NEW YORK STATE DEPARTMENT OF HEALTH
Office of Health Insurance Programs

Medicaid Presumptive Eligibility (PE) for the Family Planning Benefit Program (FPBP) Provider Screening Form

1. Applicant's Personal Information

a. Applicant's Legal Name: _____
First Name Middle Initial Last Name

b. Legal Residence Address: _____
House/Apt # Street City Zip Code

County of Legal Residence: _____ Resident of New York City (NYC): ☐ Yes ☐ No

Is it OK for us to send a Family Planning Benefit Program benefit card and related mail to your residence address? . . . . . ☐ Yes ☐ No
If not, please provide us with a confidential mailing address below:

Confidential Mailing Address: _____
House/Apt # Street City Zip Code

c. Home Telephone Number (with area code): (_____) _____ – _____

Is it OK for you to get calls related to your application at this number? If not, please provide us with a confidential contact number below:

Confidential Telephone Number (with area code): (_____) _____ – _____

d. Social Security Number: _____ – _____ – _____

e. Date of Birth: _____ / _____ / _____
MM DD YYYY

f. Sex: ☐ Female ☐ Male

g. Citizenship/Immigration Status: (1) Are you a U.S. Citizen? . . . . . ☐ Yes ☐ No

(2) If no, do you have satisfactory immigration status? . . . . . ☐ Yes ☐ No ☐ I Don't Know

To be eligible for PE for the Family Planning Benefit Program, you must be a U.S. Citizen or have satisfactory immigration status. If you are not documented, or are a temporary non-immigrant, you may be able to get Medicaid for the treatment of an emergency medical condition or a pregnancy, if you are determined to be otherwise eligible. To apply for this coverage, contact your local department of social services (LDSS) or the Human Resources Administration (HRA), if you live in NYC.

If the answer to **both 1 and 2** is either "NO" or "I Don't Know", **STOP the Screening Process**

If the answer to **either 1 or 2** is "YES", **CONTINUE the Screening Process**

2. Health Insurance

Public Health Insurance:

Do you have or have you recently applied for: Medicaid/Family Health Plus (MA/FHPlus) . . . . . ☐ Yes ☐ No

Child Health Plus (CHPlus) . . . . . ☐ Yes ☐ No

Temporary Cash Assistance (TA) . . . . . ☐ Yes ☐ No

If you are enrolled in Medicaid, Family Health Plus, or Temporary Cash Assistance, you are not eligible for the FPBP. If you have recently applied for these programs, contact the place where you applied and follow through on the completion of your current application. If you already have CHPlus, you may still apply for PE for the FPBP if you need confidential family planning services.

If you have received services in the past and know your CIN, enter it here _____

Private or Employer Sponsored Health Insurance:

Are you covered by any other health insurance or plan? . . . . . ☐ Yes ☐ No ☐ I Don't Know

If yes, what is the name of the Health Care Insurance Plan? _____

What is the policy holder's name and their relationship to you? _____

If there is a premium that the household pays out of pocket for health insurance, what is the monthly amount? $ _____

If you are under age 21, it is not required for you to provide this information to us.

3. Good Cause Question

a. 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

b. Good Cause Authorization

If 3(a) is "YES", Provider must call 1-800-541-2831 for a Good Cause Authorization

Good Cause Authorization Call Date: _____ Approved? . . . . ☐ Yes ☐ No

Name of Call Center Representative: _____

Duration of Good Cause: From _____ to _____

4. Under 21 Income Rule

If you are under age 21 and you live with your parent(s), we must count their monthly income together with your own income (if you have any), to arrive at a total amount for household (HH) income.

However, if you are unable to obtain your parent's income information without causing harm to your physical or emotional health or safety, and/or interfering with the privacy and confidentiality of your application for or your receipt of family planning services, we are able to determine your eligibility for PE for the FPBP using only your own monthly income.

Are you able to get parental income information? . . . . . ☐ Yes ☐ No

If "No", please provide only your individual income information.

5. Household Size

Count these individuals in your household:

APPLICANT		1
# of parents of applying individual living in HH (Do not count if their income is not included – see Section 4)		
# of applicant's children under age 21 living in HH (Can be counted whether or not they are applying)		
Spouse of applicant living in HH (Count only if they live with you)	+	
a. **HH size** (Total # of individuals counted)	=	**Total HH Size**

Notes: Pregnant Women are counted as 2 (Pregnant Woman + Unborn)
When you count an individual in the HH, you must also count their income

6. Household Income Calculation

a. Household's total monthly **gross** income (Before taxes and any deductions) $ _____

Include all wages, tips, commissions, social security retirement, survivors, and disability benefits, child support, alimony, unemployment benefits, worker's compensation payments, disability payments, etc. (Do not include wages, grants or loans of students or any Temporary Cash Assistance or SSI payments).

b. Deductions allowed (monthly amounts)

$90.00 from earned income only		$
Child care expenses related to employment ($175.00 maximum per child over age 2 or over; $200.00 maximum per child under age 2)		$
$100.00 per HH from child support received by applicant		$
Health insurance premium (amount paid by applicant or parent if parental income is included)		$
Total deductions (add previous 4 lines)	**6b +**	$
NET MONTHLY INCOME:	**6a minus 6b = 6c**	**$**

7. Presumptive Eligibility for FPBP Determination

Compare the NET monthly income amount on line 6(c) to 200% of the FPL for the applicable HH size on line 5a.

If the Net Monthly Income is:

***Less than or equal to 200% of the FPL for the applicable HH size:** . . . . . ☐ Yes

Applicant IS Presumptively Eligible for the FPBP. Give PE Determination Letter and FPBP Document Checklist. Provider must submit PE Screening Form, PE Determination Letter and FPBP Document Checklist to the NYSDOH Designated Agent within five (5) business days of the screening date. The PE individual must also sign, date and complete an application for FPBP (DOH-4282) to have eligibility determined for ongoing FPBP services. If a signed, dated and completed application for FPBP was completed, forward it and any documents provided, they should also be included or later forwarded to the NYSDOH Designated Agent.

***More than 200% of the FPL for the applicable HH size:** . . . . . ☐ No

Applicant IS NOT Presumptively Eligible for the FPBP. No further action is required. Give applicant PE Determination Letter.

8. Contact Information and Screening Date

FPBP Provider Agency Name: _____

Provider Site Address: _____

Screener's Phone Number (with area code): (_____) _____ – _____ ext _____

Screener's Fax Number (with area code): (_____) _____ – _____

Presumptive Eligibility Screener's Name: _____

Screener's Signature: _____

Date Screening Form/Determination Completed: _____ / _____ / _____
MM DD YYYY