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A New Updated Manual

This 2013 edition of the Oregon Reproductive Health Program Manual is designed to serve as a reference and orientation tool for:

- Agencies receiving grants from the Reproductive Health Program as part of the state’s federally funded Title X Program
- Agencies participating in Oregon Contraceptive Care (CCare)

In many instances, these agencies are identical. Others, however, may be participating only in CCare. Guidelines for the Oregon Title X Program do not apply to those agencies. Even so, much of the material in this manual can be a useful resource for any agency seeking to provide a high quality family planning program and to understand the statewide system through which Oregonians receive services.

What’s New

In this revision, we’ve maintained the same order of information as the earlier edition, and hope you will find it more current, convenient, user-friendly, and concise.

Some changes include removing the summaries of the Title X Program Instructions and including them in their entirety in Section B, Exhibit 8. You will also notice some other new Exhibits and that the previous Section E, Region X Infertility Prevention Program Guidelines (IPP) is now Appendix G.

This manual is designed to work in tandem with the Reproductive Health Program website. A wealth of supplemental materials and tools can be found there. The website also features a complete e-version of this manual. Sections and exhibits are also available separately on the website so you may print sections as needed or access original forms.

As in the past, we will post alerts in the RH Update newsletter to inform you of periodic updates to help keep this manual current.

Oregon Reproductive Health Program Website
http://www.healthoregon.org/rhmateri

January 2013 Introduction to the Manual i
Reproductive Health Program Manual
January 2013

Section A

The Oregon Reproductive Health Program

Center for Prevention and Health Promotion
Oregon Health Authority – Public Health
The Oregon Reproductive Health Program

Purpose

The purpose of the Oregon Reproductive Health Program is to:

- Develop programs and recommend policies that prevent unintended pregnancy and associated problems.
- Ensure that education and services addressing voluntary and effective family planning methods are available to all Oregonians.

Funding

The Reproductive Health Program receives funding from two principal sources:

- Title X grant from the U.S. Department of Health and Human Services-Office of Population Affairs (HHS-OPA); and
- Medicaid (Title XIX) reimbursement through the Oregon Contraceptive Care (CCare) Program.

Please note that operational guidelines, funding requirements, services, and definitions often differ between the two funding sources. These distinctions have been highlighted throughout this manual, starting here and with the comparison chart on pages A.1-3 and A.1-4.

Services

Title X

Title X grant funds provide basic support to a system of reproductive health clinics throughout the state. These clinics serve low-income Oregonians with a range of reproductive health services: physical exams for women and men; breast and cervical cancer screenings; testing and counseling for sexually transmitted diseases including HIV; infertility services; birth control methods, reproductive health education and referrals.

Clinics that receive Title X grant funds must follow Title X requirements. See Section B.1 for a complete copy of the Title X requirements.
OregonContraceptiveCare (CCare)
In 1999, Oregon received a waiver to expand Medicaid coverage for contraceptive services. OregonContraceptiveCare (CCare) serves Oregonians not enrolled in the Oregon Health Plan (OHP) with incomes at or below 250% of the federal poverty level (FPL). CCare services include: annual exams; follow-up visits to evaluate or manage problems associated with contraceptive methods; medical procedures, lab tests, and counseling services associated with contraceptive management; and birth control supplies and devices.

Many OHP enrollees can and do receive services at reproductive health clinics. These benefits are managed by the Division of Medical Assistance Programs (DMAP), not the Division of Public Health. However, every effort is made to coordinate OHP and CCare. CCare requirements were originally based on Title X guidelines and are in Section C.

Outcomes
In 1998, the Oregon Reproductive Health Program served over 50,000 people in more than 90 clinics. By 2011, more than 150 clinics in all 36 counties were providing services to 115,000 Oregonians, at just $218 per client per year. The 2011 investment averted an estimated 17,000 unintended pregnancies, resulting in $29.5 million in savings.

Estimates show that every $1.00 invested in reproductive health, in Oregon, produces more than $4.50 in savings from averting unintended births.
## Oregon Reproductive Health Program Specifics

<table>
<thead>
<tr>
<th>Program Requirement</th>
<th>Title X Federal Family Planning Grant</th>
<th>OregonContraceptiveCare (Medicaid Waiver Title XIX)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Client</strong>&lt;br&gt;Definition/Gender/Age</td>
<td>A person of reproductive age (female 10-60; male 10 and older) who receives reproductive health services related to contraception, sterilization, infertility treatment.</td>
<td>A person of reproductive age (female 10-60; male 10 and older) who receives reproductive health. People who have been sterilized for more than six months do not qualify.</td>
</tr>
<tr>
<td><strong>Eligibility</strong></td>
<td>Client may not be denied service or be subjected to any variation of services based on inability to pay.</td>
<td>Client must qualify based on U.S. citizenship, Oregon residency, financial need, reproductive age, and insurance status.</td>
</tr>
<tr>
<td><strong>Citizenship</strong></td>
<td>Not considered</td>
<td>U.S. citizen, refugee/asylee, or lawful permanent resident for 5+ years.</td>
</tr>
<tr>
<td><strong>Residence</strong></td>
<td>Not considered</td>
<td>Oregon resident</td>
</tr>
<tr>
<td><strong>Income and Fee Assessment</strong></td>
<td>- Based on number in household and household income. Proof of income is not required, but is assessed.&lt;br&gt;- Information is collected at least annually.&lt;br&gt;- Minors (under 18): If receiving confidential services, use minor’s income only.&lt;br&gt;- No charge at or below 100% of federal poverty level (FPL).&lt;br&gt;- Use sliding fee scale for clients between 101% and 250% FPL.&lt;br&gt;- Priority for services given to persons from low-income families.&lt;br&gt;- Agency may establish policies to waive fees for specific circumstances.</td>
<td>- Based on number in household and household income. Proof of income is not required, but is verified by the Reproductive Health program.&lt;br&gt;- Information is assessed annually.&lt;br&gt;- Teens (under 20): May qualify on own income regardless of whether confidential services are requested.&lt;br&gt;- Collect info annually.&lt;br&gt;- No charge at or below 250% FPL.</td>
</tr>
<tr>
<td><strong>Services Offered</strong></td>
<td>Broad range of reproductive health services.</td>
<td>Narrow definition of services: contraceptive management only.</td>
</tr>
<tr>
<td><strong>Infertility/STDs</strong></td>
<td>- STD/HIV testing required when clinically indicated.&lt;br&gt;- Follow-up required for positive STD/HIV results.&lt;br&gt;- Infertility Level 1 services (interview, exam, education, counseling, referral) required.</td>
<td>- STD testing may be allowable if part of a routine reproductive health visit or related to contraceptive management.&lt;br&gt;- No infertility/STD treatment reimbursement.</td>
</tr>
</tbody>
</table>
Every agency in Oregon’s Reproductive Health Program network must appoint a Reproductive Health (RH) Coordinator, who will serve as the primary point of contact between the agency and state Reproductive Health Program staff. The RH Coordinator attends trainings and meetings provided by the RH Program and must assume responsibility for conveying pertinent information and updates from the RH Program to personnel at all clinic sites, including subcontracted sites.
Resources and Contacts

The Reproductive Health Program website features useful resources. They include:

- Reproductive Health Program Manual
- Administrative rules for CCare
- Training announcements
- Posters, fact sheets, brochures
- CCare provider resources including enrollment packets, provider standards, and tools to assist clients with eligibility requirements
- Title X provider resources including guidelines and site review tools
- A list of reproductive health clinics in Oregon
- Social marketing resources including, promotional tools, newsletters, quality improvement information, and other resources
- Internet links to reproductive health websites
- Bi-monthly RH Update newsletters with the latest information, training announcements, and resources

OHA Reproductive Health Program

800 NE Oregon Street
Suite #370
Portland, OR 97232-2162
Phone: (971) 673-0355
Fax: (971) 673-0371

http://www.healthoregon.org/rhmateria ls

Contact information for specific aspects of the Oregon Reproductive Health Program can be found in Appendix B.
The information in this section and the organization charts that follow provide an overview of functions and the chain of responsibilities that govern Oregon’s Reproductive Health Program.

**Federal Level:**

**National**

**U.S. Congress.** Creates/amends the law (Title X) that authorizes the National Family Planning Program and appropriates grant funds for family planning projects. Creates and amends laws affecting Medicaid benefits for family planning.

**U.S. Department of Health and Human Services, Office of Public Health and Science, Office of Population Affairs (OPA).** Provides national Title X program administration, including issuance of regulations and guidelines within the authorizing legislation.

**U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS).** Administers Medicaid programs, including demonstration or waiver programs for family planning benefits, such as CCare.

**Federal Level:**

**Regional**

**Region X DHHS Office, Seattle, WA.** Reviews state application for Title X grants and for Medicaid state plans and waivers; distributes funding; and provides technical assistance to Alaska, Idaho, Oregon, and Washington.

**State Level**

**Oregon Legislature.** Creates and amends laws and appropriates funds for the Reproductive Health Program.

**Oregon OHA, Public Health Division, Reproductive Health Program.** Allocates and distributes federal and state dollars to local projects.
provides technical assistance, reviews local projects. Administers Title X and Oregon Contraceptive Care (CCare) programs.

Local Level

Local Agencies. County health departments and other health care agencies provide reproductive health services as Title X delegates and/or as Medicaid reproductive health providers.

Who Writes Regulations

Federal Statutes originate in Congress and are signed into law by the president. Examples include the Americans with Disabilities Act of 1990 (ADA) and the Public Health Services Act.

Federal Administrative Rules or Regulations are written by a federal agency, to provide governmental agencies and others with detailed information on how to comply with an act passed by Congress. For example, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), released by the Department of Health and Human Services.

Federal Guidelines are also written by a federal agency. Unlike statutes and regulations, they are not put through a rule-making or legislative process. They help interpret federal laws and regulations in operational terms and provide assistance with compliance. For example, Program Guidelines for Project Grants for Family Planning Services.

Oregon Revised Statutes (ORS) are originated in the state legislature and signed into law by the governor. For example, a state statute created the Oregon Health Plan.

Oregon Administrative Rules (OAR) are written by a state agency to explain how to comply with state statutes. Examples are the Oregon Administrative Rules specific to CCare or the general rules written by the Division of Medical Assistance Programs.
The statutes and regulations referred to in this section are subject to revision by the Oregon Legislature. Your primary resource for specific legal questions should be your organization’s attorney (county health departments should consult your county counsel).

Issues addressed in this section:

- Mandate for family planning services
- Services to minors
- Sterilization
- Informed Consent and confidentiality
- Dispensing rules
- Emergency Contraception for victims of sexual assault
- Contraceptive equity
- Mandatory Reporting Requirements

For more details on Oregon laws related to birth control and sterilization, refer to Chapters 435 and 436 of the Oregon Revised Statutes, available online at: [http://www.leg.state.or.us/ors/](http://www.leg.state.or.us/ors/).

**Mandate for Family Planning Services**

ORS 435.205, passed in 1967, authorized the establishment of family planning and birth control services by OHA and county health departments.

Family planning and birth control services include: interviews with trained personnel; distribution of literature; referral to licensed physicians for consultation, examination, medical treatment, and prescriptions; and the initial supply of a contraceptive method, and similar products.

With the consent of the county governing body, any county health department may adopt a fee schedule and collect fees for services provided by the department. The fees shall be reasonably calculated not to exceed costs of services provided and may be adjusted on a sliding scale reflecting the client’s ability to pay. Such fees may be used to meet the expenses of providing the services authorized by this section.
Services to Minors

**Birth Control Services**
Any physician or nurse practitioner may provide birth control information and services to any person without regard to the age of the person (ORS 109.640).

**Other Reproductive Health Services**
A minor 15 years of age or older may give consent to:

- Hospital care, medical or surgical diagnosis or treatment by a licensed physician; and
- Diagnosis and treatment by a licensed nurse practitioner who is acting within the scope of practice for a nurse practitioner without the consent of a parent or guardian, except as may be provided by ORS 109.660.

In addition, a minor of any age who may have come into contact with a reportable sexually transmitted infection (STI) may consent to hospital, medical, or surgical care related to the diagnosis or treatment of the infection. The consent of parent(s) or legal guardian is not necessary; however, having not given consent, they shall not be liable for payment for care provided (ORS 109.610). Reportable conditions are defined by OHA and listed in Chapter 333-018-0015 of the Oregon Administrative Rules.

**Parental Notification**
A hospital or any physician or nurse practitioner may advise the parent(s) or legal guardian(s) of any minor of the care, diagnosis or treatment or the need for any treatment without the consent of the patient. In such cases, the hospital, physician or nurse practitioner is not liable for advising the parent, parents or legal guardian without the legal consent of the patient (ORS 109.650).

**NOTE:** The above parental notification practice is not recommended.

Title X family planning grant guidelines (as well as other community practice standards) require that client consent be obtained before disclosure of any medical information or record (See Section B.1, Title X Program Guidelines). Although Oregon law permits disclosure of a minor's record, it does not require such disclosure. Guidelines relating to patient confidentiality must be maintained for all clinics receiving Title X funds or operating under Title X standards.
Sterilization

A person may be sterilized upon his or her request and upon the advice of a physician licensed by the Oregon Medical Board. The person must give his or her informed consent to the procedure, however, Oregon law is specific about the way in which informed consent must be obtained. (ORS 436.225 and 435.305) No physician or hospital may be held liable for performing a sterilization without obtaining the consent of the spouse of the person sterilized. Free clinics to sterilize males may be conducted as part of the family planning and birth control services offered by public agencies as described in ORS 435.205.

Informed Consent

Informed consent is a fundamental aspect of medical care. The basic elements of informed consent are described in ORS 677.097 but certain procedures, such as sterilization, carry specific informed consent requirements. Title X grant recipients should refer to *Program Guidelines for Project Grants for Family Planning Services* (section B1) for requirements regarding general and method-specific informed consent.

Confidentiality

Many statutes, cases, and rules confirm the right of medical patients to confidentiality and the obligations of providers to honor that right. A broad policy in support of confidentiality of health information is contained in ORS 192.553. State licensure laws also place a duty of confidentiality on providers.

Two suggested references for summaries of laws and rules related to confidentiality are:


Specific information about issues related to confidentiality should be explored with legal counsel. If you are a Title X grant recipient, you should also refer to Program Guidelines for Project Grants for Family Planning Services for requirements regarding confidentiality and medical records. If you are a CCare provider, refer to the OARs specific to CCare.

**Dispensing**

The Oregon Board of Pharmacy issues licenses for both county health clinics and reproductive health clinics, among other entities. The rules about who can dispense what kinds of drugs and devices differ slightly between the two categories, as detailed below.

**County Health Clinics**

A registered nurse who is an employee of a local health department established under the authority of a county or district board of health and registered with the Oregon Board of Pharmacy under ORS 689.305 may dispense a drug or device to a client for purposes of birth control or prevention or treatment of a communicable disease. The dispensing must be pursuant to an order by a person authorized to prescribe, and is subject to rules jointly adopted by the board and Oregon OHA – Public Health. (OAR 855-043-0110)

**Reproductive Health Clinics**

A registered nurse or a nurse practitioner who is an employee of a reproductive health clinic supported by the Oregon Public Health Division and licensed by the Oregon Board of Pharmacy under ORS 689.305 may dispense drugs or devices from the board’s approved formulary to a client for purposes of birth control, treatment of amenorrhea, hormone deficiencies, urinary tract infections, or sexually transmitted diseases. The dispensing must be pursuant to the prescription of a person authorized to prescribe, and is subject to rules jointly adopted by the board and the Oregon Public Health Division. (OAR 855-043-0300)

In clinics with this type of dispensing license, staff assistants may perform non-judgmental dispensing functions under the following circumstances:

1. The initial dispensing must have been done either by a physician, pharmacist, registered nurse, or nurse practitioner.
2. The patient’s medication profile must not have changed after the initial dispensing.
3. The accuracy and completeness of the prescription must be verified by a physician, nurse, or nurse practitioner prior to being delivered or transferred to the patient.

This license requires that a consultant pharmacist must conduct and document an annual inspection of the clinic (OAR 855-043-0310).

Emergency Contraception for Victims of Sexual Assault

Hospitals providing care to a female victim of a sexual assault must:

- Promptly provide the victim with unbiased, medically and factually accurate written and oral information about emergency contraception (materials must be approved by OHA);
- Promptly orally inform the victim of her option to be provided emergency contraception at the hospital; and
- If requested by the victim and if not medically contraindicated, provide the victim with emergency contraception immediately at the hospital. (OAR 333-505-0120)

Mandatory Reporting Requirements

All Reproductive Health Clinic staff are considered mandatory reporters for purposes of Oregon’s Mandatory Child Abuse Reporting statutes (ORS 419B.005 to .050). As such, each agency is required to have policies in place to regulate staff compliance with these reporting statutes. Refer to Exhibit 4 of this section for information about policy requirements.
Benefits and Billing

This section provides specific information on Medicaid family planning benefits and billing procedures for clients eligible for the Oregon Health Plan (OHP), which is administered through the Department of Medical Assistance Programs (DMAP). Clients must be screened for private insurance and OHP eligibility, and any covered reimbursement must be collected from these entities before OregonContraceptiveCare (CCare) or Title X family planning funds may be used for payment.

OHP Eligibility for Family Planning Services

- OHP clients may seek family planning services from any family planning provider enrolled with the Department of Medical Assistance Programs, even if the client is enrolled in a Coordinated Care Organization (CCO).
- Oregon Health Plan (OHP) clients with CCO coverage do not need a referral from a primary care provider or primary care manager in order to obtain family planning services.
- Providers should call the OHP Automated Voice Response (AVR) to verify a client’s OHP eligibility or coverage before submitting family planning bills. The number is 1-866-692-3864.
- Clients who may be eligible for OHP but have not yet been determined eligible should request an application (see DMAP contact information on page A5-4).

OHP Covered Family Planning Services

A broad range of reproductive health services are covered for clients of childbearing age (including minors who are considered to be sexually active). Services covered by OHP may include:

- Annual exams
- Contraceptive education and counseling
• Laboratory tests
• Radiology services
• Medical and surgical procedures, including tubal ligations and vasectomies
• All family planning methods and supplies
• Emergency Contraception (EC)

Billing for Family Planning Visits

Reimbursement for family planning services is made either by the client’s Coordinated Care Organization (CCO) or by DMAP, as per the following:

• If the provider is contracted with the client’s CCO for family planning services, the provider must bill the CCO.
• If the provider is an enrolled DMAP provider, but is not contracted with the client’s CCO for family planning services, the provider may bill DMAP directly. When submitting the claim to DMAP, be sure to:
  o Enter “Y” in the family planning box (24H) on the CMS-1500 claim form.
  o Add the FP modifier after all CPT and HCPCS codes. See A. Exhibit 1 for family planning ICD-9 and HCPCS codes accepted by DMAP.
  o Enter “N/C, Confidential” in box 9 on the CMS-1500 claim form if the client has requested special confidentiality.

Hard-copy claims should be submitted directly to: Attn: Judy Brazier, Division of Medical Assistance Programs, 500 Summer Street, NE E-44, Salem, OR 97301.

Billing for Lab Services

• Only the provider who performs the test(s) may bill DMAP.
• DMAP will not reimburse separately for collection and/or handling of specimens such as Pap or other cervical cancer screening tests, voided urine samples, or stool specimens. Reimbursement is bundled in the reimbursement for the exam
and/or lab procedures and is not payable in addition to the laboratory test.

- Pass-along charges from the performing laboratory to another laboratory, medical practitioner, or specialized clinic are not covered for payment and are not to be billed to DMAP.

- Clinical Laboratory Improvement Amendments (CLIA) Certification:
  - Laboratory services are reimbursable only to providers who are CLIA certified by the Centers for Medicare and Medicaid Services (CMS). CLIA requires all entities that perform even one test, including waived tests on “materials derived from the human body for the purpose of providing information for the diagnosis, prevention or treatment of any disease or impairment of, or the assessment of the health of, human beings” to meet certain federal requirements. If an entity performs tests for these purposes, it is considered under CLIA to be a laboratory.
  - Providers must notify DMAP of the assigned ten-digit CLIA number; payment is limited to the level of testing authorized by the CLIA certificate at the time the test is performed.

- Please refer to Appendix F for Monthly Income Guidelines for Medicaid Coverage.

### Medicaid Resources and Information

- **OHA DMAP Provider Services** 1-800-336-6016
- **OHA DMAP General Rulebook** (ORS 410-120):
  [http://www.dhs.state.or.us/policy/healthplan/guides/genrules/main.html](http://www.dhs.state.or.us/policy/healthplan/guides/genrules/main.html)
- **OHA DMAP Medical-Surgical Services Rulebook** (ORS 410-130):
  [http://www.dhs.state.or.us/policy/healthplan/guides/medsurg/main.html](http://www.dhs.state.or.us/policy/healthplan/guides/medsurg/main.html)
- Guidance on use of ICD-9, CPT, HCPCS, and FP modifier codes:
  - OARS 410-130-0585 for general family planning service providers;
  - OARS 410-130-0680 for laboratory and radiology services;
  - OARS 410-130-0587 for enrolled family planning clinics only.

## DMAP / OHP Contact Points

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<tr>
<th>Program</th>
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<th>Web site</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Program</strong></td>
<td><strong>Phone/E-mail</strong></td>
<td><strong>Web site</strong></td>
</tr>
<tr>
<td><strong>Provider Resources</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Info on OHP diagnosis/treatment pairs</td>
<td>1-800-393-9855</td>
<td></td>
</tr>
<tr>
<td>OHP Provider Enrollment</td>
<td>1-800-422-5047 <a href="mailto:provider.enrollment@state.or.us">provider.enrollment@state.or.us</a></td>
<td><a href="http://www.oregon.gov/OHA/healthplan/tools_prov/providerenroll.shtml">http://www.oregon.gov/OHA/healthplan/tools_prov/providerenroll.shtml</a></td>
</tr>
<tr>
<td>DMAP/OHP Provider Contact Handbook</td>
<td></td>
<td><a href="https://apps.state.or.us/Forms/Served/oe3046.pdf">https://apps.state.or.us/Forms/Served/oe3046.pdf</a></td>
</tr>
<tr>
<td><strong>Client Resources</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OHP Statewide Processing</td>
<td>1-800-699-9075</td>
<td></td>
</tr>
<tr>
<td>Other patient insurance resources</td>
<td></td>
<td><a href="http://www.oregonhealthconnect.org/index.cfm?fuseaction=mainProv_list">http://www.oregonhealthconnect.org/index.cfm?fuseaction=mainProv_list</a></td>
</tr>
</tbody>
</table>
Purchasing Family Planning Supplies  

A.6

Broad Range of Methods

Care and Title X providers must offer a broad range of acceptable and effective FDA approved family planning methods on-site. This includes:

- A choice of combination oral contraceptives (phasic and monophasic)
- At least one non-oral combination contraceptive (ring or patch)
- A progestin-only pill and injectable
- IUD and IUS*
- Sub-dermal implant*
- Latex and non-latex male condoms
- Female condoms
- Two types of spermicide
- Diaphragm or cervical cap*
- Fertility Awareness Method (FAM)
- Information about abstinence and withdrawal
- Information and referral for sterilization*
- Emergency contraception pills (ECP) for immediate and future use (discussed and offered to all clients)

* It is understood that not all agencies have the staff or skills needed for some methods, such as IUD and implant insertion. In this case, a client wanting a method that isn’t available should be provided with a specific referral, preferably to another CCare provider.

340B Public Health Pricing

The Federal Office of Pharmacy Affairs (OPA) manages the 340B supply purchasing program which limits the cost of outpatient drugs for certain covered entities. Title X delegate agencies and Federally Qualified Health Centers (FQHCs) are covered entities eligible for 340B public health pricing.
When setting up contracts with supply manufacturers, distributors or vendors, you are required to provide your agency’s 340B ID number in order to access the discount pricing. You can locate your ID# at the OPA 340B covered entities database: [http://opanet.hrsa.gov/opa/Default.aspx](http://opanet.hrsa.gov/opa/Default.aspx).

A complete list of distributors can be found through the 340B Prime Vendor Program:

- Apexus 340B Prime Vendor Program  
  Contact: John Barnes (972) 910-6643  
  Email: jbarnes@340Bpvp.com

**Supply Purchasing Resource**

Whether you qualify for 340B or Non-340B supply purchasing, see Exhibit 2 of this section for a list of companies that manufacture or distribute family planning products and supplies.
Male sterilization (vasectomy) services are covered under both CCare and the Oregon Vasectomy Project (OVP), formerly known as the Title X Oregon Vasectomy Project. Both Title X sub-recipient and CCare-only agencies are eligible to provide vasectomy services and receive reimbursement through OVP. All sterilization services provided by agencies through the Oregon Reproductive Health (RH) Program must comply with federal regulations, including those that are required for Oregon Health Plan (OHP) clients. The following are additional references and resources for sterilization services:

- Section A, Exhibit 4: Consent for Sterilization
- Section A, Exhibit 6: Flow of OVP Services
- Section A, Exhibit 7: Vasectomy Referral Form
- Section A, Exhibit 8: Services Rendered Form
- Section A, Exhibit 9: Sample Vasectomy CVRs with OVP as SOP
- Section B, Exhibit 3: Title X Service and Supply Discount Schedule
- Section B, Exhibit 4: Reproductive Health Program Sliding Fee Scale
- Section B.1, Attachment C: Regulations Relating to Sterilization of Persons in Federally Assisted Family Planning Projects
- Section B.4: Sterilization Regulations, Federal Title X requirements
- Section C: Oregon CCare Program
- Section C, Exhibit 8: Reimbursement Rates for CCare Visits and Supplies

**Contracting with a Local Vasectomy Provider**

While some agencies have the capacity to provide vasectomies on site, most do not. Agencies may also contract with a local vasectomy provider to perform vasectomy procedures for a set fee. The fee covers the surgical procedure and the post-vasectomy semen analysis.

Any locally-contracted vasectomy provider must agree to the reimbursement amount set forth in the contract or agreement with the agency and must not charge the client any additional fees, including no-
show fees, lab fees for the follow-up semen analysis, or fees for a post-procedure follow-up visit. The contracted reimbursement amount is considered a global payment for the provision of the vasectomy and all routine follow-up.

**State-Contracted Vasectomy Provider**

In addition to contracting with a local provider, agencies may utilize the services of a state-contracted vasectomy provider (vasectomist). State-contracted vasectomists travel throughout Oregon to perform vasectomies in areas where access to vasectomies is limited.

To access the services of a state-contracted vasectomist, visit the Oregon Reproductive Health Program website. Exhibit 6 of this section describes a walk-through of how services are provided by a state-contracted vasectomist, called Flow of OVP Services.

**Screening and Eligibility**

Men seeking vasectomy services must be at least 21 years of age by the date of the procedure. Agencies should screen clients for CCare eligibility using the established criteria and processes. Clients requiring assistance with citizenship documents may be enrolled and receive services, including the vasectomy procedure, under the one-time reasonable opportunity period (ROP) until citizenship can be verified. Clients not eligible for CCare should be provided services through OVP. Prior authorization from the RH Program is not required. Clients with OHP coverage may also receive vasectomy services through OVP if they meet the age requirement. CCare and OVP vasectomy eligibility and service requirements are summarized in the table on page A7-7.

**Vasectomy Counseling and Informed Consent**

Once enrolled in CCare or assessed for OVP, clients must receive a sterilization counseling visit. Clients wishing to pursue the
vasectomy procedure at the conclusion of the visit will be asked to review and sign a consent form (Section A, Exhibit 4 - Consent for Sterilization).

The counseling and consent process must assure that the client’s decision to undergo sterilization is completely voluntary and made with full knowledge of the permanence, risks, and benefits associated with male sterilization procedures. Federal regulations require that the procedure be provided at least 30 days after the day the client signs the consent form and no more than 180 days from the signature date.

Federal regulations also require that all boxes be checked and all blank lines be filled-in on the consent form in order for the form to be considered complete and compliant. Note that a specific doctor must be named in the client’s portion of the form and that name must match the “Physician’s Signature” on the bottom of the form. If the original vasectomy provider listed on the consent form is unable to perform the vasectomy, then the performing provider and the client should complete a new consent form and attach it to the original. (In this event, it is not required to wait an additional 30 days before the procedure is provided).

**Referral for Procedure**

If the client wishes to pursue a vasectomy at the conclusion of his counseling visit, the agency should:

*State-Contracted Vasectomist*: Forward a copy of the consent form, along with the Vasectomy Referral Form (Section A, Exhibit 7), Release of Information Form, any relevant medical information about the client, and insurance information, if applicable, to the vasectomist. Depending on the preference of the contracted vasectomist, either the client or the agency should schedule the vasectomy appointment with the vasectomy provider.

*Locally-Contracted Vasectomy Provider*: Forward a copy of the consent form to the contracted vasectomy provider. Depending on the preference of the contracted vasectomy provider, either the client or the agency should schedule the vasectomy appointment with the vasectomy provider.
In-House Vasectomy Provider: Follow normal clinic flow to schedule a vasectomy appointment for the client.

**Procedure and Follow-Up**

During the medical visit, the client should be instructed on the collection and submission of a semen sample for the post-procedure semen analysis.

In the rare event a post-vasectomy visit is required to follow-up with a potential medical complication; the agency may bill CCare or OVP for a contraceptive management office visit. However, treatment of medical complications is not covered under CCare or OVP.

**Billing**

Separate CVRs must be submitted for the counseling visit and the medical procedure for payment to be rendered.

In-House or Locally-Contracted Vasectomy Provider: If the agency or a locally-contracted provider performs the services, the agency should follow their normal procedure for submitting CVRs for the counseling visit and the sterilization procedure.

State-Contracted Vasectomist: If a state-contracted provider performs the services, he or she should send a copy of the Services Rendered Form (Section A, Exhibit 8), including any amount paid by a third party payer or the client, the client’s medical records, a copy of the final signed Consent for Sterilization Form (Section A, Exhibit 4), and any other relevant information to the client’s home agency. If the client has private insurance or OHP, the contracted provider must bill insurance first and then bill OVP or CCare the difference, if any, up to the maximum rate. The client’s home agency will then use the information on the Services Rendered Form to complete a paper CVR using the state-contracted vasectomist’s Project/Site number. The CVR will then need to be sent via mail to Ahlers.
Both CCare and OVP are payers of last resort. Agencies and contracted providers should bill private insurance or OHP first, if applicable. For those eligible, CCare may be billed for any balance remaining after private insurance has been billed. For those ineligible for CCare, OVP may be billed for any balance remaining after private insurance or OHP has been billed.

The Title X sliding-fee scale should be applied to assess any fees for OVP clients, when indicated. This applies to all agencies offering OVP services, even those agencies that are not Title X sub-recipients.

If a client fails to appear for an appointment, neither the client, CCare, OHP or OVP may be billed a “no show” fee. The agency may be billed for a client’s “no show” fee only if it is written into the locally-contracted vasectomy provider’s contract.

*Clients with OHP Coverage:* When billing DMAP for vasectomy services provided to OHP clients, mail a copy of the completed Consent for Sterilization form to DMAP at, 500 Summer Street NE, E44, Salem, OR 97301. DMAP will withhold payment if the client does not sign and date the form 30 days prior to performing the sterilization. See OAR 410-130-0580 for more information about sterilization consent procedures and exceptions under DMAP.

*Clients with No Source of Coverage:* Agencies must not deny or delay delivery of services due to a client’s inability to pay. Agency staff are expected to make a minimum of two contact attempts to collect payment due from the client, if any, before billing OVP for services rendered. Contact attempts may be made via phone or mail and must be documented in the client’s record. If the client does not provide payment, OVP will reimburse for the cost of services up to the full reimbursement rate.

For additional information, refer to Section B, Exhibit 3: Title X Service and Supply Discount Schedule and Exhibit 4: Reproductive Health Program Sliding Fee Scale.
Vasectomy Referral Fee

In recognition of the administrative work related to facilitating vasectomy referrals, the Oregon RH Program allows agencies that refer clients to vasectomy providers to recoup a $50 Vasectomy Referral Fee. To be eligible for the referral fee, the reimbursement rates for both the counseling visit and the vasectomy procedure must be passed on in full to the contracted provider who performed the services.

To be reimbursed the $50 Vasectomy Referral Fee, complete a CVR:

- Complete sections A-E, 1-7, 8
  - In section 3 Date of Visit enter the day AFTER the counsel, as multiple CVRs with the same Date of Visit will be rejected
- Check box 11-OVP in section 9 Source of Pay
- Complete sections 9B, 18, 10, 11 (if applicable)
- Check box 8-Vasectomy Referral (w/OVP SOP) in section 12 Purpose of Visit
- Check box 18-Vasectomy Referral Fee in section 13A Medical Services
- Complete section 15A Primary Contraceptive Method

See Section A, Exhibit 9 for an example Vasectomy Referral Fee CVR.

