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DOH-4286 (8/14)

NEW YORK STATE DEPARTMENT OF HEALTH
Office of Health Insurance Programs

Family Planning Benefit Program Application Instructions

CONFIDENTIALITY STATEMENT

All of the information you provide on this application will remain confidential. The only people who will see this information are the enrollment facilitators and the state or local agencies and family planning providers who need to

know this information in order to determine if you (the applicant) are eligible. The person helping you with this application cannot discuss the information with anyone, except a supervisor or the state or local agencies or family planning providers who need this information.

INSTRUCTIONS

These are the instructions for completing the Family Planning Benefit Program application. This application is for people applying for the Family Planning Benefit Program (FPBP) only.

You must sign the declination on the application stating that you do not want your eligibility determined for Medicaid. You may apply for Medicaid any time in the future. The Medicaid program covers many other health care services in addition to family planning services. If you want your eligibility determined for Medicaid, you should apply through the NY State of Health website at http://healthbenefitexchange.ny.gov/.

Please read the entire application and instructions before you begin to fill out the application. You may attach an additional sheet of paper if there is not enough room for your answers on the application.

SECTION A APPLICANT INFORMATION

In this section, we ask for your full legal name and information about how to contact you. The home address is where you live. The Common Benefit Identification card, all notices and other information will be sent to the home address unless a different mailing address is provided.

If you wish to use a different mailing address for confidentiality reasons, please tell the person who is assisting you and complete the section entitled 'Mailing Address' to ensure all correspondence will be sent to the address you request. If you do not need to use a different mailing address, please check the box that says 'No confidential address needed.'

To prevent delays, please either check the box or provide a different mailing address.

SECTION B HOUSEHOLD INFORMATION

List your name and the names of the people in your family who live with you. Listing other household members may allow us to give you a higher eligibility level. You may list your spouse and your children (who are under 21), even though they are not applying. Fill out the information requested for each household member listed:

- A social security number must be provided for the person applying. If you do not have a social security number, you must apply for one. It is not needed for other household members.
- Race/Ethnic Group: This information is optional. It is asked to make sure all people have access to the program. If you fill out this information, use one of the codes shown on the application that best describes your race or ethnic background.

SECTION C INCOME

In this section, list all types of income and the gross amount you receive. Be sure to include current earnings

from work, self-employment, unemployment benefits, interest, Social Security Benefits, pension, disability payments, money from relatives or friends or any other type of payments received.

If you have no income, please explain how you are being supported.

If you have any unpaid medical bills, related to family planning, from the last 3 months, you must provide proof of your income and residency for the month(s) when unpaid services were received.

Be sure to list your gross income, which is the amount before any taxes or deductions are taken.

To prevent delays, please explain if you have recently started or ended a job. Our computer system searches for income matches. Explain any matches we may find that are not consistent with the current income information you have provided.

SECTION D CITIZENSHIP

This information is required for all people applying for the Family Planning Benefit Program. The State will not report any information on this application to the USCIS, formerly the INS. You must provide documentation of citizenship and identity according to the Federal guidelines. The person helping you with your application will tell you what are considered acceptable forms of documentation.

For US Citizens, the State will do a data match using your Social Security Number to verify identity, citizenship and date of birth.

SECTION E HEALTH INSURANCE

It is important to tell us whether you have health insurance or are covered by someone else's insurance, because:

- It helps us determine which insurance should pay first. Medicaid is always the payer of last resort; any other insurance you may have will be billed before Medicaid.
- If you are covered by someone else's insurance, notification may be sent to the policyholder indicating that family planning services were paid on your behalf.

If you have Medicaid, Medicare, or Child Health Plus, please let us know. This may help us reduce paperwork for you.

If you do not know if you are covered by other health insurance, please check 'I Don't Know'

If you want this application and receipt of FPBP to be kept confidential from the health insurance policyholder, please check 'Yes' in the box for the question that asks if billing any other health insurance will cause you harm or interfere with your privacy and confidentiality. You should let the person assisting you with the application know this, too.

Please be sure to supply us with a confidential mailing address and contact number so we are able to keep all information regarding your application and any subsequent notices (including renewal information) private if you are found eligible. If your residential or mailing

addresses change, please be sure to let your local Department of Social Services know as soon as possible.

Please sign your name and date your application on the back page.