# APPLICATION
# FAMILY PLANNING BENEFIT PROGRAM

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

## SECTION A: CONTACT INFORMATION

Tell us who you are and how to contact you.

| **NAME** First | Middle Initial | Last | Primary Language Spoken |
|---|---|---|---|
| | | | |

| Home Address | Street | Apt# | City | State | Zip Code | County |
|---|---|---|---|---|---|---|
| | | | | | | |

**If you do not want to receive mail or a benefit card at your home address, give a different address below.**

| Mailing Address (if different) | Street | Apt# | City | State | Zip Code | County |
|---|---|---|---|---|---|---|
| | | | | | | |

Phone number(s) where you can be reached:

Is anyone in the household a veteran? If YES, Name:

Does anyone who is applying have family planning bills from the past three months? Yes ❒ No ❒
The Family Planning Benefit Program may be able to help pay them.

**Do you need these services kept confidential? Yes ❒ No ❒**

## SECTION B: HOUSEHOLD INFORMATION

List the names of everyone applying. If you are applying, list yourself first. List other people living with you even if they are not applying. You must list your spouse and you may list your children.

| | First Name, Middle Initial, Last Name (Use another page if you need to list more people) | Date of Birth (MM/DD/YY) | Sex M/F | Relationship to Person on Line 1 | Is this person applying for family planning benefits (Yes/No) | **Applicants only** Social Security Number | **Applicants only** Race/Ethnic Group (See Codes) |
|---|---|---|---|---|---|---|---|
| 01 | | | | Self | | | |
| 02 | | | | | | | |
| 03 | | | | | | | |
| 04 | | | | | | | |

**Race/ Ethnic Affiliation Codes:** *(optional)*
**B**= Black or African American **W**= White **I**= American Indian or Alaskan Native **U**= Unknown
**A**= Asian **H**= Hispanic or Latino **P**= Native Hawaiian or other Pacific Islander

## SECTION C: HOUSEHOLD INCOME

List the types of money and the amount received by anyone listed in Section B. Be sure to include earnings from work, child support payments, unemployment benefits, interest, Social Security Benefits, pensions, disability payments, money from relatives or friends or other payments.

| Name of person working or receiving money | Type of income (example: wages) | How much does the person receive (before taxes) | How often is the income received? (weekly, every two weeks, monthly, other) |
|---|---|---|---|
| | | | |
| | | | |

If no income, please explain how you are meeting your needs (for example, living with friend or relative):

Do you have to pay for child care (or for care of a disabled adult) in order to work or go to school? Yes ❒ No ❒

| If yes | Name(s): | How much? $ | How often? (example: weekly, monthly) |
|---|---|---|---|
| | | | |

## SECTION D: CITIZENSHIP

This information is needed for those people applying for family planning benefits.

Is everyone who is applying a U.S. citizen? (*If yes, skip to Section E*) Yes ❒ No ❒

If NO, please give the following information for anyone **applying** for family planning benefits who is not a U.S. citizen. Your answers to these questions will be kept completely confidential.

| First Name, Middle Initial, Last Name | Does this person belong to any of the categories listed below? Check the appropriate box. | | | If A or B, on what date did the person enter the United States? (mm/dd/yy) |
|---|---|---|---|---|
| | A ❒ | B ❒ | None ❒ | |
| | A ❒ | B ❒ | None ❒ | |

**A**.: Check A if the person is under one of the following categories:

Legal Permanent Resident (green card holder)
Asylee Refugee Amerasian Cuban/Haitian Entrant
Withholding of Deportation Parolee for at least one year
Conditional Entrant Some battered immigrants and/or children
Native American born in Canada who is at least 50% Native American

**B**.: Check B if the person is under one of the following categories:

Order of Supervision Stay of Deportation Suspension of Deportation
Voluntary Departure Deferred Action status Parolee for less than one year
Covered by an approved immediate relative petition
Properly filed or granted application for adjustment of status
Has lived continuously in the United States since before January 1, 1972
Living in the United States with the knowledge and permission or acquiescence of the INS and whose departure INS does not contemplate enforcing.

## SECTION E: HEALTH INSURANCE

You may still be eligible even if you have other health insurance

Does anyone applying have Medicaid, Family Health Plus or Child Health Plus? If YES, give the name of anyone with coverage:

Does anyone have other health insurance that covers a person applying for the Family Planning Benefit Program Yes ❒ No ❒ Don't know ❒

| If YES | | |
|---|---|---|
| | Person(s) Covered: | |
| | Name of Policy Holder: | Group/Policy # |
| | Insurance Company Name: | Monthly Cost$ |

## 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 needed 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 social services district. The social services district may be able to help in getting the information.

I understand the FPBP may check the information given by me for this application. The state, social services district and provider who assist in completing this application will keep this 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 age or 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 be given civil penalties.

## 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 to the Medicaid agency any rights they may have to medical support or other insurance payments for family planning services. When I sign this application for myself, or for another person for whom I can legally give away rights, I am giving to the Medicaid agency all of my rights to receive medical support and third party payments for family planning services for the entire time I am on Medicaid.

**REIMBURSEMENT OF MEDICAL EXPENSES**

I understand that I have a right as part of my FPBP application to request reimbursement of expenses I paid for covered family planning services and supplies received during the three month period prior to the month of my application, but no earlier than October 1, 2002. 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 the records in other agencies, such as the Social Security Administration 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 who 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.

**I certify that I am a U.S. citizen or national, or an alien with satisfactory immigration status. The social services district can assist me in determining my status if I request help.**

Date_____ Applicant's Signature X_____

**Immigration Information:** The Immigration and Naturalization Service (INS) has said that enrollment in Medicaid CANNOT affect a person's ability to get a green 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 psychiatric hospital). **The State will not report any information on this application to the INS.**

**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 X_____ Spouse's Signature (if applying)_____**

**Declination of Medicaid and Family Health Plus Eligibility Determinations:**

**I, _____, have been informed of the benefits available under Medicaid and Family Health Plus. I choose not to apply for Medicaid and Family Health Plus at this time, and have requested an eligibility determination for the Family Planning Benefit Program only. I understand that I may apply for these other programs in the future if I wish.**

**Date_____ Applicant's Signature X_____**

**Provider/Medicaid Staff Signature _____**

**IF AFTER READING AND COMPLETING THIS FORM, YOU DECIDE THAT YOU DO NOT WANT TO APPLY FOR THE FAMILY PLANNING BENEFIT PROGRAM, SIGN your name below:**

**Date_____ I consent to withdraw my application: X_____**

**FOR OFFICE USE ONLY:**

To be completed by the person assisting with the application:

Signature of Person Who Obtains Eligibility Information: Employed By:

X_____ _____

To be completed by the Local Social Services District:

Eligibility Determined by: Date: Eligibility Approved By: Date:

_____ _____ _____ _____

Center Office: Application Date: Unit ID: Worker ID: Ver:

Case Name: District: Case Type: Case No:

Effective Date: MA Disposition Reason Code: Proxy: Reg. No.