Training and Outreach Resources

The Reproductive Health Provider Resources section of the Oregon RH Program website offers provider resources, including sample fee assessment and collection policy and procedures.

The RH Update newsletter includes training announcements and policy updates. State program staff are also available to assist with policy, operations and billing questions related to vasectomy.

For additional resources contact the Oregon RH Program.
<table>
<thead>
<tr>
<th>Process</th>
<th>CCare</th>
<th>OVP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eligibility Criteria</td>
<td>• Male &gt;21 years&lt;br&gt;• Income ≤ 250% FPL&lt;br&gt;• Not enrolled in OHP, may have private insurance&lt;br&gt;• Social Security Number&lt;br&gt;• Proof of U.S. citizenship, or have been lawful permanent residents for ≥5 years&lt;br&gt;• Oregon resident&lt;br&gt;• Proof of ID</td>
<td>• Male &gt;21 years&lt;br&gt;• Income ≤ 250% FPL&lt;br&gt;• Not eligible for CCare&lt;br&gt;• May be enrolled in OHP or have private insurance</td>
</tr>
<tr>
<td>Charges to Client</td>
<td>No Charges</td>
<td>Title X Sliding Fee Scale – See Section B, Exhibit 3</td>
</tr>
<tr>
<td>CVR</td>
<td><strong>Normal CVR instructions should be followed (see Section D). In addition, the following items must be completed in order to receive payment:</strong></td>
<td></td>
</tr>
<tr>
<td>Counseling Visit CVR</td>
<td>• Check box 08-CCare in section 9 (Source of Pay)&lt;br&gt;Check box 4-Counseling Only in section 12 (Purpose of Visit)&lt;br&gt;Check box 03-Sterilization in section 14A (Counseling Education Provided)</td>
<td>• Check box 11-OVP in section 9 (Source of Pay)&lt;br&gt;Check box 4-Counseling Only in section 12 (Purpose of Visit)&lt;br&gt;Check box 03-Sterilization in section 14A (Counseling Education Provided)</td>
</tr>
<tr>
<td>Sterilization Procedure CVR</td>
<td>• Check box 08-CCare in section 9 (Source of Pay)&lt;br&gt;Check box 3-Other Medical in section 12 (Purpose of Visit)&lt;br&gt;Check box 20-Sterilization Procedure in section 13A (Medical Services)</td>
<td>• Check box 11-OVP in section 9 (Source of Pay)&lt;br&gt;Check box 3-Other Medical in section 12 (Purpose of Visit)&lt;br&gt;Check box 20-Sterilization Procedure in section 13A (Medical Services)</td>
</tr>
<tr>
<td>CVR Submission Deadlines</td>
<td>12 months from date of service</td>
<td>90 days from date of service</td>
</tr>
<tr>
<td>Reimbursement Rate</td>
<td>• See Section C, Exhibit 8 for current vasectomy reimbursement rates&lt;br&gt;Less payment received from private insurance (if any)</td>
<td>• See Section C, Exhibit 8 for current vasectomy reimbursement rates&lt;br&gt;Less payment received from insurance and/or client charges (if any)</td>
</tr>
</tbody>
</table>
Planning and evaluation are critical aspects of our work. They allow us to learn how well our communities are being served and where improvements can be made. Equally important, this information is critical for helping to demonstrate to partners and stakeholders the great value of family planning services.

We understand that the day-to-day demands of serving clients may leave little time and resources for in-depth evaluation or planning. Fortunately, many sources of data and technical assistance (TA) are available to help agencies regularly assess and improve the quality and scope of their family planning programs.

Technical Assistance Sources

For questions or help on assessing client and community needs, monitoring the services you provide, or measuring your program’s impact, contact the Oregon Reproductive Health Program.

Among other things, Reproductive Health Program staff can:

1. Offer training for your staff on topics ranging from clinical practice to billing operations.
2. Provide assistance with access to data and/or data analysis.
3. Offer help implementing the Culturally and Linguistically Appropriate Services (CLAS) standards.
4. Arrange, in some cases, specific TA using limited funds from Region X. This option applies to Title X delegates only.

Even when program staff cannot assist you directly, they often know who to contact for further information and resources.
Data Sources

OREGON REPRODUCTIVE HEALTH DATA

Oregon Reproductive Health Information System (Ahlers data). An enormous amount of CVR data on the clients you see and the services you provide are available from Ahlers & Associates. Data are accessible in three main formats: standardized reports; customized tables; and “raw” visit-level records. See the CVR Manual in Section D for more information and instructions on each of these formats.

Oregon Reproductive Health Client Satisfaction Survey (CSS). Every two years, state staff work with local agencies to conduct a multi-clinic customer satisfaction survey. Even if your clinic/agency did not participate in the last round of the CSS, you may find the statewide results useful. The most recent report is available online at http://www.healthoregon.org/rhmaterials. You may also contact Oregon Reproductive Health Program staff for more information or a copy of the latest CSS report.

Title X Local Agency Review. If your agency receives Title X funding, the state’s family planning nurse consultants conduct a detailed review of your clinical and administrative practices once every three years (see Section B.10, Agency Reviews). The final report from your review contains a wealth of information to inform your program assessment efforts.

OREGON POPULATION DATA

The Center for Health Statistics in the Oregon Health Authority (OHA) maintains records for every vital event (birth, abortion, marriage, divorce, death) that occurs in Oregon. A wide array of statistics, such as teen pregnancy data, are published in annual statewide and county reports, available online at http://public.health.oregon.gov/BIRTHDEATHCERTIFICATES/VITALSTATISTICS/Pages/index.aspx Or contact the Center for Health Statistics by phone at (971) 673-1190.

The Population Research Center at Portland State University publishes an annual report containing detailed estimates of Oregon’s
population by age, sex, and geographic location. 
http://www.pdx.edu/prc/annual-population-estimates.
The center also conducts demographic and economic analyses and
publishes reports on a variety of other topics including housing, school
enrollment, and population change. For more information, contact the
Population Research Center at (503) 725-3922.

OREGON SURVEY DATA

The Behavioral Risk Factor Surveillance System (BRFSS) is an
ongoing telephone survey to capture behavioral risk factor data for the
adult population (18 years and over) living in households. It typically
includes a number of questions related to family planning and sexual
behavior. Year-by-year tabulations of data by topic are available at
http://www.healthoregon.org/brfss.

Note: Single-year BRFSS data is too small to generate county-specific
estimates; however, every few years, the Center for Health Statistics
combines 4 years of BRFSS data to examine selected topic areas by
county. The most recent county-specific data tabulations are available at

Oregon Healthy Teens (OHT) is an annual, voluntary, school-based
survey of risk and protective factors for healthy youth development.
About one-third of the state’s eighth and eleventh graders are surveyed
each year; a smaller sample of ninth through twelfth graders is
surveyed every other year. Topics covered on the questionnaire
include: sexual activity and HIV/AIDS knowledge; tobacco, alcohol
and other drug use; personal safety behaviors and perceptions;
vigilance-related behaviors; diet and exercise; extracurricular activities;
health conditions and access to care; and individual, peer, community,
and family influences on risk behaviors and health. Year-by-year
tabulations of data by topic (and by county, in most cases) are at
http://public.health.oregon.gov/BirthDeathCertificates/Surveys/Oregon
HealthyTeens/Pages/index.aspx or by calling the Center for Health
Statistics at (971) 673-1190.
The Oregon Population Survey, conducted by telephone every other year on behalf of the Oregon Progress Board, covers issues such as health insurance coverage, educational attainment, childcare arrangements, and Oregonians’ perceptions on the quality of public services and sense of community. Results are available for the state as a whole and for eight separate regions. Access the information at http://www.oregon.gov/DAS/OEA/Pages/popsurvey.aspx.

Oregon’s Pregnancy Risk Assessment Monitoring System (PRAMS) is an ongoing mail- and telephone-based survey of recent mothers in Oregon. PRAMS collects data on maternal attitudes and experiences prior to, during, and immediately after pregnancy, including pregnancy intent and contraceptive behavior. Year-by-year data and copies of the questionnaire are at: http://public.health.oregon.gov/HealthyPeopleFamilies/DataReports/prams/Pages/index.aspx
For more information call (971) 673-0237.

Note: The PRAMS sample is designed to be representative of the state target population, so the number of respondents is generally not large enough to generate county-specific estimates.

NATIONAL FAMILY PLANNING-RELATED DATA

The Guttmacher Institute (GI), formerly the Alan Guttmacher Institute, is a nonprofit organization focused on sexual and reproductive health research, policy analysis, and public education. The GI website features hundreds of data tables, reports, and research articles, as well as a custom table maker. http://www.guttmacher.org

GI also produces periodic estimates of the number of Women In Need of contraceptive services and supplies at national, state, and county levels. Estimates can be broken down further by age, poverty status, and race/ethnicity. The Oregon Reproductive Health Program uses these estimates regularly, for example, when requesting annual plans from counties. See the website at: http://www.guttmacher.org/pubs/win/contraceptive-needs-2008.pdf
The **CDC Division of Reproductive Health** provides a wealth of family planning-related data at:

http://www.cdc.gov/reproductivehealth/Data_Stats/index.htm

The **National Center for Health Statistics** administers an in-person nationwide survey every five to seven years called the National Survey of Family Growth (NSFG). The NSFG asks women and men aged 15–44 many in-depth questions about sexual activity, marriage, divorce and cohabitation, fertility and infertility, pregnancy and childbearing, contraceptive use, and use of family planning services. Data are not broken out for Oregon specifically, but the national-level reports may still be useful. See [http://www.cdc.gov/nchs/](http://www.cdc.gov/nchs/).
Section A: Exhibits

Exhibit 1: ICD-9 Family Planning Codes

Exhibit 2: Purchasing Family Planning Supplies

Exhibit 3: [removed]

Exhibit 4: Consent for Sterilization Form (English and Spanish)

Exhibit 5: RH Program Abuse Reporting Standard

Exhibit 6: Flow of OVP Services

Exhibit 7: Vasectomy Referral Form

Exhibit 8: Services Rendered Form

Exhibit 9: Sample Vasectomy CVRs with OVP as Source of Pay
Reproductive Health Program Manual
January 2013

Section B

Federal Title X
Regulations and Requirements

Center for Prevention and Health Promotion
Oregon Health Authority – Public Health
Federal Title X Regulations and Requirements

This section describes the federal regulations and requirements for Title X reproductive health grant programs. Agencies and clinics that do not receive Title X grant funds are not subject to Title X rules. However, these regulations still provide good direction for delivering high quality, comprehensive reproductive health services.

Section B contains material directly from the Office of Population Affairs (OPA), followed by Oregon-specific information.

OPA’s Program Guidelines require Title X clinics to have written clinical reproductive health protocols and client education plans on all services provided. See Exhibit 9 of this section for clarification of this Title X requirement.

Title X Definitions

**Family Planning:** When an individual can determine freely the number and spacing of children.

**Reproductive Health Services:** Clinical, informational, educational, social, and referral services offered to anyone of reproductive age requesting family planning and reproductive health care.
PROGRAM GUIDELINES
For Project Grants
For Family Planning Services

United States Department of Health and Human Services
Office of Public Health and Science
Office of Population Affairs
Office of Family Planning
4350 East West Highway, Suite 200
Bethesda, Maryland 20814

January 2001
Program Guidelines for Family Planning Services

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Attachments

A. The Law: Title X Population Research and Voluntary Family Planning Programs
B. Regulations: Grants for Family Planning Services under Title X of the Public Health Service Act
C. Sterilization of Persons in Federally Assisted Family Planning Projects
D. DHHS Regional Offices – Regional Program Consultants for Family Planning Resource Documents
PART I

1.0 Introduction to the Program Guidelines

This document, Program Guidelines for Project Grants for Family Planning Services (Guidelines), has been developed by the Office of Population Affairs (OPA), U.S. Department of Health and Human Services (DHHS), to assist current and prospective grantees in understanding and utilizing the family planning services grants program authorized by Title X of the Public Health Service Act, 42 U.S.C. 300, et seq. The Office of Population Affairs also provides more detailed guidance, updated clinical information and clarification of specific program issues in the form of periodic Program Instructions to the Regional Offices.

This document is organized into two parts. Part I (sections 1–6) covers project management and administration, including the grant application and award process. Part II (sections 7–11) covers client services and clinic management.

Reference is made throughout the document to specific sections of the Title X law and implementing regulations, which are contained in Attachments A and B, respectively. (Reference to specific sections of the regulations will appear in brackets, e.g., [45 CFR Part 74, Subpart C].) Federal sterilization regulations are contained in Attachment C. The DHHS regional offices are listed in Attachment D. Selected other materials that provide additional guidance in specific areas are classified as Resource Documents.

1.1 Definitions

Throughout this document, the word “must” indicates mandatory program policy. “Should” indicates recommended program policy relating to components of family planning and project management that the project is urged to utilize in order to fulfill the intent of Title X. The words “can” and “may” indicate suggestions for consideration by individual projects.

The “grantee” is the entity that receives a Federal grant and assumes legal and financial responsibility and accountability for the awarded funds and for the performance of the activities approved for funding. The “project” consists of those activities described in the grant application and supported under the approved budget. “Delegate/contract agencies” are those entities that provide family planning services with Title X funds under a negotiated, written agreement with a grantee. “Service sites” are those locations where services actually are provided by the grantee or delegate/contract agency.
2.0 The Law, Regulations, and Guidelines

To enable persons who want to obtain family planning care to have access to such services, Congress enacted the Family Planning Services and Population Research Act of 1970 (Public Law 91-572), which added Title X, “Population Research and Voluntary Family Planning Programs” to the Public Health Service Act. Section 1001 of the Act (as amended) authorizes grants “to assist in the establishment and operation of voluntary family planning projects which shall offer a broad range of acceptable and effective family planning methods and services (including natural family planning methods, infertility services, and services for adolescents)” (see Attachment A). The mission of Title X is to provide individuals the information and means to exercise personal choice in determining the number and spacing of their children.

The regulations governing Title X [42 CFR Part 59, Subpart A] set out the requirements of the Secretary, Department of Health and Human Services, for the provision of family planning services funded under Title X and implement the statute as authorized under Section 1001 of the Public Health Service Act. Prospective applicants and grantees should refer to the regulations (see Attachment B). This document, Program Guidelines for Project Grants for Family Planning Services, interprets the law and regulations in operational terms and provides a general orientation to the Federal perspective on family planning.

3.0 The Application Process

3.1 Eligibility

Any public or nonprofit private entity located in a state (which, by definition, includes the District of Columbia, Guam, the Commonwealth of Puerto Rico, the Northern Mariana Islands, the U.S. Virgin Islands, American Samoa, the U.S. Outlying Islands [Midway, Wake, et al.], the Marshall Islands, the Federated States of Micronesia and the Republic of Palau) is eligible to apply for a Title X family planning services project grant [59.2, 59.3].

To promote the purposes of Section 1001 of the Act in the most cost effective and efficient manner, grants will be made to public and non-profit private entities to foster projects most responsive to local needs. A non-profit private agency, institution, or organization must furnish evidence of its non-profit status in accordance with instructions accompanying the project grant application form. Under the law, grants cannot be made to entities that propose to offer only a single method or an unduly limited number of family planning methods. A facility or entity offering a single method can receive assistance under Title X by participating as a delegate/contract agency in an approvable project that offers a broad range of acceptable and effective medically approved family planning methods and services [59.5(a)(1)].
3.2 Needs Assessment

A n assessment of the need for family planning services must be conducted prior to applying for a competitive grant award. The needs assessment documents the need for family planning services for persons in the service area and should include:

- Description of the geographic area including a discussion of potential geographic, topographic, and other related barriers to service;
- Demographic description of the service area including objective data pertaining to individuals in need of family planning services, maternal and infant morbidity/mortality rates, birth rates and rates of unintended pregnancies by age groups, poverty status of the populations to be served, cultural and linguistic barriers to services, etc.;
- Description of existing services and need for additional family planning services to meet community/cultural needs;
- Need indicators that include rates of STDs and HIV prevalence (including perinatal infection rates) in the grantee area;
- Identification and descriptions of linkages with other resources related to reproductive health; and
- Identification and discussion of high priority populations and target areas.

Grantees should perform periodic reassessment of service needs. Competitive grant applications must include a full and updated needs assessment.

3.3 The Application

T he Department of Health and Human Services’ Office of Population Affairs administers the Title X Family Planning Program through the DHHS Regional Offices. An annual announcement of the availability of Title X service grant funds sets forth specific application requirements and evaluation criteria. Applications must be submitted to the Office of Grants Management for Family Planning Services on the form required by the Department. The application forms are available from the Office of Grants Management for Family Planning Services. Assistance regarding programmatic aspects of proposal preparation is available from the Regional Office. For assistance with administrative and budgeting aspects of proposal preparation, contact the Office of Grants Management for Family Planning Services.
Unless otherwise instructed, applicants are to respond to the standard instructions contained in the application kit and to the PHS supplemental instructions. An application must contain:

- a needs assessment

- a narrative description of the project and the manner in which the applicant intends to conduct it in order to carry out the requirements of the law and regulations;

- a budget that includes an estimate of project income and costs, with justification for the amount of grant funds requested [59.4(c)(2)] and which is consistent with the terms of Section 1006 of the Act, as implemented by regulation [59.7(b)];

- a description of the standards and qualifications that will be required for all personnel and facilities to be used by the project;

- project objectives that are specific, realistic, and measurable; and

- other pertinent information as required [59.4(c)(4)].

The application must address all points contained in section 59.7(a) of the regulations, which are the criteria DHHS Regional Offices will use to decide which family planning projects to fund and in what amount. The application shall not include activities that cannot be funded under Title X, such as abortion, fundraising, or lobbying activities.

3.4 Project Requirements

Projects must adhere to:

- Section 59.5 and all other applicable provisions of the regulations, which list the requirements to be met by each project supported by Title X.

- The applicable requirements of these Program Guidelines for Project Grants for Family Planning Services.

- Other Federal regulations which apply to grants made under Title X [59.10]. For assistance in identifying other relevant regulations, contact the Regional Office.
3.5 Notice of Grant Award

The notice of grant award will inform the grantee how long DHHS intends to support the project without requiring it to recompete for funds [59.8]. This period of funding is called the “project period.” The project will be funded in increments called “budget periods.” The budget period is normally twelve months, although shorter or longer budget periods may be established for compelling administrative or programmatic reasons.

4.0 Grant Administration

All grantees must comply with the applicable legislative, regulatory and administrative requirements described in the Public Health Service Grants Policy Statement. A copy of the Public Health Service Grants Policy Statement may be obtained from the Office of Grants Management for Family Planning Services.

5.0 Legal Issues

5.1 Voluntary Participation

Use by any individual of project services must be solely on a voluntary basis. Individuals must not be subjected to coercion to receive services or to use or not to use any particular method of family planning. Acceptance of family planning services must not be a prerequisite to eligibility for, or receipt of, any other service or assistance from or participation in any other programs of the applicant [59.5(a)(2)].

Project personnel must be informed that they may be subject to prosecution under Federal law if they coerce or endeavor to coerce any person to undergo an abortion or sterilization procedure.

5.2 Confidentiality

Every project must assure client confidentiality and provide safeguards for individuals against the invasion of personal privacy, as required by the Privacy Act. No information obtained by the project staff about individuals receiving services may be disclosed without the individual’s written consent, except as required by law or as necessary to provide services to the individual, with appropriate safeguards for confidentiality. Information may otherwise be disclosed only in summary, statistical, or other form that does not identify the individual [59.11].
5.3 Conflict of Interest

Grantees must establish policies to prevent employees, consultants, or members of governing or advisory bodies from using their positions for purposes of private gain for themselves or for others.

5.4 Liability Coverage

Grantees and/or delegates/contractors should ensure the existence of adequate liability coverage for all segments of the project funded under the grant, including all individuals providing services. Governing boards should obtain liability coverage for their members.

5.5 Human Subjects Clearance (Research)

Grantees considering clinical or sociological research using Title X clients as subjects must adhere to the legal requirements governing human subjects research at 45 CFR Part 46, as applicable. A copy of these regulations may be obtained from the Regional Office. Grantees must advise the Regional Office in writing of research projects involving Title X clients or resources in any segment of the project.

6.0 Project Management

6.1 Structure of the Grantee

Family planning services under Title X grant authority may be offered by grantees directly and/or by delegate/contract agencies operating under the umbrella of the grantee. However, the grantee is responsible for the quality, cost, accessibility, acceptability, reporting, and performance of the grant-funded activities provided by delegate/contract agencies. Grantees must therefore have a negotiated, written agreement with each delegate/contract agency and establish written standards and guidelines for all delegated project activities consistent with the appropriate section(s) of the Program Guidelines for Project Grants for Family Planning Services, as well as other applicable requirements such as Subpart C of 45 CFR Part 74, or Subpart C of 45 CFR Part 92. If a delegate/contract agency wishes to subcontract any of its responsibilities or services, a written negotiated agreement that is consistent with Title X requirements and approved by the grantee must be maintained by the delegate/contractor. Delegate/contract agencies should be invited to participate in the establishment of grantee standards and guidelines.
6.2 Planning and Evaluation

All projects receiving Title X funds must provide services of high quality and be competently and efficiently administered. To meet these requirements, each competitive application must include a plan which identifies overall goals and specific measurable objectives for the project period. The objectives may be directed to all clients or to specific groups of clients and must be consistent with Title X objectives. The plan must include an evaluation component that addresses and defines indicators by which the project intends to evaluate itself.

6.3 Financial Management

Grantees must maintain a financial management system that meets the standards specified in Subpart C of 45 CFR Part 74 or Subpart C of 45 CFR Part 92, as applicable, as well as any other requirements imposed by the Notice of Grant Award, and which complies with Federal standards to safeguard the use of funds. Documentation and records of all income and expenditures must be maintained as required.

- Charges, Billing, and Collections

A grantee is responsible for the implementation of policies and procedures for charging, billing, and collecting funds for the services provided by the project. The policies and procedures should be approved by the governing authority or board of the grantee and the Regional Office.

Clients must not be denied project services or be subjected to any variation in quality of services because of the inability to pay. Billing and collection procedures must have the following characteristics:

1. Charges must be based on a cost analysis of all services provided by the project. At the time of services, clients who are responsible for paying any fee for their services must be given bills directly. In cases where a third party is responsible, bills must be submitted to that party.

2. A schedule of discounts must be developed and implemented with sufficient proportional increments so that inability to pay is never a barrier to service. A schedule of discounts is required for individuals with family incomes between 101% and 250% of the Federal poverty level. Fees must be waived for individuals with family incomes above this amount who, as determined by the service site project director, are unable, for good cause, to pay for family planning services.

3. Clients whose documented income is at or below 100% of the Federal poverty level must not be charged, although projects must bill all third parties authorized or legally obligated to pay for services.
Individual eligibility for a discount must be documented in the client’s financial record.

4. Bills to third parties must show total charges without applying any discount.

5. Where reimbursement is available from Title XIX or Title XX of the Social Security Act, a written agreement with the Title XIX or the Title XX state agency at either the grantee level or delegate/contract agency level is required.

6. Bills to clients must show total charges less any allowable discounts.

7. Eligibility for discounts for minors who receive confidential services must be based on the income of the minor.

8. Reasonable efforts to collect charges without jeopardizing client confidentiality must be made.

9. A method for the “aging” of outstanding accounts must be established.

10. Voluntary donations from clients are permissible. However, clients must not be pressured to make donations, and donations must not be a prerequisite to the provision of services or supplies. Donations from clients do not waive the billing/charging requirements set out above.

11. Client income should be re-evaluated at least annually.

Effective financial management will assure the short and long term viability of the project, including the efficient use of grant funds. Technical assistance in achieving this objective is available from the Regional Office. Title X projects offering services that are not required by the statute, regulations or these Guidelines should whenever possible seek other sources of funding for such services before applying Title X funds to those activities.

**Financial Audit**

Audits of grantees and delegate/contract agencies must be conducted in accordance with the provisions of 45 CFR Part 74, Subpart C, and 45 CFR Part 92, Subpart C, as applicable. The audits must be conducted by auditors meeting established criteria for qualifications and independence.
6.4 Facilities and Accessibility of Services

Facilities in which project services are provided should be geographically accessible to the population served and should be available at times convenient to those seeking services, i.e., they should have evening and/or weekend hours in addition to daytime hours. The facilities should be adequate to provide the necessary services and should be designed to ensure comfort and privacy for clients and to expedite the work of the staff. Facilities must meet applicable standards established by the Federal, state and local governments (e.g., local fire, building and licensing codes).

Projects must comply with 45 CFR Part 84, which prohibits discrimination on the basis of handicap in Federally assisted programs and activities, and which requires, among other things, that recipients of Federal funds operate their Federally assisted programs so that, when viewed in their entirety, they are readily accessible to people with disabilities. A copy of Part 84 may be obtained from the Regional office. Projects must also comply with any applicable provisions of the Americans With Disabilities Act (Public Law 101-336).

Emergency situations may occur at any time. All projects must therefore have written plans and procedures for the management of emergencies.

6.5 Personnel

Grantees and delegate/contract agencies are reminded of their obligation to establish and maintain personnel policies that comply with applicable Federal and state requirements, including Title VI of the Civil Rights Act, Section 504 of the Rehabilitation Act of 1973, and Title I of the Americans With Disabilities Act. These policies should include, but need not be limited to, staff recruitment, selection, performance evaluation, promotion, termination, compensation, benefits, and grievance procedures. Project staff should be broadly representative of all significant elements of the population to be served by the project, and should be sensitive to and able to deal effectively with the cultural and other characteristics of the client population [59.5 (b)(10)].

Grantees must also ensure that:

- Projects are administered by a qualified project director;
- The clinical care component of the project operates under the responsibility of a medical director who is a licensed and qualified physician with special training or experience in family planning;
- Protocols exist that provide all project personnel with guidelines for client care;
• Personnel records are kept confidential;
• Licenses of applicants for positions requiring licensure are verified prior to employment and that there is documentation that licenses are kept current.

6.6 Training and Technical Assistance

Projects must provide for the orientation and in-service training of all project personnel, including the staffs of delegate agencies and service sites. All project personnel should participate in continuing education related to their activities. Documentation of continuing education should be maintained and used in evaluating the scope and effectiveness of the staff training program.

Training through regional training centers is available to all projects under the Title X program. In addition to training, grantees may receive technical assistance for specific project activities. Technical assistance is provided by contract from the OPA and administered through the Regional Office. Information on training and technical assistance is available from the Regional Office.

6.7 Reporting Requirements

Grantees must:

1. comply with the financial and other reporting requirements of 45 CFR Part 74 or 45 CFR Part 92, as applicable; and

2. comply with other reporting requirements as required by DHHS.

6.8 Review and Approval of Informational and Educational Materials

An advisory committee of five to nine members (the size of the committee can differ from these limits with written documentation and approval from the Regional Office) who are broadly representative of the community must review and approve all informational and educational (I&E) materials developed or made available under the project prior to their distribution to assure that the materials are suitable for the population and community for which they are intended and to assure their consistency with the purposes of Title X. Oversight responsibility for the I&E committee(s) rests with the grantee. The grantee may delegate the I & E operations for the review and approval of materials to delegate/contract agencies.
The I&E committee(s) must:

- Consider the educational and cultural backgrounds of the individuals to whom the materials are addressed;
- Consider the standards of the population or community to be served with respect to such materials;
- Review the content of the material to assure that the information is factually correct;
- Determine whether the material is suitable for the population or community to which it is to be made available; and
- Establish a written record of its determinations [59.6].

The committee(s) may delegate responsibility for the review of the factual, technical, and clinical accuracy to appropriate project staff. However, final approval of the I &E material rests with the committee(s).

6.9 Community Participation, Education, and Project Promotion

Boards and advisory committees for family planning services should be broadly representative of the population served.

- Community Participation

Title X grantees and delegate/contract agencies must provide an opportunity for participation in the development, implementation, and evaluation of the project (1) by persons broadly representative of all significant elements of the population to be served, and (2) by persons in the community knowledgeable about the community’s needs for family planning services [59.5(b)(10)].

The I & E advisory committee may serve the community participation function if it meets the above requirements, or a separate group may be identified. In either case, the grantee project plan must include a plan for community participation. The community participation committee must meet annually or more often as appropriate.
• Community Education

Each family planning project must provide for community education programs [59.5(b)(3)]. This should be based on an assessment of the needs of the community and should contain an implementation and evaluation strategy.

Community education should serve to enhance community understanding of the objectives of the project, make known the availability of services to potential clients, and encourage continued participation by persons to whom family planning may be beneficial.

• Project Promotion

To facilitate community awareness of and access to family planning services, projects must establish and implement planned activities whereby their services are made known to the community [59.5(b)(3)]. Projects should review a range of strategies and assess the availability of existing resources and materials. Promotion activities should be reviewed annually and be responsive to the changing needs of the community. For more information, contact the Regional Offices.

6.10 Publications and Copyright

Unless otherwise stipulated, publications resulting from activities conducted under the grant need not be submitted to DHHS for prior approval. The word “publication” is defined to include computer software. Grantees should ensure that publications developed under Title X do not contain information which is contrary to program requirements or to accepted clinical practice. Federal grant support must be acknowledged in any publication. Except as otherwise provided in the conditions of the grant award, the author is free to arrange for copyright without DHHS approval of publications, films, or similar materials developed from work supported by DHHS. Restrictions on motion picture film production are outlined in the Public Health Service Grants Policy Statement. Any such copyrighted materials shall be subject to a royalty-free, non-exclusive, and irrevocable right of the Government to reproduce, publish, or otherwise use such materials for Federal purposes and to authorize others to do so [45 CFR 74.36][45 CFR 92.34].

6.11 Inventions or Discoveries

Family planning projects must comply with Government-wide regulations, 37 CFR Part 401, which apply to the rights to inventions made under government grants, contracts and cooperative agreements.
PART II

7.0 Client Services

Projects funded under Title X must provide clinical, informational, educational, social and referral services relating to family planning to clients who want such services. All projects must offer a broad range of acceptable and effective medically approved family planning methods and services either on-site or by referral [59.5(a)(1)]. Projects should make available to clients all methods of contraception approved by the Federal Food and Drug Administration.

Part II of this document has been developed to assist grantees in determining those services which will be provided to fulfill the mission of Title X.

- Projects must provide services stipulated in the law or regulations, or which are required by these Guidelines for the provision of high-quality family planning services.
- Projects may also provide those services that are intended to promote the reproductive and general health care of the family planning client population.

7.1 Service Plans and Protocols

The service plan is the component of the grantee’s project plan, as set forth in the competitive application, which identifies those services to be provided to clients under Title X by the project. As part of the project plan, all grantees must assure that delegate/contractors have written clinical protocols and plans for client education, approved by the grantee and signed by the service site Medical Director, which outline procedures for the provision of each service offered and which are in accordance with state laws. Clinical protocols must be consistent with the requirements of these Guidelines.

Under exceptional circumstances, a waiver from a particular requirement may be obtained from the Regional Office upon written request from a grantee. In submitting a request for an exception, the grantee must provide epidemiologic, clinical, and other supportive data to justify the request and the duration of the waiver.
7.2 Procedural Outline

The services provided to family planning clients, and the sequence in which they are provided, will depend upon the type of visit and the nature of the service requested. However, the following components must be offered to and documented on all clients at the initial visit:

**Education**
- Presentation of relevant information and educational materials, based upon client needs and knowledge;

**Counseling**
- Interactive process in which a client is assisted in making an informed choice;

**Informed Consent**
- Explanation of all procedures and obtaining a general consent covering examination and treatment and, where applicable, a method-specific informed consent form;

**History**
- Obtaining of a personal and family medical and social history;

**Examination**
- Performance of a physical examination and any necessary clinical procedures, as indicated;

**Laboratory Testing**
- Performance of routine and other indicated laboratory tests;

**Follow-up & Referrals**
- Planned mechanism for client follow-up;
- Performance of any necessary clinical procedures;
- Provision of medications and/or supplies as needed; and
- Provision of referrals as needed.
Return visits, with the exception of routine supply visits, should include an assessment of the client’s health status, current complaints, and evaluation of birth control method, as well as an opportunity to change methods. The following components must be offered to and documented on all clients at the return visit:

**History**
- Updating a personal and family medical and social history;

**Examination**
- Performance of a physical examination and any necessary clinical procedures, as indicated;

**Laboratory Testing**
- Performance of routine and other indicated laboratory tests;

**Follow-up & Referrals**
- Planned mechanism for client follow-up;
- Performance of any necessary clinical procedures;
- Provision of medications and/or supplies as needed; and
- Provision of referrals as needed.

