APPLICATION FOR MISSISSIPPI FAMILY PLANNING SERVICES

MISSISSIPPI DIVISION OF MEDICAID

(This application is for women or men age 13 – 44 who have not had any surgery to prevent reproduction. It is for family planning services only.)

1. Name of Applicant _____
(First name) (Middle or maiden name) (Last name)

2. Social Security Number _____ - _____ - _____ **3.** Date of Birth _____

4. Gender ❑ Female ❑ Male **5.** Race _____

6. Address _____
(Street address) (City) (State) (Zip) (County)

7. Mailing address (if different) _____
(Street or PO Box) (City) (Zip) (County)

8. Telephone number(s) _____ _____ _____
(Home) (Cell) (Work)

9. Are you disabled? ❑ Yes ❑ No **10.** If female, are you pregnant? ❑ Yes ❑ No

11. Have you had a hysterectomy, tubal ligation (Female) or vasectomy (Male)? ❑ Yes ❑ No

12. Do you have health insurance? ❑ Yes ❑ No If you have health insurance, complete the following:

Policyholder's Name _____

Insurance Company _____ Policy/Group # _____

Does your insurance cover family planning services? ❑ Yes ❑ No

13. Are you a U.S. citizen? ❑ Yes ❑ No If no, are you a legal permanent resident who arrived in the U.S. prior to 5 years prior to this application date? ❑ Yes ❑ No

14. Are you married? ❑ Yes ❑ No If yes, name of spouse _____

Spouse's SSN* _____ - _____ - _____ Date of Birth _____
(You are not required to give us your spouse's Social Security Number (SSN) but it will speed up the application process. We use SSNs to check income and verify your eligibility.)

15. Household members: List members of your household, their age & relationship to you. **NOTE**: Applicants under age 19 do not have to complete this section

Name of Household Member	Age	Relationship to You

16. Income: Provide income information for you and/or your spouse. Include all types of income from work or from any other source.
NOTE: Applicants under age 19 do not have to complete this section

Source of Income (Employer's Name or other source)	Amount (before deductions or taxes)	How Often Received?	If working, average hours worked per week
	$		
	$		
	$		

If you and/or your spouse are self-employed, list the total net income (profit after allowable IRS expenses). $ _____ How often received? _____

17. **Read and Sign this Application:** I am signing this application under penalty of perjury which means I have provided true answers to all the questions on this form to the best of my knowledge. I know that I may be subject to civil and criminal penalties under federal law if I provide false and/or untrue information.

_____ _____

(Signature of Applicant) (Date)

For assistance, call the Office of Eligibility 800-421-2408. Submit the application as follows:

Mail: MS Division of Medicaid ATTN: Office of Eligibility
550 High Street, Suite 1000 Jackson, MS 39201-1399
Fax: (601) 576-4164
In-Person: at any Medicaid Regional Office

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 information to Medicaid relating to your examination and treatment for family planning.