
Cuba	12
Ecuador	13
El Salvador	14
France	15
French Guiana	16
Germany	17
Great Britain	18

COUNTRY OF BIRTH, IF NOT USA (continued)	
Guam	
Guatemala	
Guyana	
Honduras	
India	2
Japan	
North Korea	
South Korea	
Laos	
Mexico	
Nicaragua	
Panama	
Paraguay	
Peru	
Philippines	
Puerto Rico	
Russia	
Samoa	
Spain	
Surinam	
Thailand	
Uruguay	
Venezuela	
Vietnam	
Virgin Islands	
Other	

DEACTIVATION CODES	
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
06	Permanent deactivation of HAP card (lost/stolen)

Retroactive Eligibility

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

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, 2020, the client may be eligible back to January 1, 2020.

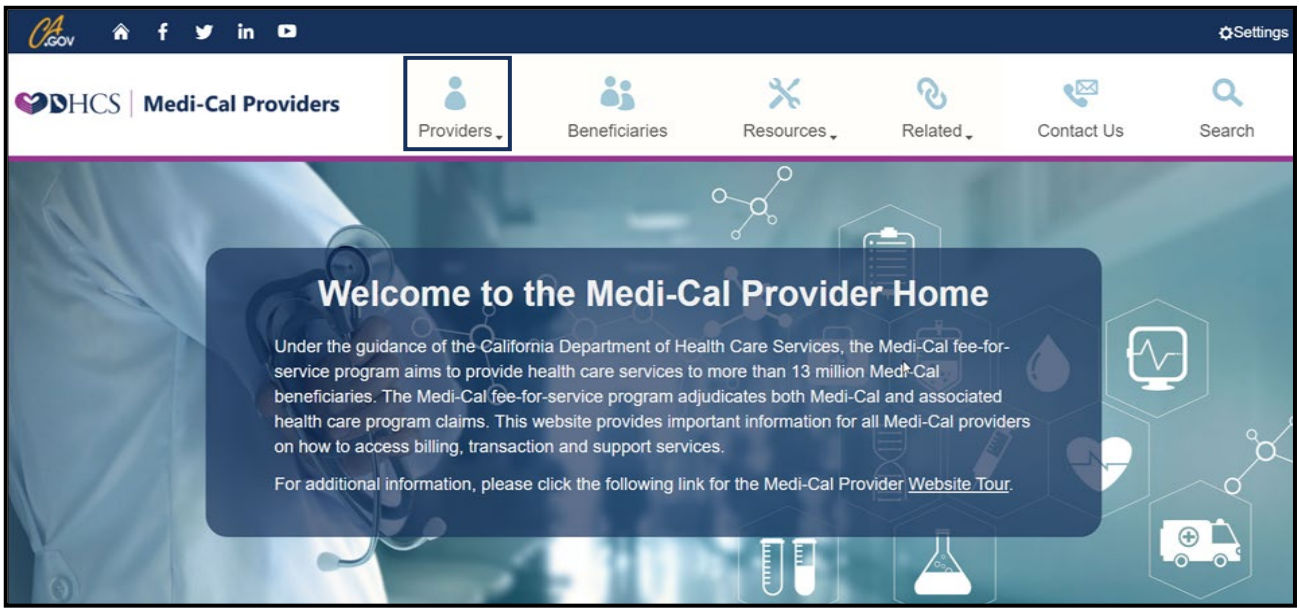
NOTE
Only the client is responsible for claim submission.

For more information or to file a claim, the client may call the Beneficiary Service Center – Family PACT at (916)403-2007 TDD: (916)-635-6491.