### 7.3 Emergencies

Emergency situations involving clients and/or staff may occur at any time. All projects must therefore have written plans for the management of on-site medical emergencies. At a minimum, written protocols must address vaso-vagal reactions, anaphylaxis, syncope, cardiac arrest, shock, hemorrhage, and respiratory difficulties. Protocols must also be in place for emergencies requiring transport, after-hours management of contraceptive emergencies, and clinic emergencies. All project staff must be familiar with these plans. Appropriate training, including training in CPR, should be available to staff.
7.4 Referrals and Follow-up

Grantees must assure that delegate/contract agencies provide all family planning services listed in Section 8.0 under “Required Services,” either on-site or by referral. When required services are to be provided by referral, the grantee must establish formal arrangements with a referral agency for the provision of services and reimbursement of costs, as appropriate.

Agencies must have written policies/procedures for follow-up on referrals that are made as a result of abnormal physical examination or laboratory test findings. These policies must be sensitive to clients’ concerns for confidentiality and privacy.

For services determined to be necessary but which are beyond the scope of the project, clients must be referred to other providers for care. When a client is referred for non-family planning or emergency clinical care, agencies must:

- Make arrangements for the provision of pertinent client information to the referral provider. Agencies must obtain client’s consent to such arrangements, except as may be necessary to provide services to the patient or as required by law, with appropriate safeguards for confidentiality;
- Advise client on their responsibility in complying with the referral; and
- Counsel client on the importance of such referral and the agreed upon method of follow-up.

Efforts may be made to aid the client in identifying potential resources for reimbursement of the referral provider, but projects are not responsible for the cost of this care. Agencies must maintain a current list of health care providers, local health and human services departments, hospitals, voluntary agencies, and health services projects supported by other Federal programs to be used for referral purposes. Whenever possible, clients should be given a choice of providers from which to select.

8.0 Required Services

The services contained in this section must be provided by all projects funded under Title X.

The client’s written informed voluntary consent to receive services must be obtained prior to the client receiving any clinical services. In addition, if a client chooses a prescription method of contraception, a method-specific consent form must be obtained and updated routinely at subsequent visits to reflect current information about that method.
8.1 Client Education

Grantees and/or delegate/contract agencies must have written plans for client education that include goals and content outlines to ensure consistency and accuracy of information provided. Client education must be documented in the client record. The education provided should be appropriate to the client’s age, level of knowledge, language, and socio-cultural background and be presented in an unbiased manner. A mechanism to determine that the information provided has been understood should be established.

Education services must provide clients with the information needed to:

- Make informed decisions about family planning;
- Use specific methods of contraception and identify adverse effects;
- Perform breast/testicular self examination;
- Reduce risk of transmission of sexually transmitted diseases and Human Immunodeficiency Virus (HIV);
- Understand the range of available services and the purpose and sequence of clinic procedures; and
- Understand the importance of recommended screening tests and other procedures involved in the family planning visit.

Clients should be offered information about basic female and male reproductive anatomy and physiology, and the value of fertility regulation in maintaining individual and family health. Additional education should include information on reproductive health and health promotion/disease prevention, including nutrition, exercise, smoking cessation, alcohol and drug abuse, domestic violence and sexual abuse.

Method-Specific Informed Consent

Written informed consent, specific to the contraceptive method, must be signed before a prescription contraceptive method is provided. Prior to implementation, informed consent forms should be approved by the service site Medical Director.

The consent forms must be written in a language understood by the client or translated and witnessed by an interpreter. To provide informed consent for contraception, the client must receive information on the benefits and risks, effectiveness, potential side effects, complications, discontinuation issues and danger signs of the contraceptive method chosen. Specific education and consent forms for the contraceptive method provided must be part of the project’s service plan.
The signed informed consent form must be a part of the client’s record. All consent forms should contain a statement that the client has been counseled, provided with the appropriate informational material, and understands the content of both. The method-specific consent form should be renewed and updated when there is a major change in the client’s health status or a change to a different prescriptive contraceptive method.

Federal sterilization regulations [42 CFR Part 50, Subpart B], which address informed consent requirements, must be complied with when a sterilization procedure is performed or arranged for by the project (see Attachment C).

8.2 Counseling

The primary purpose of counseling in the family planning setting is to assist clients in reaching an informed decision regarding their reproductive health and the choice and continued use of family planning methods and services. The counseling process is designed to help clients resolve uncertainty, ambivalence, and anxiety about reproductive issues and to enhance their capacity to arrive at a decision that reflects their considered self-interest.

The counseling process involves mutual sharing of information. Persons who provide counseling should be knowledgeable, objective, nonjudgmental, sensitive to the rights and differences of clients as individuals, culturally aware and able to create an environment in which the client feels comfortable discussing personal information. The counselor must be sufficiently knowledgeable to provide accurate information regarding the benefits and risk, safety, effectiveness, potential side effects, complications, discontinuation issues and danger signs of the various contraceptive methods. Additionally, the counselor should be knowledgeable about the other services offered by the agency. Documentation of counseling must be included in the client’s record.

• Method Counseling

Method counseling refers to an individualized dialogue with a client that covers the following:

• Results of physical exam and lab studies;
• Effective use of contraceptive methods, including natural family planning (NFP), and the benefit and efficacy of the methods;
• Possible side effects/complications;
• How to discontinue the method selected and information regarding back-up method use, including the use of certain oral contraceptives as post-coital emergency contraception;
• Planned return schedule;
• Emergency 24-hour telephone number;
• Location where emergency services can be obtained; and
• Appropriate referral for additional services as needed.

**Sexually Transmitted Disease (STD) and HIV Counseling**

All clients must receive thorough and accurate counseling on STDs and HIV. STD/HIV counseling refers to an individualized dialogue with a client in which there is discussion of personal risks for STDs/HIV, and the steps to be taken by the individual to reduce risk, if necessary. Persons found to have behaviors which currently put them at risk for STD/HIV must be given advice regarding risk reduction and must be advised whether clinical evaluation is indicated. All projects must offer, at a minimum, education about HIV infection and AIDS, information on risks and infection prevention, and referral services. On an optional basis, clinics may also provide HIV risk assessment, counseling and testing by specially trained staff. When the project does not offer these optional services, the project must provide the client with a list of health care providers who can provide these services.

**8.3 History, Physical Assessment, and Laboratory Testing**

**History**

At the initial comprehensive clinical visit, a complete medical history must be obtained on all female and male clients. Pertinent history must be updated at subsequent clinical visits. The comprehensive medical history must address at least the following areas:

• Significant illnesses; hospitalizations; surgery; blood transfusion or exposure to blood products; and chronic or acute medical conditions;
• Allergies;
• Current use of prescription and over-the-counter medications;
• Extent of use of tobacco, alcohol, and other drugs;
• Immunization and Rubella status;
• Review of systems;
• Pertinent history of immediate family members; and
• Partner history
  o injectable drug use
  o multiple partners
  o risk history for STDs and HIV
  o bisexuality.

Histories of reproductive function in female clients must include at least the following:
• Contraceptive use past and current (including adverse effects);
• Menstrual history;
• Sexual history;
• Obstetrical history;
• Gynecological conditions;
• Sexually transmitted diseases, including HBV;
• HIV;
• Pap smear history (date of last Pap, any abnormal Pap, treatment); and
• In utero exposure to diethylstilbestrol (DES).

Histories of reproductive function in male clients must include at least the following:
• Sexual history;
• Sexually transmitted diseases (including HBV);
• HIV; and
• Urological conditions.

• Physical Assessment (female)

For many clients, family planning programs are their only continuing source of health information and clinical care. Therefore, an initial complete physical examination, including height and weight, examination of the thyroid, heart, lungs, extremities, breasts, abdomen, pelvis, and rectum, should be performed.
While most client services will necessarily relate to fertility regulation, family planning clinics must provide and encourage clients to use health maintenance screening procedures, initially and as indicated. Clinics must provide and stress the importance of the following to all clients:

- Blood pressure evaluation;
- Breast exam;
- Pelvic examination which includes vulvar evaluation and bimanual exam;
- Pap smear;
- Colorectal cancer screening in individuals over 40; and
- STD and HIV screening, as indicated.

Following counseling about the importance of the above preventive services, if a client chooses to decline or defer a service, this should be documented in their record. Counseling must include information about the possible health risks associated with declining or delaying preventive screening tests or procedures.

All physical examination and laboratory test requirements stipulated in the prescribing information for specific methods of contraception must be followed. Physical examination and related prevention services should not be deferred beyond 3 months after the initial visit, and in no case may be deferred beyond 6 months, unless if in the clinician’s judgment there is a compelling reason for extending the deferral. All deferrals, including the reason(s) for deferral, must be documented in the client record. Project protocols should be developed accordingly.

- Physical Assessment (male)

Family planning clinics also may be an important source of reproductive health care for male clients. Physical examination should be made available to male clients, including height and weight, examination of the thyroid, heart, lungs, breasts, abdomen, extremities, genitals and rectum. Examination should also include palpation of the prostate, as appropriate, and instructions in self-examination of the testes. Clinics should stress the importance of the following to male clients:

- Blood pressure evaluation;
- Colorectal cancer screening in individuals over 40; and
- STD and HIV screening, as indicated.
• Laboratory Testing

Specific laboratory tests are required for the provision of specific methods of contraception. Laboratory tests can also be important indicators of client health status and useful for diagnostic purposes. Pregnancy testing must be provided onsite. The following laboratory procedures must be provided to clients if required in the provision of a contraceptive method, and may be provided for the maintenance of health status and/or diagnostic purposes, either on-site or by referral:

- Anemia assessment
- Gonorrhea and Chlamydia test
- Vaginal wetmount
- Diabetes testing
- Cholesterol and lipids
- Hepatitis B testing
- Syphilis serology (VDRL, RPR)
- Rubella titer
- Urinalysis
- HIV testing

• Notification of Abnormal Lab Results

A procedure which addresses client confidentiality must be established to allow for client notification and adequate follow-up of abnormal laboratory results.

• Other Laboratory Services or Procedures

Other procedures and lab tests may be indicated for some clients and may be provided on-site or by referral.
• Revisits

Revisit schedules must be individualized based upon the client’s need for education, counseling, and clinical care beyond that provided at the initial and annual visit.

Clients selecting hormonal contraceptives, intrauterine devices (IUDs), cervical caps, or diaphragms for the first time should be scheduled for a revisit as appropriate after initiation of the method to reinforce its proper use, to check for possible side effects, and to provide additional information or clarification. A new or established client who chooses to continue a method already in use need not return for this early revisit unless a need for reevaluation is determined on the basis of the findings at the initial visit.

8.4 Fertility Regulation

• Reversible Contraception

Currently, the reversible methods of contraception include barrier methods (female and male), IUDs, fertility awareness methods, natural family planning, and hormonal methods (injectables, implants, orals). Certain oral contraceptive regimens have been found by the Federal Food and Drug Administration to be safe and effective for use as postcoital emergency contraception when initiated within 72 hours after unprotected intercourse. More than one method of contraception can be used simultaneously by a client and may be particularly indicated to minimize the risks of STDs/HIV and pregnancy. Consistent and correct use of condoms should be encouraged for all persons at risk for STDs/HIV.

• Permanent Contraception

The counseling and consent process must assure that the client’s decision to undergo sterilization is completely voluntary and made with full knowledge of the permanence, risks, and benefits associated with female and male sterilization procedures. Federal sterilization regulations, which address informed consent requirements, must be complied with when a sterilization procedure is performed or arranged for by the project (see Attachment C).
8.5 Infertility Services

Grantees must make basic infertility services available to women and men desiring such services. Infertility services are categorized as follows:

- **Level I** Includes initial infertility interview, education, physical examination, counseling, and appropriate referral.

- **Level II** Includes such testing as semen analysis, assessment of ovulatory function and postcoital testing.

- **Level III** More sophisticated and complex than Level I and Level II services.

Grantees must provide Level I infertility services as a minimum. Level II infertility services may be offered in projects with clinicians who have special training in infertility. Level III services are considered to be beyond the scope of Title X program.

8.6 Pregnancy Diagnosis and Counseling

Projects must provide pregnancy diagnosis and counseling to all clients in need of this service. Pregnancy testing is one of the most common reasons for a first visit to the family planning facility. It is therefore important to use this occasion as an entry point for providing education and counseling about family planning.

Pregnancy cannot be accurately diagnosed and staged through laboratory testing alone. Pregnancy diagnosis consists of a history, pregnancy test, and physical assessment, including pelvic examination. Projects should have available a pregnancy test of high sensitivity. If the medical examination cannot be performed in conjunction with the laboratory testing, the client must be counseled as to the importance of receiving a physical assessment as soon as possible, preferably within 15 days. This can be done on-site, by a provider selected by the client, or by a provider to which the client has been referred by the project. For those clients with positive pregnancy test results who elect to continue the pregnancy, referral for early initiation of prenatal care should be made. Clients planning to carry their pregnancies to term should be given information about good health practices during early pregnancy, especially those which serve to protect the fetus during the first three months (e.g., good nutrition, avoidance of smoking, drugs, and exposure to x-rays). For clients with a negative pregnancy diagnosis, the cause of delayed menses should be investigated. If ectopic pregnancy is suspected, the client must be referred for immediate diagnosis and therapy.
Projects must offer pregnant women the opportunity to be provided information and counseling regarding each of the following options:

- Prenatal care and delivery;
- Infant care, foster care, or adoption; and
- Pregnancy termination.

If requested to provide such information and counseling, provide neutral, factual information and nondirective counseling on each of the options, and referral upon request, except with respect to any option(s) about which the pregnant woman indicates she does not wish to receive such information and counseling [59.5(a)(5)].

Clients who are found not to be pregnant should be given information about the availability of contraceptive and infertility services, as appropriate.

### 8.7 Adolescent Services

Adolescent clients require skilled counseling and age-appropriate information. Appointments should be available to them for counseling and clinical services as soon as possible.

Adolescents seeking contraceptive services must be informed about all methods of contraception. Abstinence as well as contraceptive and safer sex practice options to reduce risks for STD/HIV and pregnancy must be discussed with all adolescents. It is important not to assume that adolescents are sexually active simply because they have come for family planning services. As the contraceptive needs of adolescents frequently change, counseling should prepare them to use a variety of methods effectively.

Adolescents must be assured that the counseling sessions are confidential and, if follow-up is necessary, every attempt will be made to assure the privacy of the individual. However, counselors should encourage family participation in the decision of minors to seek family planning services and provide counseling to minors on resisting attempts to coerce minors into engaging in sexual activities. Title X projects may not require written consent of parents or guardians for the provision of services to minors. Nor can the project notify parents or guardians before or after a minor has requested and received Title X family planning services.
8.8 Identification of Estrogen-Exposed Offspring

The children of women who received DES or similar hormones during pregnancy may have abnormalities of their reproductive systems or other fertility related risks. As part of the medical history, clients born between 1940 and 1970 should be asked if their mothers took estrogens during pregnancy. Clients prenatally exposed to exogenous estrogens should receive information/education and special screening either on-site or by referral.

9.0 Related Services

The following related health services, which can improve quality of care, may be offered if skilled personnel and equipment are available.

9.1 Gynecologic Services

Family planning programs should provide for the diagnosis and treatment of minor gynecologic problems so as to avoid fragmentation or lack of health care for clients with these conditions. Problems such as vaginitis or urinary tract infection may be amenable to on-the-spot diagnosis and treatment, following microscopic examination of vaginal secretions or urine. More complex procedures, such as colposcopy, may be offered, provided that clinicians performing these services have specialized training.

9.2 Sexually Transmitted Diseases (STD) and HIV/AIDS

The increasing incidence and prevalence of STDs, particularly among adolescents, requires that family planning projects increase their efforts to provide education and information about the more common STDs and HIV/AIDS. Projects should make available detection and treatment of the more common STDs. At-risk clients should be urged to undergo examination and treatment as indicated, either directly or by referral. When treatment is provided on-site, appropriate follow-up measures must be undertaken.

Gonorrhea and Chlamydia tests must be available for clients requesting IUD insertion. Tests for gonorrhea, syphilis, chlamydia and HIV should be provided as indicated by client request or evidence of increased risk for infection.

Grantees and/or delegate contract agencies must comply with state and local STD reporting requirements.
9.3 Special Counseling

Clients should be offered appropriate counseling and referral as indicated regarding future planned pregnancies, management of a current pregnancy, and other individual concerns (e.g., substance use and abuse, sexual abuse, domestic violence, genetic issues, nutrition, sexual concerns, etc.) as indicated. Preconceptional counseling should be provided if the client’s history indicates a desired pregnancy in the future.

9.4 Genetic Information and Referral

Basic information regarding genetic conditions should be offered to family planning clients who request or are in need of such services. Extensive genetic counseling and evaluation is beyond the scope of the Title X program. Referral systems should be in place for those who require further genetic counseling and evaluation.

9.5 Health Promotion/Disease Prevention

Family planning programs should, whenever possible, provide or coordinate access to services intended to promote health and prevent disease. Programs are encouraged to assess the health problems prevalent in the populations they serve and to develop strategies to address them.

9.6 Postpartum Care

Family planning programs may provide postpartum care in collaboration with local agencies or institutions which provide prenatal and/or intrapartum care. If a family planning program undertakes responsibility for postpartum care, such care should be directed toward assessment of the woman’s physical health, initiation of contraception if desired, and counseling and education related to parenting, breast feeding, infant care, and family adjustment.

10.0 Clinic Management

10.1 Equipment and Supplies

Equipment and supplies must be appropriate to the type of care offered by the project. Projects are expected to follow applicable Federal and state regulations regarding infection control.
10.2 Pharmaceuticals

A agencies must be operated in accordance with Federal and state laws relating to security and record keeping for drugs and devices. The inventory, supply, and provision of pharmaceuticals must be conducted in accordance with state pharmacy laws and professional practice regulations.

It is essential that each facility maintain an adequate supply and variety of drugs and devices to effectively manage the contraceptive needs of its clients. Projects should also ensure access to other drugs or devices that are necessary for the provision of other medical services included within the scope of the Title X project.

10.3 Medical Records

Projects must establish a medical record for every client who obtains clinical services. These records must be maintained in accordance with accepted medical standards and State laws with regard to record retention. Records must be:

- Complete, legible and accurate, including documentation of telephone encounters of a clinical nature;
- Signed by the clinician and other appropriately trained health professionals making entries, including name, title and date;
- Readily accessible;
- Systematically organized to facilitate prompt retrieval and compilation of information;
- Confidential;
- Safeguarded against loss or use by unauthorized persons;
- Secured by lock when not in use; and
- Available upon request to the client.
Content of the Client Record

The client’s medical record must contain sufficient information to identify the client, indicate where and how the client can be contacted, justify the clinical impression or diagnosis, and warrant the treatment and end results. The required content of the medical record includes:

- Personal data;
- Medical history, physical exam, laboratory test orders, results, and follow-up;
- Treatment and special instructions;
- Scheduled revisits;
- Informed consents;
- Refusal of services; and
- Allergies and untoward reactions to drug(s) recorded in a prominent and specific location.

The record must also contain reports of clinical findings, diagnostic and therapeutic orders, and documentation of continuing care, referral, and follow-up. The record must allow for entries by counseling and social service staff. Projects should maintain a problem list at the front of each chart listing identified problems to facilitate continuing evaluation and follow-up. Client financial information should be kept separate from the client medical record. If included in the medical record, client financial information should not be a barrier to client services.

Confidentiality and Release of Records

A confidentiality assurance statement must appear in the client’s record. The written consent of the client is required for the release of personally identifiable information, except as may be necessary to provide services to the client or as required by law, with appropriate safeguards for confidentiality [59.11]. HIV information should be handled according to law, and kept separate whenever possible. When information is requested, agencies should release only the specific information requested. Information collected for reporting purposes may be disclosed only in summary, statistical, or other form which does not identify particular individuals. Upon request, clients transferring to other providers must be provided with a copy or summary of their record to expedite continuity of care.
10.4 Quality Assurance and Audit

A quality assurance system must be in place that provides for ongoing evaluation of project personnel and services. The quality assurance system should include:

- An established set of clinical, administrative and programmatic standards by which conformity would be maintained;
- A tracking system to identify clients in need of follow-up and/or continuing care;
- Ongoing medical audits to determine conformity with agency protocols;
- Peer review procedures to evaluate individual clinician performance, to provide feedback to providers, and to initiate corrective action when deficiencies are noted;
- Periodic review of medical protocols to insure maintenance of current standards of care;
- A process to elicit consumer feedback; and
- Ongoing and systematic documentation of quality assurance activities.
Federal Guidelines Attachments

Attachment A: Title X – Population Research and Voluntary Family Planning Programs

Attachment B: Title X Family Planning Program Regulations

Attachment C: Sterilization of Persons in Federally Assisted Family Planning Projects

Attachment D: Regional Office Program Consultants for Family Planning Regional Health Administrators, U.S. Public Health Service

Resources for Title X Family Planning Programs
- The Law, Regulations, and Guidelines
- Application, Grants Administration, and Legal Issues
- Project Management and Reporting Requirements
- Client Services
- Health Promotion/Disease Prevention
TITLE X - POPULATION RESEARCH AND VOLUNTARY FAMILY PLANNING PROGRAMS (Title X Statute)

PROJECT GRANTS AND CONTRACTS FOR FAMILY PLANNING SERVICES
SEC. 1001 [300]

(a) The Secretary is authorized to make grants to and enter into contracts with public or nonprofit private entities to assist in the establishment and operation of voluntary family planning projects which shall offer a broad range of acceptable and effective family planning methods and services (including natural family planning methods, infertility services, and services for adolescents). To the extent practicable, entities which receive grants or contracts under this subsection shall encourage family participation in projects assisted under this subsection.

(b) In making grants and contracts under this section the Secretary shall take into account the number of patients to be served, the extent to which family planning services are needed locally, the relative need of the applicant, and its capacity to make rapid and effective use of such assistance. Local and regional entities shall be assured the right to apply for direct grants and contracts under this section, and the Secretary shall by regulation fully provide for and protect such right.

(c) The Secretary, at the request of a recipient of a grant under subsection (a), may reduce the amount of such grant by the fair market value of any supplies or equipment furnished the grant recipient by the Secretary. The amount by which any such grant is so reduced shall be available for payment by the Secretary of the costs incurred in furnishing the supplies or equipment on which the reduction of such grant is based. Such amount shall be deemed as part of the grant and shall be deemed to have been paid to the grant recipient.

(d) For the purpose of making grants and contracts under this section, there are authorized to be appropriated $30,000,000 for the fiscal year ending June 30, 1971; $60,000,000 for the fiscal year ending June 30, 1972; $111,500,000 for the fiscal year ending June 30, 1973, $111,500,000 each for the fiscal years ending June 30, 1974, and June 30, 1975; $115,000,000 for fiscal year 1976; $115,000,000 for the fiscal year ending September 30, 1977; $136,400,000 for the fiscal year ending September 30, 1978; $200,000,000 for the fiscal year ending September 30, 1979; $230,000,000 for the fiscal year ending September 30, 1980; $264,500,000 for the fiscal year ending September 30, 1981; $126,510,000 for the fiscal year ending September 30, 1982; $139,200,000 for the fiscal year ending September 30, 1983; $150,030,000 for the fiscal year ending September 30, 1984; and $158,400,000 for the fiscal year ending September 30, 1985.

1So in law. See section 931(b)(1) of Public Law 97-35 (95 Stat. 570). Probably should be “family.”
FORMULA GRANTS TO STATES FOR FAMILY PLANNING SERVICES
SEC. 1002 [300a]
(a) The Secretary is authorized to make grants, from allotments made under subsection (b), to State health authorities to assist in planning, establishing, maintaining, coordinating, and evaluating family planning services. No grant may be made to a State health authority under this section unless such authority has submitted, and had approved by the Secretary, a State plan for a coordinated and comprehensive program of family planning services.
(b) The sums appropriated to carry out the provisions of this section shall be allotted to the States by the Secretary on the basis of the population and the financial need of the respective States.
(c) For the purposes of this section, the term "State" includes the Commonwealth of Puerto Rico, the Northern Mariana Islands, Guam, American Samoa, the Virgin Islands, the District of Columbia, and the Trust Territory of the Pacific Islands.
(d) For the purpose of making grants under this section, there are authorized to be appropriated $10,000,000 for the fiscal year ending June 30, 1971; $15,000,000 for the fiscal year ending June 30, 1972; and $20,000,000 for the fiscal year ending June 30, 1973.

TRAINING GRANTS AND CONTRACTS; AUTHORIZATION OF APPROPRIATIONS
SEC. 1003 [300a-1]
(a) The Secretary is authorized to make grants to public or nonprofit private entities and to enter into contracts with public or private entities and individuals to provide the training for personnel to carry out family planning service programs described in section 1001 or 1002 of this title.
(b) For the purpose of making payments pursuant to grants and contracts under this section, there are authorized to be appropriated $2,000,000 for the fiscal year ending June 30, 1971; $3,000,000 for the fiscal year ending June 30, 1972; $4,000,000 for the fiscal year ending June 30, 1973; $3,000,000 each for the fiscal years ending June 30, 1974 and June 30, 1975; $4,000,000 for fiscal year ending 1976; $5,000,000 for the fiscal year ending September 30, 1977; $3,000,000 for the fiscal year ending September 30, 1978; $3,100,000 for the fiscal year ending September 30, 1979; $3,600,000 for the fiscal year ending September 30, 1980; $4,100,000 for the fiscal year ending September 30, 1981; $2,920,000 for the fiscal year ending September 30, 1982; $3,200,000 for the fiscal year ending September 30, 1983; $3,500,000 for the fiscal year ending September 30, 1984; and $3,500,000 for the fiscal year ending September 30, 1985.

RESEARCH
SEC. 1004 [300a-2]
The Secretary may –
(1) conduct, and
(2) make grants to public or nonprofit private entities and enter into contracts with public or private entities and individuals for projects for, research in the biomedical, contraceptive development, behavioral, and program implementation fields related to family planning and population.
INFORMATIONAL AND EDUCATIONAL MATERIALS

SEC. 1005 [300a-3]
(a) The Secretary is authorized to make grants to public or nonprofit private entities and to enter into contracts with public or private entities and individuals to assist in developing and making available family planning and population growth information (including educational materials) to all persons desiring such information (or materials).

(b) For the purpose of making payments pursuant to grants and contracts under this section, there are authorized to be appropriated $750,000 for the fiscal year ending June 30, 1971; $1,000,000 for the fiscal year ending June 30, 1972; $1,250,000 for the fiscal year ending June 30, 1973; $909,000 each for the fiscal years ending June 30, 1974, and June 30, 1975; $2,000,000 for fiscal year 1976; $2,500,000 for the fiscal year ending September 30, 1977; $600,000 for the fiscal year ending September 30, 1978; $700,000 for the fiscal year ending September 30, 1979; $805,000 for the fiscal year ending September 30, 1980; $926,000 for the fiscal year ending September 30, 1981; $570,000 for the fiscal year ending September 30, 1982; $600,000 for the fiscal year ending September 30, 1983; $670,000 for the fiscal year ending September 30, 1984; and $700,000 for the fiscal year ending September 30, 1985.

REGULATIONS AND PAYMENTS

SEC. 1006 [300a-4]
(a) Grants and contracts made under this subchapter shall be made in accordance with such regulations as the Secretary may promulgate. The amount of any grant under any section of this title shall be determined by the Secretary; except that no grant under any such section for any program or project for a fiscal year beginning after June 30, 1975, may be made for less than 90 per centum of its costs (as determined under regulations of the Secretary) unless the grant is to be made for a program or project for which a grant was made (under the same section) for the fiscal year ending June 30, 1975, for less than 90 per centum of its costs (as so determined), in which case a grant under such section for that program or project for a fiscal year beginning after that date may be made for a percentage which shall not be less than the percentage of its costs for which the fiscal year 1975 grant was made.

(b) Grants under this title shall be payable in such installments and subject to such conditions as the Secretary may determine to be appropriate to assure that such grants will be effectively utilized for the purposes for which made.

(c) A grant may be made or contract entered into under section 1001 or 1002 for a family planning service project or program only upon assurances satisfactory to the Secretary that--

(1) priority will be given in such project or program to the furnishing of such services to persons from low-income families; and

(2) no charge will be made in such project or program for services provided to any person from a low-income family except to the extent that payment will be made by a third party (including a government agency) which is authorized or is under legal obligation to pay such charge.
For purposes of this subsection, the term “low-income family” shall be defined by the Secretary in accordance with such criteria as he may prescribe so as to insure that economic status shall not be a deterrent to participation in the programs assisted under this title.

(d)(1) A grant may be made or a contract entered into under section 1001 or 1005 only upon assurances satisfactory to the Secretary that informational or educational materials developed or made available under the grant or contract will be suitable for the purposes of this title and for the population or community to which they are to be made available, taking into account the educational and cultural background of the individuals to whom such materials are addressed and the standards of such population or community with respect to such materials.

(2) In the case of any grant or contract under section 1001, such assurances shall provide for the review and approval of the suitability of such materials, prior to their distribution, by an advisory committee established by the grantee or contractor in accordance with the Secretary's regulations. Such a committee shall include individuals broadly representative of the population or community to which the materials are to be made available.

VOLUNTARY PARTICIPATION

SEC. 1007 [300a-5]
The acceptance by any individual of family planning services or family planning or population growth information (including educational materials) provided through financial assistance under this title (whether by grant or contract) shall be voluntary and shall not be a prerequisite to eligibility for or receipt of any other service or assistance from, or to participation in, any other program of the entity or individual that provided such service or information.

PROHIBITION OF ABORTION

SEC. 10081 [300a-6]
None of the funds appropriated under this title shall be used in programs where abortion is a method of family planning.

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1Section 1009 was repealed by section 601(a)(1)(G) of Public Law 105-362 (112 Stat. 3285).
Title X Family Planning Program Regulations

**Subpart A–Project Grants for Family Planning Services**

Sec. 59.1 To what programs do these regulations apply?

Sec. 59.2 Definitions.

Sec. 59.3 Who is eligible to apply for a family planning services grant?

Sec. 59.4 How does one apply for a family planning services grant?

Sec. 59.5 What requirements must be met by a family planning project?

Sec. 59.6 What procedures apply to assure the suitability of informational and educational material?

Sec. 59.7 What criteria will the Department of Health and Human Services use to decide which family planning services projects to fund and in what amount?

Sec. 59.8 How is a grant awarded?

Sec. 59.9 For what purposes may grant funds be used?

Sec. 59.10 What other HHS regulations apply to grants under this subpart?

Sec. 59.11 Confidentiality.

Sec. 59.12 Additional conditions.

**Subpart B [Reserved]**

**Subpart C–Grants for Family Planning Service Training**

Sec. 59.201 Applicability.

Sec. 59.202 Definitions.

Sec. 59.203 Eligibility.

Sec. 59.204 Application for a grant.

Sec. 59.205 Project requirements.

Sec. 59.206 Evaluation and grant award.

Sec. 59.207 Payments.

Sec. 59.208 Use of project funds.

Sec. 59.209 Civil rights.

Sec. 59.210 Inventions or discoveries.

Sec. 59.211 Publications and copyright.

Sec. 59.212 Grantee accountability.

Sec. 59.213 [Reserved]

Sec. 59.214 Additional conditions.

Sec. 59.215 Applicability of 45 CFR part 74.
Virgin Islands, American Samoa, the U.S. Outlying Islands (Midway, Wake, et al.), the Marshall Islands, the Federated State of Micronesia and the Republic of Palau.

[65 FR 41278, July 3, 2000; 65 FR 49057, Aug. 10, 2000]

Sec. 59.3 Who is eligible to apply for a family planning services grant?

Any public or nonprofit private entity in a State may apply for a grant under this subpart.

Sec. 59.4 How does one apply for a family planning services grant?

(a) Application for a grant under this subpart shall be made on an authorized form.

(b) An individual authorized to act for the applicant and to assume on behalf of the applicant the obligations imposed by the terms and conditions of the grant, including the regulations of this subpart, must sign the application.

(c) The application shall contain--

(1) A description, satisfactory to the Secretary, of the project and how it will meet the requirements of this subpart;

(2) A budget and justification of the amount of grant funds requested;

(3) A description of the standards and qualifications which will be required for all personnel and for all facilities to be used by the project; and

(4) Such other pertinent information as the Secretary may require.

Sec. 59.5 What requirements must be met by a family planning project?

