

This application is for women 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.)				
LAST NAME		FIRST NAME	MIDDLE INITIAL	
SOCIAL SECURITY NUMBER	GENDER <input type="checkbox"/> FEMALE	RACE	DATE OF BIRTH	
ADDRESS WHERE YOU LIVE	STREET	CITY	STATE	ZIP CODE
MAILING ADDRESS (IF DIFFERENT)	STREET/PO BOX	CITY	STATE	ZIP CODE
HOME TELEPHONE NUMBER	WORK TELEPHONE NUMBER	OTHER TELEPHONE NUMBER		
COUNTY WHERE YOU LIVE	MAY WE CONTACT YOU AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		ARE YOU A U.S. CITIZEN? <input type="checkbox"/> YES <input type="checkbox"/> NO If "NO" are you a permanent legal resident who arrived in the U.S. prior to 5 years before this application? <input type="checkbox"/> YES <input type="checkbox"/> NO	

ELIGIBILITY REQUIREMENTS

- | | 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 IF "YES" STOP HERE  | <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)? | <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"/> |

NAME AND ADDRESS OF COMPANY

POLICY NUMBER / GROUP NUMBER

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

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 08-24-2005)

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**

Fold Here

**Fold Here
DO NOT STAPLE
Seal with tape**