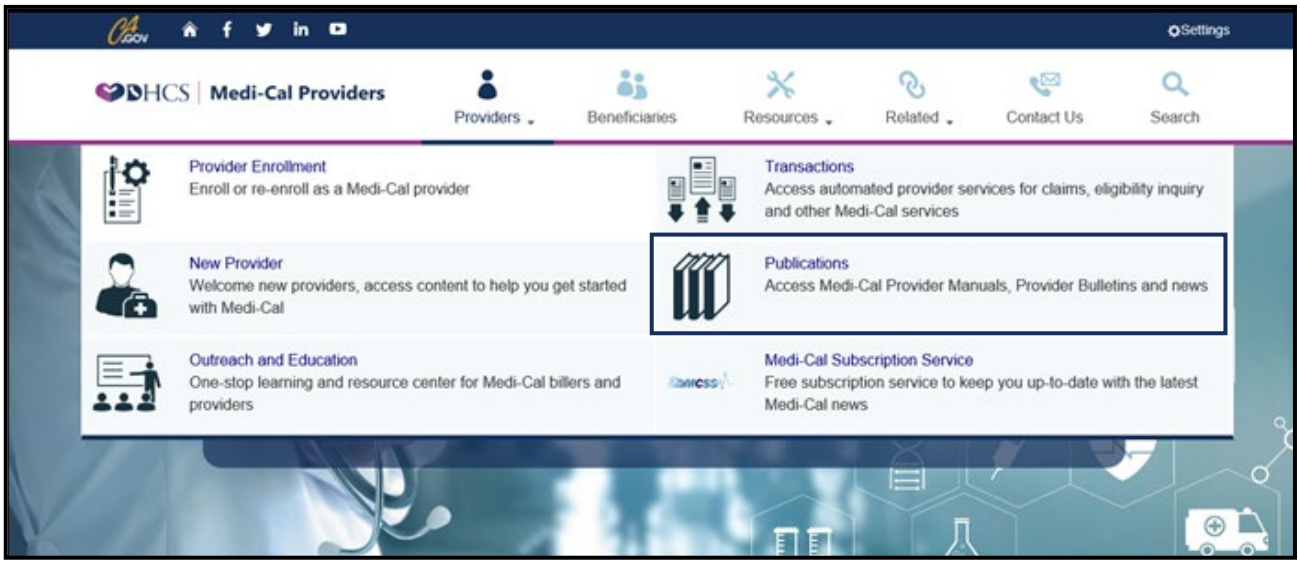
Accessing Family PACT Forms

Open an internet browser, type (www.medi-cal.ca.gov) in the address bar and select enter.

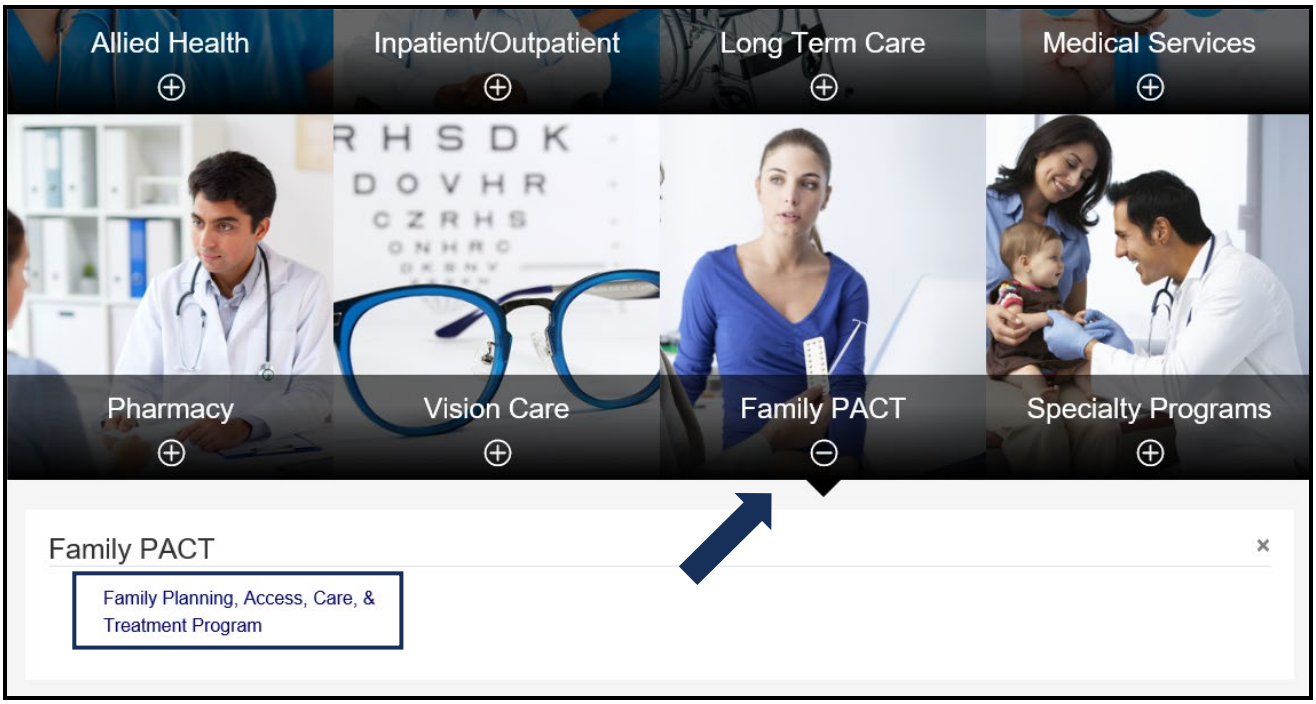
1. Select the Providers tab from the Medi-Cal Provider Home Page.