(a) Each project supported under this part must:

(1) Provide a broad range of acceptable and effective medically approved family planning methods (including natural family planning methods) and services (including infertility services and services for adolescents). If an organization offers only a single method of family planning, it may participate as part of a project as long as the entire project offers a broad range of family planning services.

(2) Provide services without subjecting individuals to any coercion to accept services or to employ or not to employ any particular methods of family planning. Acceptance of services must be solely on a voluntary basis and may not be made a prerequisite to eligibility for, or receipt of, any other services, assistance from or participation in any other program of the applicant.

(3) Provide services in a manner which protects the dignity of the individual.

(4) Provide services without regard to religion, race, color, national origin, handicapping condition, age, sex, number of pregnancies, or marital status.

(5) Not provide abortion as a method of family planning. A project must:

(i) Offer pregnant women the opportunity to be provided information and counseling regarding each of the following options:

(A) Prenatal care and delivery;

(B) Infant care, foster care, or adoption; and

(C) Pregnancy termination.

(ii) If requested to provide such information and counseling, provide neutral, factual information and nondirective counseling on each of the options, and referral upon request, except with respect to any option(s) about which the pregnant woman indicates she does not wish to receive such information and counseling.

(6) Provide that priority in the provision of services will be given to persons from low-income families.

(7) Provide that no charge will be made for services provided to any persons from a low-income family except to the extent that payment will be made by a third party (including a government agency) which is authorized to or is under legal obligation to pay this charge.

(8) Provide that charges will be made for services to persons other than those from low-income families in accordance with a schedule of discounts based on ability to pay, except that charges to persons from families whose annual income exceeds 250 percent of the levels set forth in the most recent Poverty Guidelines issued pursuant to 42 U.S.C. 9902(2) will be made in accordance with a schedule of fees designed to recover the reasonable cost of providing services.

(9) If a third party (including a Government agency) is authorized or legally obligated to pay for services, all reasonable efforts must be made to obtain the third-party payment without application of

1 Section 205 of Pub. L. 94-63 states: “Any (1) officer or employee of the United States, (2) officer or employee of any State, political subdivision of a State, or any other entity, which administers or supervises the administration of any program receiving Federal financial assistance, or (3) person who receives, under any program receiving Federal assistance, compensation for services, who coerces or endeavors to coerce any person to undergo an abortion or sterilization procedure by threatening such person with the loss of, or disqualification for the receipt of, any benefit or service under a program receiving Federal financial assistance shall be fined not more than $1,000 or imprisoned for not more than one year, or both.”
any discounts. Where the cost of services is to be reimbursed under title XIX, XX, or XXI of the Social Security Act, a written agreement with the title XIX, XX or XXI agency is required.

(10)(i) Provide that if an application relates to consolidation of service areas or health resources or would otherwise affect the operations of local or regional entities, the applicant must document that these entities have been given, to the maximum feasible extent, an opportunity to participate in the development of the application. Local and regional entities include existing or potential subgrantees which have previously provided or propose to provide family planning services to the area proposed to be served by the applicant.

(ii) Provide an opportunity for maximum participation by existing or potential subgrantees in the ongoing policy decisionmaking of the project.

(11) Provide for an Advisory Committee as required by Sec. 59.6.

(b) In addition to the requirements of paragraph (a) of this section, each project must meet each of the following requirements unless the Secretary determines that the project has established good cause for its omission. Each project must:

(1) Provide for medical services related to family planning (including physician’s consultation, examination prescription, and continuing supervision, laboratory examination, contraceptive supplies) and necessary referral to other medical facilities when medically indicated, and provide for the effective usage of contraceptive devices and practices.

(2) Provide for social services related to family planning, including counseling, referral to and from other social and medical services agencies, and any ancillary services which may be necessary to facilitate clinic attendance.

(3) Provide for informational and educational programs designed to--
   (i) Achieve community understanding of the objectives of the program;
   (ii) Inform the community of the availability of services; and
   (iii) Promote continued participation in the project by persons to whom family planning services may be beneficial.

(4) Provide for orientation and in-service training for all project personnel.

(5) Provide services without the imposition of any durational residency requirement or requirement that the patient be referred by a physician.

(6) Provide that family planning medical services will be performed under the direction of a physician with special training or experience in family planning.

(7) Provide that all services purchased for project participants will be authorized by the project director or his designee on the project staff.

(8) Provide for coordination and use of referral arrangements with other providers of health care services, local health and welfare departments, hospitals, voluntary agencies, and health services projects supported by other federal programs.

(9) Provide that if family planning services are provided by contract or other similar arrangements with actual providers of services, services will be provided in accordance with a plan which establishes rates and method of payment for medical care. These payments must be made under agreements with a schedule of rates and payment procedures maintained by the grantee. The grantee must be prepared to substantiate, that these rates are reasonable and necessary.

(10) Provide, to the maximum feasible extent, an opportunity for participation in the development, implementation, and evaluation of the project by persons broadly representative of all significant elements of the population to be served, and by others in the community knowledgeable about the community's needs for family planning services.

[65 FR 41278, July 3, 2000; 65 FR 49057, Aug. 10, 2000]

Sec. 59.6 What procedures apply to assure the suitability of informational and educational material?

(a) A grant under this section may be made only upon assurance satisfactory to the Secretary that the project shall provide for the review and approval of informational and educational materials developed or made available under the project by an Advisory Committee prior to their distribution, to assure that the materials are suitable for the population or community to which they are to be made available and the purposes of title X of the Act. The project shall not disseminate any such materials which are not approved by the Advisory Committee.

(b) The Advisory Committee referred to in paragraph (a) of this section shall be established as follows:

(1) Size. The Committee shall consist of no fewer than five but not more than nine members, except that this provision may be waived by the Secretary for good cause shown.

(2) Composition. The Committee shall include individuals broadly representative (in terms of demographic factors such as race, color, national
(3) Function. In reviewing materials, the Advisory Committee shall:
   (i) Consider the educational and cultural backgrounds of individuals to whom the materials are addressed;
   (ii) Consider the standards of the population or community to be served with respect to such materials;
   (iii) Review the content of the material to assure that the information is factually correct;
   (iv) Determine whether the material is suitable for the population or community to which it is to be made available; and
   (v) Establish a written record of its determinations.

Sec. 59.7 What criteria will the Department of Health and Human Services use to decide which family planning services projects to fund and in what amount?

(a) Within the limits of funds available for these purposes, the Secretary may award grants for the establishment and operation of those projects which will in the Department's judgment best promote the purposes of section 1001 of the Act, taking into account:
   (1) The number of patients, and, in particular, the number of low-income patients to be served;
   (2) The extent to which family planning services are needed locally;
   (3) The relative need of the applicant;
   (4) The capacity of the applicant to make rapid and effective use of the federal assistance;
   (5) The adequacy of the applicant's facilities and staff;
   (6) The relative availability of non-federal resources within the community to be served and the degree to which those resources are committed to the project; and
   (7) The degree to which the project plan adequately provides for the requirements set forth in these regulations.

(b) The Secretary shall determine the amount of any award on the basis of his estimate of the sum necessary for the performance of the project. No grant may be made for less than 90 percent of the project's costs, as so estimated, unless the grant is to be made for a project which was supported, under section 1001, for less than 90 percent of its costs in fiscal year 1975. In that case, the grant shall not be for less than the percentage of costs covered by the grant in fiscal year 1975.

(c) No grant may be made for an amount equal to 100 percent of the project's estimated costs.

Sec. 59.8 How is a grant awarded?

(a) The notice of grant award specifies how long HHS intends to support the project without requiring the project to recompete for funds. This period, called the project period, will usually be for three to five years.

(b) Generally the grant will initially be for one year and subsequent continuation awards will also be for one year at a time. A grantee must submit a separate application to have the support continued for each subsequent year. Decisions regarding continuation awards and the funding level of such awards will be made after consideration of such factors as the grantee's progress and management practices, and the availability of funds. In all cases, continuation awards require a determination by HHS that continued funding is in the best interest of the government.

(c) Neither the approval of any application nor the award of any grant commits or obligates the United States in any way to make any additional, supplemental, continuation, or other award with respect to any approved application or portion of an approved application.

Sec. 59.9 For what purpose may grant funds be used?

Any funds granted under this subpart shall be expended solely for the purpose for which the funds were granted in accordance with the approved application and budget, the regulations of this subpart, the terms and conditions of the award, and the applicable cost principles prescribed in 45 CFR Part 74 or Part 92, as applicable.

Sec. 59.10 What other HHS regulations apply to grants under this subpart?

Attention is drawn to the following HHS Department-wide regulations which apply to grants under this subpart. These include:

37 CFR Part 401--Rights to inventions made by nonprofit organizations and small business firms under government grants, contracts, and cooperative agreements
42 CFR Part 50, Subpart D--Public Health Service grant appeals procedure
45 CFR Part 16--Procedures of the Departmental Grant Appeals Board
45 CFR Part 74--Uniform administrative requirements for awards and subawards to
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institutions of higher education, hospitals, other nonprofit organizations, and commercial organizations; and certain grants and agreements with states, local governments and Indian tribal governments

45 CFR Part 80--Nondiscrimination under programs receiving Federal assistance through the Department of Health and Human Services effectuation of Title VI of the Civil Rights Act of 1964

45 CFR Part 81--Practice and procedure for hearings under Part 80 of this Title

45 CFR Part 84--Nondiscrimination on the basis of handicap in programs and activities receiving or benefitting from Federal financial assistance

45 CFR Part 91--Nondiscrimination on the basis of age in HHS programs or activities receiving Federal financial assistance

45 CFR Part 92--Uniform administrative requirements for grants and cooperative agreements to state and local governments

Sec. 59.11 Confidentiality.

All information as to personal facts and circumstances obtained by the project staff about individuals receiving services must be held confidential and must not be disclosed without the individual's documented consent, except as may be necessary to provide services to the patient or as required by law, with appropriate safeguards for confidentiality. Otherwise, information may be disclosed only in summary, statistical, or other form which does not identify particular individuals.

Sec. 59.12 Additional conditions.

The Secretary may, with respect to any grant, impose additional conditions prior to or at the time of any award, when in the Department's judgment these conditions are necessary to assure or protect advancement of the approved program, the interests of public health, or the proper use of grant funds.

[65 FR 41278, July 3, 2000; 65 FR 49057, Aug. 10, 2000]

Subpart B [Reserved]

Subpart C--Grants for Family Planning Service Training

Authority: Sec. 6(c), 84 Stat. 1507, 42 U.S.C. 300a-4; sec. 6(c), 84 Stat. 1507, 42 U.S.C. 300a-1.

Source: 37 FR 7093, Apr. 8, 1972, unless otherwise noted.

Sec. 59.201 Applicability.

The regulations in this subpart are applicable to the award of grants pursuant to section 1003 of the Public Health Service Act (42 U.S.C. 300a-1) to provide the training for personnel to carry out family planning service programs described in sections 1001 and 1002 of the Public Health Service Act (42 U.S.C. 300, 300a).

Sec. 59.202 Definitions.

As used in this subpart:

(a) Act means the Public Health Service Act.

(b) State means one of the 50 States, the District of Columbia, Puerto Rico, Guam, the Virgin Islands, American Samoa, or the Trust Territory of the Pacific Islands.

(c) Nonprofit private entity means a private entity no part of the net earnings of which inures, or may lawfully inure, to the benefit of any private shareholder or individual.

(d) Secretary means the Secretary of Health and Human Services and any other officer or employee of the Department of Health and Human Services to whom the authority involved has been delegated.

(e) Training means job-specific skill development, the purpose of which is to promote and improve the delivery of family planning services.

Sec. 59.203 Eligibility.

(a) Eligible applicants. Any public or nonprofit private entity located in a State is eligible to apply for a grant under this subpart.

(b) Eligible projects. Grants pursuant to section 1003 of the Act and this subpart may be made to eligible applicants for the purpose of providing programs, not to exceed three months in duration, for training family planning or other health services delivery personnel in the skills, knowledge, and attitudes necessary for the effective delivery of family planning services: Provided, That the Secretary may in particular cases approve support of a program whose duration is longer than three months where he determines (1) that such program is consistent with the purposes of this subpart and (2) that the program's objectives cannot be accomplished within three months because of the unusually complex or specialized nature of the training to be undertaken.

[37 FR 7093, Apr. 8, 1972, as amended at 40 FR 17991, Apr. 24, 1975]

Sec. 59.204 Application for a grant.
(a) An application for a grant under this subpart shall be submitted to the Secretary at such time and in such form and manner as the Secretary may prescribe. The application shall contain a full and adequate description of the project and of the manner in which the applicant intends to conduct the project and carry out the requirements of this subpart, and a budget and justification of the amount of grant funds requested, and such other pertinent information as the Secretary may require.

(b) The application shall be executed by an individual authorized to act for the applicant and to assume for the applicant the obligations imposed by the regulations of this subpart and any additional conditions of the grant.

(37 FR 7093, Apr. 8, 1972, as amended at 49 FR 38116, Sept. 27, 1984)

An approvable application must contain each of the following unless the Secretary determines that the applicant has established good cause for its omission:

(a) Assurances that:
(1) No portion of the Federal funds will be used to train personnel for programs where abortion is a method of family planning.
(2) No portion of the Federal funds will be used to provide professional training to any student as part of his education in pursuit of an academic degree.
(3) No project personnel or trainees shall on the grounds of sex, religion, or creed be excluded from participation in, be denied the benefits of, or be subjected to discrimination under the project.

(b) Provision of a methodology to assess the particular training (e.g., skills, attitudes, or knowledge) that prospective trainees in the area to be served need to improve their delivery of family planning services.

(c) Provision of a methodology to define the objectives of the training program in light of the particular needs of trainees defined pursuant to paragraph (b) of this section.

Sec. 59.205 Project requirements.

(d) Provision of a method for development of the training curriculum and any attendant training materials and resources.

(e) Provision of a method for implementation of the needed training.

(f) Provision of an evaluation methodology, including the manner in which such methodology will be employed, to measure the achievement of the objectives of the training program.

Sec. 59.206 Evaluation and grant award.

(a) Within the limits of funds available for such purpose, the Secretary may award grants to assist in the establishment and operation of those projects which will in his judgment best promote the purposes of section 1003 of the Act, taking into account:

(1) The extent to which a training program will increase the delivery of services to people, particularly low-income groups, with a high percentage of unmet need for family planning services;
(2) The extent to which the training program promises to fulfill the family planning services delivery needs of the area to be served, which may include, among other things:
   (i) Development of a capability within family planning service projects to provide pre- and in-service training to their own staffs;
   (ii) Improvement of the family planning services delivery skills of family planning and health services personnel;
   (iii) Improvement in the utilization and career development of paraprofessional and paramedical manpower in family planning services;
   (iv) Expansion of family planning services, particularly in rural areas, through new or improved approaches to program planning and deployment of resources;
(3) The capacity of the applicant to make rapid and effective use of such assistance;
(4) The administrative and management capability and competence of the applicant;
(5) The competence of the project staff in relation to the services to be provided; and
(6) The degree to which the project plan adequately provides for the requirements set forth in Sec. 59.205.

(b) The amount of any award shall be determined by the Secretary on the basis of his estimate of the sum necessary for all or a designated portion of direct project costs plus an additional amount for indirect costs, if any, which will be calculated by the Secretary either: (1) On the basis of his estimate of

1 Applications and instructions may be obtained from the Program Director, Family Planning Services, at the Regional Office of the Department of Health and Human Services for the region in which the project is to be conducted, or the Office of Family Planning, Office of the Assistant Secretary for Health, Washington, DC 20201.
the actual indirect costs reasonably related to the project, or (2) on the basis of a percentage of all, or a portion of, the estimated direct costs of the project when there are reasonable assurances that the use of such percentage will not exceed the approximate actual indirect costs. Such award may include an estimated provisional amount for indirect costs or for designated direct costs (such as travel or supply costs) subject to upward (within the limits of available funds) as well as downward adjustments to actual costs when the amount properly expended by the grantee for provisional items has been determined by the Secretary.

(c) Allowability of costs shall be in conformance with the applicable cost principles prescribed by Subpart Q of 35 CFR part 74.

(d) All grant awards shall be in writing, shall set forth the amount of funds granted and the period for which support is recommended.

(e) Neither the approval of any project nor any grant award shall commit or obligate the United States in any way to make any additional, supplemental, continuation, or other award with respect to any approved project or portion thereof. For continuation support, grantees must make separate application annually at such times and in such form as the Secretary may direct.

[37 FR 7093, Apr. 8, 1972, as amended at 38 FR 26199, Sept. 19, 1973]

Sec. 59.207 Payments.

The Secretary shall from time to time make payments to a grantee of all or a portion of any grant award, either in advance or by way of reimbursement for expenses incurred or to be incurred in the performance of the project to the extent he determines such payments necessary to promote prompt initiation and advancement of the approved project.

Sec. 59.208 Use of project funds.

(a) Any funds granted pursuant to this subpart as well as other funds to be used in performance of the approved project shall be expended solely for carrying out the approved project in accordance with the statute, the regulations of this subpart, the terms and conditions of the award, and, except as may otherwise be provided in this subpart, the applicable cost principles prescribed by subpart Q of 45 CFR part 74.

(b) Prior approval by the Secretary of revision of the budget and project plan is required whenever there is to be a significant change in the scope or nature of project activities.

(c) The Secretary may approve the payment of grant funds to trainees for:

(1) Return travel to the trainee's point of origin.

(2) Per diem during the training program, and during travel to and from the program, at the prevailing institutional or governmental rate, whichever is lower.

[37 FR 7093, Apr. 8, 1972, as amended at 38 FR 26199, Sept. 19, 1973]

Sec. 59.209 Civil rights.

Attention is called to the requirements of Title VI of the Civil Rights Act of 1964 (78 Stat. 252, 42 U.S.C. 2000d et seq.) and in particular section 601 of such Act which provides that no person in the United States shall, on the grounds of race, color, or national origin be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance. A regulation implementing such title VI, which applies to grants made under this part, has been issued by the Secretary of Health and Human Services with the approval of the President (45 CFR part 80).

Sec. 59.210 Inventions or discoveries.

Any grant award pursuant to Sec. 59.206 is subject to the regulations of the Department of Health and Human Services as set forth in 45 CFR parts 6 and 8, as amended. Such regulations shall apply to any activity for which grant funds are in fact used whether within the scope of the project as approved or otherwise. Appropriate measures shall be taken by the grantee and by the Secretary to assure that no contracts, assignments or other arrangements inconsistent with the grant obligation are continued or entered into and that all personnel involved in the supported activity are aware of and comply with such obligations. Laboratory notes, related technical data, and information pertaining to inventions and discoveries shall be maintained for such periods, and filed with or otherwise made available to the Secretary, or those he may designate at such times and in such manner, as he may determine necessary to carry out such Department regulations.

Sec. 59.211 Publications and copyright.

Except as may otherwise be provided under the terms and conditions of the award, the grantee may copyright without prior approval any publications,
films or similar materials developed or resulting from a project supported by a grant under this part, subject, however, to a royalty-free, nonexclusive, and irrevocable license or right in the Government to reproduce, translate, publish, use, disseminate, and dispose of such materials and to authorize others to do so.

**Sec. 59.212  Grantee accountability.**

(a) Accounting for grant award payments. All payments made by the Secretary shall be recorded by the grantee in accounting records separate from the records of all other grant funds, including funds derived from other grant awards. With respect to each approved project the grantee shall account for the sum total of all amounts paid by presenting or otherwise making available evidence satisfactory to the Secretary of expenditures for direct and indirect costs meeting the requirements of this part: Provided, however, That when the amount awarded for indirect costs was based on a predetermined fixed-percentage of estimated direct costs, the amount allowed for indirect costs shall be computed on the basis of such predetermined fixed-percentage rates applied to the total, or a selected element thereof, of the reimbursable direct costs incurred.

(b) [Reserved]

(c) Accounting for grant-related income—(1) Interest. Pursuant to section 203 of the Intergovernmental Cooperation Act of 1968 (42 U.S.C. 4213), a State will not be held accountable for interest earned on grant funds, pending their disbursement for grant purposes. A State, as defined in section 102 of the Intergovernmental Cooperation Act, means any one of the several States, the District of Columbia, Puerto Rico, any territory or possession of the United States, or any agency or instrumentality of a State, but does not include the governments of the political subdivisions of the State. All grantees other than a State, as defined in this subsection, must return all interest earned on grant funds to the Federal Government.

(d) Grant closeout—(1) Date of final accounting. A grantee shall render, with respect to each approved project, a full account, as provided herein, as of the date of the termination of grant support. The Secretary may require other special and periodic accounting.

(2) Final settlement. There shall be payable to the Federal Government as final settlement with respect to each approved project the total sum of:

(i) Any amount not accounted for pursuant to paragraph (a) of this section;

(ii) Any credits for earned interest pursuant to paragraph (c)(1) of this section;

(iii) Any other amounts due pursuant to subparts F, M, and O of 45 CFR part 74.

Such total sum shall constitute a debt owed by the grantee to the Federal Government and shall be recovered from the grantee or its successors or assignees by setoff or other action as provided by law.


**Sec. 59.213  [Reserved]**

**Sec. 59.214  Additional conditions.**

The Secretary may with respect to any grant award impose additional conditions prior to or at the time of any award when in his judgment such conditions are necessary to assure or protect advancement of the approved project, the interests of public health, or the conservation of grant funds.

**Sec. 59.215  Applicability of 45 CFR part 74.**

The provisions of 45 CFR part 74, establishing uniform administrative requirements and cost principles, shall apply to all grants under this subpart to State and local governments as those terms are defined in subpart A of that part 74. The relevant provisions of the following subparts of part 74 shall also apply to grants to all other grantee organizations under this subpart.

45 CFR Part 74

Subpart:
A General.
B Cash Depositories.
C Bonding and Insurance.
D Retention and Custodial Requirements for Records.
F Grant-Related Income.
G Matching and Cost Sharing.
K Grant Payment Requirements.
L Budget Revision Procedures.
M Grant Closeout, Suspension, and Termination.
O Property.
Q Cost Principles.

[38 FR 26199, Sept. 19, 1973]
Sterilization of Persons in Federally Assisted Family Planning Projects

Sec. 50.201 Applicability.
The provisions of this subpart are applicable to programs or projects for health services which are supported in whole or in part by Federal financial assistance, whether by grant or contract, administered by the Public Health Service.

Sec. 50.202 Definitions.
As used in this subpart:

Arrange for means to make arrangements (other than mere referral of an individual to, or the mere making of an appointment for him or her with, another health care provider) for the performance of a medical procedure on an individual by a health care provider other than the program or project.

Hysterectomy means a medical procedure or operation for the purpose of removing the uterus.

Institutionalized individual means an individual who is (1) involuntarily confined or detained, under a civil or criminal statute, in a correctional or rehabilitative facility, including a mental hospital or other facility for the care and treatment of mental illness, or (2) confined, under a voluntary commitment, in a mental hospital or other facility for the care and treatment of mental illness.

Mentally incompetent individual means an individual who has been declared mentally incompetent by a Federal, State, or local court of competent jurisdiction for any purpose unless he or she has been declared competent for purposes which include the ability to consent to sterilization.

Public Health Service means the Office of the Assistant Secretary for Health, Health Resources and Services Administration, National Institutes of Health, Centers for Disease Control, Alcohol, Drug Abuse and Mental Health Administration and all of their constituent agencies.

The Secretary means the Secretary of Health and Human Services and any other officer or employee of the Department of Health and Human Services to whom the authority involved has been delegated.

Sterilization means any medical procedure, treatment, or operation for the purpose of rendering an individual permanently incapable of reproducing.

[43 FR 52165, Nov. 8, 1978, as amended at 49 FR 38109, Sept. 27, 1984]
(5) A full description of the discomforts and risks that may accompany or follow the performing of the procedure, including an explanation of the type and possible effects of any anesthetic to be used;

(6) A full description of the benefits or advantages that may be expected as a result of the sterilization; and

(7) Advice that the sterilization will not be performed for at least 30 days except under the circumstances specified in Sec. 50.203(d) of this subpart.

(b) An interpreter must be provided to assist the individual to be sterilized if he or she does not understand the language used on the consent form or the language used by the person obtaining the consent.

(c) Suitable arrangements must be made to insure that the information specified in paragraph (a) of this section is effectively communicated to any individual to be sterilized who is blind, deaf or otherwise handicapped.

(d) A witness chosen by the individual to be sterilized may be present when consent is obtained.

(e) Informed consent may not be obtained while the individual to be sterilized is:

(1) In labor or childbirth;
(2) Seeking to obtain or obtaining an abortion; or
(3) Under the influence of alcohol or other substances that affect the individual's state of awareness.

(f) Any requirement of State and local law for obtaining consent, except one of spousal consent, must be followed.

Sec. 50.205 Consent form requirements.

(a) Required consent form. The consent form appended to this subpart or another consent form approved by the Secretary must be used.

(b) Required signatures. The consent form must be signed and dated by:

(1) The individual to be sterilized; and
(2) The interpreter, if one is provided; and
(3) The person who obtains the consent; and
(4) The physician who will perform the sterilization procedure.

(c) Required certifications. (1) The person obtaining the consent must certify by signing the consent form that:

(i) Before the individual to be sterilized signed the consent form, he or she advised the individual to be sterilized that no Federal benefits may be withdrawn because of the decision not to be sterilized;

(ii) He or she explained orally the requirements for informed consent as set forth on the consent form, and

(iii) To the best of his or her knowledge and belief, the individual to be sterilized appeared mentally competent and knowingly and voluntarily consented to be sterilized.

(2) The physician performing the sterilization must certify by signing the consent form, that:

(i) Shortly before the performance of the sterilization, he or she advised the individual to be sterilized that no Federal benefits may be withdrawn because of the decision not to be sterilized,

(ii) He or she explained orally the requirements for informed consent as set forth on the consent form, and

(iii) To the best of his or her knowledge and belief, the individual to be sterilized appeared mentally competent and knowingly and voluntarily consented to be sterilized.

(3) If an interpreter is provided, the interpreter must certify that he or she translated the information and advice presented orally, read the consent form and explained its contents and to the best of the interpreter's knowledge and belief, the individual to be sterilized understood what the interpreter told him or her.

Sec. 50.206 Sterilization of a mentally incompetent individual or of an institutionalized individual.

Programs or projects to which this subpart applies shall not perform or arrange for the performance of a sterilization of any mentally incompetent individual or institutionalized individual.
Sec. 50.207  Sterilization by hysterectomy.

(a) Programs or projects to which this subpart applies shall not perform or arrange for the performance of any hysterectomy solely for the purpose of rendering an individual permanently incapable of reproducing or where, if there is more than one purpose to the procedure, the hysterectomy would not be performed but for the purpose of rendering the individual permanently incapable of reproducing.

(b) Except as provided in paragraph (c) of this section, programs or projects to which this subpart applies may perform or arrange for the performance of a hysterectomy not covered by paragraph (a) of this section only if:

1) The person who secures the authorization to perform the hysterectomy has informed the individual and her representative, if any, orally and in writing, that the hysterectomy will make her permanently incapable of reproducing; and

2) The individual or her representative, if any, has signed a written acknowledgment of receipt of that information.

(c)(1) A program or project is not required to follow the procedures of paragraph (b) of this section if either of the following circumstances exists:

i) The individual is already sterile at the time of the hysterectomy.

ii) The individual requires a hysterectomy because of a life-threatening emergency in which the physician determines that prior acknowledgment is not possible.

(2) If the procedures of paragraph (b) of this section are not followed because one or more of the circumstances of paragraph (c)(1) exist, the physician who performs the hysterectomy must certify in writing:

i) That the woman was already sterile, stating the cause of that sterility; or

ii) That the hysterectomy was performed under a life-threatening emergency situation in which he or she determined prior acknowledgment was not possible. He or she must also include a description of the nature of the emergency.

Sec. 50.208  Program or project requirements.

(a) A program or project must, with respect to any sterilization procedure or hysterectomy it performs or arranges, meet all requirements of this subpart.

(b) The program or project shall maintain sufficient records and documentation to assure compliance with these regulations, and must retain such data for at least 3 years.

(c) The program or project shall submit other reports as required and when requested by the Secretary.

Sec. 50.209  Use of Federal financial assistance.

(a) Federal financial assistance administered by the Public Health Service may not be used for expenditures for sterilization procedures unless the consent form appended to this section or another form approved by the Secretary is used.

(b) A program or project shall not use Federal financial assistance for any sterilization or hysterectomy without first receiving documentation showing that the requirements of this subpart have been met. Documentation includes consent forms, and as applicable, either acknowledgments of receipt of hysterectomy information or certification of an exception for hysterectomies.

[43 FR 52165, Nov. 8, 1978, as amended at 47 FR 33701, Aug. 4, 1982]

Sec. 50.210  Review of regulation.

The Secretary will request public comment on the operation of the provisions of this subpart not later than 3 years after their effective date.

APPENDIX TO SUBPART B OF PART 50—REQUIRED CONSENT FORM

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

CONSENT TO STERILIZATION

I have asked for and received information about sterilization from (doctor or clinic). When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as A.F.D.C. or Medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED PERMANENT AND NOT REVERSIBLE. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.
I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a . The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least 30 days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on (day), (month), (year).

I, , hereby consent of my own free will to be sterilized by a method called . My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to:

Representatives of the Department of Health and Human Services or
Employees of programs or projects funded by that Department but only for determining if Federal laws were observed.

I have received a copy of this form.

Signature
Date: (Month, day, year)

You are requested to supply the following information, but it is not required:

Ethnicity and Race Designation
Ethnicity:
Hispanic or Latino
Not Hispanic or Latino

Race (mark one or more):
American Indian or Alaska Native
Asian
Black or African American
Native Hawaiian or Other Pacific Islander
White

If an interpreter is provided to assist the individual to be sterilized:

I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

Interpreter
Date

Before (name of individual), signed the consent form, I explained to him/her the nature of the sterilization operation , the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure.

Signature of person obtaining consent
Date
Facility
Address
PHYSICIAN'S STATEMENT

Shortly before I performed a sterilization operation upon (name of individual to be sterilized), on (date of sterilization), (operation), I explained to him/her the nature of the sterilization operation (specify type of operation), the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

(Instructions for use of alternative final paragraphs: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

(1) At least 30 days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

Premature delivery
Individual's expected date of delivery:
Emergency abdominal surgery:
(Describe circumstances):

Physician
Date

PAPERWORK REDUCTION ACT STATEMENT

A Federal agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays the currently valid OMB control number. Public reporting burden for this collection of information will vary; however, we estimate an average of one hour per response, including for reviewing instructions, gathering and maintaining the necessary data, and disclosing the information. Send any comment regarding the burden estimate or any other aspect of this collection of information to the OS Reports Clearance Officer, ASBTF/Budget Room 503 HHH Building, 200 Independence Avenue, SW., Washington, DC 20201.

Respondents should be informed that the collection of information requested on this form is authorized by 42 CFR part 50, subpart B, relating to the sterilization of persons in federally assisted public health programs. The purpose of requesting this information is to ensure that individuals requesting sterilization receive information regarding the risks, benefits and consequences, and to assure the voluntary and informed consent of all persons undergoing sterilization procedures in federally assisted public health programs. Although not required, respondents are requested to supply information on their race and ethnicity. Failure to provide the other information requested on this consent form, and to sign this consent form, may result in an inability to receive sterilization procedures funded through federally assisted public health programs.

All information as to personal facts and circumstances obtained through this form will be held confidential, and not disclosed without the individual's consent, pursuant to any applicable confidentiality regulations.


[Revised as of October 1, 2003]
Program Guidelines | Attachment D
Office of Population Affairs

Regional Office Program Consultants for Family Planning

**Region I** – *CT, ME, MA, NH, RI, VT*
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**Region III** – *DE, D.C., MD, PA, VA, WV*
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Program Guidelines | Attachment D
Office of Population Affairs

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Resource List for Title X Family Planning Programs

The following is a list of selected resources that provide additional guidance in specific areas. It is intended to assist programs in administering their Title X grant and in providing services to clients. The list is not intended to be exhaustive, nor does it imply endorsement of any of the non-governmental resources.

The Law, Regulations, and Guidelines

The Title X Family Planning statute (42 USC 300 et. seq.) and regulations can be obtained from:

- Office of Family Planning
  Office of Population Affairs
  Office of Public Health and Science
  U.S. Department of Health and Human Services
  4350 East West Highway, Suite 200
  Bethesda, MD 20817
  (301) 594-4008
  http://www.hhs.gov/opa/
  opa@hhs.gov

Application, Grants Administration, and Legal Issues

- Grants Management
  http://www.hhs.gov/grantsnet

- Grants Process Policy Notices for Title X Family Planning Services, rev. 1999
  (Available from Title X Grants Management Office. 1301 Young Street, Ste.766, Dallas, TX 75202; 214-767-3490)
Project Management and Reporting Requirements

- Annual Report for OPA Title X Family Planning Program Grantees Forms and Instructions (Available from the Regional Office).


