FAMILY PLANNING SERVICES – A Program of the Pennsylvania Dept of Human Services

Name (first, last, middle initial)			**Today's Date**
Address (street # & street name)		**Address (city)**	
Address (state)	**Address (zip)**	**County in which you live**	

Select one:

☐ I agree to have mail regarding this program come from the PA Dept. of Human Services to the above address.

☐ Mail to the above address would violate my confidentiality; please use the address below instead.

Alternate Confidential Address (street # & street name)	**Alternate Confidential Address (city)**
Alternate Confidential Address (state)	**Alternate Confidential Address (zip)**

Preferred contact phone #	**School district in which you live:**
( ) ____________________ ☐ home ☐ work ☐ cell Best time to call: ☐ anytime ☐ morning ☐ afternoon ☐ evening	

Date of birth	**Social Security #**	**Citizenship/Immigration Status**
		☐ US Citizen ☐ Perm resident (5 years or more) **Green Card #** A________________ ☐ Parolee/refugee/asylee ☐ other ______________

Family Members – List only your spouse (if legally married) and children/step-children who live with you

☐ spouse ☐ child ☐ step-child	**Last name, first name, middle initial**	☐ male ☐ female	☐ married ☐ single	Date of birth	☐ US Citizen ☐ Perm. resident
☐ spouse ☐ child ☐ step-child	**Last name, first name, middle initial**	☐ male ☐ female	☐ married ☐ single	Date of birth	☐ US Citizen ☐ Perm. resident
☐ spouse ☐ child ☐ step-child	**Last name, first name, middle initial**	☐ male ☐ female	☐ married ☐ single	Date of birth	☐ US Citizen ☐ Perm. resident
☐ spouse ☐ child ☐ step-child	**Last name, first name, middle initial**	☐ male ☐ female	☐ married ☐ single	Date of birth	☐ US Citizen ☐ Perm. resident

Marital Status	**If legally married, list your spouse's social security number**
☐ never married ☐ married ☐ divorced ☐ separated ☐ widowed	

☐ **I am not currently working.**	☐ **I have worked in the past 30 days** (complete following section)	☐ **I am currently working** (complete following section)

My employer is _____ I began my job on _____/_____/____.

☐ I am salaried and annually (yearly) I am paid $_____

☐ I work hourly and I am paid $_____ per hour. I work _____ hours per week. I was last paid ____/_____/___.

I am paid ☐ weekly ☐ every two weeks ☐ monthly ☐ _____. My total paycheck before taxes is $_____.

The state I work in is ☐ Pennsylvania ☐ New Jersey ☐ _____.

My **spouse's** employer is _____ They began their job on _____/_____/____.

☐ They are salaried and annually (yearly) they are paid $_____

☐ They work hourly and are paid $_____ per hour. They work _____ hours per week. They were last paid ____/_____/___.

They are paid ☐ weekly ☐ every two weeks ☐ monthly ☐ _____. Their total paycheck before taxes is $_____.

The state they work in is ☐ Pennsylvania ☐ New Jersey ☐ _____.

A **child** who lives with me and is financially dependent is employed by _____

They began their job on _____/_____/____. The state they work in is ☐ Pennsylvania ☐ New Jersey ☐ _____.

☐ They are salaried and annually (yearly) they are paid $_____

☐ They work hourly and are paid $_____ per hour. They work _____ hours per week. They were last paid ____/_____/___.

They are paid ☐ weekly ☐ every two weeks ☐ monthly ☐ _____. Their total paycheck before taxes is $_____.