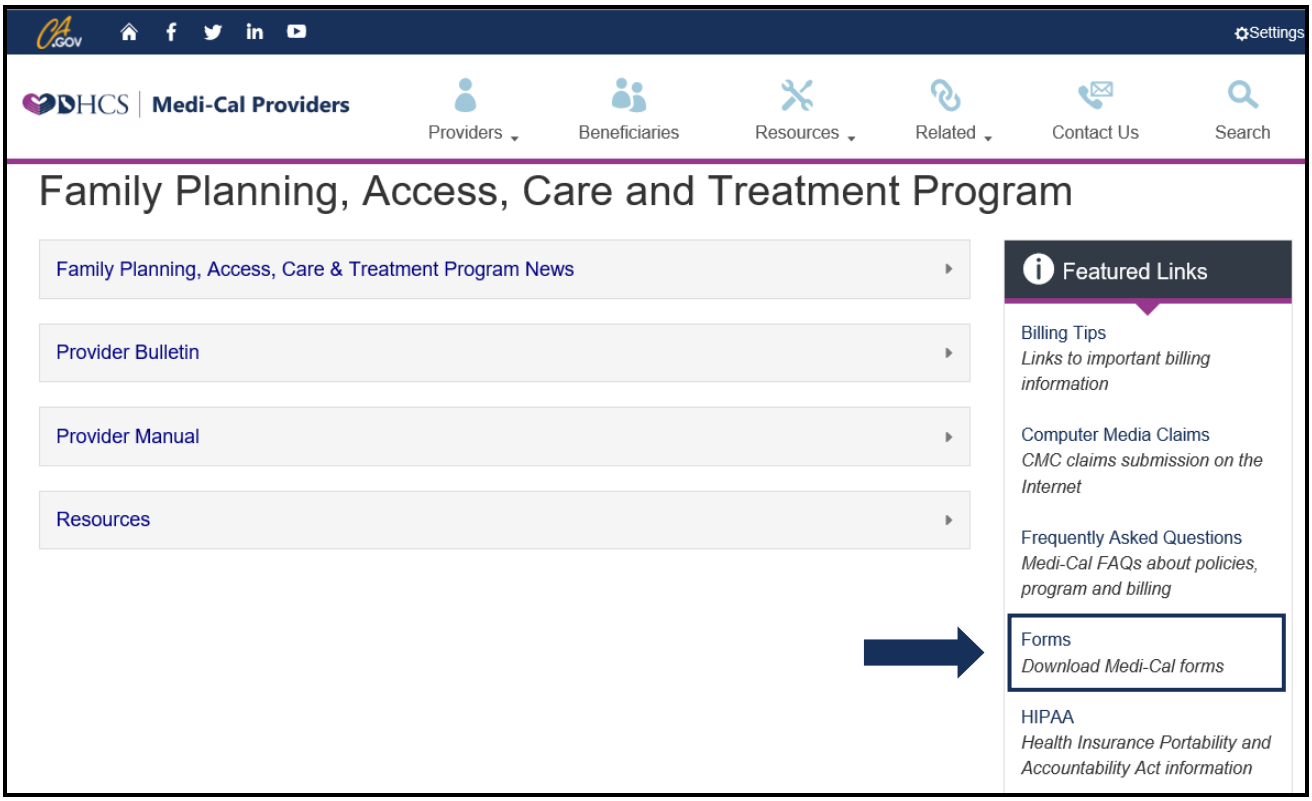
2. From the Provider's drop-down menu, select **Publications**.



3. Next, select the **Family PACT** community and click on the **Family Planning, Access, Care and Treatment** program link.

