Iowa Department of Human Services

Family Planning Program Review

County Number

Worker Name

Case Number

State ID

Age

Telephone

It is time for your annual review. Your family planning coverage will stop unless you fill out and return this form by . If you have any questions, call us at

List the people who live with you:

Name	How are they related to you?	Age
	Self	

List pregnant people who live in your home	Due Date (MMDDYY)

Have you had any medical procedures or surgeries that keep you from bearing children or fathering children? ☐ Yes ☐ No

Income:

- List the income you received in the last 30 days and send in pay stubs or other proof of this income.
- If you are unmarried and live with your parents, only list your income.
- If you are married, list the income of your spouse and children that live with you.

Who gets the money?	Where does the money come from?	Amount per month

Expenses:

Does anyone in your home pay for someone to care for a child or disabled adult who lives with you? ☐ Yes ☐ No

Who gets the care?	Amount per month

Does anyone in your home pay court-ordered child support or alimony for a person who does not live with you? ☐ Yes ☐ No

Who pays?	Amount per month

My rights and responsibilities were provided to me on the following page. I have read and removed the Rights and Responsibilities sheet from this *Family Planning Program Review* for my future use.

I CERTIFY, UNDER PENALTY OF PERJURY, THAT THESE STATEMENTS ARE CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

HIPAA law requires DHS to obtain consent from individuals authorizing the Department to share data. By signing below, I give DHS permission to share my Medicaid information with the DHS staff working under the Family Planning Program (FPP) for purposes of determining my eligibility for the FPP. This authorization will continue as long as I qualify for the FPP unless I terminate this authorization before then. If at any time I no longer wish for my Medicaid information to be shared, I must tell DHS in writing. I understand that I will lose FPP benefits if I terminate this authorization. I also understand that information disclosed through this authorization will remain within DHS and will continue to be protected by state and federal privacy laws.

Signature	Date

Your Responsibilities

You must tell us when something changes. Within ten days, tell us if you:

- Have a change in your mailing address
- Become pregnant
- Turn 55 years old
- Have moved out of Iowa
- Are no longer capable of bearing or fathering children
- Are approved for Medical Assistance benefits

If you don't tell us when changes happen, you will have to pay back what you got in error.

You may still get family planning services if you have health insurance. If you have health insurance coverage and have good cause for not filing family planning related claims with the insurance company, be sure to tell your clinic or Department of Human Services (DHS) worker why.

You must give the DHS any money you get to pay medical bills that have already been sent to DHS to be paid. If you don't, your family planning benefits may be stopped.

Your social security number (SSN) is required to be eligible for family planning services. Your SSN will be used to check the identity of household members, keep you from getting the same benefits in other places, and to make changes easily.

Your SSN may also be used in a computer match with the Social Security Administration and the Internal Revenue Service to check the answers you gave us for income and other eligibility information about all household members. This is done to make sure that you are eligible for benefits. The information we get from this computer match may result in court action or administrative claims for over issuance of benefits against persons fraudulently receiving benefits.

You Have the Right to Appeal

You, or the person helping you, may request an appeal hearing if you do not agree with any action taken on your case. You can appeal in person, by telephone or in writing. To appeal in writing, do **one** of the following:

- Complete an appeal electronically at https://hhs.iowa.gov/programs/appeals; **or**
- Write a letter telling us why you think a decision is wrong, **or**
- Fill out an Appeal and Request for Hearing form. You can get this form from you county DHS office.

Send or take your appeal to the Department of Human Services, Appeals Section, 5th Floor, 1305 E. Walnut Street, Des Moines, IA 50319-0114. If you need help filing an appeal, ask your county DHS office.

You can represent yourself. Or, you can have a friend, relative, lawyer or someone else act on your behalf.

You may contact your county DHS office about legal services. You may have to pay for these legal services. If you do, your payment will be based on your income. You may also call Iowa Legal Aid at (800) 532-1275. If you live in Polk County, call (515) 243-1193.

You Will Not Be Discriminated Against

It is the policy of the Iowa Department of Human Services (DHS) to provide equal treatment in employment and provision of services to applicants, employees, and clients without regard to race, color, national origin, sex, sexual orientation, religion, age, disability, political belief or veteran status.

If you feel DHS has discriminated against or harassed you, you can send a letter of complaint to: Iowa Department of Human Services, Hoover Building, 5th Floor – Bureau of Policy Coordination, 1305 E. Walnut, Des Moines IA 50319-0114 or via email inclusion@hhs.iowa.gov