



## Health Insurance Application for Extended Family Planning Benefits

A Special Medicaid Program

**Office Date Received Stamp:**

<b>Name:</b>	First	M.I.	Last	Maiden Name	Area Code (      )	Phone Number
<b>Residence:</b>	Number	Street	Apt. No.	City	County	State      Zip Code
<b>Mailing Address</b> (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?		** If no, give INS ID Number	Date of Entry	Applied for Medicaid?	
								Yes	No			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			<b>Child Care Cost for Job:</b>
	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.**