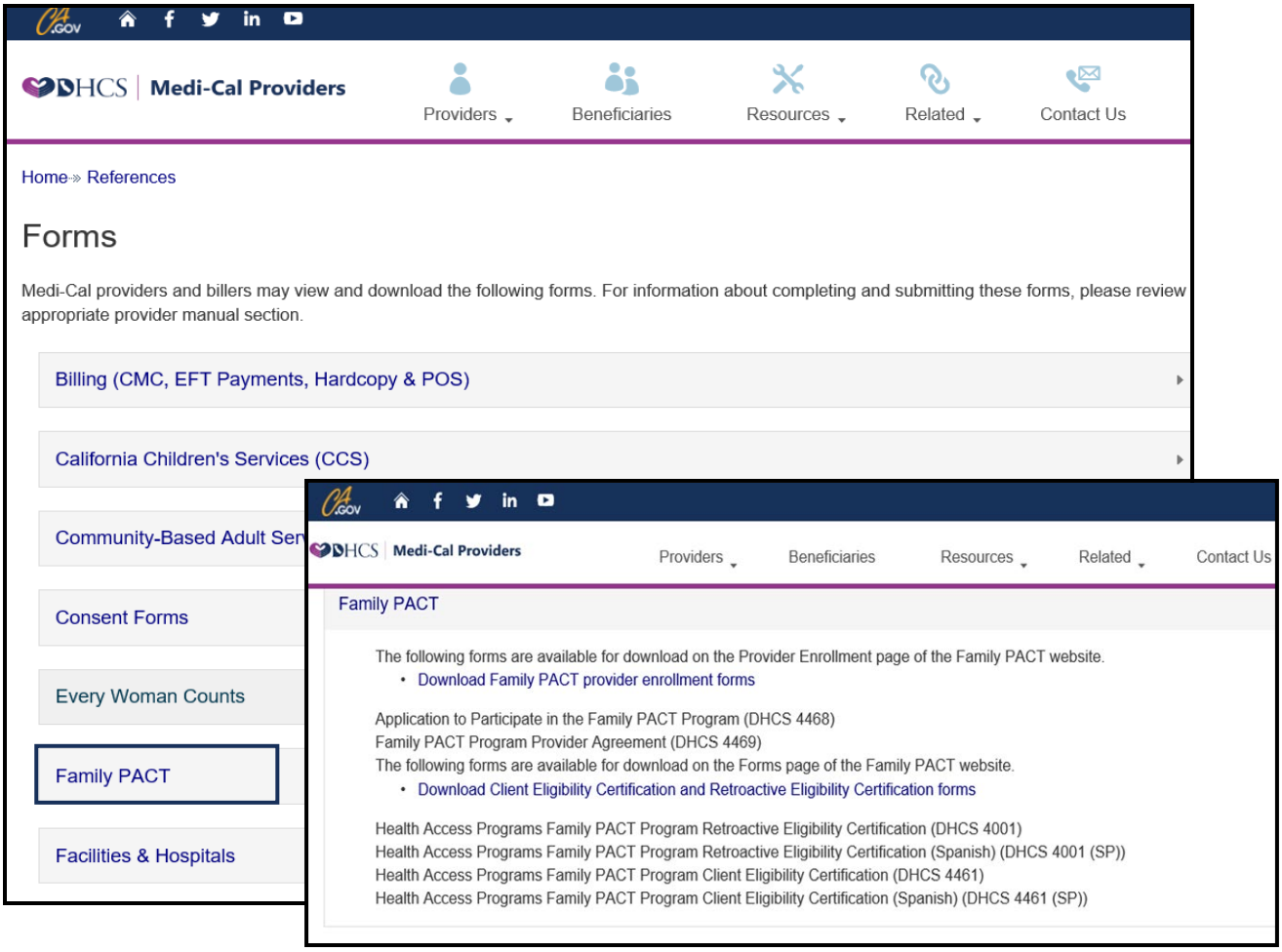


4. From the **Featured Links**, you may select **Forms** to view and download.



5. Select Family PACT to view and download the available Family PACT forms.

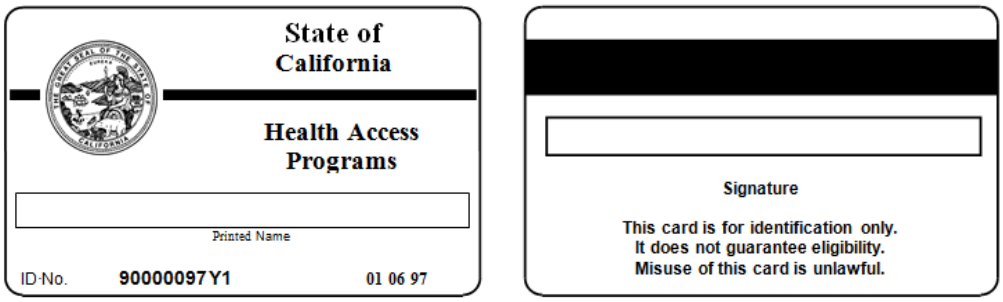
- Family PACT Provider enrollment forms
- *Application to participate in the Family PACT Program* (DHCS 4468),
- *Client Eligibility Certification* (DHCS 4461)and *Retroactive Eligibility Certification* (DHCS 4001)forms



NOTE

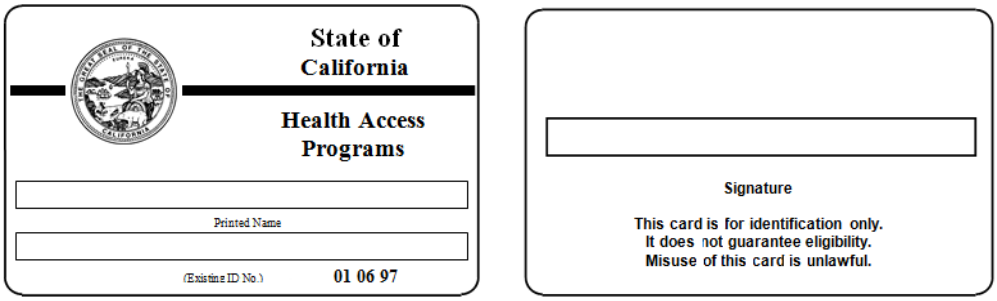
Family PACT's forms are also available for download from the Family PACT website *(www.familypact.org)* and the DHCS website *(www.dhcs.ca.gov).*

HAP Card



Sample: HAP Initial Teal Card

Replacement Card



Sample: HAP Replacement Teal Card

HAP Card Terms and Conditions

The HAP card must be issued and activated at the time a client is enrolled. Activation must be on the date of service for new clients. Eligibility extends for 365 days and must be recertified annually. Clients who possess a HAP card may present their HAP card to any Family PACT provider in California.

HAP card issuance and activation must occur exclusively at the service site (enrolled address) represented by the enrolled Family PACT provider's NPI to whom the sequential cards were distributed. HAP cards may not be provided or activated at health fairs, outreach events or anywhere other than the assigned site in which the cards were requested and distributed. Failure to adhere to this policy will result in disenrollment from Family PACT.

Replacement Card

If the client loses their HAP card, attempt to contact the previous Family PACT provider for the HAP card number. Family PACT providers must maintain a record of the original HAP card number issued to each client. Providers must write the client's name and original HAP # from the client's CEC form onto the blank replacement card. Family PACT tracks blank cards issued to a provider.

HAP Card Distribution

All new providers are issued 200 pre-numbered, sequential HAP cards and 50 blank replacement cards. HAP cards shall be distributed only to provider locations enrolled in the Family PACT program.

Additional HAP Cards

The Office of Family Planning (OFP) reviews all requests for additional HAP cards, and the number of additional cards approved will be on a case-by-case basis. Additional HAP cards may be requested by calling the Telephone Service Center (TSC) at 1-800-541-5555.

Lost or Stolen Card

Providers are responsible for the safekeeping of the HAP cards and must store them securely. OFP tracks sequential cards by activation and date of service. Cards issued and activated are traced and will determine the ability of a provider to receive additional cards when requested. Lost or stolen HAP cards must be reported immediately to the TSC at 1-800-541-5555.

