

INSTRUCTIONS FAMILY PLANNING BENEFIT PROGRAM APPLICATION

Confidentiality Statement:

All of the information you provide on this application will remain confidential. The only people who will see this information are the enrollment facilitators and the state or local agencies and family planning providers who need to know this information in order to determine if you (the applicant) and your household members are eligible. The person helping you with this application cannot discuss the information with anyone, except a supervisor or the state or local agencies or family planning providers who need this information.

INSTRUCTIONS. These are the instructions for completing the Family Planning Benefit Program application. This application is for people applying for the Family Planning Benefit Program (FPBP) only.

Applicants must sign the declination on the application stating that they do not want their eligibility determined for Medicaid or Family Health Plus. You may apply for Medicaid or Family Health Plus any time in the future. These programs cover many other health care services in addition to family planning services. If you want your eligibility determined for Medicaid or Family Health Plus, you must complete the “Access NY Health Care” (DOH-4220) application.

PLEASE READ the entire application and instructions before you fill out the application. You may attach an additional sheet of paper if there is not enough room for your answers on the application.

SECTION A: Contact Information

In this section, we ask for the applicant’s name and information about how to contact the applicant. The home address is where the persons applying for the FPBP live. The mailing address, if different, is where the Common Benefit card, all notices and other information will be sent.

Applicants can receive confidential family planning services. If you want confidential notification, check “YES” after the question, “Do you need these services kept confidential?”. If you use a different mailing address to insure confidentiality, complete the next section “Mailing Address (if different)”, circle the mailing address and write “Confidential” in the margin next to it.

Also, enter whether anyone in the household is a veteran. Indicate whether you or anyone who is applying has unpaid or recently paid family planning bills from the past three months. If so, the FPBP may be able to help pay them.

SECTION B: Household Information

List the names of all the people living with you who want to apply for FPBP. 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. Fill out the information requested for each household member:

- Indicate whether the person listed on the line is also applying for FPBP (enter “yes” or “no”).
- A social security number must be provided for all persons applying. If anyone applying does not have a social security number, they must apply for one. Applicants may attest to their social security number.
- Race/Ethnic Group – this information is optional. It is asked to make sure all people have access to the program. If you fill out this information, use one of the codes shown on the application that best describes the person’s race or ethnic background.

SECTION C: Household Income

In this section, list all types of income and the amount received by the people you 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.

- If the household has no income, please explain how the applicants are being supported.
- Indicate if you have to pay for child care or for care of a disabled adult in order to work or go to school. Check the appropriate box. If yes, give the name of the individual(s) who receives the care, how much you pay for the care, and how often you pay the amount listed (for example weekly, monthly).

SECTION D: Citizenship

This information is needed for those people applying for family planning benefits. The State will not report any information on this application to the INS.

SECTION E: Health Insurance

It is important to tell us whether anyone in your household has health insurance or is covered by someone else’s insurance, because:

- For certain applicants, we will subtract the cost of the health insurance from your income;
- For future medical bills, it helps us determine which insurance should pay first.

If anyone in the household has Medicaid, Family Health Plus or Child Health Plus, give the name(s) of the household member(s). This may help us reduce paperwork for you.

If anyone in the household has other health insurance coverage, provide the information requested.

If you do not know or cannot get the health insurance information, please check “Don’t know”. If you want this application and receipt of FPBP to be kept confidential from the health insurance policyholder, please write or print in large letters “Good Cause” across Section E on the front of the application.