I receive the following additional forms of income ***per month:*** When did you last receive this income? _____/_____/_____

Child support: $_____ Alimony: $_____ Worker's comp: $_____ Social Security: $_____

Unemployment: $_____ Pension: $_____ Other *cash* support: $_____ (type: _____)

Does anyone in your household plan to file a **federal income tax return?** ☐ No ☐ Yes (if yes, complete table below)

List each person in the household who will file federal income taxes:		
Will you file jointly with a spouse or claim any dependents? ☐ No ☐ Yes (if yes, list their name)	**Spouse**	**Dependent(s)**

Do you have any **tax deductible expenses** you will claim? ☐ No ☐ Yes (if yes, complete table below)

☐ Student loan interest deduction	Who will claim this expense? ☐ self ☐ _____	When did this deduction begin? _____/_____/____	
☐ Self-employed health insurance deduction	Who will claim this expense? ☐ self ☐ _____	When did this deduction begin? _____/_____/____	
☐ Deductible part of self-employment tax	Who will claim this expense? ☐ self ☐ _____	When did this deduction begin? _____/_____/____	
☐ Other tax deductible expense	Who will claim this expense? ☐ self ☐ _____	What type of deduction?	When did this deduction begin?_____/_____/____

Have you been in foster care at the age of 18 or older? ☐ Yes ☐ No

Is anyone in the household currently in prison or another correctional facility (incarcerated)? ☐ Yes ☐ No

If yes, who? _____ County: _____ Date of admission: _____/_____/____

Do you pay for adult or child care so you can work? ☐ No ☐ Yes (if yes, complete table below)

Name of child/adult:	Monthly care expense:	How many months is this expense paid per year?

Medical Insurance Coverage

☐ I have no medical insurance.

☐ Using my current insurance would cause me physical, emotional, or other harm.

☐ I have insurance that does not provide family planning coverage.

☐ I give permission for my Family Planning Services application to be submitted/signed electronically by Planned Parenthood.

☐ I understand that I may be eligible for other medical assistance but now wish only to apply for Family Planning Services.

☐ I have read the Family Planning Services rights and responsibilities and agree to provide the necessary documentation.

Signature: _____ Date: _____

Staff Use Only

Paper application reviewed by: _____ Date: _____

- ☐ Photo ID copied
- ☐ Birth certificate/passport copied
- ☐ Income verification/zero income statement provided
- ☐ Address verified to match on application and encounter bill.

Compass application completed by: _____ Date: _____

W#: _____ Date documentation faxed/scanned to CAO or DHS: _____

Please take this page home with you after speaking with your healthcare provider about the Pennsylvania Department of Human Services Family Planning Services Program

Patient Rights and Responsibilities

- I understand the information I've provided on this form will be kept confidential and used only to administer benefits.
- I authorize the release of personal, financial, and medical information for the purpose of determining eligibility for the *Family Planning Services* program.
- I understand that I must report all changes in my household or financial situation to the County Assistance Office, Central Office or Change Center within 10 days.
- I understand that I can request a hearing if I do not agree with the decision made on this application.
- I understand that the information reported on this application is subject to verification from employers, financial sources and other third parties.
- I understand that a *Family Planning Services* applicant must provide their Social Security Number (42 U.S. C. § 1320b-7). This number may be used to check the information on this application.
- I certify that all information on this application is true under penalty of perjury.
- I certify that I am a U.S. citizen or have satisfactory immigration status for Medical Assistance.
- I certify to the best of my knowledge that I understand my rights and responsibilities.

Congratulations on signing up for Family Planning Services! In order to finalize your application, copies of the following items are required to be shared with the Department of Human Services (DHS):

- ☐ pay stubs that show a typical month's salary OR your most recent Federal Tax Return
- ☐ proof of other income (spousal income, unemployment, child support) – copies of checks or eligibility notices
- ☐ your birth certificate OR United States passport

Within **seven days,** please bring the items above back to this health center, or you can fax or mail copies to:

Planned Parenthood of Western PA
933 Liberty Avenue
Pittsburgh, PA 15222
Fax: 412-434-8974

What's next?

- You should receive a letter from DHS in a few weeks saying that you are enrolled or that documentation is still needed. If you do provide documentation, and meet all the criteria, you'll get a second letter saying you're enrolled. If you fail to provide documentation, you'll get a notice saying your case has been closed.
- If you are enrolled, and have never had an Access card before, you'll get a card in the mail. Receipt of this card does not mean you've been enrolled. If you previously had an Access card, you won't get a new one.
- Your enrollment is good for one year. DHS will contact you in twelve months about how to renew.
- If your application has been denied and you believe it is an error contact the case worker listed on the letter or your County Assistance Office (CAO).