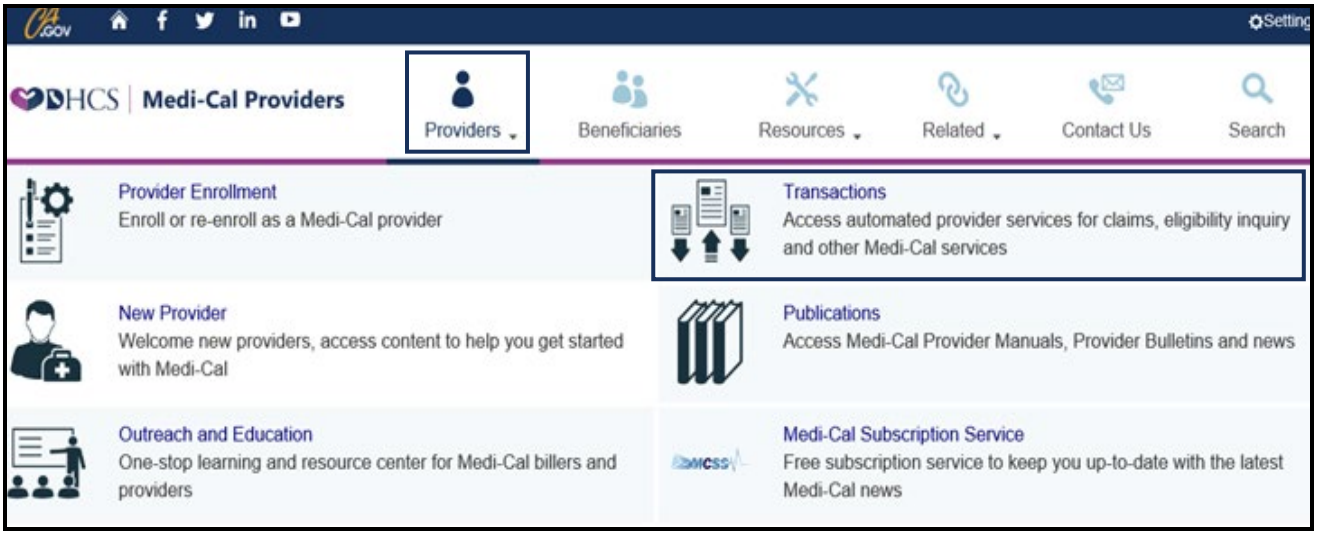
Unused HAP Cards

Unused HAP cards must be returned to the Fiscal Intermediary (FI) at the time of voluntary or involuntary disenrollment from Family PACT. Unused cards must be packaged with a cover letter, including the provider number or National Provider Identifier (NPI) used to order the cards, and returned by UPS to the FI at:

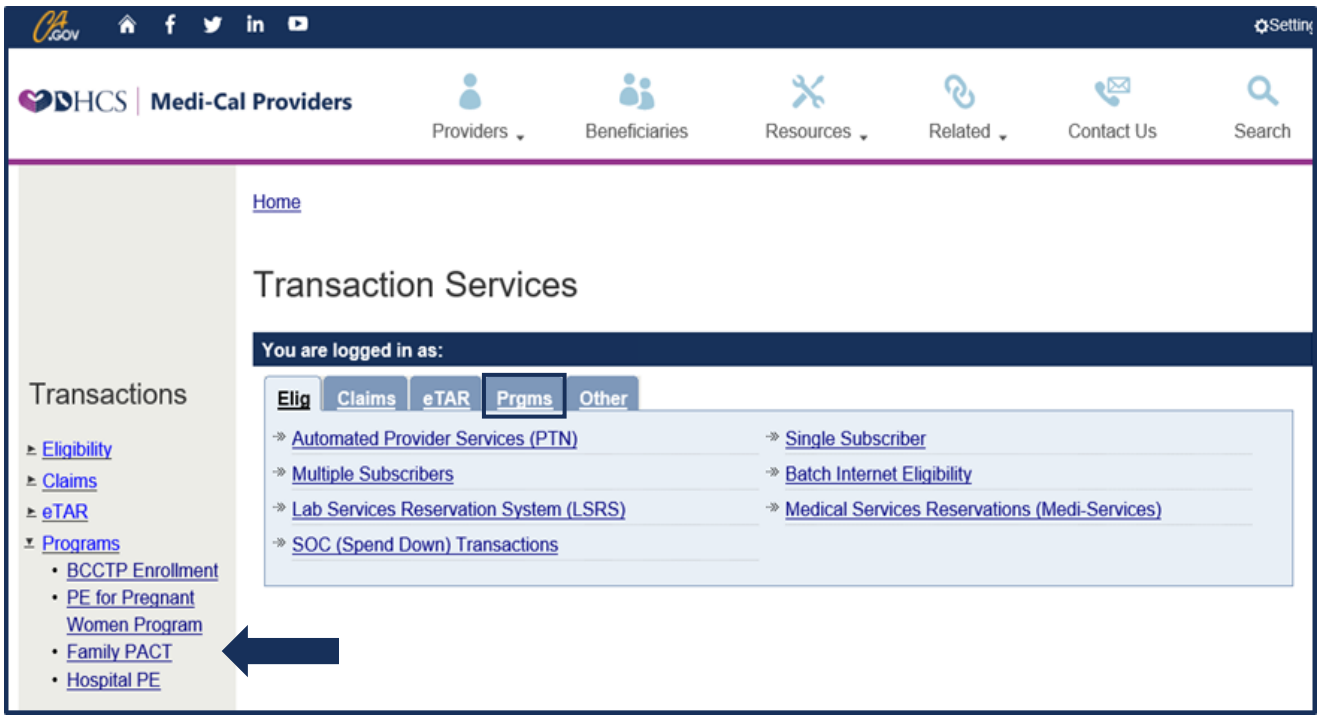
California MMIS Fiscal Intermediary
Attn: Print and Distribution Center
830 Stillwater Road
West Sacramento, CA 95605

