Medicaid Family Planning Waiver Application

Date received in office (stamp):

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:

- Lost your full Medicaid within the last 24 months
- Have not had a hysterectomy or tubal ligation
- Not pregnant
- Desire family planning services
- Income is less than or equal to 191% current federal poverty level

Enrollees will only be provided with a maximum of two 12-month coverage periods per each loss of Medicaid State Plan eligibility.

To assist with this determination, we need you to complete the application, answer the questions (1-7) and sign and date the form. Failure to complete the application will delay the determination for benefits and the time you may be on this program, if eligible**.** 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. Please print.

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

If you are pregnant or had a sterilization procedure (Hysterectomy, Tubal ligation/Tubal Occlusion), stop here. You do not qualify for this program.

Please answer the following questions:

1. The benefits you will receive are intended to delay pregnancy through family planning services.
Do you wish to receive these services? ☐ Yes ☐ No If no, stop here.

2. List all the people who you intend to claim on your Federal tax return (write your name first).:

First M.I. Last	Relationship to Applicant	# of Claimed Tax Dependents	Date of Birth	Race	Sex	Medicaid ID or Card Number	Last 4 digits of Social Security #
	(Self)						

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3. Income: Complete the following information on anyone in your home (your Federal tax filing unit) who gets money from any source (include your parents if you are under age 21, AND unmarried, AND live with them) and attach proof of income showing 4 weeks of your most recent income:

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:
	Taxable Earnings/ Earned Income			
	Scholarships/Fellowships/Grants Funds			
	Unemployment Benefits			
	Social Security			
	Other Income – List Type			

4. Do you have health insurance? ☐ Yes ☐ No If yes, give the name of the insurance company: _____

5. If you answered yes to question 4, does your insurance have family planning as a benefit? ☐ Yes ☐ No

6. If you are 18 or under, are you enrolled in the KidCare program? ☐ Yes ☐ No

7. Please attach proof of photo identity to this application. Evidence of identity includes but is not limited to: State Drivers License or State ID with photo, a U.S. Passport. Include this information with your application.

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, Healthy Start, 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: _____ FLMMIS Termination Date: _____

Mail this application, your identification and proof of income to your local county health department to be processed.
Find a local county health department: http://www.floridahealth.gov/all-county-locations.html
The application is not processed at the Agency for Health Care Administration (AHCA) Florida Medicaid, or the Department of Children and Families (DCF).

If you have any questions, or need an application in Creole or Spanish, call the Family Health Line at 1-800-451-2229.
A complete listing of all reimbursable service codes for the FPW is available at: http://ahca.myflorida.com/Medicaid/Family_Planning/reim_services.shtml