womens community clinic

PATIENT REGISTRATION

CONFIDENTIAL

Name and Date of Birth: _____ **Social Security Number:** _____-_____-_____

Nickname or preferred name: _____ **Gender pronoun (ex: she, he, they):** _____

What is your yearly income before taxes? _____ **How many people does this support?** _____

If you are married, what is your spouse's annual income before taxes? _____

Do you need an interpreter to communicate in English?

□ Yes □ No

Which of these best describes your living situation?

□ Own a home
□ Rent home/ apartment/room
□ Permanently live with relative/friend
□ Temporarily live with relative/friend, or living in a hotel/motel
□ Shelter
□ Street, camping, or vehicle

What is your ethnicity?

□ Hispanic
□ Non-Hispanic
□ Decline to state

We know that these categories do not capture the rich diversity of our clients. If you feel that none of these fit you, please mark "decline to state."

What is your race?

Please check all that apply.

□ American Indian
□ Alaskan Native
□ Asian
□ Black or African American
□ Native Hawaiian
□ Pacific Islander
□ White (includes Middle Eastern)
□ Decline to state

What is your primary language?

_____

Do you work on a farm?

□ No
□ Yes, I work on a farm part of the year
□ Yes, and I move around for farm work

Are you a veteran of the US Armed Forces?

□ Yes □ No

Emergency contact name: _____

Relationship to you: _____

Phone number: _____

Do you have a physical or mental disability?

□ Yes □ No

How did you hear about us?

□ workshop/health fair/community event
□ relative/friend
□ another medical provider
□ print ads
□ postcard
□ condom ladies/Ladies Night
□ walking by
□ web search
□ yelp

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 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 in the last 3 months? ☐ Yes ☐ No

Do we need to keep your family planning services confidential from your partner, spouse, or parent? If so, how may we contact you if we need to talk to you about something? ☐ Yes ☐ No

Confidentiality

***Provider Use Only*—CODE**

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

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

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

Number of live births	County of residence	***Provider Use Only*—CODE**	Nine-digit ZIP code

Gender ☐ Male ☐ Female	***Provider Use Only*—CODE**	Social security number ____ ____ ____ / ____ ____ / ____ ____ ____ ____	Mother's first name

Date of birth (mm/dd/yyyy) / /_ _ _ _	Place of birth (county, if California)	***Provider Use Only*—CODE**	State (if not California)	***Provider Use Only*—CODE**	Country (if not USA)	***Provider Use Only*—CODE**

Race/ethnicity

1 ☐ Asian 2 ☐ Black 3 ☐ Filipino 4 ☐ Hispanic

5 ☐ Native American 6 ☐ Pacific Islander 7 ☐ White 0 ☐ Other

Primary Language

3 ☐ English 1 ☐ Armenian 2 ☐ Cantonese 4 ☐ Hmong 5 ☐ Khmer/Cambodian

8 ☐ Spanish 6 ☐ Korean 7 ☐ Tagalog 9 ☐ Vietnamese 0 ☐ Other

Privacy Statement (Civil Code Section 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.

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 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	Date	Signature of witness to mark or interpreter	Date

FOR PROVIDER USE ONLY

Provider certification: ☐ Eligible for Family PACT Program

☐ Ineligible for Family PACT Program (Give applicant Fair Hearing Rights.)

Medi-Cal client eligible for Family PACT verified: ☐ Limited scope ☐ Unmet share-of-cost

Based upon the information provided by the applicant and according to state and federal requirements, I certify that the applicant identified on this Client Eligibility Certification is eligible to receive family planning services under the Family PACT Program. If ineligible, the client has received a copy of this form which includes the Fair Hearing Rights. I also certify that the client has received the Notice of Privacy Practices.

Print name	Signature	Date

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

Fair Hearing Rights

Any applicant for, or recipient of, services under the Family PACT Program 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

Electronic Privacy at Women's Community Clinic

Epic

Women's Community Clinic uses an electronic health record system called Epic. Records in Epic can be shared with other health care providers that use the same system, like Kaiser and UCSF. The information that can be shared includes your medications, your labs, and notes from your visits with your provider.