Accessing Medi-Cal's HAP Eligibility System

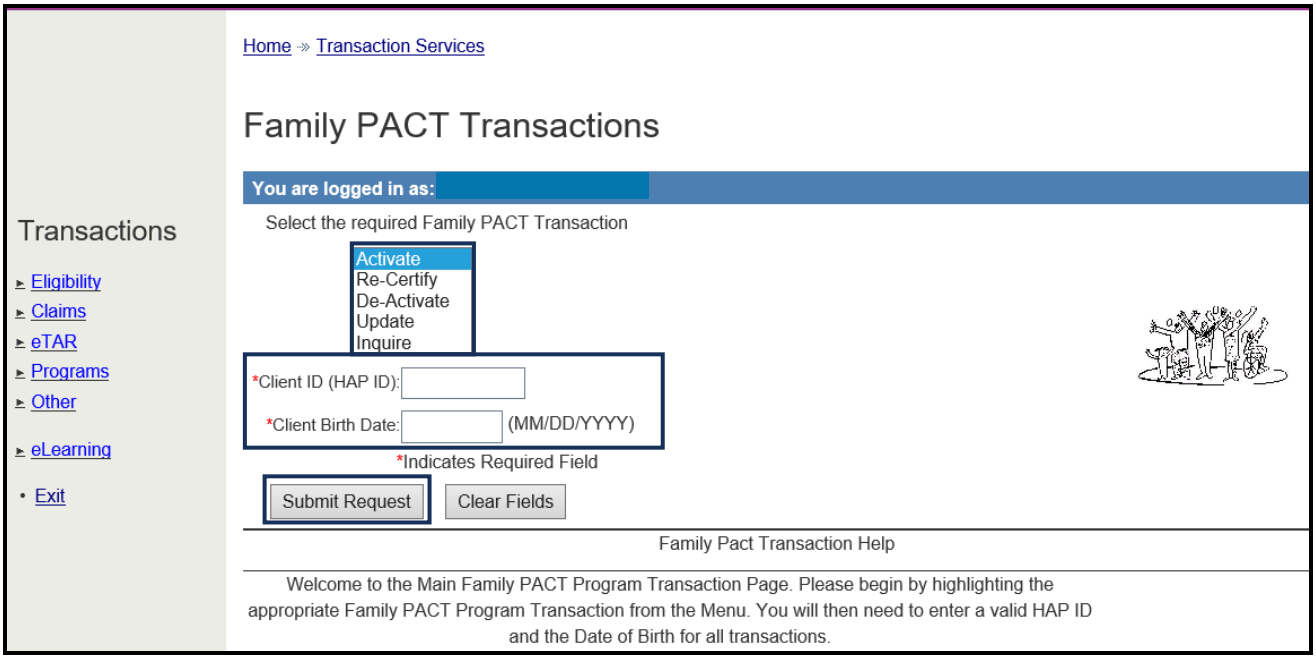
1. From the Providers drop-down menu, select **Transactions**.



2. Next, from the Transaction Services screen, choose the **Prgms** Tab. From the Programs drop-down, select **Family PACT**.



3. Highlight the appropriate Family PACT Transaction from the menu. Enter a valid HAP ID and the Date of Birth for all transactions. Click the ***Submit Request*** button at the bottom of the page.