Client Services

- Cultural Competence
  [http://minorityhealth.hhs.gov](http://minorityhealth.hhs.gov)


Health Promotion/Disease Prevention


o *Guidelines for Health Education and Risk Reduction Activities*. CDC, National Center for Prevention Services, Division of Sexually Transmitted Diseases/HIV Prevention. Publication date: 04/01/1995. [http://www.cdc.gov/hiv/resources/guidelines/herrg/activities_ind-group.htm](http://www.cdc.gov/hiv/resources/guidelines/herrg/activities_ind-group.htm)

Title X Program Priorities

The purpose of the Title X program is to assist in the establishment and operation of voluntary family planning projects. Services consist of education, comprehensive medical services, a broad range of acceptable and effective family planning methods, and social services necessary to aid individuals to determine freely the number and spacing of their children. Agencies receiving Title X funding must make these services their primary activity. The priority is to serve those from low-income families.

In addition, the Office of Population Affairs, the federal agency that funds Title X, has established a set of national priorities, some of which they may elect to emphasize during a given Title X grant cycle. These may change over time. The current program priorities, legislative mandates, and other key issues are listed below.

OPA Program Priorities

The following priorities represent the overarching goals for the Title X program:

1. Assuring the delivery of quality family planning and related preventive health services, where evidence exists that those services should lead to improvement in the overall health of individuals, with priority for services to individuals from low-income families;

2. Expanding access to a broad range of acceptable and effective family planning methods and related preventive health services that include natural family planning methods, infertility services, and services for adolescents, emphasizing the important role Title X plays in teen pregnancy prevention. The broad range of services does not include abortion as a method of family planning;

3. Providing preventive health care services in accordance with nationally recognized standards of care. This includes, but is not limited to, breast and cervical cancer screening and prevention services; sexually transmitted disease (STD) and HIV prevention services; diabetes screening and treatment; and prenatal care services.
education, testing, and referral; and, other related preventive health services;

4. Emphasizing the importance of counseling family planning clients on establishing a reproductive life plan, and providing preconception counseling as a part of family planning services, as appropriate;

5. Addressing the comprehensive family planning and other health needs of individuals, families, and communities through outreach to hard-to-reach and/or vulnerable populations, and partnering with other community-based health and social service providers that provide needed services.

6. Identifying specific strategies for addressing the provisions of health care reform (“The Patient Protection and Affordable Care Act”), and for adapting delivery of family planning and reproductive health services to a changing health care environment, and assisting clients with navigating the changing health care system. This includes, but is not limited to, enhancing the ability of Title X clinics to bill third party payers, private insurance, and Medicaid.

**Federal Legislative Mandates**

The following legislative mandates have been part of the Title X appropriations for each of the last several years. Title X family planning projects should include administrative, clinical, counseling, and referral services necessary to ensure adherence to these requirements.

“None of the funds appropriated in this Act may be made available to any entity under Title X of the Public Health Service Act unless the applicant for the award certifies to the Secretary that it encourages family participation in the decision of minors to seek family planning services and that it provides counseling to minors on how to resist attempts to coerce minors into engaging in sexual activities.”
“Notwithstanding any other provision of law, no provider of services under Title X of the Public Health Service Act shall be exempt from any state law requiring notification or the reporting of child abuse, child molestation, sexual abuse, rape, or incest.”

**Other Key Federal Issues**

In addition to the Program Priorities and Legislative Mandates, the following key issues have implications for Title X projects and should be acknowledged in the project plan:

1. Efficiency and effectiveness in program management and operations;
2. Cost of contraceptives, including long acting reversible contraceptives (LARC), other pharmaceuticals, and laboratory tests;
3. Management and decision-making through performance measures and accountability for outcomes;
4. Linkages and partnerships with HIV care and treatment providers, and mental health, drug and alcohol treatment providers;
5. HIV prevention integration in family planning settings, incorporating CDC’s “Revised Recommendations for HIV Testing of Adults, Adolescents and Pregnant Women in Health Care Settings;”
6. Incorporation of electronic technologies, such as electronic health records and practice management systems;
7. Data collection (such as the Family Planning Annual Report (FPAR)) for use in monitoring performance and improving family planning services;
8. Service delivery improvement through translation into practice of research outcomes that focus on family planning and related population issues;
9. Utilizing practice guidelines and recommendations, developed by recognized national professional organizations and Federal agencies, in the provision of evidence-based Title X clinical services; and,
10. Encouraging vaccination of patients and providers as the best protection against influenza.
Title X Abortion Restrictions

The Federal Regulation

Section 1008 of Title X of the Public Health Service Act (the law that established federally funded family planning programs) states that “none of the funds appropriated under this title shall be used in programs where abortion is a method of family planning.”

The Federal Interpretation

The federal government interprets Section 1008 to mean that abortions as well as any activities that promote or encourage abortions may not be conducted by Title X family planning programs. Activities such as the following have been found by federal officials to promote or encourage abortion:

- Providing counseling that promotes any particular option
- Making abortion appointments for clients
- Having clients sign abortion consent forms
- Providing speakers to debate in opposition to anti-abortion speakers
- Advocating the need for abortion in the community
- Producing or showing audio-visual aids which encourage or promote a favorable attitude to abortion

Every family planning program must provide non-directive pregnancy diagnosis and counseling to all clients in need of this service, even though activities related to abortion are restricted. See Options Counseling on the following page.

A number of federal documents have been published to clarify and interpret the Section 1008 abortion regulations. If you need additional information on this issue, please contact the Reproductive Health Program.
Options Counseling

Section 8.6, Pregnancy Diagnosis and Counseling, of the federal Program Guidelines for Project Grants for Family Planning Services states:

Projects must offer pregnant women the opportunity to be provided information and counseling regarding each of the following options:

- Prenatal care and delivery;
- Infant care, foster care, or adoption; and,
- Pregnancy termination.

If requested to provide such information and counseling, provide neutral, factual information and nondirective counseling on each of the options, and referral upon request, except with respect to any option(s) about which the pregnant woman indicates she does not wish to receive such information and counseling.

This nondirective counseling is also referred to as options counseling.

Due to the sensitive nature of this issue for staff and local communities, we require that clients with unintended pregnancies be given a single handout that provides referral information to local resources for all three options. If there are no local resources for a given option, indicate where a member of your community can go to receive the services. This will help fulfill the requirement for nondirective counseling, as well as serving clients who may change their minds, or who want to consider a different alternative after leaving the clinic.
Sterilization Regulations

Federal Requirements

Sterilization is one of the many contraceptive services your family planning clinic must make available to clients. You can meet this requirement by providing information and/or referrals for the procedure.

Any sterilization service provided in Title X clinics must comply with federal regulations. This includes services made available through Oregon Contraceptive Care (CCare) or the Oregon Vasectomy Project (OVP). Clients eligible for the Oregon Health Plan (OHP) may have sterilizations funded with state resources through the Division of Medical Assistance Programs (DMAP). Most, but not all, of the same federal regulations apply in these cases. See the online OHP provider guide for more information: http://www.dhs.state.or.us/policy/healthplan/main.html

If your Family Planning Program provides sterilization services, you must follow federal sterilization regulations. Federal sterilization regulations are included as Attachment C of the Program Guidelines for Project Grants for Family Planning Services (Section B.1 of this manual). See the Vasectomy section of this manual (A.7) for additional information related to participation in the Oregon Vasectomy Project.

Informed Consent

Federal regulations require that clients must voluntarily give informed consent prior to sterilization. Exhibit 4 of Section A contains the current consent forms in English and Spanish from the Office of Population Affairs (OPA) Clearinghouse, which you can photocopy for use in your program. Forms can also be downloaded from the OPA Clearinghouse website at: http://www.hhs.gov/opa/pdfs/consent-for-sterilization-english-updated.pdf

Federal funds may not be used to pay for sterilization procedures to persons under age 21.
The site also includes a wide variety of publications on sterilization and other family planning issues.

**Status After Sterilization**

Sterilized persons remain eligible to be served in Title X family planning clinics as long as they are of reproductive age (female 10–60; male 10 and older) and they receive medical services and/or counseling related to Title X’s broad definition of family planning. However, Medicaid services for family planning (OHP or CCare) are limited to those individuals who require contraceptive care.
Infertility Services  B.5

Federal Requirements

Title X requires that clinics must make basic infertility services available to women and men desiring such services. At a minimum, Level I services must be provided.

- Level I includes initial infertility interview, education, physical examination, counseling, and appropriate referral.
- Level II includes such testing as semen analysis, assessment of ovulatory function, and postcoital testing.
- Level III is more complex than Level I and II services and is considered to be beyond the scope of a Title X program.

See Program Guidelines for Project Grants for Family Planning Services, Section 8.5, for additional information.
Other Requirements

Federal Assurances

As with other programs for which your agency receives federal funds through OHA – Public Health, your family planning program must assure compliance with federal laws relating to such issues as:

- Nondiscrimination [Title VI of the Civil Rights Act of 1964]
- Consideration of the disabled [Title II of the Americans with Disabilities Act (ADA) of 1990]
- Protection of human subjects [Code of Federal Regulations, Title 45, Part 46 (2005)]
- Restrictions on the use of federal funds for lobbying [31 USC, Section 1352 (the “Byrd Amendment”)]
- Drug-free workplace [Drug-Free Workplace Act of 1988 for federal contractors and grantees]
- HIPPA, the Health Insurance Portability and Accountability Act of 1996
- Prohibition of smoking

Program Instructions

The Office of Population Affairs periodically sends out Program Instructions and other memos that update or clarify the Program Guidelines. It is required that a paper manual be on-site and updated with the most current Program Instructions from OPA. Exhibit 8 of this section contains all Program instructions released since January, 2001.

Program Instructions and memos are also available at:
http://www.hhs.gov/opa/familyplanning/toolsdocs/xinstruction.html
Application and Funding

LPHA Contracts

Each year, every local public health authority (LPHA) in Oregon receives a comprehensive community assessment and annual plan packet that must be completed and returned. Several areas of the packet specifically address family planning.

All Title X family planning delegates also receive a Notice of Grant Award (NGA) and an extensive interagency agreement/contract from the OHA Contracts Office in Salem. The contract and NGA must be signed and returned to OHA prior to July 1 so that funding for the next fiscal year can begin.

**Program elements:** The contract contains general and specific program elements (formerly called assurances). A copy of the current program element for family planning services follows at the end of this section in Exhibit 1. Minor revisions are anticipated in a future contract amendment.

**Funding:** Family planning grant funding is based on a formula agreed upon by the Center for Prevention and Health Promotion (CPHP) and the Conference of Local Health Officials (CLHO). The current formula provides a small base amount and distributes the remaining funds on a per client basis. It is described in more detail on page B7-3.

The Title X funding period is July 1 through June 30. Any changes in funding throughout the year are initiated through the contract amendment process.
Supplemental Funding

Oregon Health Authority – Public Health Reproductive Health Program Manual

Supplemental Funding

PA occasionally makes additional funding available in the form of “directed supplement” or “special project” funds. When applying for these funds, keep in mind that consideration is often given to projects that address specific national program priorities. You’ll find a list of the current priorities in Section B.2.

We recommend developing outlines for appropriate special projects in advance, since proposal deadlines for this additional funding are often very tight.

Expenditure Reports

Title X grant payments are made to your agency monthly. You are required to submit quarterly expenditure reports to the Office of Financial Services. A sample of the current Revenue and Expenditure Report is included in this section as Exhibit 2.

Accuracy is important. Please take care to ensure that expenditure reports are accurate by line item. Personal service expenditures must be based on time activity reports where appropriate.

Final expenditure reports. Family Planning Service Grant funds may not be carried forward to the next year. Therefore, it is in your interest to spend up to the limit of your grant. We recommend spending CPHP funds before local funds so that there is no danger of funds being lost.
Family Planning Funding Formula

The Center for Prevention and Health Promotion and the Conference of Local Health Officials have approved the current version of the family planning funding formula, which went into effect beginning July 1, 2006. The formula is used to distribute Title X and Title V grant funds to serve low-income clients who do not have public or private medical insurance.

After exploring a variety of funding models during 2005, an ad hoc funding formula workgroup recommended the following formula:

1. Distribute a base amount of $5,000 to each agency.
2. Distribute the remaining funds on a per-client basis, using the total number of non-Medicaid (non-CCare and non-OHP) clients served by each agency in the prior year.

This straightforward solution, the workgroup judged, would reflect a set of critical guiding principles (see list below), while also avoiding potential problems due to subjective weighting or poor quality data.

Guiding Principles

1. Family planning services should be available in every county.
2. Title X funds should be focused on providing direct family planning services to low-income women and others who can’t access services elsewhere.
3. Title X providers are required to follow the Title X Standards of Care.
4. Some funding stability should be maintained in order to support continuity of services.
5. Some consideration should be given to equity in revenue per client.
Fee Collection

Establishing Fee Collection Policies

Title X requires every family planning project to set fees for all family planning services and supplies. Fees should be designed to recover the reasonable costs of providing services and may include clinical, support, and administrative costs. (Requirements are listed in Program Guidelines for Project Grants for Family Planning Services, Section 6.3.)

Each agency is responsible for developing its own fee collection policies to meet its own unique circumstances. The information in this section is intended to help. Please note, however, that it does not cover every situation that may arise.

Important Basic Guidelines

- The goal is to charge fees based on the client's ability to pay. Fee collection policies and practices should never be a barrier to a client receiving services.
- Clients may not be subjected to any variation in quality of services because of inability to pay.
- Employees within the same agency must deliver consistent messages to clients about fee collection.

Clients Who Are Unable to Pay

Federal regulations clearly state that clients must never be denied services because of an inability to pay. This fact should be reflected in your clinic’s fee policy, in any clinic signage addressing fees, and in any discussions with clients about fees.

Who Qualifies As “Unable to Pay”

Clients with incomes at or below 100% of the federal poverty level are assumed to be unable to pay and cannot be charged.
A client whose income is above the federal poverty level but is unable to pay for good cause (as determined by the project director) may have the fee waived, in full or in part. The project must determine, as accurately as possible, the client’s ability to pay based upon family income.

**Note:** In the case of minors seeking confidential services, just the minor’s income may be used in fee assessments.

**Family Planning Fees Must Be Kept Separate**

In accordance with federal rules, fees collected in all family planning clinics funded through Oregon’s Center for Prevention and Health Promotion must be kept separate from other funds and shall be used only to support the Family Planning Program. Program income collected must be fully used within the period of the LPHA contract agreement and not carried over into subsequent years. See Program Element 41 in Exhibit 1 of this section for details.

**Donations Must Be Voluntary**

Voluntary donations from clients are permissible, under the following conditions:

- Clients must not be pressured to make donations, and donations must not be a prerequisite to the provision of services or supplies.
- Client donations do not waive billing/charging requirements.
- Any donation policy, including information offered about the agency's ability to accept donations, must be applied consistently across all clients, regardless of fee or payment status.
**Sliding Fee Scale**

Your program must base its fees on an authorized sliding fee scale that incorporates federal poverty guideline figures. The current scales issued by the federal government ("Title X Service and Supply Discount Schedule" and "Reproductive Health Program Sliding Fee Scale") are in Exhibit 3 and Exhibit 4 of this section, respectively. If your family planning program prefers to use a different scale, it must have sufficient proportional increments so the inability to pay is never a barrier to service.

In order to apply the sliding fee scale, you must determine the client’s family size and income. Instructions for making those calculations are spelled out in the CVR Manual for Title X and CCare on page D3-9 in Section D of this manual.

**Important Considerations about Fees**

- Clients whose incomes are at or above 250% of the federal poverty level must be charged the full fee for services and supplies.
- Clients whose incomes are between 100% and 250% of the federal poverty level must be charged according to an approved sliding fee scale.
- Clients whose incomes are at or below 100% of the federal poverty level must not be charged.
- No flat or minimum fees of any sort (no-show fees, dispensing fees, family planning lab handling fees, etc.) may be charged. As noted previously, voluntary donations may be discussed with all clients.
- No one may be denied services based on an inability to pay.
- Proof of income is not required to receive Title X services.
Reporting Requirements B.9

Clinic Visit Record

The Clinic Visit Record (CVR) serves as the data collection tool for the Family Planning Information System and as the billing mechanism for services provided to CCare clients.

All agencies (Title X and CCare) must fill out a CVR for every family planning visit by a client of Oregon’s Reproductive Health Program. For complete information on filling out a CVR, see Section D.

Other Important Reports and Dates

Reporting deadlines and other important dates that apply specifically to recipients of federal grant funds (Title X or Title V) follow:

Agency Reviews
Agency reviews for Title X delegate agencies are scheduled on a rotating basis. (See Exhibit 5 of this section for a current schedule.)

Annual Plan Request
Each local public health authority must submit an annual plan for family planning services covering the period July 1 through June 30 of the succeeding year. The Reproductive Health Program will supply the required format, deadline and current service data for use in completing the plan.

Annual Request for Information
Known as “the January mailing,” this packet requests information required for the State of Oregon’s federal Title X grant application. It also provides the opportunity to update contact information and assess training needs. The request is usually sent to local agencies in early January and is due back to the state in approximately three weeks.
**Budget Projection**
A projected budget for Family Planning Services covering the period of July 1 through June 30 of the succeeding year is submitted to the Reproductive Health Program annually. The required format and due date are supplied by the Program, generally as part of the local agency contract process. See Exhibit 7 for a sample budget projection worksheet and instructions.

**Local Agency Contracts**
A contract outlining all requirements for funding must be signed annually between the State of Oregon and each local public health authority. The contract contains a specific program element for the Reproductive Health Program. This signing process takes place in May and June.

**Expenditure Reports**
Quarterly expenditure reports are due to the Office of Financial Services on October 25, January 25, April 25, and July 25. For more information on local agency contracts and expenditure reports, see Section B.7.

**Pap Smear Results**
All agencies are now required to provide data about abnormal cervical cancer screening test results for the previous calendar year for purposes of the Federal Family Planning Annual Report. This information will be requested in the Annual Request for Information packet described above.
Agency Reviews

Agency reviews are part of an ongoing effort to evaluate and provide technical assistance to Title X-funded agencies. They are conducted on-site by OHA Public Health every third year, on a rotating basis. The Reproductive Health Program staff provides follow-up during the other two years.

The current on-site agency review schedule through 2015 can be found in Exhibit 5 of this section. In Exhibit 6, copies of the Reproductive Health Program Review, Reproductive Health Records Review, and Region X IPP/Family Planning Chart Audit tools are included.
Section B: Exhibits

Exhibit 1: Program Element #41
Exhibit 2: OHA Revenue & Expenditure Report
Exhibit 3: Title X Service and Supply Discount Schedule
Exhibit 4: Reproductive Health Program Sliding Fee Scale
Exhibit 5: Reproductive Health Program Review Schedule
Exhibit 6: Agency Review Tools
Exhibit 7: Budget Projection Worksheet and Instructions
Exhibit 8: Title X Program Instructions
Exhibit 9: Guidance on Protocol Development
Reproductive Health Program Manual
January 2013

Section C

Oregon
Contraceptive Care
(CCare)

Center for Prevention and Health Promotion
Oregon Health Authority – Public Health
Program Overview

History

In 1999, the Public Health Division and the Department of Medical Assistance Programs (DMAP) joined efforts to improve the well-being of Oregon children and families by using a Section 1115(a) waiver to expand Medicaid coverage for family planning services to women and men. Oregon Contraceptive Care (CCare) provides contraceptive management services to Oregonians at or below 250% of the federal poverty level (FPL). CCare is renewed by the Centers for Medicare and Medicaid Services (CMS) every three years.

Project Goal and Objectives

The CCare Program aligns with national and state family planning and maternal and child health objectives, including those contained in Healthy People 2020 and Oregon benchmarks. The project goal is to improve the well-being of children and families by reducing unintended pregnancies and improving access to primary health care services. Short term and long term project objectives are:

1. Increase the number of Oregon women, men, and teens receiving services from publicly funded reproductive health clinics.
2. Increase the proportion of reproductive health clients who receive help accessing primary health care services.
3. Increase the proportion of reproductive health clients who use more effective contraceptive methods.
4. Reduce the proportion of unintended births and associated costs among Oregon women.
5. Reduce the teen pregnancy rate.
Provider Requirements and Information

Considerations for Prospective CCare Provider Agencies

Prospective CCare provider agencies should review this section carefully before applying to join the agency network. Of particular importance are the Standards of Care, beginning on the following page.

Clinics or individuals interested in becoming CCare agencies may do so in one of two ways:

1. Sub-contract with an existing CCare provider, or
2. Enroll directly with the Reproductive Health Program.

Agencies wishing to subcontract should approach the local health department or another CCare agency in their area. Those who wish to enroll directly in CCare should contact the Reproductive Health Provider Liaison for more information by calling 971-673-0355.

Key Points

CCare is a targeted family planning program in which providers:

- Offer expanded visits for clinical and preventive contraceptive management services
- Make referrals for psycho-social and primary care
- Directly dispense a full range of contraceptive methods
- Participate in a program-specific billing and data collection system
CCare Standards of Care

These standards set forth minimum clinical and administrative services that an agency must offer in order to participate in CCare. We recommend existing agency providers also read this section to confirm their understanding of the program.

### PROGRAM ISSUE

<table>
<thead>
<tr>
<th>PROGRAM ISSUE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
</table>
| A. Informed Consent | 1. The informed consent process, provided verbally and supplemented with written materials, must be presented in a language the client understands.  
2. A signed consent must be obtained from the individual client receiving contraceptive management services.  
3. A separate, signed contraceptive method-specific consent must be obtained from the client for each prescription contraceptive method received. |
| B. Confidentiality | 1. Clients must be assured of the confidentiality of services and of their medical and legal records.  
2. Records cannot be released without written client consent, except as required by law, or otherwise permitted by HIPAA. |
| C. Availability of Contraceptive Services | 1. If the agency’s clinical staff lack the specialized skills to provide vasectomies, intra-uterine devices (IUDs) or subdermal contraceptives, or if there is insufficient volume to ensure and maintain high skill level for these procedures, clients must be referred to another qualified agency for these procedures.  
2. Clients shall be able to get their first choice of contraceptive method during their visits unless there are specific contraindications.  
3. Contraceptive methods, including emergency contraception, must be available at the clinic site and available to the client at the time of service. See Program Issue H for exceptions. |
<table>
<thead>
<tr>
<th>D. Linguistic and Cultural Competence</th>
<th>1. The agency shall employ bilingual or bicultural staff, personnel or volunteers skilled or certified in the provision of medical and clinical interpretation during all clinic encounters for clients with limited English proficiency or who otherwise need this level of assistance. All persons providing interpretation services must adhere to confidentiality guidelines.</th>
</tr>
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<tbody>
<tr>
<td>All services, support and other assistance must be provided in a manner that is responsive to the beliefs, interpersonal styles, attitudes, language and behaviors of the clients receiving services, and in a manner that has the greatest likelihood of ensuring maximum program participation.</td>
<td>2. The agency must assure the competency of language assistance provided to limited English proficiency clients by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services, unless requested by the client.</td>
</tr>
<tr>
<td>3. The agency must make interpretation services available to all clients needing or requesting such assistance at no cost to the client. The agency must notify clients in need of interpretation services of the availability of such services in accordance with the Civil Rights Act of 1964.</td>
<td>4. The agency shall make available easily understandable print materials available to clients and post signage in the languages of groups represented or commonly encountered in the service area.</td>
</tr>
<tr>
<td>5. All print, electronic and audiovisual materials shall be appropriate in terms of the client's language and literacy level. A client's need for alternate formats must be accommodated.</td>
<td>E. Access to Care</td>
</tr>
<tr>
<td>Services covered by CCare must be provided without cost to eligible clients. Clients must be informed of the scope of services available through the program.</td>
<td>1. Appointments for established clients shall be available within a reasonable time period, generally less than two weeks. New clients who cannot be seen within this time period shall be referred to other qualified provider agencies in the area.</td>
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<tr>
<td>2. Clinics with the appropriate license from the Oregon Board of Pharmacy may offer established clients the option of receiving their contraceptive methods by mail.</td>
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<tr>
<td>a) Use of this option is at the discretion of the client; it cannot be offered as the only way in which to receive contraceptive methods.</td>
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<tr>
<td>b) Contraceptive methods that require a written prescription may only be mailed to established clients who have been using the method(s) for at least three months with no problems or contraindications.</td>
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</tr>
<tr>
<td>c) Non-prescription methods may be mailed to any established client, regardless of the client’s previous use of the method(s).</td>
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</table>
### Access to Care (Cont.)

- **d)** Clients must not incur any cost for the option of receiving contraceptive methods through the mail.
- **e)** Clinics must package and mail supplies in a manner that ensures the integrity of contraceptive packaging and effectiveness of the method upon delivery.

3. Although not covered by CCare, treatment and supplies for sexually transmitted infections must be available at the clinic site, or by referral.

4. Clients in need of additional medical or psychosocial services beyond the scope of the agency must be provided with information about available local resources, including domestic violence and substance abuse related services. Clients must also be given a brochure listing locations of free or low-cost primary care services in the area.

5. All services must be provided to eligible clients without regard to age, marital status, race, parity, disability, gender identity, or sexual orientation.

6. All counseling and referral-to-care options appropriate to a positive or negative pregnancy test result during authorized contraceptive services must be provided in an unbiased manner, allowing the client full freedom of choice between prenatal care, adoption counseling or pregnancy termination services.

### F. Clinical and Preventive Services

- **1.** The scope of contraceptive management services offered to women and female-bodied clients at each CCare clinic site must include:
  - **a)** A comprehensive health history, including health risk behaviors and a complete obstetrical, gynecological, contraceptive, personal and family medical history and a sexual health history, in conjunction with contraceptive counseling;
  - **b)** An initial physical examination including cervical cancer screening as indicated, that follows a nationally recognized standard of care;
  - **c)** Routine laboratory tests related to the decision-making process for contraceptive choices;
  - **d)** Provision of a broad range of FDA-approved contraceptive methods, devices, supplies, and procedures, including emergency contraception;
  - **e)** Follow-up care for maintenance of a client's contraceptive method or for change of method;
Clinical and Preventive Services (Cont.)

<p>| | |</p>
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| f) | Information about providers available for meeting primary care needs and direct referral for needed medical services not covered by CCare, including management of high-risk conditions and specialty consultation if needed; and  
| g) | Preventive and control services for communicable diseases, provided within the context of a contraceptive management visit, including:  
| i. | Testing and diagnosis for sexually transmitted infections (STIs) as indicated; and  
| ii. | Reporting of STIs, as required, to appropriate public health agencies for contact management, prevention, and control.  

2. The scope of contraceptive management and clinical preventative services offered to men and male-bodied clients must include:  
   a) A health history, including health risk behaviors and a sexual health history, in conjunction with contraceptive counseling and provision of contraceptive barrier methods;  
   b) Vasectomy or referral for vasectomy;  
   c) Vasectomy counseling, including a comprehensive health history that includes health risk behaviors and a complete contraceptive, personal and family medical history and a sexual health history;  
   d) Physical examination if indicated within the context of a contraceptive management visit;  
   e) Information about providers available for meeting primary care needs and direct referral for needed medical services not covered by CCare, including management of high-risk conditions and specialty consultation if needed; and  
   f) Preventive and control services for communicable diseases, provided within the context of a contraceptive management visit, including:  
      i. Testing and diagnosis for sexually transmitted infections (STIs) as indicated; and  
      ii. Reporting of sexually transmitted infections (STI), as required, to appropriate public health agencies for contact management, prevention, and control.  

3. All services must be documented in the client’s medical record.
G. Education and Counseling Services

1. The following elements comprise the required education and counseling services that must be provided to all contraceptive management clients:
   a) Initial clinical assessment, and re-assessment as needed, of the client's contraceptive management educational needs and knowledge about reproductive health, including:
      i. Counseling and education about a broad range of FDA-approved contraceptive methods, devices, supplies, and procedures, including emergency contraception;
      ii. A description of services and clinic procedures;
      iii. Relevant reproductive anatomy and physiology;
      iv. Preventive health care, nutrition, preconception health maintenance, and pregnancy plans, and STI and Human Immunodeficiency Virus (HIV) prevention;
      v. Psychosocial issues, such as partner relationship and communication, risk-taking, and decision-making; and
      vi. An explanation of how to locate and access primary care services not covered by CCare.

2. Initial and all subsequent education and counseling sessions must be provided in a way that is understandable to the client and conducted in a manner that respects the dignity and privacy of the client and facilitates the client's ability to make informed decisions about reproductive health behaviors and goals, and must include:
   a) An explanation of the results of the physical examination and the laboratory tests;
   b) Information on where to obtain 24-hour emergency care services;
   c) The option of including a client's partner in the education/counseling session, and other services at the client's discretion; and
   d) Effective educational information that takes into account diverse cultural and socioeconomic factors of the client and the psychosocial aspects of reproductive health.

3. Each client must be provided with adequate information to make an informed choice about contraceptive management methods, including:
   a) A general verbal or written review of all FDA-approved contraceptive methods, including sterilizations and emergency contraception, along with the opportunity for
Education and Counseling Services (Cont.)

- the client to ask questions. Documentation of this method education must be maintained in the client record;

- A description of the implications and consequences of sterilization procedures, if provided;

- Specific instructions for care, use, and possible danger signs for the selected method;

- Documentation of method-specific information must be maintained in the client record;

- The opportunity for questions concerning procedures or methods; and

- Written information about how to obtain services for contraceptive management related complications or emergencies.

4. Clinicians and other agency staff persons providing education and counseling must be knowledgeable about the psychosocial and medical aspects of reproductive health, and trained in client-centered counseling techniques. Agency staff must make referrals for more intensive counseling as indicated.

H. Exceptions

1. School-Based Health Centers are exempt from the requirement to make contraceptive methods available for on-site dispensing described in Program Issue C and Number 2 of Program Issue E. Because some school boards prohibit dispensing contraceptives on school grounds, School-Based Health Centers may offer contraceptive methods to clients either on-site or by referral. When offered by referral, School-Based Health Centers must have an established referral agreement in place, preferably with another CCare clinic. The RH Program must be notified of the parties involved in order to ensure proper billing and audit practices. When the referral clinic participates in CCare, that clinic may submit claims directly to CCare for reimbursement of the dispensed supplies. When referral clinics do not participate in CCare, payment arrangements must be made between the referring and receiving clinics. Dispensing by any clinic must not result in a charge to the client.

2. Non-School-Based Health Center clinic sites:
   a) Agencies may bill CCare for individual counseling and education services conducted at a school site, Grade 12 and under, if the site meets the following criteria:
      i. The school site must have no established School-Based Health Center;
| Exceptions (Cont.) | ii. The school site must be within a program-approved distance from the enrolled CCare agency to ensure adequate access to client birth control method of choice; |
| | iii. The school site must have a dedicated, private room(s) for services to be conducted. |
| b) Agencies wishing to bill CCare for individual counseling and education services conducted at secondary school sites must adhere to the following standards: |
| i. The agency must notify the RH Program of the school site to be enrolled and must request from the RH Program a unique site number for the school site; |
| ii. The agency must receive written approval from the school site to conduct services; |
| iii. For newly enrolling clients, the agency must ensure that clients meet all eligibility criteria and are enrolled according to CCare guidelines at the school site; |
| iv. For clients already enrolled in CCare, the agency must ensure that clients have active eligibility; |
| v. The agency must follow all standards of care for contraceptive management services with the exception of supplies dispensed on-site and clinical and preventive services; |
| vi. The agency must offer clients a written referral to the enrolled CCare clinic for supply pick-up and full array of clinical services; |
| vii. The agency must submit claims for services conducted at the school site using the assigned project and site number of the school site. |
Elements of Reproductive Health Services

Reproductive health visits differ from other medical encounters in several important ways. CCare service elements and their definitions include:

**Reproductive Health Client** – An individual of reproductive capacity who receives contraceptive medical or counseling services and for whom a medical record is established.

**Reproductive Health Visit** – An encounter where medical or counseling services are provided to a client in conjunction with contraception, and the services are recorded in the medical record. This must be a face-to-face contact with a reproductive health service provider.

**Reproductive Health Service Provider** – A licensed health care provider operating within a scope of practice at an agency that is authorized by the Oregon Reproductive Health Program to bill for contraceptive management services for eligible CCare clients.

