

CONTACT INFORMATION: Accurate contact information is necessary for us to notify you of any abnormal medical findings. You must give us some way to contact you. If a phone call is necessary, we can identify ourselves as "Toni" rather than as PPGG.

Patient Information

Last Name: _____

Address: _____

First Name: _____

Middle Name: _____

City: _____

Nickname: _____

State: _____ Zip Code: _____

Social Security Number: _____ - _____ - _____

Home Phone: (_____) _____ - _____

Birth Date: ____ / ____ / _____

Day Phone: (_____) _____ - _____

Sex: Female Male Transgender

Email (optional): _____

Emergency Contact

Phone: (_____) _____ - _____ Name: _____ Relationship: _____

Contact Preferences

How can you receive mail from PPGG? In a PPGG envelope In a plain envelope

If we need to call you how should we identify ourselves? PPGG Dr's Office Toni

Would you like to receive email from PPGG regarding new services, news, and events? Yes No

Demographic Information: Please check only one box in each column.

Race

- White
- African American
- Asian
- Asian - Filipino
- Pacific Islander
- Native American
- Multi-racial
- Other: _____

Ethnicity

Do you consider yourself to be Hispanic or Latino?
 Yes
 No

Primary Language

- English
- Spanish
- Chinese
- Tagalog
- Cantonese
- Vietnamese
- Russian
- Other: _____

Marital Status

- Single
- Single With Partner
- Domestic Partnership
- Married
- Legally Separated

Insurance Information

Do you have medical insurance? Yes No If yes, name of insurance carrier: _____

Family Size and Income

Monthly household income before taxes: \$ _____

Number supported by this income (including yourself): _____

Special Populations: Please indicate if you meet the criteria for any of the special populations below.

- Yes No **Migrant Worker:** An individual who moves regularly in order to find work.
- Yes No **Disabled:** An individual who has a physical or mental condition that severely limits day-to-day activities.
- Yes No **Substance User:** An individual whose use/abuse of legal and/or illegal substances has affected his/her physical, mental, or social health.
- Yes No **Homeless:** An individual who lacks a regular and adequate nighttime residence (includes individuals residing in transitional housing and those living with friends or relatives for a short period of time).

Marketing Plan

Of the sources below, which ONE was the most important in getting you to contact PPGG for services?

- Friend or Family
- PPGG Community Educator
- PPGG Promotora
- PPGG Web site
- Radio
- School Newspaper
- Television
- Yellow Pages
- Other: _____

NAME: _____ DATE OF BIRTH: _____ CLIENT #: _____

<p align="center">FAMILY HISTORY</p> <p><i>Have your PARENTS, BROTHERS OR SISTERS ever had:</i></p> <p><input type="checkbox"/> yes <input type="checkbox"/> no Heart attack before age 50</p> <p><input type="checkbox"/> yes <input type="checkbox"/> no High blood pressure</p> <p><input type="checkbox"/> yes <input type="checkbox"/> no High cholesterol</p> <p><input type="checkbox"/> yes <input type="checkbox"/> no Sickle cell, Tay Sachs, PKU, or other genetic conditions</p> <p><input type="checkbox"/> yes <input type="checkbox"/> no Diabetes</p> <p><input type="checkbox"/> yes <input type="checkbox"/> no Stroke</p> <p><input type="checkbox"/> yes <input type="checkbox"/> no Cancer (Type: _____)</p> <p><input type="checkbox"/> yes <input type="checkbox"/> no Birth defects</p> <p><input type="checkbox"/> yes <input type="checkbox"/> no Did you or your mother take DES (a hormone) during pregnancy?</p> <p><input type="checkbox"/> yes <input type="checkbox"/> no Are you adopted?</p>	<p align="center">MENSTRUAL HISTORY</p> <p><i>(When not taking birth control pills)</i></p> <p>Age first period started: _____</p> <p>Periods come every _____ days</p> <p>They last _____ days</p> <p>Pads/tampons used per day: _____</p> <p>Cramps: None ___ Moderate ___ Severe ___</p> <p>Bleeding between periods: yes ___ no ___</p>	<p align="center">GYNECOLOGICAL HISTORY</p> <p><i>Check if you have ever had any of these problems.</i></p> <table style="width:100%; border: none;"> <tr> <td style="width:10%; border: none;">Yes</td> <td style="width:10%; border: none;">No</td> <td style="border: none;">Disease of or surgery on:</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/></td> <td style="border: none;"><input type="checkbox"/></td> <td style="border: none;">Breast</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/></td> <td style="border: none;"><input type="checkbox"/></td> <td style="border: none;">Uterus</td> </tr> <tr> <td style="border: none;"><input 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<tr> <td colspan="3" style="border: none;">Date of last pap smear: _____</td> </tr> <tr> <td colspan="3" style="border: none;">pap smear: _____</td> </tr> <tr> <td colspan="3" style="border: none;">Was it normal? yes no</td> </tr> </table>	Yes	No	Disease of or surgery on:	<input type="checkbox"/>	<input type="checkbox"/>	Breast	<input type="checkbox"/>	<input type="checkbox"/>	Uterus	<input type="checkbox"/>	<input type="checkbox"/>	Cervix	<input type="checkbox"/>	<input type="checkbox"/>	Tubes	<input type="checkbox"/>	<input type="checkbox"/>	Ovaries	<input type="checkbox"/>	<input type="checkbox"/>	Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Pap Smear	<input type="checkbox"/>	<input type="checkbox"/>	Freezing of cervix	<input type="checkbox"/>	<input type="checkbox"/>	Uterine abnormalities	<input type="checkbox"/>	<input type="checkbox"/>	Infertility	<input type="checkbox"/>	<input type="checkbox"/>	Pain with sex	<input type="checkbox"/>	<input 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Yes no Number of partners in the last 3 months: _____ male _____ female</p> <table style="width:100%; border: none;"> <tr> <td style="width:15%; border: none;"><input type="checkbox"/> yes <input type="checkbox"/> no</td> <td style="width:40%; border: none;">Does your partner(s) have other partners?</td> <td style="width:15%; border: none;"><input type="checkbox"/> yes <input type="checkbox"/> no</td> <td style="width:30%; border: none;"><i>In the last year:</i></td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> yes <input type="checkbox"/> no</td> <td style="border: none;">Male partner treated for painful urination or discharge?</td> <td style="border: none;"><input type="checkbox"/> yes <input type="checkbox"/> no</td> <td style="border: none;">Have you had vaginal intercourse?</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> yes <input type="checkbox"/> no</td> <td style="border: none;">Do you have any concerns about sex? 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All services are confidential, however, in cases of life threatening emergencies and physical or sexual abuse, we may need to make a referral to another agency.