> **Why this can be helpful:** Sharing this information can give you better care. If you go to an emergency room that uses Epic, they will be able to see your medical history. If you see a new provider who uses Epic, you will not need to transfer your records to them.
>
> **Why this might not be right for you:** If you are coming to Women's Community Clinic because you have concerns about privacy, you should know that this information could be shared with other providers. For example, if you had Kaiser Insurance through your parents, your provider at Kaiser could see the birth control method that we prescribed for you.

We can lock your record so that your information is not visible to other health care providers through Epic. Please see our Notice of Privacy Practices for other ways we may use your health information.

◯ Please **lock** my record so that my information is not visible to other health care providers through Epic.

◯ Please keep my record **open** so that other providers who use Epic can see my information if they need to.

Other health care providers and facilities can only see your information if you are or have been their patient, and they have to follow state and federal privacy laws like we do.

Pharmacies

Most pharmacies now use big databases to track patients and prescriptions. Epic automatically checks your name, date of birth, and Social Security number against these databases. If it finds a match it will tell us what prescriptions you have gotten from other providers. This is very helpful to make sure that we do not give you new prescriptions that will interact badly with your existing ones. We want you to know that it can work both ways—other providers may be able to see the prescriptions we give you. We cannot turn off this feature of data-matching to pharmacy databases.

California Immunization Registry

Women's Community Clinic has to report all immunizations (vaccines) and tuberculosis tests to the California Immunization Registry. This is very helpful to make sure that you get all your immunizations, and don't get immunizations that you don't need. However, if you are here for privacy reasons, we want you to know that your school or family provider could see that you got an immunization at our clinic.

If we give you a vaccination, we have to report your vaccination to the state registry, but we can tell the registry never to share your immunization information with other providers. If you want us to do that, we will need you to sign a special consent form.

◯ Please ask the Immunization Registry to **not** share my immunization information with other providers.

◯ Please **allow** the Immunization Registry to share my immunization information with other providers.

Sign: _____ **Print Name:** _____ **Date**: _____

womens community clinic

Health History Form

Name: _____ **DOB: _____**

Allergies to medications, latex, or shellfish: _____
Allergic reaction (like hives, trouble breathing, vomiting):_____
Current Medications: _____

Your Past Medical History

No Yes anxiety
No Yes depression
No Yes other mental health concerns: _____
No Yes asthma or lung disease
No Yes cancer
No Yes HIV
No Yes clotting disorder or blood clots in legs or lungs
No Yes hypertension (high blood pressure)
No Yes heart problems or high cholesterol
No Yes incontinence
No Yes stroke
No Yes migraine headaches
No Yes breast problems (masses, lumps, surgeries)

Have you ever had any sexually transmitted infections? (STI or STD)? If yes, when?
☐Herpes (oral/genital) _____ ☐Warts _____
☐Chlamydia _____ ☐Tested positive for HPV _____
☐Gonorrhea _____ ☐Syphilis _____

When was your last pap smear? _____
Have you ever had an abnormal pap smear? ☐No ☐Yes If yes, when?_____
Do you have any other medical conditions?_____
Have you had any surgeries?_____

Your Family History

Were you adopted? ☐ No ☐ Yes

	Tell us which family members have had the following – Only parents, grandparents, siblings, and children (**please state maternal or paternal**)
Breast cancer (including aunts)	
Ovarian cancer (including aunts)	
Other cancer	
Heart attack/heart disease	
Diabetes	
High Cholesterol	
Hypertension (high blood pressure)	
Kidney Disease	
Stroke or blood clot in vein	
Other major illnesses?	

Number of past: pregnancies: _____ births: ____miscarriages: ____ abortions: ____ living children:____
Any problems with pregnancies? ☐ No ☐ Yes _____

Did you receive basic childhood vaccines? ☐No ☐Yes
When was your most recent: Flu Shot _____Tetanus Shot (Tdap or Td) _____
Hep A vaccination (series of 2 shots)_____ Hep B vaccination (series of 3 shots)_____
TB Test_____ HPV Vaccine (series of 3 shots)_____