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 CONTACT INFORMATION

Tell us who you are and how to contact you.

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

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

Mailing Address Street (If Different)	Apt. No.	City	State	Zip Code	County

Phone Number(s) Where You Can Be Reached	Is Anyone in the Household a Veteran? If **YES,** list name:

SECTION B HOUSEHOLD INFORMATION

List the names of people living with you who are applying for FPBP. You must list your spouse that lives with you even if your spouse is not applying.
If you live with others, such as your children, you may list them even if they are not applying.

First Name, Middle Initial, Last Name (Use Another Page if You Need to List More People)	Date of Birth (MM/DD/YY)	Sex	Relationship to Person on Line 1	Is this Person Applying for Family Planning Benefits?	FOR FPBP APPLICANTS ONLY	
					Social Security Number	Race/Ethnic Group (See Codes)
1		☐ Male ☐ Female	**Self**	☐ Yes ☐ No		
2		☐ Male ☐ Female		☐ Yes ☐ No		
3		☐ Male ☐ Female		☐ Yes ☐ No		
4		☐ Male ☐ Female		☐ Yes ☐ No		

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

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 any other payments.

Name of Person Working or Receiving Money	Type of Current Income (Example: Wages, UIB, SSA Benefits)	How Much Does the Person Receive? (Before Taxes)	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), and if you are a student:

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? (Weekly, Monthly)

SECTION D CITIZENSHIP

This information is needed for all person(s) applying for family planning benefits.

All persons applying for Family Planning Benefits must submit original documentation of their citizenship and identity. If you have already done so, you do not need to show us again at renewal. Your provider or worker will advise you as to what the acceptable forms of documentation are according to Federal guidelines.

Is everyone who is applying a U.S. citizen, national or Native American? ☐ Yes ☐ No
If **NO**, please give the following information for anyone **applying** for family planning benefits who are not U.S. citizens. 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 USCIS and Whose Departure USCIS Does Not Contemplate Enforcing

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.

Does anyone in your household have ☐ Medicaid, ☐ Medicare, ☐ Family Health Plus or ☐ Child Health Plus? If **YES,** give the name of anyone with coverage:

Name(s)

Does anyone have other health insurance that covers a person applying for the Family Planning Benefit Program? ☐ Yes ☐ No ☐ I Don't Know If **YES:**

Name(s) of Person(s) Covered	
Name of Subscriber/Policy Holder	Group/Policy Number
Insurance Company Name	Monthly Premium Cost

If you are not the policy holder, do you have a reason the health insurance company should not be billed? ☐ Yes ☐ No Please explain:

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 without my confidentiality being compromised. 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 may also be given civil penalties.

I understand that I must provide original documentation of my citizenship and identity to the Social Services District or to the Family Planning Provider on behalf of the local district to receive Family Planning Benefits. I also understand that the social services district can assist me in determining my status and obtaining any necessary documents if I request help. Once I have provided my original documents for the worker to document 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 original documents, I should not mail them, but should go to the local district office to show them to a worker, so they may record the originals have been seen. Social Services will not keep my original documents.

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 to the Medicaid agency any rights they may have to medical support or other insurance payments 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 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
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 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 members of my family for whom I can give consent by: my Primary Care Provider, any other health care provider or the New York State Department of Health (SDOH) and any health care provider involved in caring for me or my family, as reasonably necessary for my providers to carry out treatment, payment, or health care operations, to SDOH and other authorized federal, state, and local agencies for purposes 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 the 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 _____ Spouse's Signature (If Applying) _____

DECLINATION OF MEDICAID AND FAMILY HEALTH PLUS ELIGIBILITY DETERMINATIONS

I, _____, have been informed of the enhanced benefits and additional services and coverage 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 at any time in the future if I wish.

Date _____ Applicant's Signature _____ 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, please SIGN your name below:

I consent to withdraw my application, and understand that I may reapply at any time:

Date _____ Applicant's Signature _____

FOR OFFICE USE ONLY

To Be Completed By the Person Assisting With the Application:

Signature of Person Who Obtains Eligibility Information_____ Employed By _____

Have Original Documents Been Seen for Citizenship/Identity? ☐ Yes ☐ No (Applied For)

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: _____ Version: _____

Case Name: _____ District: _____ Case Type: _____ Case No: _____

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