HABITS AND LIFESTYLE

- 1. Do you take prescribed medications, over the counter medications, or street drugs? yes no
If so, please list:
If in the past, please list:
2. If you take drugs, how do you take them (snort, shoot up, skin pop, smoke, pop, etc.)?
3. Do you drink alcohol? yes no Number of drinks per day: per week:
4. Do you consider yourself to have (had) a problem with drugs or alcohol? yes no
5. Have you ever had a blackout while drunk or high (Have you done things you don't remember doing)? yes no
6. Do you smoke cigarettes? yes no How many cigarettes a day: per week:
7. Have you ever smoked? yes no How long: When did you quit:
8. Do you exercise? yes no What type: How many times per week: How long:
9. Do you consider your diet healthy? yes no
10. What is your current living situation (parents, friends, squat, street, shelter, foster home, school, etc.)?
11. Any recent life changes (divorce, moved, death, etc.)?
12. Has anyone ever touched you in a way that was frightening, painful, or made you feel uncomfortable? yes no
13. Is there something you need support with or a referral for? yes no If yes:

SUPPLEMENTAL MALE MEDICAL HISTORY

- Have you noticed, or had diagnosed, any of the following:
 yes no Unusual discharge from the penis? yes no Varicocele?
 yes no Skin diseases of the scrotum or penis? yes no Hydrocele?
 yes no NGU or NSU? yes no Other?

MID-LIFE HISTORY

- If you are still having menstrual periods, have you noticed a change in the past year? yes no
How? more days fewer days
 heavier flow lighter flow
 more days between cycles fewer days between cycles
How many months ago did you notice these changes?
Do you ever bleed or spot between periods? yes no
Have you experienced hot flushes/flushes or night sweats? yes no
How long ago did you first notice these symptoms?
How frequently do you experience these symptoms?
Are you having any vaginal dryness/irritation or decreased lubrication with intercourse? yes no

PERSONAL MEDICAL HISTORY

- yes no Have you had a mammogram? When:
 yes no Any problems with bladder control, leaking urine with coughing, sneezing?
 yes no Any moodiness, depression, irritability?
 yes no Any trouble sleeping?
 yes no Regularly take vitamins? What kind:
 yes no Regularly take calcium? What kind:
 yes no Consume any caffeine (chocolate, coffee, tea)? Daily amount:
 yes no Any exercise regularly? What kind:
 yes no Smoke? Amount:

SUPPLEMENTAL MEDICAL HISTORY

Current medications (please list):
Current medical problems (please list):

FAMILY HISTORY

- Any family member (parents, brothers, sisters, grandparents) had: Relationship
Menopause before age 45 yes no
Fracture of hip yes no
Compression fracture of spine yes no

To the best of my knowledge, I have answered these questions truthfully:

Reviewed by Staff:

Client Signature Date

Staff Signature Date

Staff Signature Date

Staff Signature Date

Staff Signature Date

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

Client identification number

This form is the property of the State of California, Department of Health 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 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.)
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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.)
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Number of live births	County of residence	Provider Use Only—CODE	Nine-digit ZIP code
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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.

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
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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)		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 Department of Health Services 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

Office of Family Planning
 Department of Health Services
 714 P Street, Room 440
 P.O. Box 942732
 Sacramento, CA 94234-7320

Formal Hearing

Office of Administrative Hearings and Appeals
 Department of Health Services
 714 P Street, Room 1216
 P.O. Box 942732
 Sacramento, CA 94234-7320