**Reproductive Health Lab Services** – The CCare encounter rate includes reimbursement for labs determined by the provider to be necessary within the context of a contraceptive management visit. Examples of reproductive health lab services include Pap smears, pregnancy tests, etc.

**Reproductive Health Services** – The scope of female and male reproductive health services is outlined in Program Issue F of the CCare Standards of Care. All services must be documented in the client’s medical record. This information comes from the administrative rules that govern CCare. The full set of those rules can be found at [www.healthoregon.org/rhmaterias](http://www.healthoregon.org/rhmaterias).
Primary Care Referral Requirement

Clients who receive reproductive health services at CCare clinics often need to know where they can find free or low-cost primary health care. The U.S. Department of Health and Human Services (DHHS) now requires all family planning Medicaid waiver programs (including CCare) to have a primary care referral component that directs clients to Federally Qualified Health Centers and Rural Health Clinics in their state.

Exhibit 13 of this section is a brochure created to meet this requirement (in English and Spanish). It briefly details what services CCare covers and does not cover, and where to obtain information on the Oregon Health Plan. Side two allows clinics to add local provider and clinic information.

Using the Primary Care Brochure
CCare providers who do not offer primary care in their clinics must give a copy of the brochure to each client once a year, preferably at program enrollment and re-enrollment. Those who do offer primary care should make sure that all reproductive health clients are aware of it. In both cases, the fact that this information was provided must be noted on the CCare Enrollment Form in each client’s file.

National Voter Registration Act (NVRA) Requirement

As a Medicaid program, clinics participating in CCare must offer voter-registration services to CCare clients as part of the National Voter Registration Act of 1993 (NVRA). The purpose of the NVRA is to increase the number of U.S. citizens registered to vote. As such, it requires that agencies offer clients the opportunity to register to vote at each enrollment or re-enrollment in CCare. Our website describes in greater detail the policies and procedures clinic staff must follow to comply with NVRA requirements.

All enrolling and re-enrolling clients have the opportunity to answer a question asking them “Would you like to register to vote today?” on the CCare Enrollment Form (see Section C3 for instructions on completing the
Enrollment Form). If the client marks “Yes” to this question, clinic staff should provide the client with a voter registration card. The client may take the form home to complete and mail to the elections office. If, however, the client requests help in completing and mailing the form, clinic staff should follow the procedures described on our website at http://public.health.oregon.gov/HealthyPeopleFamilies/ReproductiveSexualHealth/Resources/Pages/CCareProviders.aspx#NVRA for reporting and mailing the completed registration form to the correct agency.

All forms necessary for complying with NVRA requirements can be downloaded electronically from http://oregonvotes.org/pages/publications/forms/index.html#nvra.

**Notice of Privacy Practices (N OPP) Requirement**

The U.S. Department of Health and Human Services (HHS) has moved forward to strengthen the privacy and security protections for health information established under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The final omnibus rule greatly enhances a patient’s privacy protections, provides individuals new rights to their health information and strengthens the government’s ability to enforce the law.

As part of these HIPAA privacy implementation efforts, the Oregon DHS/OHA Information Security and Privacy Office has developed a Notice of Privacy Practices (N OPP) document that must be given to any client receiving medical or premium assistance through programs administered by OHA. This requirement applies to Oregon ContraceptiveCare (CCare) clients and all CCare providers are required to comply with this effort. The NOPP document may be accessed here: https://apps.state.or.us/Forms/Served/me2090.pdf.

- Keep a stack of printed NOPP documents at the check-in desk.
- Offer the NOPP document to every CCare client at each visit.
- You may offer the NOPP to family planning clients with other sources of coverage (e.g. private insurance; Oregon Health Plan; and no coverage with fees assessed using a sliding fee schedule) if it...
makes sense for your clinic flow. However, CCare clients are the only ones for whom you are required to offer the Notice.

- At check-in, ask the client “Have you seen the Notice of Privacy Practices Document? Please feel free to take one.” The client may decline to take the Notice. You are only required to offer the document.
Client Eligibility and Enrollment

CCare Eligibility

Oregon women and men are eligible for CCare if they meet the following criteria:

- Resident of Oregon
- Reproductive age (10 – 60 for women; 10 and older for men)
- Not sterilized
- Can provide proof of ID
- Can provide Social Security Number
- Can prove U.S. citizenship or status of a refugee/asylee, or have been lawful permanent residents for five years or more
- At or below 250% of the federal poverty level (FPL) based on family income and size. (Teens are determined eligible based on individual income).

Once determined, eligibility is effective for 12 months regardless of income or FPL changes during that period. However, enrollment into OHP will require termination of CCare eligibility.

CCare Eligibility

Procedures Overview

Screening individuals for eligibility and enrolling them into CCare involves four main steps:

- Check the CCare Eligibility Database for the potential client’s current eligibility and citizenship verification status;
- Ask & assist clients who are not currently enrolled to complete the CCare Enrollment Form;
  - Please note that clients who have been auto-enrolled into CCare from OHP post-partum do not need to complete a CCare Enrollment Form (see Section C, Exhibit 1 for more information about completing the enrollment process for auto-enrollees).

Key Points

- Eligibility and enrollment must be documented on the CCare Enrollment Form, as part of the client's medical record, and in the CCare Eligibility Database.
- As necessary, offer clients assistance with documenting their U.S. citizenship; and
- Enter the Enrollment Form information to the CCare Eligibility Database for final determination by the system.
Completing the CCare Enrollment Form

The CCare Enrollment Form ensures accurate documentation; eases review processes; and provides the Centers for Medicare and Medicaid Services (CMS) with assurance of appropriate program eligibility screening.

The form must be completed by every client requesting CCare-covered services prior to receiving her or his first CCare service, and updated each year thereafter. During an audit, the clinic must be able to produce this form as documentation of eligibility screening and requests for special confidentiality. All boxes must be completed, even if the answer is “0” or “N/A.” No eligibility card will be issued to the client. The Enrollment Form data needs to be entered into the online CCare Eligibility Database. For instructions on using the database, see Exhibit 1 of this section.

The CCare Enrollment Form is located in Exhibit 2 of this section. In the following pages are instructions to help you and your clients fill out the Enrollment Form. Note that the standardized form may not be altered by individual agencies. However, you may print the back of the form on a separate sheet of paper as long as it is kept with the front of the form.
Instructions for Completing the CCare Enrollment Form

1: Where did you hear about us?
This section lists examples of where the client may have heard about CCare services. Please have client check all that apply.

2, 3, 4: Last Name, First Name, Middle Initial
This client information is vital for clinic records and must be complete, accurate, and legible.

5, 6, 7: Oregon Address, City, Zip

8: Have you been sterilized for more than 6 months?
Clients who have been sterilized (female sterilization, hysterectomy, or vasectomy) for more than six months are not eligible for CCare. The purpose of CCare is to prevent unintended pregnancies, so applicants must be capable of having or causing a pregnancy.

9, 10, and 11: Are you a U.S. Citizen or Lawful Permanent Resident (LPR) for at least 5 years or Refugee/Asylee?
The federal Deficit Reduction Act (DRA) of 2005 requires all CCare applicants who are U.S. citizens to provide proof of citizenship and identity prior to enrolling in CCare. Please see Exhibit 3 for examples of acceptable documents and page C4-2 for resources to help clients provide the needed documentation.

Lawful Permanent Residents do not need to show proof of citizenship or identity at the time of the application.

Clients who are refugees/asylees are required to show proof of refugee/asylee status at the time of enrollment. See Exhibit 16.

Clients must check only one box indicating their status.

Note: Clients who are eligible for Citizen/Alien-Waived Emergency Medical (CAWEM) coverage through DMAP do not qualify for CCare
because they do not meet the Lawful Permanent Resident requirement. Title X clinics should use grant resources for clients who do not meet the citizen eligibility requirement of CCare.

12: Voter Registration:
The National Voters Registration Act (NVRA) requires clinic staff to offer voter-registration services to clients at enrollment and re-enrollment in CCare.

Any client who meets the requirements to vote in Oregon may register:
- A resident of Oregon;
- At least 17 years old; and,
- A U. S. citizen (LPRs are not eligible to vote).

The client may choose one of three response options on the Enrollment Form:
- Yes – Clinic staff must provide the client with the Voter Registration Card (SEL 503). The client may take the form home to complete and mail to the elections office. If, however, the client requests help in completing and mailing the form, follow the procedure outlined in the NVRA policy on our website at http://public.health.oregon.gov/HealthyPeopleFamilies/ReproductiveSexualHealth/Resources/Pages/CCareProviders.aspx#NVRA.
- No – This will serve as the official client declination as required by the NVRA.
- N/A (LPR or under 17 years old) – No further action is required.

13a: Do you have health insurance?
Applicants who have private insurance may still qualify for CCare. CCare is a Medicaid program and should be the payer of last resort. If an applicant has private health insurance, bill their insurance first. CCare will pay the difference not covered by insurance up to the maximum amount CCare would have paid in the absence of insurance.

13b: Are you on the Oregon Health Plan or Healthy Kids?
Those with the Oregon Health Plan or Healthy Kids coverage do not qualify for CCare.
14, 15: Household Size and Total Gross Monthly Household Income

This information is used to assess whether the applicant meets the financial eligibility requirements for CCare. An accurate answer requires that both you and the applicant understand what is included and what is not included in income, and precisely what constitutes a household for the purposes of CCare.

**Determining Household Size**

A household is defined as a social unit composed of one person, or two or more persons living together sharing a source of income. Household members do not need to be married to be counted in household income; dependents away at school also are included. The income of all these persons should be counted to calculate the total income of the family. Examples include:

- a married couple, with or without children
- domestic partners, with or without children
- one parent with one or more children
- a married couple sharing the home of a husband’s or wife’s parents
- two related married couples sharing a single household

Roommates living together are not considered a household; each person should be considered a household of one. However, any income received as a result of the arrangement (e.g., rent) is considered income contributed to the client and should be counted.

Foster children or other unrelated children living in a household are not considered part of the family; payments received for caring for foster children is not considered income.

**Guidelines for Determining Income**

- If the applicant is a full-time salaried employee, base the average gross monthly income on the applicant’s most recent month’s income.
- If the applicant works part time, on a commission basis, or otherwise has an unsteady income, use the average gross monthly income for

Start with Household Size

Using the instructions in the sidebar at the left, determine how many people live in the applicant’s household.

Determining Household Income

Next, compute the gross monthly income (i.e., before taxes) of each of these people and enter the total amount in whole dollars in the enrollment form. See the chart on page C3-7 for the kinds of income that should and should not be included.

Make every attempt to get an actual or estimated figure. Note, however, that applicants are not required to provide proof of income for CCare eligibility.
the previous 12 months. If the applicant is currently working on a part-time or commission basis, but has been unemployed during the previous year, divide the total dollar amount earned by the number of months worked in the previous 12 months.

- If the applicant is currently unemployed, count any unemployment benefits currently received. Do not count employment income from previous months.
- If the applicant knows only the amount of net income (take-home pay), calculate gross income by multiplying net income by 1.15.
- If the applicant is living with a partner but has no personal income, base income on financial support received from the partner.

<table>
<thead>
<tr>
<th>These sources of income should be included</th>
<th>These sources of income should NOT be included</th>
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<tbody>
<tr>
<td>• Salaries, wages, tips</td>
<td>• Grants</td>
</tr>
<tr>
<td>• Help from relatives and non-relatives</td>
<td>• Loans</td>
</tr>
<tr>
<td>• Public assistance*</td>
<td>• Withdrawal from savings</td>
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<tr>
<td>• Unemployment compensation</td>
<td>• Food stamps</td>
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<td>• Worker’s compensation</td>
<td>• Tax refunds</td>
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<td>• Veterans benefits</td>
<td>• Receipts from sale of possessions</td>
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<td>• Sick pay</td>
<td>• Inheritances</td>
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<tr>
<td>• Social Security cash benefits (including widow’s and children’s benefits)</td>
<td>• Lump sum compensation for injury or legal damages</td>
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<tr>
<td>• Alimony</td>
<td>• Maturity payments on insurance policies</td>
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<tr>
<td>• Child support</td>
<td>• Payments for foster parenting</td>
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<tr>
<td>• Net investment income (rent, interest, dividends)</td>
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<tr>
<td>• Net earnings from self employment</td>
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<tr>
<td>• Pensions, annuities</td>
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<tr>
<td>• Royalties and commissions</td>
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<tr>
<td>• Business profits</td>
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<tr>
<td>• Deductions commonly taken out of income before the client receive it. These include:</td>
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<tr>
<td>o Federal, state and local taxes</td>
<td><em>Note: A client who is receiving cash assistance through TANF is likely to have OHP coverage and would not qualify for CCare. Call OHP AVR to verify OHP coverage. See page A5-4 for DMAP/OHP contact information.</em></td>
</tr>
<tr>
<td>o Social Security payments</td>
<td></td>
</tr>
<tr>
<td>o Deductions for savings bonds, other savings plans, or union dues</td>
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</table>
Income Eligibility

- Individuals 20 years of age and older (adults) with household incomes from 0-250% of FPL are eligible for CCare. Refer to the Medicaid Income Guidelines in Appendix F to assess whether clients qualify, based on household size and income. If an applicant is in need of special confidentiality and household income cannot be estimated without violating confidentiality, then the applicant’s own income can be used for FPL calculation.

- Individuals under 20 years of age (teens) whose household incomes exceed 250% of the federal poverty level but whose individual incomes are at or less than 250% of FPL are eligible for CCare. Teens may be screened for eligibility based on their individual income.

Providers must provide information about, and are encouraged to provide applications for OHP or FHIAP where family income is appropriate.

See Section B, Exhibit 3 or Appendix F for the Federal Poverty Level Guidelines to determine CCare income eligibility.

16: Date of Birth

CCare applicants must be of reproductive age (girls must be menstruating), generally ages 10 and older.

17: Social Security Number (SSN)

Valid social security numbers are required for all CCare applicants. If an adult claims not to have a SSN, refer the client to a local Social Security office to apply for one. Applicants who can’t remember their SSN may also be referred to get a replacement card. Another option may be to try to obtain the number from school or employment records. If the applicant is a teenager and does not know their SSN, use 477-47-7477. This will allow the teen to enroll while state staff and/or the applicant work to determine their SSN.

Be sure to give every applicant (new and renewing) a copy of the SSN statement. English and Spanish versions of this statement can be found in Exhibit 4 of this section.
18, 19: Client Declaration, Signature and Signature Date
The signature and date are required for program enrollment. The signature date must match or be prior to the eligibility effective date and the first date of service.

CLINIC STAFF USE ONLY

20: Special Confidentiality
Special Confidentiality protects clients who indicate a perceived threat of physical or emotional harm if information about their CCare visit is inadvertently disclosed to parents, partners, family, or the primary insurance policy holder. If a client indicates the need for special confidentiality, private insurance should not be billed and/or the client’s income may be assessed as a household size of one. Clients can request special confidentiality regardless of insurance status. Note that the option does not apply just to teens, nor is it to be used for all teens.

Note: When a client with private health insurance requests special confidentiality, be sure to enter the third party resource (TPR) code NC in CVR box 17A for every visit.

Clinic staff must check the appropriate box indicating if the client requests special confidentiality or not.

21, 22: Agency # and Clinic/Site #
Enter the agency number (also known as the project number) of the participating CCare agency and the specific clinic (or site) number serving the client.

23: Primary Care Information
Clinic staff must indicate whether primary care information was offered to the client. Remember, offering this information is a program requirement. Your clinic may customize the primary care information brochure in Exhibit 13 of this section in order to meet this requirement.

24: OHP Information
Clinic staff must indicate whether Oregon Health Plan information was given to the client. Remember, providing this information is a program
requirement. The primary care information brochure in Exhibit 13 includes contact numbers for inquires about OHP and FHIAP coverage.

25: Title X Clinics
Title X clinic staff should document the sliding fee scale amount/percentage regardless of whether or not the client qualifies for CCare. The client may need services that are not covered by CCare, in which case Title X sliding fee scale guidelines would be applied.

26: Staff Initials
The clinic staff member who completes the “Staff Use Only” section of the form should initial this box.

CITIZENSHIP AND IDENTITY VERIFICATION
Document verification of U.S. citizenship and identity is in this section. There are different tiers of acceptable citizenship documentation. Please refer to Exhibit 3 of this section for the document checklist.

CITIZENSHIP DOCUMENTATION PENDING:

27: Oregon Birth Information Form
Check this box if the applicant was born in Oregon and completed the Oregon Birth Information Form (Exhibit 5). This information allows state staff to search the Oregon Vital Records database for the client’s electronic birth record.
- Check the box confirming that the Oregon birth record request information from the form was entered into the CCare Eligibility Database.

28: Automated SSA Electronic Citizenship Match Verification
Check this box if the applicant was born in the United States and provided a valid SSN (not for teens enrolling with the 477-47-7477 SSN). State staff will update the database if citizenship is verified using the client’s SSN.
29: **Out-of-State Birth Record Request**

Check this box if the applicant was born in the United States in a state other than Oregon and is a teen using the 477-47-7477 SSN or the client has had to return to complete the necessary Birth Record Request documents because the SSA match failed. State-specific birth record request forms can be downloaded from the RH Program web site. Resources for requests can also be found in Section C, Exhibit 6.

- Check the box indicating that clinic staff have called the state to request an ROP extension if the client’s SSA match failed – the client will need this extension while the state processes the birth record request.
- Check the box indicating that all the necessary forms have been mailed to the state for processing.

**IDENTITY DOCUMENTATION PENDING:**

30: **Client will Supply Identity Document**

Check this box if the applicant uses the reasonable opportunity period (see page C4-1) and states that they will bring in their identity document within 45 days.

**CITIZENSHIP DOCUMENTATION VERIFIED:**

31: **Citizenship Listed as Verified in CCare Eligibility Database**

Check this box if the applicant’s citizenship already was listed as verified in the CCare Eligibility Database prior to the date of completing this enrollment form.

32: **Citizenship Document Witnessed and Copied**

Check this box if a staff member witnessed and copied an original copy of the applicant’s citizenship documentation. Check the appropriate Tier (1-4) to indicate the type of documentation copied. Tier 1 documents, such as a U.S. passport, satisfy both the citizenship and identity verification. Tiers 2-4 require photo identification in addition to proof of citizenship.

- Check the box indicating that the information has been entered into the CCare Eligibility Database. The staff member should then date and initial.
IDENTITY DOCUMENTATION VERIFIED:

33: Identity Listed as Verified in CCare Eligibility Database
Check this box if the applicant’s identity was listed as verified in the CCare Eligibility Database prior to the date of completing this Enrollment Form.

34: Identity Document Witnessed and Copied
Check this box if a staff member witnessed and copied an original copy of the applicant’s identity documentation.
  - Check the box indicating that the information has been entered into the CCare Eligibility Database. The staff member should then date and initial.

35: Qualifies for CCare
Clinic staff should indicate whether the client qualified for CCare only after the client has fully verified his or her citizenship and identity. For example, when a client has used the reasonable opportunity period, she has not yet qualified for CCare. In this case, clinic staff should leave box #35 blank. Once citizenship has been fully verified, then clinic staff may complete box #35 to indicate that the client qualifies for CCare.

36: CCare ID#
The CCare ID# is required for reimbursement. This number is automatically generated by the CCare Eligibility Database.

37, 38: Eligible FROM and TO Dates
Clinic staff must list the dates that CCare eligibility begins and ends. The length of eligibility is one year (12 months) from the date of initial enrollment. Any fluctuation or increase in income over guideline requirements during the 12-month period will not cancel eligibility.

Clients who use the reasonable opportunity period have only 45 days of eligibility. Do not complete boxes 35, 37 and 38 until citizenship and identity have been verified and the client is eligible for a full year of regular CCare coverage.

- Please note: If a client returns to the clinic for a visit during the 45 day reasonable opportunity period and citizenship has been verified,
enter the eligibility date as the same date the Enrollment Form was signed and dated. However, if a client is unable to verify citizenship during the 45 day period but returns later for CCare services and has citizenship documentation, ask the client to complete a new CCare Enrollment Form.

- Please note: If a client was made eligible for CCare, but comes in for a subsequent visit and has OHP, the client’s CCare eligibility is terminated. If the client’s OHP eligibility ends, a new CCare Enrollment Form must be completed with a new effective date.

- The date of the client’s first CCare visit must not be prior to the effective date of CCare eligibility. Existing CCare clients may re-enroll at a supply-only pick-up encounter. New CCare clients may not enroll at a supply-only pick-up encounter unless they are an established family planning client with the agency. An established client is considered someone with an open medical chart and who has had at least one visit with a clinician in the prior two years.

39: Clinic Use (optional)

This field is for clinic-specific use only and is not required.
Reasonable Opportunity Period

The reasonable opportunity period may be used in certain circumstances to provide services to individuals who cannot provide full documentation of their U.S. citizenship. It may only be used once per client and grants 45 days of eligibility. All other CCare eligibility criteria must still be met.

There is no need to use the reasonable opportunity period for LPR clients, since they are not U.S. citizens and therefore are not required to document their U.S. citizenship.

The reasonable opportunity period provides a temporary exemption from the citizenship documentation requirement. It does not exempt clients from the SSN requirement.

Clients who use the reasonable opportunity period will not be granted regular, full-year CCare eligibility until their U.S. citizenship is fully documented.

For clients with a valid SSN, Reproductive Health staff will attempt to find a citizenship match through the Social Security Administration (SSA) using the client’s SSN. Teen clients using the 477-47-7477 SSN will need to complete either the Oregon Birth Information form or an out-of-state birth certificate request form since SSA cannot match on an invalid SSN. Clinic staff should assist all teen clients using the 477-47-7477 SSN and the reasonable opportunity period in completing the appropriate form. More information about requesting birth certificates on behalf of clients can be found on the following page.
Birth Certificate Requests and SSA Electronic Match

There are three ways in which the state Reproductive Health Program can offer assistance to clients to obtain citizenship documentation:

1. **Oregon Birth Record Request** – For clients born in Oregon, the state Reproductive Health Program is able to access the Oregon Vital Records Electronic Birth Record Database. There are two methods for submitting a birth record request for Oregon-born applicants, depending on your needs. For detailed instructions, please refer to the CCare Eligibility Database Instructions in Exhibit 1 and see the CCare Oregon Birth Information Form in Exhibit 5.

2. **SSA Electronic Citizenship Match** – Every month, state RH staff will retrieve the SSNs for all newly enrolled clients and send them to SSA for a match. The match will be attempted only for those clients with a valid SSN (not for teens enrolling with the 477-47-7477 SSN). If a match is found, the client’s citizenship verification will be automatically updated in the Eligibility Database and the client’s eligibility extended for a full year of coverage.

   Designated clinic staff will receive an eligibility report spreadsheet from the Reproductive Health Program every month. Clients who fail the SSA electronic match will need to be contacted by clinic staff to verify their SSN and return to fill out an out-of-state-birth certificate request. Clinic staff should call RH staff on the day the client returns to the clinic to complete the paperwork and ask for an ROP extension. If the ROP period ends, an extension is not possible.

3. **Out-of-State Birth Certificate Request** – The state Reproductive Health Program will order and pay for birth certificates on behalf of potential CCare clients born in states other than Oregon whose citizenship cannot be verified through the SSA electronic citizenship match. All forms necessary can also be found on our website: [www.healthoregon.org/rhm materials](http://www.healthoregon.org/rhm materials).
To order an out-of-state birth certificate follow the steps below:

- If the client is not yet in the Eligibility Database and will not be using the reasonable opportunity period for a visit that day, screen him/her for eligibility informally, to ensure that they are CCare eligible.

- Determine which state the client was born in and download the appropriate birth certificate request form (available on the Reproductive Health Program website).

- Check the State Matrix (available on the Reproductive Health Program website) for specific birth certificate request requirements.

- Ask the client to complete the Authorization to Release Birth Certificate form (see Exhibit 6 of this section). If notarization is required, use the space provided below the client’s signature to notarize the document.

- Make a copy of the client’s identification, as most states/counties require a photocopy of the requestor’s photo ID.

- Gather the state/county-specific birth certificate request form, authorization form, and photocopy of photo ID. Mail bundled requests to the Reproductive Health Program as needed.

- The Reproductive Health Program will mail all of the request documents and application fees to state/county vital records offices. When the birth certificate is received, Reproductive Health Program staff will mail the original birth certificate back to the requesting clinic. The Reproductive Health Program will also email status updates regarding birth certificate requests to clinics on the 1st and 3rd Tuesday of each month.

- Once the clinic receives the original birth certificate from the state office, update the individual’s citizenship documentation in the CCare Eligibility Database under the Tier 2 tab on the Client Info screen.

- Each clinic should keep the client’s birth certificate in the chart or medical record. Release the birth certificate to the client only if he or she requests a copy of medical records. Ask the client to complete your clinic-specific release of medical information form and be sure to photocopy the birth certificate to keep in the client’s
medical records before releasing the original birth certificate to the client.

For more detailed instructions and additional forms needed for ordering out-of-state birth certificates on behalf of clients, refer to Exhibit 6 of this section.
Billing and Data Collection

This section contains information on CCare service reimbursement; and using the CVR to bill for CCare services.

Data & Billing

System History

The Reproductive Health Program has long used the Clinic Visit Record (CVR) to collect client and visit information. CVR data are used to satisfy federal reporting requirements (like the Family Planning Annual Report, or FPAR) and for program monitoring and evaluation. The Reproductive Health Program contracts with Ahlers & Associates to store and process CVR data and every clinic has access to its aggregate data via the Ahlers website. See Section D for more information on the various online reports and data manipulation functions available through Ahlers.

Key Points

CCare is a Medicaid fee-for-service program, in which a standard encounter rate is paid per visit. Supplies are reimbursed separately. A CVR (Clinic Visit Record) must be completed and submitted for every CCare visit. CVR data are used both for billing and for program monitoring and evaluation.

When CCare began in 1999, Oregon’s CVR was modified to include a billing component for services provided to CCare clients.

CCare Reimbursement

Please see Exhibit 8 for current CCare encounter rates. The CCare encounter rate is a bundled rate that includes reimbursement for all services, with the exception of the combined Chlamydia/gonorrhea test, performed within a contraceptive management visit. The combined Chlamydia/gonorrhea test is

The Ahlers Connection

You may sometimes come across such terms as “Ahlers system” and “Ahlers data.” These refer to Ahlers and Associates, the company that has held the contract for the state’s family planning data system since 1981, and are simply unofficial references to the Family Planning Information System.
reimbursed separately. Reimbursement is triggered by checking box #29 in the Medical Services section (13A) on the CVR. Contraceptive supplies dispensed are reimbursed at the clinic’s acquisition cost and a supply-dispensing fee is included in the encounter rate.

**Billing Guidelines**

The only visits that may be billed to CCare are medically necessary visits made by eligible clients for the purposes of contraceptive management. See Exhibit 7 of this section for what is billable to CCare. The primary diagnosis code for the visit must be in the V25 series for contraceptive initiation or management. Services covered under CCare include: annual exams for women; follow-up visits to evaluate or manage problems associated with contraceptive methods; medical procedures, lab tests, and counseling services associated with contraceptive management; and birth control supplies and devices. Please see the CCare Standards of Care in Section C.2 for a complete description of services that must be offered to eligible clients. Examples of services not covered by CCare include treatment of STIs, prenatal care, repeat Pap tests, pregnancy confirmation for the Oregon Health Plan, and birth control services delivered for reasons other than pregnancy prevention (e.g. to regulate menses).

There are no absolute limits on the number CCare visits in a given time period, but the state average is approximately two per client per year. (Women using Depo-Provera® need to be seen more frequently for injections; men typically are seen less frequently.) Agencies are subject to review if providers bill for visits substantially in excess of this average.

CCare clients may visit their providers simply to get refills of their birth control method without needing other services (beyond perhaps a brief check of vital signs and reminder of how to use the method). Such encounters are known as a supply-only pick-up encounter, and only the cost of supplies should be billed to CCare. Requests for emergency
contraception (EC) often fall into this category, especially for returning clients who have already received medical evaluation and counseling about EC at previous visits.

**Billing Insurance**

Unless a client with private insurance also indicates the need for special confidentiality, federal law requires that all reasonable efforts be taken to ensure that CCare is the payer of last resort. If a client indicates having private insurance on the CCare Enrollment Form, clinic staff should either make a photocopy of the client’s insurance card or document pertinent plan information at the time of enrollment. Private insurance should then be billed for the visit and supplies, if any.

If the client does not have her/his health insurance information at the time of the visit, clinic staff are expected to try contacting the insurance company to obtain the information necessary to bill the insurance. Otherwise, it is the expectation of the program that clinic staff follow-up with the client to obtain the insurance information and document the attempt.

Box 17A of the CVR indicates there is a Third Party Resource. Either Item 1 or Item 2 must be completed. Item 1 – Explanation Code indicates why no payment was made by the private insurance company by listing a TPR code. Item 2 – Other Insurance Paid records the amount paid by the private insurance for the family planning service. CCare will then reimburse the balance up to the maximum reimbursement rate.

- If a client with insurance requests special confidentiality, insurance should not be billed and the TPR code should be “NC”.
- If the clinic’s reasonable attempts to obtain insurance information from a client who indicated they had insurance yields no results, then CCare can be billed and the TPR code “OT” should be used.
- See Section D.3 of this Manual for a complete list of commonly used TPR codes and for more information about completing the CVR.
- Claims will be rejected if a client indicates having private insurance on the enrollment form, but no dollar amount or TPR code are supplied with the claim.
billed appropriately. See Section C6 of this manual for more information about CCare audits.

There are two exceptions to the requirement that CCare be the payor of last resort. First, if a client reports having Kaiser Permanente (Kaiser) health insurance, clinics are not required to bill Kaiser prior to billing CCare since there is no mechanism to bill Kaiser. Be sure to note that the client has Kaiser on the Enrollment Form and use TPR code “NC” on the CVR. However, be aware that Kaiser also has an employer-sponsored health insurance plan called Added Choice which allows their patients to seek care from providers outside of the Kaiser network. This plan can be billed for CCare services. Front desk staff should inquire if a client has the Added Choice Plan if they report they have Kaiser coverage. The plan has a purple insurance card to differentiate it from the traditional Kaiser blue and white card. Clinics should bill services and supplies to Kaiser first using CCare as a secondary insurance payment source as is currently done when a client has any other type of insurance coverage.

The second exception to the insurance billing requirement is for clients who have Medicare coverage. Since most family planning providers are not enrolled as Medicare providers, clinics have no way to bill Medicare. Furthermore, Medicare will not reimburse visits with a V25 family planning code. Therefore, if a client has Medicare, make sure to document this on the Enrollment Form and bill CCare for the visit.

Supplies

CCare providers are reimbursed for contraceptive supplies at acquisition cost, up to a maximum allowable amount. See Exhibit 8 for maximum supply reimbursement rates as well as guidance for providers who qualify for public health (340B) pricing on supplies. Acquisition cost is defined as the cost to get the supply to the clinic: unit price plus shipping and handling. Costs of sorting, labeling, or bagging at the clinic are not included in the acquisition cost. Since prices fluctuate frequently, clinics should monitor their CCare claims against supplier invoices at least quarterly.
To ensure that a high quality of care is offered to CCare clients, clinics are expected to conduct and bill CCare for a face-to-face contraceptive management visit with a clinician before billing CCare for a supply-only encounter. However, if the client is newly enrolling in CCare but has had at least one face-to-face family planning visit with a clinician at your agency in the last two years OR the client is new to your agency but has been enrolled in CCare and established on a birth control method at another agency within the last year, the first claim submitted to CCare may be for a supply-only encounter. In order to do this, you must click on the button “Supply-only Encounter: Established family planning patient within your agency OR Established CCare client at another agency” in the CCare eligibility database. See Exhibit 1 of this section for more guidance about the eligibility database.

**Using the CVR to bill for CCare services**

The CVR is the required claim form for CCare. Paper forms are rarely submitted; instead, agencies export the CVR data elements from their in-house systems and send an electronic file to Ahlers & Associates. The CVR sections that relate directly to CCare reimbursement are: A – E, 1 - 4, 9 - 9c, 12, 17, and 17a, but all sections should be completed fully. Refer to Section D for item-by-item instructions on how to fill out a CVR and for a sample blank CVR. Refer to Exhibit 6 of Section D for file layout requirements for electronic CVR submissions.

Ahlers & Associates processes CVRs / CCare claims once a month. To be included in a given month’s processing, CVRs must be submitted by the Thursday before the 15th of that month. See Section D, Exhibit 7 for a list of monthly submission deadlines.

