This document is being provided in an alternate format (large print, audio or data CD, or Braille) for informational purposes only. Any documents that need to be completed and returned must be completed and returned in written, non-alternative format.

DOH-4282 (8/14)

NEW YORK STATE DEPARTMENT OF HEALTH

Office of Health Insurance Programs

Family Planning Benefit Program Application

Please print clearly. Please ask for help if there is anything you do not understand.

SECTION A APPLICANT INFORMATION

Tell us who you are and how to contact you. (PLEASE USE YOUR FULL LEGAL NAME)

First Name, Middle Initial, Last Name ____
Primary Language ____
Home Address ____
Street ____
Apt. No. ____
City ____
State ____
Zip Code ____
County of Residence ____

If you cannot receive mail or a benefit card at your home address due to confidentiality concerns or for other reasons, please give a different mailing address below. If you do not need to give a different mailing address, please check the box marked 'No confidential address needed'.

☐ No confidential address needed.
Mailing Address ____
Street ____

Apt. No. ____
City ____
State ____
Zip Code ____
Phone Number ____

Are you a veteran?

☐ Yes
☐ No

SECTION B HOUSEHOLD INFORMATION

List your name and the names of the people in your family who live with you. You may list your spouse and your children under 21, even though they are not applying. Please use another page if you need to list more people.

1. First Name, Middle Initial, Last Name ____
    Relationship to Person on Line 1 Self
    Date of Birth (MM/DD/YY) ____
    Sex M or F ____
    FOR FPBP APPLICANT ONLY
        Social Security Number ____
        Race/Ethnic Group (See Codes Below) ____

2. First Name, Middle Initial, Last Name ____
    Relationship to Person on Line 1 ____
    Date of Birth (MM/DD/YY) ____
    Sex M or F ____
3. First Name, Middle Initial, Last Name ____
    Relationship to Person on Line 1 ____
    Date of Birth (MM/DD/YY) ____
    Sex M or F ____
4. First Name, Middle Initial, Last Name ____
    Relationship to Person on Line 1 ____
    Date of Birth (MM/DD/YY) ____
    Sex M or F ____

Race/Ethnic Group Codes:

A: Asian
B: Black or African American
H: Hispanic or Latino
I: American Indian or Alaskan Native
P: Native Hawaiian or Other Pacific Islander
W: White
U: Unknown

SECTION C INCOME

List ALL of the type(s) and amount(s) of money you receive. Be sure to include earnings from work (including self-employment), unemployment benefits, interest, Social Security benefits, pensions, disability payments, money from relatives or friends, or any other payments.

Type of Income (Wages, UIB, SSA Benefits) ____
Amount of Gross Income (Before Taxes/Deductions) ____
How Often is the Income Received? (Weekly, Every Two Weeks, Monthly, Other) ____

If you have no income, please explain how you are meeting your needs (for example; living with friends or relatives): ____

Do you have any unpaid medical bills, related to family planning, from the last 3 months?

☐ Yes
☐ No
Yes, you must provide proof of your income and residency for the month(s) when unpaid services were received.

Have you started or ended a job in the last 6 months? If Yes, please give details below: ____

SECTION D CITIZENSHIP

Are you a U.S. citizen, national or Native American?

☐ Yes
☐ No

If No, please give the following information. Your answers to these questions will be kept completely confidential.

First Name, Middle Initial, Last Name ____
Please mark one box that indicates your current Citizenship or Immigration Status.

- ☐ Immigrant/non-citizen (Enter the date you entered the United States ____)
- ☐ Non-immigrant (Visa holder)
- ☐ None of the above

SECTION E HEALTH INSURANCE

You may still be eligible even if you have other health insurance, especially if it does not cover family planning

services, or if you have a 'good cause' reason that your health insurance should not be billed.

Do you have coverage through any of the following?

- ☐ Medicaid
- ☐ Medicare
- ☐ Child Health Plus

Do you have other private health insurance?

- ☐ Yes
- ☐ No
- ☐ I Don't Know

If Yes:

Name(s) of Person(s) Covered ____
Name of Policy Holder/Subscriber ____
Insurance Company Name ____
Group/Policy Number ____

Will billing any other health insurance cause harm to your physical or emotional health or safety, and/or will it interfere with the privacy and confidentiality of your application for or receipt of family planning services?

☐ Yes
☐ No

If Yes, please ask your provider to call for 'Good Cause'

GOOD CAUSE AUTHORIZATION

If above answer is Yes, provider must call 1-800-541-2831 for a Good Cause Authorization. (This does not need to be done if this application is accompanying a PE Screening and authorization for Good Cause was granted at that time).

