

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

(If you have Medicaid, you do not need to fill out this form.)

<b>LAST NAME</b>	<b>FIRST NAME</b>	<b>MIDDLE INITIAL</b>
<b>SOCIAL SECURITY NUMBER</b>		<b>RACE</b>
<b>DATE OF BIRTH</b>		
<input type="text"/>	<input type="text"/>	<input type="text"/>
<b>ADDRESS WHERE YOU LIVE</b>	<b>CITY</b>	<b>STATE</b>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<b>ZIP CODE</b>	<b>COUNTY</b>	
<input type="text"/>	<input type="text"/>	
<b>MAILING ADDRESS (IF DIFFERENT)</b>	<b>STREET/PO BOX</b>	<b>CITY</b>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<b>STATE</b>	<b>ZIP CODE</b>	
<input type="text"/>	<input type="text"/>	
<b>HOME TELEPHONE NUMBER</b>	<b>WORK TELEPHONE NUMBER</b>	<b>OTHER TELEPHONE NUMBER</b>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<b>ARE YOU A U.S. CITIZEN?</b> 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"/>		<b>YOU NEED TO SEND:</b> 1) <b>Copy of State issued ID</b> Example: copy of a driver's license or school ID 2) <b>AND a copy of a Certified Birth Certificate</b>
<b>MAY WE CONTACT YOU AT WORK?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>		

**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? <input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/>	<input type="checkbox"/>
2. Are you disabled?	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you had a hysterectomy or tubal ligation? <input type="checkbox"/> YES <input type="checkbox"/> NO <b>IF "YES" STOP HERE</b>	<input type="checkbox"/>	<input type="checkbox"/>
5. 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)? <b>Please provide proof of income with COPY of current check stub.</b>	<input type="checkbox"/>	<input type="checkbox"/>
6. 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"/>
7. Do you live in Mississippi?	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you have Health/Hospital Insurance?	<input type="checkbox"/>	<input type="checkbox"/>

<b>NAME AND ADDRESS OF COMPANY</b>	<b>POLICY NUMBER / GROUP NUMBER</b>
<input type="text"/>	<input type="text"/>

**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.

<b>SIGNATURE OF APPLICANT</b>	<b>DATE</b>
<input type="text"/>	<input type="text"/>

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 08-16-2006)

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From:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

First Class  
Postage  
Required  
Post Office  
Will Not  
Deliver

**TO: Division of Medicaid  
ATTN: Maternal Child Health  
239 North Lamar Street, Suite 801  
Jackson, Mississippi 39201-1399**

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

**THIS IS THE  
BACK FLAP**

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

**DO NOT STAPLE**

**DO NOT TAPE**

(Peel and Stick Tape Here)

↑↑  
**DO NOT STAPLE  
DO NOT TAPE  
USE PEEL  
AND STICK**

**THIS IS THE  
INSIDE FLAP**