

IMPORTANT: CHECK ONE BOX **INITIAL APPLICATION?** **or** **REDETERMINATION?**
 This application is for **WOMEN ONLY** aged 13 to 44 who have not had any surgery to prevent pregnancy.
 The Care For Yourself Program is for family planning services only.

APPLICATION FOR MISSISSIPPI FAMILY PLANNING SERVICES

PLEASE PRINT NOTE: You may choose to enroll in the Family Planning Waiver Program instead of Medicaid or SCHIP

LAST NAME	FIRST NAME	MIDDLE INITIAL
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SOCIAL SECURITY NUMBER	RACE	DATE OF BIRTH										
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ADDRESS WHERE YOU LIVE	CITY	STATE	ZIP CODE	COUNTY
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MAILING ADDRESS (IF DIFFERENT)	STREET/PO BOX	CITY	STATE	ZIP CODE
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HOME TELEPHONE NUMBER	WORK TELEPHONE NUMBER	OTHER TELEPHONE NUMBER
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MAY WE CONTACT YOU AT WORK? YES <input type="checkbox"/> NO <input type="checkbox"/>	<p>FOR INITIAL APPLICATION YOU NEED TO SEND:</p> 1) <u>Copy of State issued ID</u> Example: copy of a driver's license or school ID 2) <u>AND a copy of a Certified Birth Certificate</u>	ARE YOU A U.S.CITIZEN? YES <input type="checkbox"/> NO <input type="checkbox"/> If "NO" are you a permanent legal resident who arrived in the U.S. prior to 5 years before this application? YES <input type="checkbox"/> NO <input type="checkbox"/>
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NOT FOR PREGNANT WOMEN ELIGIBILITY REQUIREMENTS NOT FOR PREGNANT WOMEN

	YES	NO
1. Are you under age 19? If yes, do you live with one or both parents? YES <input type="checkbox"/> NO <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you had a hysterectomy or tubal ligation? YES <input type="checkbox"/> NO <input type="checkbox"/> IF "YES" STOP HERE	<input type="checkbox"/>	<input type="checkbox"/>
4. My total monthly income is: (This includes myself and spouse) \$ _____ If you are under age 19, does this income include the income of your parent(s)? YOU NEED TO SEND MOST RECENT PAYSTUBS FOR ONE MONTH'S PAY.	<input type="checkbox"/>	<input type="checkbox"/>
5. My family size is. (This includes myself, spouse, children) _____ If you are under age 19, does this number include your parent(s)?	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you have Health/Hospital Insurance?	<input type="checkbox"/>	<input type="checkbox"/>

NAME AND ADDRESS OF COMPANY	POLICY NUMBER / GROUP NUMBER
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DECLARATION AND SIGNATURE

I have read and understand the information on this application. I declare, under penalty of perjury;

- that I am a Mississippi resident,
- I am a United States citizen, or a lawful permanent resident who arrived in the United States five (5) years prior to the date of this application.
- I have reported all my total monthly income.
- All information I gave in this application is true, correct and complete to the best of my knowledge.

SIGNATURE OF APPLICANT	DATE
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Information that you give is confidential. Your medical information can only be released if needed to administer the Family Planning Waiver. If you receive family planning services under this waiver, you authorize your family planning provider to release to Medicaid information relating to your examination and treatment for family planning.

THIS APPLICATION IS FOR WOMEN AGED 13 TO 44 WHO HAVE NOT HAD ANY SURGERY TO PREVENT PREGNANCY.
 PLEASE MAIL TO THE ADDRESS SHOWN ON THE BACK OF THIS APPLICATION (revised 10-01-2008)

DO NOT STAPLE DO NOT TAPE DO NOT STAPLE DO NOT TAPE DO NOT STAPLE DO NOT TAPE

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DO NOT STAPLE DO NOT TAPE DO NOT STAPLE DO NOT TAPE DO NOT STAPLE DO NOT TAPE

From:

First Class
Postage
Required
Post Office
Will Not
Deliver

**TO: Division of Medicaid
ATTN: Maternal Child Health Bureau
550 High Street, Suite 1000
Jackson, Mississippi 39201-1399**

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**DO NOT STAPLE
DO NOT TAPE
Fold Here**
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**THIS IS THE
BACK FLAP**

**DO NOT STAPLE
DO NOT TAPE
Fold Here**
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DO NOT STAPLE

DO NOT TAPE

(Peel and Stick Tape Here)

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**DO NOT STAPLE
DO NOT TAPE
USE PEEL
AND STICK**
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**THIS IS THE
INSIDE FLAP**