Good Cause Authorization Call Date: ____
  Approved?
    ☐ Yes
    ☐ No
Name of Call Center Representative: ____
  Duration of Good Cause:
    From ____ to ____

TERMS, RIGHTS, AND RESPONSIBILITIES

By completing and signing this application, I am applying for the Family Planning Benefit Program (FPBP). I agree

to the release of personal and financial information from this application and any other information to determine eligibility. I understand that I may be asked for more information. I agree to immediately report any changes to the information on this application.

I understand that I must provide the information needed to prove my eligibility, if I have been unable to get the information, I will tell the New York State Department of Health (SDOH) or its designee. The SDOH or its designee may be able to help in getting the information.

I understand the FPBP may check the information given by me for this application without my confidentiality being compromised. The state, social services district and provider who assist in completing this application will keep the information confidential according to 42 U.S.C. 1396a(a)(7) and 42 CFR 431.300-431.307, and any federal and state laws and regulations.

I understand that my eligibility for this program will not be affected by my race, color, disability, sex, or national origin. I also understand that depending on the requirements of this program my citizenship status may be a factor in whether or not I am eligible.

I understand that anyone who knowingly lies or hides the truth in order to receive services under this program is committing a crime and subject to federal and state penalties and may have to repay the amount of benefits received and may also be given civil penalties.

I understand that I must provide documentation of my citizenship and identity to the SDOH or its designee or to the Family Planning Provider on behalf of the SDOH to receive Family Planning Benefits. I also understand that SDOH or its designee can assist me in determining my status and obtaining any necessary documents if I request help. Once I have provided my documents proving my citizenship and identity, I will not have to provide them again. If I am filling out this form as a mail-in renewal, and have not yet provided these documents, I will need to provide them.

Immigration: United States Citizenship and Immigration Services (USCIS) has said that enrollment in Medicaid CANNOT affect a person's ability to get an identification card, become a citizen, sponsor a family member or travel in and out of the country (except if Medicaid pays for long term care in a place like a nursing home or a psychiatric hospital).

The State will not report any information on this application to the USCIS.

ASSIGNMENT OF RIGHTS FOR MEDICAL SUPPORT AND THIRD PARTY PAYMENT

I understand that FPBP does not pay medical expenses that insurance or another person is supposed to pay, unless there is good cause not to use other insurance. All persons applying for FPBP are required to give the SDOH or its designee any rights they may have to medical support or other insurance payment for family planning services, unless they request and receive a good cause exemption. When I sign this application for myself, or for another person for whom I can legally give away rights, I am giving to the SDOH or its designee all of my right to receive medical support and third party payments for family planning services for the entire time I am on Medicaid.

REIMBURSEMENT OF MEDICAL EXPENSES

After the date of my application, reimbursement of covered family planning services and supplies will only be available if obtained from Medicaid-enrolled providers.

SOCIAL SECURITY NUMBER (SSN)

I understand that I must give my SSN in order to receive FPBP. This is required by section 1137(a) of the Social Security Act and the Medicaid regulations (42 CFR 435.910 and 42 U.S.C. 1320b-7(a)). The FPBP will use the SSN to verify my income, eligibility and the amount of medical assistance payments made on my behalf. The information may be matched with records in other agencies, such as the Social Security Administration and/or the Internal Revenue Service.

CONFIDENTIALITY STATEMENT

All of the information you provide to us will remain confidential. The only people who will see this information are the state or local agencies and the person assisting you in completing the application that need to know this information in order to determine if you are eligible. The person helping you with this application cannot discuss the information with anyone, except a supervisor or the state or local agencies that need this information.

RELEASE OF MEDICAL INFORMATION

I consent to the release of any medical information about me and any member of my family for whom I can give consent by: my Primary Care Providers, any other health care provider, or the SDOH or its designee and any health care provider involved in caring for me or my family, as reasonably necessary for my providers to carry about treatment, payment, or health care operations, to SDOH or its designee and other authorized federal state, and local agencies for purposed of administration of the Medicaid program. I also agree that the information released may include HIV, mental health or alcohol and substance abuse information about me and members of my family to extent permitted by law.

I certify that I have read and understand the Terms, Rights and Responsibilities above. I certify under penalty of perjury that everything on this application is the truth as best I know.

Date ____
Applicant's Signature ____

DECLINATION OF MEDICAID ELIGIBILITY DETERMINATION

I, ____, have been informed of the enhanced benefits and additional services and coverage available under Medicaid. I choose not to apply for Medicaid at this time, and have requested an eligibly determination for the Family Planning Benefit Program only. I understand that I may apply for Medicaid or other insurance programs at any time in the future if I wish.

Date ____
Applicant's Signature ____
Provider/Medicaid Staff Signature ____

AUTHORIZED REPRESENTATIVE DESIGNATION

By signing below, you are allowing another person or agency to apply for Family Planning Benefits for you, discuss your application or case if needed, and receive notices and/or correspondence on your behalf.

Name and address of person or agency to be given general health information:

Name: ____
Address: ____
Phone Number ____
Date ____
Applicant's Signature ____
Representative's Signature ____