Instructions for the Family Planning Program Application

Complete this form if you live in Iowa and want to get Family Planning Program assistance which provides limited coverage for family planning services.

To apply for help, follow these three steps:

1. **Complete the Application**
   Fill out, sign, and date the application. Use blue or black ink. Be truthful. If you are helping someone else, answer the questions for that person.

2. **File the Application**
   Applications can be filed with an approved family planning agency or the local DHS office. The date your help starts is based on the date the family planning agency or DHS gets your application.

3. **Provide Any Needed Proof**
   See the table below for what may be needed. Including copies of the proof will help speed up the processing of your application.

Proof you may need to send:

In addition to your application, the following proof may be needed for the Family Planning Program:

Proof needed	Examples of proof
Proof of who you are (identity)	Driver's license, birth certificate, etc.
Proof you are a U.S. citizen or national	Birth certificate with identity, U.S. passport, etc.
Proof of your lawful immigration status	Copy of Immigration document
Proof of income or any other money coming into your household	Paystubs from the last 30 days if you are employed If you are self-employed, you may provide proof such as income tax records, award letters for Social Security, veterans' benefits, etc.
Proof of child care, dependent adult care costs, child support, or alimony paid	Receipt or statement from child care/dependent adult care provider, print out from Child Support Recovery Unit, etc.
Proof you have applied for a Social Security Number (if you don't already have one)	Receipt from Social Security Administration

RIGHTS AND RESPONSIBILITIES – READ AND KEEP THIS SHEET

INFORMATION FOR INDIVIDUALS APPLYING FOR THE FAMILY PLANNING PROGRAM

- I understand I assume full responsibility for the accuracy of the statements on this form. I understand these statements will be used to determine my eligibility for the Family Planning Program.
- I understand my eligibility will not be affected by my race, creed, color, national origin, age, disability, sex, sexual orientation, religion, political belief, or veteran status except where this is restricted by law.
- I understand that I have the right to a hearing if this application is denied or not acted upon promptly or if services granted are terminated, reduced, or suspended. I understand that I can get a hearing by making a request to my local DHS office and that I may represent myself or use a lawyer, relative, friend, or other spokesperson.
- I am aware that my case may be picked by the Department for a complete Quality Control or other review of my eligibility for assistance. If my case is selected for verification, I will cooperate fully in the verification. I hereby authorize all persons to release confidential information concerning my eligibility to a DHS reviewer. I understand that failure to cooperate with such a review can result in denial or cancellation of benefits.
- I understand that I am to notify my medical providers (doctors, pharmacist, etc.) if another party may be liable to pay my medical expenses. Failure to comply with my responsibilities can give the Department cause to deny or terminate Family Planning Program eligibility.
- I understand that I am to reimburse the Department for any money paid to me or paid to a provider on my behalf to which I was not entitled.
- I further understand that the Department will provide documents or claim forms describing the services paid by the Family Planning Program upon my request or the request of an attorney acting on my behalf. Such documents may also be provided to a third party when necessary to establish the extent of the Department's claim for reimbursement.
- I understand that federal and state law and rules permit access by authorized federal and state officials to Family Planning Program providers' records. I also fully understand that my acceptance of Family Planning Program assistance is my consent for these authorized persons to have access to my medical and health care records during the time I am eligible for the Family Planning Program, as necessary to verify appropriate family planning services payment.
- Anyone who obtains, or tries to obtain, or helps any other person to obtain public assistance to which the person is not entitled is guilty of violating the laws of the state of Iowa. These laws include, but are not limited to, Iowa Code Chapters 243, 239B, and 249A.
- I understand and agree that I may need to provide the Department with either documentation from the U.S. Citizenship and Immigration Services (USCIS) or other documents the Department considers to be proof of the immigration status of each person in my household who is not a United States citizen or national. I understand that alien status may be subject to verification with USCIS, which will require submission of certain information from this application form to USCIS. I further understand that information received from USCIS may affect my household's eligibility and level of benefits.
- Your social security number (SSN) is required to be eligible for family planning services in accordance with 8 U.S.C. 1621 and 42 U.S.C. section 405(c)(2)(C)(i). 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 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

Department of HUMAN SERVICES

Family Planning Program Application

HOUSEHOLD INFORMATION				
First Name	Middle Name	Last Name		
Home Address	City	State	County	Zip Code
Mailing Address (if different from above) OR Payee or Representative's Name and Address				
Home Phone Number ( )	Message Number ( )	Name of Message Contact Person		

Starting with yourself, list all the people who live in your home and mark the box **yes** or **no** if you are applying for that person. If you choose no, you only need to list their name, relationship to you, and their date of birth.

NAME (First, Middle, Last)	Are you applying for this person?	How is this person related?	Sex	Birth Date	Social Security Number	U.S. Citizen?	If Alien, Status	Ethnicity*	Race**	Currently on Medicaid?
	☐ Yes ☐ No	SELF	☐ Male ☐ Female			☐ Yes ☐ No				☐ Yes ☐ No
	☐ Yes ☐ No		☐ Male ☐ Female			☐ Yes ☐ No				☐ Yes ☐ No
	☐ Yes ☐ No		☐ Male ☐ Female			☐ Yes ☐ No				☐ Yes ☐ No
	☐ Yes ☐ No		☐ Male ☐ Female			☐ Yes ☐ No				☐ Yes ☐ No
	☐ Yes ☐ No		☐ Male ☐ Female			☐ Yes ☐ No				☐ Yes ☐ No

We have to ask your ethnicity and race, but you don't have to answer. Your answer won't affect how much you get or how soon. If you answer, use the following coding:

* Ethnicity: H = Hispanic or Latino; N = Not Hispanic or Latino

** Race (Choose all that apply): W = White; B = Black or African American; A = Asian; I = American Indian or Alaskan Native; N = Native Hawaiian or other Pacific Islander

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

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

INCOME: List all income the people living in your home get. Include income from work, self-employment, Social Security, veteran's benefits, unemployment insurance, child support, worker's compensation, railroad retirement, IPERS, pensions, civil service, and any other income you get.

Person who received money	Employer or income source	Amount before taxes or deductions	How often is this amount paid?	Is this income expected to continue? If 'NO,' explain:
			☐ Weekly ☐ Every other week ☐ Monthly ☐ Twice a month ☐ Other_____	☐ Yes ☐ No
			☐ Weekly ☐ Every other week ☐ Monthly ☐ Twice a month ☐ Other_____	☐ Yes ☐ No
			☐ Weekly ☐ Every other week ☐ Monthly ☐ Twice a month ☐ Other_____	☐ Yes ☐ No
			☐ Weekly ☐ Every other week ☐ Monthly ☐ Twice a month ☐ Other_____	☐ Yes ☐ No

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

If yes, who pays?_____ Amount per month_____

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

If yes, who gets the care?_____ Amount per month_____

SOCIAL SECURITY NUMBER (SSN)

You must fill in the SSN of all persons applying for the Family Planning Program. If you do not want Family Planning Program assistance, you do not have to give us your SSN. The SSN will be used:

- To check income and eligibility.
- To comply with law that requires release of information from records.
- To match with records in other agencies such as: Social Security Administration and Internal Revenue Services. These matches may be done by computer or on an individual basis.

My rights and responsibilities were provided to me on the back of the instructions for this Family Planning Program Application. I have read and removed the Rights and Responsibilities sheet from this Family Planning Program Application 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 or mark of applicant Date

Signature of person, if any, who helped complete this form Date