**Timely Submission**

CCare claims are payable within 12 months of the date of service only. Providers should keep the monthly processing dates in mind to avoid having claims rejected for being older than 12 months. For example, a visit from May 27, 2011 that was sent to Ahlers on May 24, 2012 technically meets the 12-month requirement. But that claim will not be processed until a day or
two after the June submission deadline, at which point it would be rejected for being untimely.

Claims Processing
Before claims for CCare payment are accepted, they are reviewed against Oregon Medicaid eligibility records to ensure that clients are not already eligible for family planning services under regular Medicaid (OHP). If a match is found, the CCare claim is rejected and the service should be billed to DMAP instead.

CCare claims may be rejected for reasons other than a client’s OHP eligibility, although that is one of the most common causes for rejection. Other common errors that result in rejected claims include: the client was not eligible on the claim date of service; the client’s CCare number was missing or invalid; or the purpose of visit was missing or invalid. A full list of claim rejection scenarios and explanations can be found in Section D, Exhibit 8. Rejected claims can be corrected and resubmitted with the next month’s batch of CVRs. The State pays a nominal fee for each claim processed, so please be mindful and resubmit only those claims that need correction, not the entire batch.

Remittances
Following each month’s processing, your agency receives two reports from Ahlers & Associates: a billing Register/Remittance Advice for all successfully processed CCare claims, and a CVR Error Report showing rejected claims and explanations. A sample of each report can be found in Exhibit 12 and Section D, Exhibit 9 respectively. Electronic remittance advices, in HIPAA-compliant 835 format, are also available. If your agency is interested in electronic remittances, please contact Ahlers directly.

Payment
CCare reimbursement is issued once a month by the Reproductive Health Program, based on the amounts listed on each agency’s billing register. Payments are made via electronic banking transfer.
C.Care Program Integrity Plan C.6

This section contains audit related policies and procedures for the C.Care Program.

Purpose/Overview

The Oregon Health Authority Reproductive Health Program has an obligation to state and federal funders, as well as to Oregon taxpayers, to oversee funding for reproductive health services to assure compliance with program regulations. Outlined in this manual are the various screening and audit procedures used to assure program integrity and reduce risk of overpayment.

It is not the goal of the audit process to impose additional fees or penalties, but rather to recover payments that were made in error or to correct practices that are not in keeping with program regulations.

The Oregon Administrative Rules (OARS) pertaining to this program are 333-004-000 through 333-004-0230.

Types of C.Care Audits

MONTHLY DESK AUDIT

- CVRs Rejected - Several automatic checks for errors (edits) are built into the Ahlers data collection/billing system used by C.Care providers. These edits cause a Client Visit Record (CVR) to be rejected from the system and therefore not included in the billing summary or data. A report showing the number of CVRs rejected per agency and the associated reasons for rejection is reviewed monthly to help detect systems problems and to determine where training and technical assistance is needed.

- Billing Register Review - Ahlers & Associates provides a monthly billing summary or “billing register” to the state and to each agency which details every client transaction by date of service. This
summary includes client information, visit purpose, contraceptive method used and costs associated. Review of the monthly billing register by agency and site supplies a wealth of information for audit purposes.

Examples include:

- How much an agency is billing CCare for supplies
- Quantities of methods dispensed
- Revenue received by billing third party resources

Each month the billing register is reviewed and a Billing Register Desk Audit Chart is used to track any unusual circumstances or findings. The chart contains a space to document follow-up needed. Generally, follow-up consists of a phone call or e-mail to the specific agency to discuss the issue. It may be easily resolved over the phone or through e-mail.

If the same problem occurs in several agencies at a time, a memo is sent to providers describing the problem and the expected course of action to resolve it. The state provider liaison is also notified so that the recurring problem can be addressed in future training. The audit chart, specific to each month’s billing, is referenced in subsequent months to determine if the identified problem has been resolved.

Additionally, supply billing is monitored against purchasing data or supplier invoices to track changes in supply prices and billing accuracy.

**VISIT FREQUENCY AUDIT**

A visit frequency audit is performed by generating a separate report from Ahlers client data showing visits by date of service for a specific time period (usually one year). Review of this report helps identify clients with a high number of visits, which can indicate the need for a chart audit. A large number of clients with more visits than the statewide average of two per year (or one for males) can be an indicator of incorrect billing practice. Clients who use Depo Provera as a birth control method are not included in the visit frequency report, as the injections are required four times per year.
Agency visit frequency reports are run on an as-needed basis.

Review of a visit frequency report can lead to a chart audit of specific clients who have an unusually high amount of repeat visits.

**RANDOM SAMPLE CHART AUDIT**

The need for a random sample chart audit may be identified by any of the other audit functions described above, but is also done on a regular rotating quarterly schedule. Chart audits are done using a statistically valid random sampling, with sufficient sample size allowing a confidence interval of 95%.

Agencies will be asked to produce either random or specific charts by client number within a time period of 90 days. Usually, photocopies of the charts are sent to the state office for review but in some instances the reviewer(s) may go to the agency site to review the charts. When the reviewer(s) come to the agency site a dedicated room/office must be available for the process and entrance and exit discussions that are required.

Charts are reviewed by Reproductive Health Program reviewer(s) using the CCare Chart Review Tool (see Section C, Exhibit 15) and a matrix of findings is developed identifying the results of each chart reviewed. The findings are provided to the agency for review. Upon receipt of the matrix, the agency has a period of ten days to review and/or challenge the findings.

A primary reason for a chart audit is to substantiate whether or not visits are appropriately billed to CCare; however, other findings may also be identified. For a visit to be billed to CCare, contraceptive management for the purpose of preventing pregnancy must be the primary purpose of the visit and it must be accurately supported/documented in the chart notes.

Charts determined to be billed in error are to be corrected in the Ahlers system by the agency using the void/resubmit process with the next claims submission.
ELIGIBILITY AND ENROLLMENT FORM AUDIT

The CCare enrollment form and its citizenship verification components are also reviewed as part of the chart audit. Examples of what reviewers will be looking for include:

- CCare Enrollment Form is complete and accurate
- Date of client signature matches the beginning eligibility date in the client eligibility database
- Citizenship and identity are verified

Enrollment forms are regularly requested and reviewed for completeness and accuracy. Proof of identity and citizenship are reviewed and monitored against the CCare database and income and SSNs are verified.

CCARE AUDITS DURING REGULAR TITLE X REVIEW

Agencies receiving Title X funding are reviewed for compliance with Title X Family Planning Program regulations on a triennial basis. Chart reviews are performed as part of the process. Reviewers will also follow a checklist of components to review 10 CCare charts when reviewing charts for Title X compliance. This review tool is also given to CCare clinics to encourage regular self audit.

VASECTOMY CONSENT FORM AUDIT

Vasectomy consent forms are sampled and reviewed for completeness and accuracy from clinics that bill CCare for this service.

MONITORING AGENCY INSURANCE BILLING

Unless a client with private insurance also indicates the need for special confidentiality, federal law requires that all reasonable efforts be taken to ensure that CCare is the payor of last resort.

Agency insurance billing is monitored for clients who have indicated having insurance on the CCare Enrollment Form. The process matches clients who have marked “yes” to private insurance on the CCare Enrollment Form to subsequent claims, on a quarterly basis, to determine if a dollar amount was paid by the insurance carrier or an explanation code was provided.
If there is no indication that the insurance carrier was billed, the agency will be contacted for an explanation to be provided within 30 days. Failure to bill a client’s private insurance carrier may be grounds for payment recovery or sanction.

**OTHER REQUESTS FOR INFORMATION**

The state Reproductive Health Program may request specific information on an as-needed basis.

**Types of Findings**

**ADMINISTRATIVE**

Administrative findings, identified by review or chart audit, are not related to incorrect billing or overpayment, but are program elements not being met. Examples:

- An agency consistently gives only one package of pills per visit
- An agency shows no evidence of billing third party reimbursement

**FINANCIAL**

Financial findings identified by chart audit procedure consist of incorrect billing that resulted in overpayment to the provider. The specific OAR for Recovery of Over-payments to Agencies Resulting from Review or Audit is 333-004-0150.

**Financial Finding Procedure**

- Overpayment is established through chart audit and documented in the matrix of findings.
- Amount of overpayment may be calculated by extrapolation of the random sample or may be the actual overpayment.
- A cover letter and notice of overpayment (invoice) is sent.
- Agency has a 10-day period to review the matrix/chart audit findings.
A repayment agreement is signed by the agency OR if the agency is in disagreement, the contested case hearing procedure is followed.

Generally the overpayment is recouped by the state within the next payment cycle. OHA has the discretion to negotiate a repayment schedule if requested.
Section C: Exhibits

Exhibit 1: CCare Eligibility Database Instructions
Exhibit 2: CCare Enrollment Form (English and Spanish)
Exhibit 3: CCare Citizenship and Identity Document Checklist
Exhibit 4: Social Security Number Statement (English and Spanish)
Exhibit 5: CCare Oregon Birth Information Form
Exhibit 6: Out of State Birth Certificate Instructions and Authorization to Release Form
Exhibit 7: Clinical Requirements for CCare Billable Visits
Exhibit 8: Reimbursement Rates for CCare Visits and Supplies
Exhibit 9: [removed] see Section D, Exhibit 7
Exhibit 10: [removed] see Section D, Exhibit 8
Exhibit 11: [removed] see Section D, Exhibit 9
Exhibit 12: Sample Billing Register/Remittance Advice
Exhibit 13: CCare Primary Care Referral Brochure (English and Spanish)
Exhibit 14: Affidavit/Statement of Identity
Exhibit 15: CCare Chart Review Tool
Exhibit 16: Refugee/Asylee Policy
Section D

CVR Manual for Title X and CCare

Center for Prevention and Health Promotion
Oregon Health Authority – Public Health
This manual is designed to help inform and assist those who collect data for the state of Oregon and for the billing system of the Oregon’s family planning Medicaid waiver, Oregon Contraceptive Care (CCare).

**Background: Title X and Data Collection**

Title X is funded by a federal grant from the Department of Health and Human Services-Office of Population Affairs (HHS-OPA). To qualify for Title X grant funds, clinics must follow Title X requirements, which include submitting data of services provided, which is used in required reports to the federal Office of Population Affairs. The Oregon clinic visit record (CVR) was developed to collect the data needed to meet these requirements. The current CVR is located in Exhibit 5 of this section.
CCare and Oregon's CVR

In 1999, Oregon was granted a Medicaid waiver to expand Medicaid coverage for family planning services. The resulting Oregon Contraceptive Care Program or CCare (formerly known as the Family Planning Expansion Project or FPEP) expanded eligibility, established its own enrollment process, and enlarged the provider network. To streamline the billing process for CCare providers, the Oregon CVR was modified to collect the information necessary to bill Medicaid for Oregon clients enrolled in CCare. These additions make the Oregon CVR different from the CVR used in other states.

Purpose of the Oregon CVR

In addition to providing the reports required by OPA for funding purposes and serving as the billing mechanism for services provided to CCare clients, Oregon’s CVR is an important source of data for:

- Describing family planning clients who receive services in Oregon
- Constructing financial and internal reports
- Planning the allocation of resources
- Measuring outcomes
- Analyzing clinic effectiveness and efficiency
- Providing data to the Region X Office of Family Planning, the Centers for Medicare and Medicaid Services (CMS), the Oregon Health Authority Public Health Division, and delegate agencies

CVR Development and Revision

Occasionally changes need to be made to the Oregon CVR. Updates relating to Title X are based on changing data requirements by OPA. Changes in relation to CCare receive input from members of the CCare Workgroup who provide guidance on CVR elements needed for billing or administration. Oregon Reproductive Health Program staff make final decisions about Oregon’s CVR in consultation with the contractor for CVR data processing and billing, Ahlers and Associates. A software patch is
provided by Ahlers for download by agencies using the Ahlers billing software system. Revised paper CVRs are also provided by Ahlers to those agencies that use them.
Q. What exactly is a CVR? And other important questions...

The Oregon CVR (Clinic Visit Record) is a specialized data collection tool for recording required Title X and CCare visit information about a family planning client.

A variety of methods and software can be used to collect CVR data. In most clinics, the CVR is incorporated as a section of a computerized billing/client information system. Your clinic may be using the software developed by the regional data processor, Ahlers and Associates (Ahlers), or any number of other billing and/or client information software packages. A few clinics continue to use a paper CVR.

Whichever format you use, the tool is identical, and the same definitions and guidelines apply. Section D.3 describes how to complete a CVR.

Q. When and for whom do I record a CVR?

Clinics that receive Title X funding and follow Title X guidelines are expected to generate a CVR for every family planning client visit (except a non-CCare supply-only pick-up encounter), regardless of the source of pay. Non-Title X clinics that participate in CCare are expected to submit a CVR for every CCare visit. A CVR must be submitted to generate payment for the visit.

A CVR is required for the following types of visits and services:

- All initial, annual, and other medical visits for clients who are receiving family planning medical and/or counseling services and for whom a client record is established and updated for each visit. This applies to both female and male clients, and to clients who are using abstinence or sterilization as their contraceptive method.

- Off-site services that meet the criteria of a family planning visit, e.g., nurse home visits.

- Pregnancy test visits where testing and professional counseling services related to pregnancy test results are provided and recorded on the client record (Title X).

- Vasectomy visits that include professional counseling services and establishment of a client record.
• Vasectomy medical services provided by a provider or a contracted referral provider.

• Counseling-only visits where the information is placed in the client record.

• Emergency contraceptive visits that include establishment or update of a client record.

• Supply-only pick-up encounters in which an established client receives refills of their birth control method without needing other services (CCare only).

Q. Who should complete the CVR?

As stated above, the purpose of the CVR is to collect required visit information for family planning clients. The CVR helps capture the rational behind clinical decision making and provides the data for the Family Planning Annual Report. Therefore it is best practice for the clinician who performed the visit to complete the medical services portion of the CVR. If completion of the CVR is left to staff who were not present during the visit, there is potential for inaccuracies in data and billing.

Q. What happens to the CVR data?

CVR data are collected at each registered clinic site in the agency and then transmitted via mail (paper CVRs) or electronically through a HIPAA-compliant website to Ahlers. The information is scanned for errors, tallied, and parsed into usable form in tabular region-wide reports. CVR data are reported by project (all clinic sites at the agency included) and by each individual clinic site.

Q. How does information from the CVR help me?

Ahlers provides a wealth of statistical data broken down by date of service: quarterly, calendar year (January – December), fiscal year (July – June), FPAR (December 1 – November 30 of the following year), and special request. These reports are provided at no additional charge.

Q. How can I obtain reports from Ahlers?

We strongly encourage using the on-line reporting section of the Ahlers website at www.ahlerssoftware.com. To gain access, you must have a user
ID and password from Ahlers. See Exhibit 1 for a project/site number request form from the RH Program and Exhibit 2 for a login and password application for the Ahlers system.

Once you enter the secure portion of the website, you can access and print all of your clinic’s or agency’s data for the last three years as standard reports (under the View Reports option) or as custom tables that you create (using the Build a Report function). Sample reports are also included as Exhibit 3. Raw, visit-level data can be downloaded and manipulated to meet your needs. Exhibit 4 describes the steps to access data.

Agencies and clinics needing access to paper versions of reports should contact Ahlers.

**Q. We use Ahlers’ WINCVR software. Is it the same as the paper CVR?**

Yes. Ahlers built their WINCVR system around a modular client information system geared specifically toward public health, particularly family planning. The Title X and CCare CVR components are integrated into this system.

**Q. We use third-party billing software. How will it capture CVR information?**

Most CVR components are common to client registration systems (super bills) and most standard billing software. Oregon may collect a few items that are not included in your system, such as data on referrals or counseling. To capture the required CVR data correctly, you may need to add elements to your clinic software. To transmit the data, use the standard file format included as Exhibit 6.

**Q. What are the deadlines for transmitting data to Ahlers?**

Because the CVR is used for both billing and data collection, there are two sets of data submission deadlines: one for claims payment and one for report generation.

**Claims Payment:** CCare reimbursements are generated monthly. In order to receive a timely payment, you must submit the CVR data no later than the Thursday before the 15th of the month. (See Section C, Exhibit 9 for current deadlines.) These data typically consist of CVRs from the previous month, but may include CVRs with dates of service up to the deadline date or as old as one year.
Report Generation: CVR data should be submitted by the processing deadline for each month to ensure that your agency’s Ahlers reports are accurate and comprehensive.

<table>
<thead>
<tr>
<th>Month</th>
<th>Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>February</td>
<td>Annual Report</td>
</tr>
<tr>
<td>April</td>
<td>Quarter 1 Report</td>
</tr>
<tr>
<td>July</td>
<td>Quarter 2 Report</td>
</tr>
<tr>
<td>August</td>
<td>Fiscal Year Report</td>
</tr>
<tr>
<td>October</td>
<td>Quarter 3 Report</td>
</tr>
<tr>
<td>December</td>
<td>FPAR Report</td>
</tr>
<tr>
<td>January</td>
<td>Quarter 4 Report</td>
</tr>
</tbody>
</table>

Q. How do we know our data are really reaching Ahlers? Can we run a test batch?

Yes. In fact, any time the CVR is upgraded or revised or you change your information system, it’s advisable to transmit a monitored test batch of data. This should be done prior to the cutoff for monthly data to resolve any problems. You should also provide Ahlers with a contact e-mail address. Upon request, Ahlers will send back tallies of the number of records received after an electronic transmission. An Ahlers employee can walk you through the process and help you look for data anomalies and incomplete files. See the contact information for Ahlers on the last page of the CCare Eligibility Database Instructions (Section C, Exhibit 1).

Q. How do we resubmit a CVR that has been rejected?

Data errors and billing errors can cause your CVR to be rejected. Along with your monthly billing register, your agency will receive a CVR Error Report (See Exhibit 9 for a sample report) that shows CVR rejections and an explanation for each rejection.

You can correct any rejected CVRs and resubmit them with the next month’s batch of CVRs. In some cases, you will need to supply missing
information and in others, you will need to make a billing error edit correction.

**Q. How does HIPAA affect the Family Planning Information System?**

HIPAA, the Health Insurance Portability and Accountability Act of 1996, requires that all information transferred via the Internet be encrypted to protect client privacy.

**HIPAA information is available on many websites. Two of the more comprehensive are:**

- [http://www.aspe.hhs.gov/ADMNSIMP](http://www.aspe.hhs.gov/ADMNSIMP) - subscribe to a HIPAA registration list to receive regular email updates on the law.

For more information, visit www.ahlerssoftware.com and click on HIPAA.
How to Complete a CVR

Here are item-by-item instructions for completing each numbered section of the CVR. The instructions are the same, whether you use a paper form or an electronic version.

Top Section: Client Information

<table>
<thead>
<tr>
<th>A. LAST NAME</th>
<th>B. FIRST NAME</th>
<th>C. M.I.</th>
<th>D. SOC. SEC. NO.</th>
<th>E. CCare NO.</th>
</tr>
</thead>
</table>

The Client Information section must be completed if you intend to bill CCare for the visit or if your agency or clinic uses the information for administrative purposes. If those situations don’t apply to you, you may leave it blank.

1. Clearly print the client’s last name, first name, and middle initial in items A, B, and C, as indicated.
2. Print the client’s Social Security number in item D. CCare will reject claims without a Social Security number.
3. Print the client’s CCare number in item E. See the Eligibility Database Instructions in the RH Program Manual, Section C, Exhibit 1 for information about accessing the client’s CCare number.

If you submit paper CVRs to Ahlers for data entry, you should send them the top (white) copy. The yellow copy is for local agency use. The CVR is not a charting form and should not be part of the client’s medical record. However, services documented on the CVR must match those documented in the medical chart.

Section 1: Service Site Number

1. SERVICE SITE NUMBER

You must fill in all seven boxes. If your service site number is fewer than seven digits, use leading zeros. For example, site number 4321 should be entered as 0004321.

Please use only the service site number assigned by the Oregon Reproductive Health Program (see sidebar at right).

Project and site numbers are ID numbers assigned by Ahlers and Associates and the information systems manager for data collection. Project numbers are assigned to projects; site numbers are assigned to individual clinic sites.

If you do not have a number: Contact the Oregon Reproductive Health Program. They will then contact Ahlers to obtain a number for your site.
Section 2: Client Number

The client number is the unique identifier your agency or clinic assigns to the client. It can be found in the client’s medical records or other client information files.

You must fill in all nine boxes in the CVR. If the client number is fewer than nine digits, use leading zeros. For example, client number 1122 should be entered as 000001122. (Ahlers WINCVR automatically fills in leading zeros.)

Assigning Client Numbers

The client number is an agency-specific identifier used in conjunction with the date of birth field to ensure that the correct data are matched to the client. Each agency may follow its own procedures for assigning numbers, as long as the numbers meet the following requirements:

- There are no duplicate numbers:
- No two clients within a service site (clinic) may have the same number.
- No two clients within a project (agency) may have the same number.
- The client number must not contain alphabetic or non-numeric characters.
- The client number cannot be longer than nine digits.
- Projects with multiple clinic sites may want to use prefixes to better identify clients from each site. This will also help to avoid duplicates. Example:
  - Site A assigns numbers with a 1 prefix: 100000789.
  - Site B assigns numbers with a 2 prefix: 200000789.

If a client has been inactive in the system for 36 months or more, Ahlers will discontinue that client number. If the client returns to the system, that old number can be reactivated, or a new one assigned. Do not assign a previously used number to a different client.
Section 3: Date of Visit

3. DATE OF VISIT

Section 3 requests the actual date on which the client received medical and/or counseling services at the service site. It is not the date you enter the information. Be sure to use the actual visit date, even if you fill out the CVR at a later time.

Enter the date in month/day/year format (mm/dd/yyyy). Convert month and day to two-digit numbers:

- January 01
- February 02
- March 03
- April 04
- May 05
- June 06
- July 07
- August 08
- September 09
- October 10
- November 11
- December 12

For example: if you see a client on July 9, 2012, enter the date as 07/09/2012.

Section 4: Date of Birth

4. DATE OF BIRTH

The date of birth is the month, day, and year the client was born. Record as much of this information as the client is able to give. If the birth year is unknown, ask the client, “How old are you?” and calculate the year. If the birth month is unknown, use July 15, a default date used by the processor for unknown data.

Enter the date in month/day/year format (mm/dd/yyyy), using the same two-digit code as in date of visit. For example: If the client’s date of birth is June 3, 1988, enter the date as 06/03/1988.

A client can have only one date of birth. If you’re using Ahlers’ WINCVR software, be sure to always record the same birth date as on the CVR for the client’s first visit. Otherwise, the CVR will be rejected. Clients sometime give different dates at different times, so check the actual records.
Section 5: Gender

| 5. GENDER | □ 1 - Female | □ 2 - Male |

Determine the client’s gender by observation or from medical records and check the appropriate box.

Section 6: Ethnicity

| 6. ETHNICITY | □ 6 - Hispanic or Latino | □ 9 - Not Hispanic or Latino |

You must check one and only one box: Hispanic or Latino; or Not-Hispanic or Latino

If ethnicity is not included on the client’s medical record, try asking a clarifying question, such as “Do you consider yourself Hispanic or Non-Hispanic?” Do not make assumptions or rely on observation to complete this box; neither are reliable means of ascertaining ethnicity.

Hispanic origin or descent includes:
1. Mexican-American  Mexicana(o)-Americana(o)
2. Puerto Rican  Puerto Riqueña(o)
3. Cuban  Cubana(o)
4. Central or South American  Centro o Sudamericana(o)
5. Other Spanish Speaking  Otra Categoria Espanol

Section 6a: Race

<table>
<thead>
<tr>
<th>6a. RACE (Mark All That Apply)</th>
<th>□ 5 - Asian</th>
<th>□ 6 - Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ 1 - White</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ 2 - Black/Afr. Amer</td>
<td>□ 3 - American Indian</td>
<td>□ 4 - Alaska Native</td>
</tr>
<tr>
<td>□ 7 - Unknown/Not Reported</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ 8 - Native Hawaiian/Pac. Isl.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Check all that apply. If race is not indicated on the client’s medical record, try asking a clarifying question, such as “What race or races do you identify with?” Again, do not rely on assumptions or observation; neither are reliable means of ascertaining race. If the client doesn’t know or chooses not to answer, check box 7 – Unknown/Not reported.

Many people assume that Hispanic or Latino is a racial category; however, our funders categorize Hispanic or Latino only as ethnicity and consider race to be a separate category. Funders need to know if Hispanic/Latino clients also identify as White, African American, etc. This data is important to collect because it allows us to provide the most effective and appropriate healthcare services and to better understand the health behaviors/practices of our clients. Please work with clients, particularly those of Hispanic ethnicity, to explain why we need information about ethnicity and race and to help clients identify a racial category that best describes them.
Section 7: Additional Demographic

Limited English Proficiency describes a client who has limited ability to read, speak, or understand English and may need assistance to optimize his or her use of family planning services. Check this box if the staff must speak in the client’s native language or if a third person is used to communicate with staff/client.

Section 7A: Client Testing Dates

This section is intended to capture female clients’ most recent test dates (month and year) prior to today’s visit, as used in clinical decision-making. Test dates may be self-reported by the client or populated from client medical records, when available. If the client has never had one of these tests, 1-Never should be checked. If test dates are unknown or unavailable, 2-Unknown should be checked. Chlamydia test dates should be entered only for female clients age 24 years and younger. Pap test (cervical cytology) dates should be entered only for female clients age 21 years and older. If test dates are entered for clients outside these age ranges, Ahlers will clear out the dates upon receipt of the CVR data.

Section 8: Zip Code

Enter the zip code provided by the client. This item is important for documenting the location of the client’s residence. If the client is homeless, use the zip code of the clinic providing service, or that of the address where the client receives mail.
Section 9: Assigned Source of Payment

Use Section 9 to document how your service site expects to be paid for the services provided during the visit. This number-by-number guide will help you determine which single box to check.

01 - No Charge: Client does not qualify for third-party billing (Medicaid or insurance) and is below 100% of the Federal Poverty Level (FPL) based on income/family size assessment.

02 - Title XIX (OHP): Client is currently enrolled in the Oregon Health Plan and the visit is billable to OHP.

03 – WA Take Charge: Client has Take Charge coverage (Washington State’s family planning Medicaid waiver program) and clinic is a Take Charge provider. Take Charge will be billed for the visit.

04 - Private Insurance: Client has private insurance and today’s visit will be billed to that company. Check this box even when the billing outcome is unknown.

05 - Full Fee: Client does not have insurance or Medicaid coverage that will pay for the visit, is over 250% of the poverty level based on income/family size assessment, and will be charged the full fee for the visit. The client may not pay for all/any of the fee on the date of visit.

06 - Partial Fee: Client does not have Medicaid or private insurance for the visit and is between 100% and 250% of poverty level based on income/family size assessment. The client will be charged a partial fee and may not pay all or any of the fee on the date of visit.

07 - Other: Check this box when other, non-specified third-party payers are charged. These may include special federal or state funds for American Indians or male services.

08 - CCare: Client is eligible for CCare and the visit is for contraceptive management.

Box 9 records how your site expects to be paid. It may not be the method that eventually covers the invoice. If you expect any payment from CCare, be sure to check either 08 or 10. Otherwise, if you expect to be paid by a combination of resources (e.g., partial fee and private insurance), check the one that you think will cover the largest portion of the invoice.

Donations are not a source of payment. They are not to be reported on the CVR.
10 - Non-CCare Billable Visit/CCare Supply: Client is CCare eligible and receives services that are not for contraceptive management, but also receives contraceptive supplies that are billable to CCare. For example, a CCare eligible client comes in for an STI check and requests a refill of her oral contraceptives at the same visit. This is not considered a contraceptive management visit and therefore does not qualify for CCare billing. However, you can check box 10 to bill CCare only for the contraceptive supplies dispensed at the visit.

11 - OVP: Client is being seen for a vasectomy counseling or procedure visit under the Oregon Vasectomy Project (OVP). To receive payment for these visits, you must mark the appropriate medical services (box 20 in Section 13A) and/or counseling service (box 03 in Section 14A) on the CVR. This box should also be marked with box 8 - Vasectomy Referral in Section 12 AND box 18 - Vasectomy Referral Fee in Section 13A when billing OVP for administrative and/or referral work for a client receiving vasectomy services from a sub- or state-contracted vasectomy provider.
Section 9A: Diagnosis Code

This section is for CCare-billable visits only. Complete it if you checked box 08 – CCare or 10-Non CCare Visit/CCare Supply in box 9. Otherwise, leave it blank.

Enter the ICD-9 diagnosis code that represents the contraceptive service provided during the client’s visit. To be reimbursed by CCare, you must list a V25 code. You’ll find the CCare-reimbursable codes listed in Section C, Exhibit 7.

Use the highest level of specificity within the V25 series. That means always using five-digit codes where they are available. Assign four-digit codes if there are no five-digit codes; assign three-digit codes if there are no four-digit codes.

Section 9B: Will Insurance Be Billed for This Visit?

This section is only for visits billable to CCare. Clients with insurance coverage for contraceptive management services are also eligible for CCare. Per federal Medicaid regulations, insurance should always be billed first, so that Medicaid (CCare) is the payer of last resort.

- Client’s insurance will be billed for any portion of the visit: check 2 - Yes and enter the insurance amount in Section 17A, item 2. If the insurance company denies payment, remember to enter the appropriate TPR code in Section 17A, item 1.
- Client has insurance but it will not be billed because of special confidentiality needs: check 1 - No and enter the TPR code NC in Section 17A, item 1. (Also see instructions for Section 9C.)
- Client does not have any insurance: check 1 - No.
Section 9C: Special Confidentiality Needs

The special confidentiality option is available to any CCare client who believes she or he would be at risk of physical or emotional harm if a parent/partner or other household member learned the client was seeking family planning services. This section is not limited to teens, nor should it be used for every teen client.

Check 1 - Yes if the client has CCare as a source of pay and indicates that special confidentiality is needed; otherwise, leave the section blank. If you check 1 - Yes, be sure that:

- You also enter the TPR code NC in Section 17A. This is required and provides documentation of why insurance was not billed, which is necessary for audit purposes.
- You notify outside labs of the client’s special confidentiality request (if applicable).
- The client has also indicated her or his request for special confidentiality and staff have marked it on the CCare Enrollment Form (if applicable).

Section 18: Client Insurance Status (Principal Health Insurance Covering Primary Care)

Section 18 assess whether family planning clients have health insurance for “a broad set of primary medical care benefits” (not just family planning services). Clients may have more than one kind of coverage so ask them directly about their primary care insurance. This section should be completed for all clients. Note that the information in Section 9: Assigned Source of Payment is not a reliable indicator of what should go in Section 18.

Here are guidelines on which category to check:

1. **Public Health Insurance**: Check this box if the client is currently enrolled in the Oregon Health Plan (OHP) or has Medicare coverage for primary care. CCare should not be counted as public health insurance in this box because it does not cover primary care.

2. **Private Health Insurance**: Check this box if the client has personal or employer-sponsored primary health care insurance, whether or not the insurance pays for family planning, contraceptive services, or supplies.
3. **Uninsured:** Check this box if the client has no coverage for primary health care services. This includes clients who may receive primary care services from the Indian Health Service, as that is not considered “insurance.”

4. **Unknown:** Check this box only if you are unable to check one of the other three.

**Section 10: Income and Family Size**

<table>
<thead>
<tr>
<th>10. INCOME AND FAMILY SIZE</th>
<th>AMOUNT</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. What is your monthly family income?</td>
<td></td>
</tr>
<tr>
<td>b. How many people are in your family, that is, the number supported by this income?</td>
<td>NUMBER</td>
</tr>
</tbody>
</table>

Ask the client for this information. An accurate answer requires that both you and the client understand what is included and what is not included in income, and precisely what constitutes a family for the purposes of the CVR.

**Start with Item 10b - Family Size.** Using the definition for family (see sidebar), determine how many people are supported by this income. The answer must be at least one.

Then compute the monthly income of each person and enter the total amount in whole dollars in Item 10a. For example, if the income is $431.41 enter $431. See page D3-12 for the kinds of income that should be included.

Make every attempt to get an actual or estimated figure from the client. For CCare clients, you can use the amount given on the CCare Enrollment Form. Please note that clients are not required to provide proof of income for Title X or CCare eligibility.

**What Is Family?**

Family is defined as a social unit composed of one person, or two or more persons living together, as a household. Household members do not need to be married to be counted in household income; dependents away at school also are included. The income of all these persons should be counted to calculate the total income of the family. Examples include:

- a married couple, with or without children
- domestic partners, with or without children
- one parent with one or more children
- a married couple sharing the home of a husband’s or wife’s parents
- two related married couples sharing a single household

Roommates living together are not considered a family; each person should be considered a family of one. However, any income received as a result of the arrangement (e.g., rent) is considered income contributed to the client and should be counted.