HAP Client Eligibility System

Providers use the HAP onsite client enrollment system for certifying clients as eligible and for activating the clients' s HAP card. The HAP system also allows providers and/or designees to perform the following functions:

- Inquire
- Update
- Re-certify

Deactivate HAP Card Activation

The HAP card must be issued and activated immediately upon certification of eligibility. Failure to activate the card will result in denial of payments to providers, laboratories and pharmacies. Providers who neglect to activate a card upon certification of a client are responsible for covered services rendered or ordered by a pharmacy, laboratory, or clinical providers to whom the client is referred. Providers will not receive reimbursement until the HAP card is activated. Clients must not be charged for Family PACT services after certification is complete.

Eligibility transaction options available:

- Telephone Automated Eligibility Verification System (AEVS)
- Internet Transaction Application

HAP Card Deactivation

When a client is determined to no longer be eligible for Family PACT services, providers must deactivate the HAP card and advise the client of ineligibility. Providers should select the appropriate “deactivation” option on the internet or AEVS and indicate the reason for deactivation using the deactivation code and refrain from billing Family PACT for services.

Deactivation Codes	
01	Not a resident of California
02	Over 200 percent of the poverty level guidelines
03	Sterilized, no longer contracepting
04	Health insurance coverage for Family Planning Services
05	Full-scope Medi-Cal (does not have an unmet SOC)
06	Permanent deactivation of HAP card (lost/stolen)

Additional Information for Sterilization and Pregnancy Deactivation Codes

Permanent Sterilization (Code 03)

Clients who undergo permanent sterilization are no longer eligible for Family PACT services and the HAP card must be deactivated using deactivation code 03.

Pregnancy (Code 05)

If the client is determined to be pregnant, the client is no longer eligible for Family PACT services. The HAP card should be deactivated using deactivation code 05 on the day following the visit the diagnosis of pregnancy was determined. The HAP card may be retained in the client’s file for future use.

NOTE

Do not deactivate the client’s HAP card until the end of the designated post-operative period, or earlier, if the clinician determines the client is no longer at risk for pregnancy or causing pregnancy.

Knowledge Review

1. Retroactive eligibility may be offered to all Family PACT clients.
   a. True
   b. False
2. Clients must be recertified how often?
   a. Every time they choose a new provider
   b. Every year
   c. Every six months
3. Clients must report any changes pertinent to their eligibility status such as?
   a. Family size/income
   b. California residency
   c. Health insurance coverage changes
   d. All of the above
4. Can providers obtain signatures and store CEC/RECs electronically.
   a. True
   b. False
5. Providers must maintain the completed CEC form in the client's medical record for a period of:
   a. One year
   b. At least four years
   c. Three years
6. The provider determines the total family size and total taxable monthly income based on information provided by the client.
   a. True
   b. False
7. Clients who have been determined ineligible for Family PACT services must be offered a copy of the completed CEC form, which includes a "Fair Hearing Rights" notification.
   a. True
   b. False
8. Failure to adequately certify the client or to sign and date the CEC form may result in the provider being disenrolled.
   a. True
   b. False
9. A client may have more than one HAP card activated at any given time.
   a. True
   b. False
10. Providers must remember to clarify accessing services for reasons of "barrier to access" with all clients prior to completing the CEC form.
    a. True
    b. False

Answer Key: 1) b; 2) b; 3) d; 4) a; 5) c; 6) a; 7) a; 8) a; 9) b; 10) a

Resource Information

References

The following reference materials provide Family PACT Program and eligibility information.

Provider Manual References

Family PACT Policies, Procedures and Billing Instructions (PPBI) Manual Sections and Forms

Client Eligibility (client elig)
Family PACT Program Overview (fam)
Health Access Programs (HAP) Cards (hap cards)
Health Access Programs Family PACT Program Client Eligibility Certification (CEC) form (DHCS 4461)
Health Access Programs Family PACT Program Retroactive Eligibility Certification (REC) form (DHCS 4001)
Program Standards (prog stand)
Provider Enrollment (prov enroll)
Provider Responsibilities (prov res)

Bulletins

Family PACT Update
Medi-Cal Update

Other References

Family PACT website (*www.familypact.org*)
Medi-Cal Provider website (*www.medi-cal.ca.gov*)