Presumptive Eligibility for the Family Planning Benefit Program (FPBP)
Screening Determination Letter

To: _____ (Applicant)

[ ] According to our review of the information you told us**, <u>you are</u> presumptively eligible** for all covered Family Planning Benefit Program (FPBP) treatment, services and supplies provided by a Medicaid enrolled provider. Based on this determination, coverage has been temporarily authorized for you beginning _____/_____/_____. All treatment, services and supplies that are covered under the Family Planning Benefit Program are listed on the FPBP Fact Sheet that we provided to you. There are no co-pays for the FPBP.

In order for you to be determined eligible to receive ongoing Family Planning Benefit Program coverage, you must sign, date and complete a Family Planning Benefit Program Application (DOH-4282) and return it to us by ____/_____/_____. We will give you the application as well as a list of documents you will need to return to us. We are also able to help you fill out the Family Planning Benefit Program Application, collect your documents and answer any questions you may have about the application process.

If you do not submit a Family Planning Benefit Program Application by the last day of the month following the month of your screening, your presumptive coverage will end on that day.

We will forward your Family Planning Benefit Program Screening form, a copy of this Screening Determination Letter, your Document Checklist, your FPBP Application (if completed) and any documents you have already provided us to the NYSDOH Designated Agent's office within five (5) business days for a full FPBP eligibility determination. They may contact us for further information or documents you may need to provide. If this occurs, we will contact you or your representative at the confidential mailing address and/or phone number you gave to us to request the necessary information or documents you still need to provide.

If you have been determined to be presumptively eligible for the Family Planning Benefit Program and you have never been issued a Medicaid ID card, or if you requested a new card at the time of your presumptive eligibility screening, a card will be mailed to you at the confidential mailing address you provided to us during your screening. This card may be used at any Medicaid enrolled provider for covered family planning services and benefits.

We are able to provide most covered Family Planning Benefit Program services at our health care center(s).This screening determination letter will serve as proof that you have been found to be presumptively eligible for the FPBP, and should be presented at this provider for services you need until you receive your card in the mail. If you need covered family planning or family planning related services that we do not provide, we will refer you to other Medicaid enrolled providers, where you will be able to use your card.

If the NYSDOH Designated Agent determines that you are <u>not</u> eligible for ongoing Family Planning Benefit Program coverage, you will be sent a notice informing you of the date that your presumptive Family Planning Benefit Program coverage will end.

[ ] According to the information you told us, **<u>you are not</u> presumptively eligible** for the Family Planning Benefit Program at this time. You may apply for the Medicaid, Family Health Plus, Child Health Plus (if under age 19) and/or the Family Planning Benefit Program at any time. To get more information about applying for public health insurance programs, call 1-800-541-2831.

_____ (____)_____
Name of Screener — Screener's Phone Number

_____ _____
Provider Agency Name — Provider Agency Location

_____ _____/_____/_____
Signature of Screener — Date of Screening