Foster children or other unrelated children living in a household are not considered part of the family; payments received for caring for foster children is not considered income.
Helpful Guidelines for Determining Income

If the client is a full-time salaried employee, base the average gross monthly income on the client’s most recent month’s income. If the client works part time, on a commission basis, or otherwise has an unsteady income, use the average gross monthly income for the previous 12 months. Some clients may know only their take-home pay, or net income. To calculate gross income, multiply the net income (take-home pay) by 1.15. Do this for all contributing members of the family.

Teens living at home and college students aged 19 and under who are dependent on family income pose special challenges. CCare defines a teen as someone aged 10–19. Title X defines a teen as a minor, which in Oregon is someone aged 10–18.

• Title X Teens
  o Teens are considered as a family of one only when confidential services are necessary. In Item 10b, enter the number 1; in Item 10a, enter any personal income derived from allowances or employment.
  o For teens who consider themselves to be supported by their parents (and do not require confidential services), include the parents’ income and the total number of people supported by the parents.

• CCare Teens
  o All teens aged 19 and under can qualify for CCare based on their own income.

What Is Income?
The gross average monthly income is all money coming in that contributes to the support of the family. Sources of income that should be included are listed on the following page.
Types of Income

<table>
<thead>
<tr>
<th>These sources of income should be included</th>
<th>These sources of income should NOT be included</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Salaries</td>
<td>• Grants</td>
</tr>
<tr>
<td>• Wages</td>
<td>• Loans</td>
</tr>
<tr>
<td>• Tips</td>
<td>• Withdrawal from savings</td>
</tr>
<tr>
<td>• Help from relatives and non-relatives</td>
<td>• Tax refunds</td>
</tr>
<tr>
<td>• Public assistance</td>
<td>• Receipts from sale of possessions</td>
</tr>
<tr>
<td>• Unemployment compensation</td>
<td>• Inheritances</td>
</tr>
<tr>
<td>• Worker’s compensation</td>
<td>• Lump sum compensation for injury or legal damages</td>
</tr>
<tr>
<td>• Veterans benefits</td>
<td>• Maternity payments on insurance policies</td>
</tr>
<tr>
<td>• Sick pay</td>
<td>• Payments for foster parenting</td>
</tr>
<tr>
<td>• Social Security cash benefits (such as widow’s benefits and children’s allowances)</td>
<td>• Dollar amount of Food Stamps</td>
</tr>
<tr>
<td>• Alimony/child support</td>
<td></td>
</tr>
<tr>
<td>• Net investment income (rent, interest, dividends)</td>
<td></td>
</tr>
<tr>
<td>• Net earnings from self employment</td>
<td></td>
</tr>
<tr>
<td>• Pensions</td>
<td></td>
</tr>
<tr>
<td>• Annuities</td>
<td></td>
</tr>
<tr>
<td>• Royalties and commissions</td>
<td></td>
</tr>
<tr>
<td>• Business profits</td>
<td></td>
</tr>
</tbody>
</table>

Also included should be deductions commonly taken out of income before the client receives it. These include:

• Federal, state and local taxes
• Social Security payments
• Deductions for savings bonds, other savings plans, or union dues

Section 11: Health Insurance Enrollment Assistance

11. HEALTH INS. ENROLLMENT ASSISTANCE
☑ 1 - Onsite ☐ 2 - Referral

Section 11 is used to record if health insurance enrollment assistance (not including CCare) was provided to the client. Check **1-Onsite** when provided by a trained enrollment assister at your agency, regardless of when the assistance is provided (e.g., sent to another section of same agency later that day or soon after the original visit). Check **2-Referral** if client is referred for assistance outside of your agency (even if they are located within the same building as your agency).
Section 12: Purpose of Visit

Use Section 12 to record the **primary** reason for the client visit. Check one box only.

1. **First Annual Exam**: First comprehensive examination at your agency during which physical exam and lab services are provided as clinically indicated (see Section 13A: Medical Services Provided) and contraceptive counseling and education are given. This examination does not necessarily take place during the client’s first visit to the agency.

2. **Return Annual Exam**: Subsequent visit (often provided annually) during which the client receives a comprehensive medical examination. Physical exam and lab services should be provided as clinically indicated during this visit. Other services may also be provided. Return annual exams must occur no sooner than 11 months plus one day after the previous annual exam date. For example, if the first annual exam is 05-10-14, then the return annual exam must be on 04-11-15 or later.

3. **Other Medical**: A visit during which one or more medical services are provided for routine contraceptive, sterilization, infertility, or related care. Counseling may be provided along with the services. These services include:
   - Contraceptive follow-up, such as hormonal method supply, IUD, contraceptive injection, and diaphragm check.
   - Method prescription without complete physical exam and lab services: pill prescription, diaphragm fit, IUD insertion, etc.
   - Follow-up to initial or annual medical exam visit because all services were not provided at that time.
   - Vasectomy or tubal ligation.
   - Infertility consultation if medical or lab services are provided. If not, check box **4 - Counseling Only**.
   - Male physical examination.
   - Contraceptive method change related to method complaints: IUD removal, poor diaphragm fit, pill change, etc.
   - Exam or service related to contraceptive method complaints: pelvic exam because of abdominal pain, excessive bleeding, fatigue, etc.
   - Positive or borderline lab test follow-up: repeat Pap smear, monitoring of blood pressure, repeat gonorrhea culture, etc.
• Post-pregnancy check.
• Sickle cell, blood sugar, or other screening because of high-risk status.
• Gestation check. (Note: Prenatal exams are not included because they are not considered in the definition of family planning services).
• Emergency contraception provided, including history and counseling.

4. **Counseling Only**: A visit during which the client receives specific family planning-related consultation, but no medical services are provided. This consultation is recorded in the medical record. For examples of counseling services, see Section 14A: Counseling Education Provided.

5. **Pregnancy Test Visit**: Primary purpose for the visit is a pregnancy test and counseling. The visit may consist solely of a urine pregnancy test or the urine test plus a pelvic examination. Counseling may be provided at another visit if preferred.

6. **Supply Only-Mailed (CCare Only)**: This box should be used only for returning CCare clients who choose to have their refill of their contraceptive method mailed to their address. Use of this option is at the discretion of the client; it cannot be offered as the only way in which to receive supplies. Contraceptive methods that require a written prescription may only be mailed to established clients who have been using the method(s) for at least three months, with no problems or contraindications.

8. **Vasectomy Referral (w/OVP SOP)**: This box should be used to indicate administrative and/or referral work for clients receiving vasectomy services through a sub-contracted or state-contracted vasectomy provider. A new CVR, separate from the CVRs completed for the vasectomy counseling visit or vasectomy procedure, should be completed with a unique date of service in order to receive reimbursement for the administrative and/or referral work. This box must be marked in conjunction with box 11 – OVP in Section 9: Assigned Source of Payment, even if the vasectomy counseling visit or vasectomy procedure are being covered under a different source of payment. Additionally, box 18 – Vasectomy Referral Fee in Section 13A: Medical Services must be checked in order to receive reimbursement. Reimbursement will be reflected in the OVP payment reports generated each month by Ahlers.

9. **Supply Only Visit (CCare Only)**: This box should be used only for established CCare clients who present for a refill of their contraceptive method (more packs of pills, additional Rings and packs of EC, etc.) and receive no or very brief medical (vital stats check) or counseling services. If this visit is the first being billed to CCare, the client must be an established client at the clinic, having had a face-to-face family planning visit with a clinician within the last two years OR the client is new to your agency but has been enrolled in CCare and established on a
birth control method at another agency within the last year. Make sure that this has been indicated at the time of enrollment in the CCare eligibility database. Note that provision of Depo-Provera can be classified under box 3 - **Other Medical**, since the Depo injection requires medically trained staff.
Section 13A: Medical Services

<table>
<thead>
<tr>
<th>13A. MEDICAL SERVICES (Check all Applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Exam &amp; Lab Services</strong></td>
</tr>
<tr>
<td>□ 02 - Blood Pressure</td>
</tr>
<tr>
<td>□ 03 - Height/Weight</td>
</tr>
<tr>
<td>□ 04 - Thyroid Exam</td>
</tr>
<tr>
<td>□ 05 - Heart/Lung Auscultation</td>
</tr>
<tr>
<td>□ 06 - Breast Exam</td>
</tr>
<tr>
<td>□ 07 - Abdominal Exam</td>
</tr>
<tr>
<td>□ 08 - Extremities</td>
</tr>
<tr>
<td>□ 09 - Bimanual/Speculum Pelvic Exam</td>
</tr>
<tr>
<td>□ 23 - Hgb / Hct</td>
</tr>
<tr>
<td><strong>Contraceptive Related Services</strong></td>
</tr>
<tr>
<td>□ 17 – Diaphragm / Cap Fit</td>
</tr>
<tr>
<td>□ 19 – IUD/IUS Insert</td>
</tr>
<tr>
<td>□ 20 – Sterilization Procedure</td>
</tr>
<tr>
<td>□ 38 - Hormone Implant In</td>
</tr>
<tr>
<td>□ 39 - Hormone Implant Out</td>
</tr>
<tr>
<td><strong>Pregnancy Related Services</strong></td>
</tr>
<tr>
<td>□ 21 - Post Pregnancy Exam</td>
</tr>
<tr>
<td>□ 31 - Serum Pregnancy Test</td>
</tr>
<tr>
<td>□ 32 - Negative Pregnancy Test</td>
</tr>
<tr>
<td><strong>STD Related Services</strong></td>
</tr>
<tr>
<td>□ 11 - Vaginitis/Urethritis/Eval/Dx</td>
</tr>
<tr>
<td>□ 12 - Vaginitis/Urethritis/Eval/Rx</td>
</tr>
<tr>
<td>□ 29 - Chlamydia Test</td>
</tr>
<tr>
<td>□ 13 - Chlamydia Treatment</td>
</tr>
<tr>
<td>□ 14 - Chlamydia Presumptive Rx</td>
</tr>
<tr>
<td>□ 15 - Wart Treatment</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

Section 13A records the examination, laboratory, diagnostic, and treatment procedures provided to a client during the visit. The medical provider should complete this section at the time of service. Alternatively, the information can be transcribed from the client’s medical record at the end of the visit. Check all the boxes that apply.

Medical Services Defined
This list below describes medical services in numerical order. On the CVR, the services are divided into four categories and the services are not in numerical order. The categories are: Exam & Lab Services, Contraceptive Related Services, Pregnancy Related Services, and STD Services.

02. **Blood Pressure**: Use of a stethoscope and blood pressure cuff to measure the force exerted on the walls of arteries as blood is pumped through them.

03. **Height/Weight**: Measurement of client’s height and/or weight are recorded.

04. **Thyroid Palpation**: Manual and physical examination of the thyroid to evaluate size, shape, symmetry, or tenderness.

05. **Heart Lung Auscultation**: Evaluation of heart and lung sounds using a stethoscope.

06. **Breast Exam**: Visual inspection and palpation of the female/male breasts to evaluate the symmetry of shape, color, size, surface characteristics, and for masses.

07. **Abdominal Palpation**: Visual inspection and palpation of the abdomen to evaluate for abnormalities.
08. **Extremities:** Inspection and/or palpation of the arms and legs to evaluate for abnormalities.

09. **Bimanual/Speculum Pelvic Exam:** Visual and/or manual examination of the vulva, vagina, cervix, and pelvic organs to detect any abnormalities and collect specimens/samples for laboratory analysis when indicated.

10. **Vaginitis/Urethritis/Eval/DX:** Evaluation of the vagina, urethra, and male/female or genital area via palpation, visual inspection, and/or laboratory tests to detect infection.

11. **Vaginitis/Urethritis/Eval/Rx:** Treatment of any vaginal/genital or STD infection not specifically identified elsewhere under 13A - Medical Services Provided.

12. **Chlamydia Treatment:** Providing treatment for a laboratory diagnosed case of *Chlamydia trachomatis* (CT).

13. **Chlamydia Presumptive Treatment:** Prescribing medication to treat CT based on history, e.g., contact with a confirmed case, and/or clinical findings. This may be done without performing a CT test or prior to receiving the results of the test.

14. **Wart Treatment:** Treatment of external genital HPV infection with medication or cryotherapy. This may also include giving the client a prescription for self-administered medication.

15. **Herpes Test:** Blood tests or cultures of lesions taken to diagnose Herpes Simplex Virus (HSV).

16. **Diaphragm/Cervical Cap Fit:** Assessment for proper fit and client instruction on use of diaphragm or cervical cap.

17. **Vasectomy Referral Fee:** Administrative and/or referral work for clients receiving vasectomy services through a sub-contracted or state-contracted vasectomy provider. Box 11 – OVP in Section 9: Assigned Source of Payment AND Box 8 – Vasectomy Referral (w/OVP SOP) in Section 12: Purpose of Visit must also be checked. The vasectomy referral fee must be indicated on a unique CVR with its own date of service, separate from those of the vasectomy counseling visit and vasectomy procedure, in order to receive reimbursement.

19. **IUD/IUS Insert:** Insertion of an intrauterine contraceptive device, or system into the uterus.

20. **Sterilization Procedure:** Any procedure on a man or woman intended to provide permanent contraception; e.g., tubal ligation or vasectomy.
21. **Post Pregnancy Exam:** Physical assessment of a woman’s health status with emphasis on uterine involution, presence or absence of infection, and family planning status, following a pregnancy of any gestational age.

22. **IUD/IUS Removal:** The intrauterine contraceptive device or system is removed from the uterus.

23. **Hgb/Hct:** A measurement of the hemoglobin (HgB) content or the solids/serum ratio (Hct) of capillary blood as an indirect assessment for anemia.

24. **Urine Dip Strip/Urinalysis:** A narrow plastic strip containing chemical reagents that is dipped in a small amount of urine as to provide a quick, point-of-service check for sugar (diabetes), protein (kidney problems and dehydration), and white cells (infection). A urinalysis is a sample of urine submitted to a laboratory for a thorough evaluation with special equipment.

25. **Pap Test Conventional:** A sample of cervical cells taken during a speculum exam of the vagina and cervix to detect cervical dysplasia or cancer. The sample is submitted to a clinical laboratory on a dry glass slide.

26. **Pap Test Liquid-Based:** A sample of cervical cells taken during a speculum exam of the vagina and cervix to detect cervical dysplasia or cancer. The sample is submitted to a clinical laboratory in a small vial of liquid preservative.

27. **Colposcopy:** An examination of the cervix, vagina, or vulva with a special microscope called a coloscope, to detect for abnormal cell changes.

28. **Gonorrhea Test:** A laboratory test performed to detect the bacterium Neisseria gonorrhoeae (also called GC). Test specimens may be collected from the urethra, vagina, cervix, rectum, and throat. Tests are also commonly performed on urine samples.

29. **Chlamydia Test:** A laboratory test performed to diagnose *Chlamydia trachomatis* (also called CT). Endocervical and urethral samples are taken during a pelvic exam. Clients may self-collect samples using vaginal swabs. Tests are commonly performed on urine samples. If checked, and the source of pay is CCare, Ahlers will generate an additional reimbursement rate for a combined GC/CT test.

30. **Wet Mount:** A microscopy procedure to detect vaginitis by visually scanning a sample of vaginal discharge on a slide prepared with saline and/or KOH.

31. **Serum Pregnancy Test:** A blood test to detect pregnancy soon after conception and before a missed period; useful for assessing suspected ectopic or molar pregnancy when performed in a series. Also called a quantitative pregnancy test.
32. **Negative Pregnancy Test:** A negative test either by serum or urine HCG as part of the pregnancy diagnosis.

33. **Positive Pregnancy Test:** A positive test either by serum or urine HCG testing as part of a pregnancy diagnosis.

34. **Immunization:** Providing vaccinations for a variety of diseases including, but not limited to, hepatitis B, HPV, and rubella.

35. **Infertility Screening:** A basic Level 1 screening that includes an initial infertility interview, education, physical exam, counseling, and appropriate referral.

36. **Other Lab or Exam:** Medical services provided in conjunction with other reproductive services, and other related services.

37. **No Lab or Exam:** No medical or laboratory services were provided. This is a “counseling only” visit.

38. **Hormone Implant In:** A surgical procedure to insert a flexible, matchstick-sized rod containing small amounts of a contraceptive hormone.

39. **Hormone Implant Out:** A surgical procedure to remove implanted contraceptive hormone rod.

40. **Hormonal Injection:** An intramuscular or subcutaneous injection of the contraceptive hormone progestin.

42. **Male Genitalia Exam:** Examination of the male external genitalia via visual inspection and palpation to detect any abnormalities.

43. **HIV Test-Standard:** A laboratory test performed by a reference laboratory (“outside” lab) by any means (blood, saliva) to detect the presence of human immunodeficiency virus (HIV) antibodies. Results are typically received by the clinic in 5-15 days.

44. **HIV Test-Rapid:** A point-of-care test performed by any means (blood, saliva) to detect the presence of human immunodeficiency virus (HIV) antibodies. Results are typically available in 20 minutes.

46. **EC–Future Need:** Prescription or product given for future use, with instructions to use in the event of unprotected intercourse or birth control failure, e.g., broken condom.

47. **VDRL/RPR:** Venereal Disease Research Laboratory Test/Rapid Plasma Region blood test for syphilis, a sexually transmitted infection.

48. **EC–Immediate Need:** Emergency contraception (EC) prescribed or provided to be used as soon as possible after unprotected intercourse to prevent pregnancy.
49. **Colo-Rectal Cancer:** A fecal sample placed on a card with chemical reagent to screen for blood in the stool.

50. **HPV Test:** A laboratory test using genetic viral typing to detect human papilloma virus (HPV) infection.
Use Section 14A to record non-medical services that: (1) inform a client about available family planning and related services and supplies, and/or (2) assist the client to clarify her or his needs and examine alternatives available. The provider should complete this section at the time of service. Alternatively, the information can be transcribed from the client’s medical record at the end of the visit.

01. **Contraceptive Counseling/Education**: Consultation/Information provided to a client regarding risks, benefits, and correct use of any birth control method being considered by the client. This could also indicate general methods of education where birth control choices are discussed and information provided in pamphlets, etc.

02. **Natural Family Planning/Fertility Awareness Method**: Consultation/education provided to a client concerning the non-medical or “natural” family planning techniques including using a calendar, mucous ovulation, basal body temperature, CycleBeads, and other related methods of fertility awareness.

03. **Sterilization Counseling/Education**: Consultation/education provided to a client by trained personnel regarding a permanent birth control method, i.e., tubal ligation or vasectomy.

04. **Infertility Counseling/Education**: Consultation/education provided to a client or couple by trained personnel concerning the inability of a client or couple to conceive.

05. **Tobacco Counseling/Education**: Consultation/education provided to a client by trained personnel regarding the assessment of tobacco habit/use, its relationship to birth control and general health, and assistance with resources to promote cessation.

06. **Substance Abuse Counseling/Education**: Consultation/education and information provided to a client by trained personnel concerning substance use habits and the relationship between
use, abuse, and health. This may include education on self-assessment, risk reduction, goal setting, and behavior change.

07. **Pregnancy Options Counseling/Education**: Consultation/education provided to a client by trained personnel regarding pregnancy testing, its limitations, and all pregnancy options.

08. **Preconception Counseling/Education**: Information and counseling regarding conception, including rubella, genetics, and all other factors that can affect a pregnancy. Identification of possible pre-pregnancy risks and provision of health education are given to help women/couples make informed choices about future childbearing.

09. **STD/HIV Prevention/Education**: Consultation/education provided to a client by trained personnel concerning sexually transmitted disease (including HIV) prevention and education.

10. **HIV Pre Test or Post Test Counseling/Education**: Consultation and information provided to a client by trained personnel concerning HIV during the pre-test or post-test visit.

12. **Nutrition Counseling/Education**: Consultation/information provided to a client regarding nutrition that promotes health and prevents disease.

13. **Abstinence Counseling/Education**: Consultation/information regarding abstinence from sex (not having intercourse) and discussion of positive outcomes of this decision, such as protection from pregnancy and sexually transmitted disease.

15. **Crisis Counseling/Education**: Consultation/education provided to a client by trained personnel regarding a crisis identified by the client.

16. **Abnormal Pap**: Consultation/education between a client and trained personnel regarding an abnormal pap result.

17. **Encourage Parental/Family Involvement**: Consultation/education provided to a client by trained personnel regarding the encouragement of family participation in the decision of minors seeking family planning services.

18. **Relationship Safety**: Consultation/education provided to a client of any age by trained personnel on how to resist attempts from others to engage in unwanted sexual activities. This includes teaching refusal skills to prevent coercion. Relationship safety may also include discussions about intimate partner violence or abuse and assault and steps the client can take to avoid violent situations.

19. **BSE**: Consultation/education provided to a client by trained personnel regarding Breast Self-Exam including encouragement of regular self-breast exams.

20. **TSE**: Consultation/education provided to a client by trained personnel regarding Testicular Self-Exam including the encouragement of regular testicular self-exams.
Section 19A: Pregnancy Intention Screening

19. PREGNANCY INTENTION SCREENING

☐ 1 - Yes, Near Future  ☐ 3 - Unsure
☐ 2 - No, Maybe Later  ☐ 4 - Never

Use this section to indicate the client’s intentions regarding pregnancy in the near future (e.g. next 6-12 months), regardless of which pregnancy intention screening tool was used. If pregnancy intention screening was not conducted, this section should be left blank. Client pregnancy intentions are expected to align with medical and counseling services provided at that visit, for example, if 1-Yes, Near Future is checked, preconception counseling should occur at the visit and be checked in Section 14A. For clients whose stated intentions change during the visit, the final stated intention should be indicated.

Section 13B.14B: Provider of Medical Services/
Counseling/Education Services

13B.14B. PROVIDER OF MEDICAL SERVICES/COUNSELING/EDUCATION SERVICES (Mark all that Apply)

☐ 1 - Physicians
☐ 2 - Physician Assistants, Nurse Practitioners, Certified Nurse Midwives
☐ 3 - RNs, LPNs
☐ 4 - Other service providers, health educators, social workers, clinic aides and lab technicians.

Use this section to identify who provided the services in Section 13A and Section 14A. Check all that apply, based on the following provider categories:
1. Physician: a licensed doctor of medicine (M.D.) or osteopathy (D.O.).
2. Physician Assistants (PA), Nurse Practitioner (NP), or Certified Nurse Midwife (CNM).
3. Registered Nurse (RN) or licensed practical nurse (LPN).
4. Other service providers, health educators, social workers, clinic aides, and lab technicians.

A provider is a trained individual whose primary responsibility is to assess the client's health status and exercise independent judgment regarding which services the client needs.
Section 15A: Primary Contraceptive Method
Section 15B: If None at the End of This Visit, Give Reason

<table>
<thead>
<tr>
<th>15A. PRIMARY CONTRACEPTIVE METHOD</th>
<th>15B. IF NONE AT THE END OF THIS VISIT, GIVE REASON.</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Complete before and after blocks)</td>
<td></td>
</tr>
<tr>
<td>HIGHLY EFFECTIVE</td>
<td>BEFORE VISIT</td>
</tr>
<tr>
<td>14 - Male Sterilization</td>
<td>□ 1 - Planned</td>
</tr>
<tr>
<td>01 - Female Sterilization</td>
<td>□ 2 - Planned</td>
</tr>
<tr>
<td>11 - Hormone Implant</td>
<td>□ 3 - Seeking Pregnancy</td>
</tr>
<tr>
<td>15 - IUS</td>
<td>□ 4 - Not Sexually Active</td>
</tr>
<tr>
<td>03 - IUD</td>
<td>□ 5 - Other</td>
</tr>
<tr>
<td>22 - LAM</td>
<td>□ 6 - None</td>
</tr>
<tr>
<td>MODERATELY EFFECTIVE</td>
<td>□ 7 - Other</td>
</tr>
<tr>
<td>06 - Oral Contraceptives</td>
<td>□ 8 - Unplanned</td>
</tr>
<tr>
<td>17 - Hormonal Patch</td>
<td>□ 9 - Other</td>
</tr>
<tr>
<td>18 - Vaginal Ring</td>
<td>□ 10 - None</td>
</tr>
<tr>
<td>04 - Diaphragm/Cap</td>
<td></td>
</tr>
<tr>
<td>LESS EFFECTIVE</td>
<td></td>
</tr>
<tr>
<td>06 - Male Condom</td>
<td></td>
</tr>
<tr>
<td>19 - Female Condom</td>
<td></td>
</tr>
<tr>
<td>21 - Contraceptive Sponge</td>
<td></td>
</tr>
<tr>
<td>20 - Withdrawal</td>
<td></td>
</tr>
<tr>
<td>08 - NFP/FAM</td>
<td></td>
</tr>
<tr>
<td>07 - Spermicide</td>
<td></td>
</tr>
<tr>
<td>OTHER</td>
<td></td>
</tr>
<tr>
<td>09 - Other Method</td>
<td></td>
</tr>
<tr>
<td>13 - Abstinence</td>
<td></td>
</tr>
<tr>
<td>10 - None</td>
<td></td>
</tr>
<tr>
<td>(Complete the table according to the codes)</td>
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</tr>
</tbody>
</table>

Use Section 15A to record the contraceptive method the client used before the visit and the method the client will use as a result of the visit. It should be noted that agencies’ electronic data collection systems may not reflect the order of methods by effectiveness as shown on the paper CVR. Use Section 15B to record the reason that the client will not use a contraceptive method after the visit. Here are instructions that apply to the coding for both sections:

- In the Section 15A Before Visit space, enter the two-digit code of the primary or most effective method even if more than one method is used.
- In the Section 15A After Visit space, enter the code of the primary or most effective method to be used after the visit even if more than one method will be used. If the client receives two methods, code the primary method only.
- Clients relying on their partners’ methods should be marked as users of those methods. For example, if a male client relies on his female partner’s Depo-Provera for contraception, use code 16. Similarly, if a female client relies on her male partner’s vasectomy, use code 14.
- If no contraceptive method is continued or initiated at the end of this visit, enter code 10 (None) in Section 15A and the most important reason for this decision in Section 15B. Please note that code 3-Seeking Pregnancy in Section 15B is unallowable for CVRs with a CCare source of pay.
- In order to bill CCare for a client requesting an IUD removal for the purposes of seeking pregnancy, mark box 10 (None) in Section 15A and box 7 (Other) in Section 15B.
- For infertility clients, enter code 10 (None) in Section 15A. (Even if a method is being used as treatment, its purpose is not to prevent pregnancy, but to enhance fertility.)
- If any code except 10 is entered in the After Visit space in Section 15A, skip Section 15B.
Section 16: Referral Information

16. REFERRAL INFORMATION (Check all Applicable)

- ☐ 02 - High Risk Pregnancy  ☐ 05 - Sterilization  ☐ 10 - Social Services
- ☐ 15 - Adoption  ☐ 06 - Infertility  ☐ 09 - Nutrition
- ☐ 03 - Abortion  ☐ 07 – NFP/FAM  ☐ 13 - Substance Abuse
- ☐ 01 - Prenatal  ☐ 04 - STD  ☐ 14 - Abuse/Violence
- ☐ 16 - Breast Evaluation  ☐ 17 - Colposcopy  ☐ 16 - Breast Evaluation
- ☐ 12 - Mamnography or U.S.  ☐ 08 - Other Medical  ☐ 11 - None

Use Section 16 to indicate whether the client was referred to another agency or clinician, or to another program in a multi-service project. Check all that apply for the current visit. All referral information must be documented in the client medical record.

Section 17: Medicaid Billing

17. MEDICAID BILLING (Complete top section for CCare)

<table>
<thead>
<tr>
<th>Supplies Billed</th>
<th>Qty.</th>
<th>Unit Price</th>
<th>Supplies Billed</th>
<th>Qty.</th>
<th>Unit Price</th>
</tr>
</thead>
<tbody>
<tr>
<td>01 - Orals</td>
<td>[/]</td>
<td>[/]</td>
<td>07 - Condoms, Male</td>
<td>[/]</td>
<td>[/]</td>
</tr>
<tr>
<td>16 - EC</td>
<td>[/]</td>
<td>[/]</td>
<td>08 - Condoms, Fem.</td>
<td>[/]</td>
<td>[/]</td>
</tr>
<tr>
<td>14 - Patch</td>
<td>[/]</td>
<td>[/]</td>
<td>12 - Cervical Cap</td>
<td>[/]</td>
<td>[/]</td>
</tr>
<tr>
<td>15 - Mirena IUD</td>
<td>[/]</td>
<td>[/]</td>
<td>17 - Ring</td>
<td>[/]</td>
<td>[/]</td>
</tr>
<tr>
<td>03 - Copper IUD</td>
<td>[/]</td>
<td>[/]</td>
<td>18 - Sponge</td>
<td>[/]</td>
<td>[/]</td>
</tr>
<tr>
<td>04 - Depo Provera</td>
<td>[/]</td>
<td>[/]</td>
<td>19 - Subdermal Implants</td>
<td>[/]</td>
<td>[/]</td>
</tr>
<tr>
<td>05 - Diaphragm</td>
<td>[/]</td>
<td>[/]</td>
<td>20 - Cycle Beads</td>
<td>[/]</td>
<td>[/]</td>
</tr>
<tr>
<td>06 - Spermicide</td>
<td>[/]</td>
<td>[/]</td>
<td>21 – Skyla IUS</td>
<td>[/]</td>
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</tr>
</tbody>
</table>

Section 17 is used to generate billing for contraceptive supplies provided to clients enrolled in CCare. If the client is not enrolled in CCare or is receiving services not covered by CCare, this section can be ignored. Note that contraceptives are the only supply/medication for which you may receive payment.

Please see Section C, Exhibit 8 for the contraceptive supply codes list, with maximum allowable quantities and reimbursement rates per unit that may be billed on each date of service. Enter the appropriate quantity and CVR code for each method you dispense to the client.

Pay particular attention to the following special instructions for the billing of these methods. The patch and the ring are both billed using the quantity per each. Even though the patch comes in a box of three (one cycle), they are billed as 1/3 of the total price times the quantity of three. For Depo, the unit price is the total acquisition cost. For OHP use quantity 150 and the total unit cost, for CCare use quantity 1 or 150 and the total unit cost. The Ahlers system will convert quantity 150 to quantity 1 for CCare.
You will be reimbursed at your **acquisition cost**, not at the CCare maximum allowable amount. Each agency must document the calculations used to determine the acquisition cost of each supply. That information must be available for audit purposes. See Section C for guidance on how to calculate acquisition costs.

### Section 17A: Third Party Resource (TPR) Codes

**Complete Section 17A if the CCare client indicated having any insurance coverage on the CCare Enrollment Form.**

You must use item **1 - Explanation Code** to indicate why no payment was made by the private insurance company. (See below for the list of seven TPR codes to use.) Do not include an Explanation Code for those claims billed to CCare in which partial payment was made by the private insurance company. If you prefer, you may use an alternate list of standard claim reason/remark codes instead of the list of TPR codes listed below. These standard codes will then be converted into one of the seven TPR codes during claims processing. Contact the RH Program and request the CCare TPR and Reason/Remark Code Crosswalk for the full list. If insurance is not billed due to confidentiality needs, mark NC.

<table>
<thead>
<tr>
<th>TPR Codes: Single Insurance Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Code</strong></td>
</tr>
<tr>
<td>UD</td>
</tr>
<tr>
<td>NC</td>
</tr>
<tr>
<td>PP</td>
</tr>
<tr>
<td>NA</td>
</tr>
<tr>
<td>NP</td>
</tr>
<tr>
<td>MB</td>
</tr>
<tr>
<td>OT</td>
</tr>
</tbody>
</table>
Section D: Exhibits

Exhibit 1: Project/Site Number Request Form
Exhibit 2: CCare Eligibility Database and Ahlers Web Page User Application
Exhibit 3: Reports Generated from CVR Data
Exhibit 4: Accessing Ahlers & Associates Data Online
Exhibit 5: Oregon CVR
Exhibit 6: File Format for Data Submission from non-WINCVR Systems
Exhibit 7: CVR Submission Deadlines & Ahlers Report Creation Dates
Exhibit 8: CVR Error Messages
Exhibit 9: Sample CVR Error Report
Section E: Appendices

Appendix A: Directory of Oregon Family Planning Clinics

Appendix B: Oregon Reproductive Health Program Contacts

Appendix C: Oregon Health Authority Organizational Chart

Appendix D: Center for Prevention and Health Promotion Organizational Chart

Appendix E: Adolescent, Genetics, and Reproductive Health Section Organizational Chart

Appendix F: Medicaid Income Guidelines

Appendix G: Chlamydia Manual