FLORIDA DEPARTMENT OF HEALTH

Office Date Received

Health Insurance Application for Extended Family Planning Benefits

A Special Medicaid Program

Name: First	M.I.	Last	Maiden Name	Area Code ( ) Phone Number
Residence: Number	Street	Apt. No.	City	County State Zip Code
Mailing Address (Required if different from above):				If no home phone, number where you can be reached ( )

Please answer the following questions:

1. In the past, have you had one or both of the following services? Hysterectomy: ☐ Yes ☐ No Tubal ligation: ☐ Yes ☐ No
2. What was the date of your last menstrual period? _____ ☐ Yes ☐ No
3. The benefits you will receive are intended to delay pregnancy through family planning services. Do you wish to receive these services? ☐ Yes ☐ No
4. List all of the people who live in your home (write your name first):

****Only the applicant must provide her Social Security Number and her proof of citizenship and identity.**

First M.I. Last	Relationship to Applicant	**Social Security Number	Date of Birth	Race	Sex	US Citizen? Yes	No	** If no, give INS ID Number	Date of Entry	Applied for Medicaid? Yes	No
	(Self)										

5. Income: Complete the following information on anyone in the home who gets money from any source (include your parents if you are under age 21 and live with them):

Name of Person Receiving Income	Income Source	Gross Income (Before Deduction)	How Often Are You Paid This Amount? (weekly, biweekly, monthly)	Additional Information
	Current Job: Employer's Name			Employer's Address/Phone Number:
	Current Job: Employer's Name			Employer's Address/Phone Number:
	Child Support			**Child Care Cost for Job:**
	Contributions from Others			Paid by:
	Unemployment Benefits			Paid to:
	Social Security/SSI			Child(ren) paid for:
	Other Income – List Type			Amt. Paid: $ How often:

6. Do you have health insurance? ☐ Yes ☐ No If yes, give the name of the insurance company: _____
7. If you are 18 or under, are you enrolled in any KidCare program? ☐ Yes ☐ No
8. If yes, does your insurance have family planning as a benefit? ☐ Yes ☐ No
9. Please attach proof of US citizenship and identity to this application. Evidence of U.S. citizenship includes but is not limited to: a U.S. Passport, a U.S. Birth Certificate, Form FS-240, Report of Birth Abroad of a Citizen of the U.S. or Form FS 545 or From DS1350, Certification of Birth Abroad. Only originals or certified copies are acceptable.

CERTIFICATION AND AUTHORIZATION: **I certify that the information provided on this application is true and correct to the best of my knowledge**. By signing this form, I give consent to the Department of Health to obtain and to release my confidential financial and medical information for the purpose of determining eligibility for the Family Planning Waiver Program. I therefore authorize the following programs under Medicaid, MomCare, WIC, and DCF or their agents to contact me or my healthcare provider(s) for the purpose of coordination of care, payment of claims for services, quality improvement of services concerning my participation in the family planning waiver program. My authorization to release information includes any medical, mental health, alcohol/drug abuse, sexually transmitted disease, tuberculosis, HIV/AIDS, and adult or child abuse information. I understand that the information I have provided shall be kept confidential in accordance with Florida and federal laws. I have read and understand my rights and responsibilities as they apply to the family planning waiver program and that authorization shall remain in effect unless withdrawn in writing.

Signature of Applicant: _____ Date: _____

Eligibility Staff Signature/Date: _____ FMMIS Termination Date: _____

Mail or bring this application and any letter you received to your local county health department (see attached list). DO NOT SEND THIS APPLICATION TO MEDICAID.

DH 3212, 11/06 Stock No. 5744-000-3212-0

Florida Department of Health
Instructions for Completing the
Health Insurance Application for Extended Family Planning Benefits
(Medicaid Family Planning waiver)

The information on the application is needed to help determine if you are approved for the Medicaid Family Planning Waiver program. You are eligible for this program if you have:

- Lost your full Medicaid
- Have not had a hysterectomy or tubal ligation.
- Not pregnant.
- Desires family planning services.
- Income is less than or equal to 185% current federal poverty level.

In order to assist with this determination we need you to complete the application, answer the questions (1-9) and sign and date the form. Failure to complete the application will delay the determination for benefits as well as your duration or time on this program, if eligible**. You must sign and date the form after the date that you lost your full Medicaid.**

Fill in the rows starting with **Name**, **Residence** and **Mailing Address**. Please print your information. Please complete or fill in the information requested in these rows on the form. Please include your mailing address if different from your residence (home) address. This contact information is important. You will be contacted by phone if additional information is needed; you will be contacted by mail to let you know about your eligibility for the program.

Questions 1-3 ask for your reproductive history and whether you desire to participate in the Family Planning Waiver program. Please answer questions 1 through 3.

Question 4 asks for a list of all of the people who live with you or live in your home. Please complete the information requested of yourself as well as the other people or persons that live with you or in your home. Please note that only you, the applicant will need to provide your:

- social security number
- certified proof of your citizenship and identity, if claiming to be a U.S. Citizen and
- proof of your income, pay stubs from the last four weeks, if employed.

Question number 5 asks for the name, income sources, and relationship for not only yourself but the people living with you or in your home. Please complete the information requested of yourself as well as the other people or persons that live with you or in your home including current job, employer's address and phone number.

Please fill out the column with the heading **Child Care Cost for Job**.

Questions 6-8 ask for insurance information. Please answer questions 6-8

Read the **Certification and Authorization** section and sign and date the form. You need to mail or bring this application to your local health department.