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

SOCIAL SECURITY NUMBER	RACE	DATE OF BIRTH
☐☐☐ ☐☐ ☐☐☐☐		

ADDRESS WHERE YOU LIVE	CITY	STATE	ZIP CODE	COUNTY

MAILING ADDRESS (IF DIFFERENT)	STREET/PO BOX	CITY	STATE	ZIP CODE

HOME TELEPHONE NUMBER	WORK TELEPHONE NUMBER	OTHER TELEPHONE NUMBER

MAY WE CONTACT YOU AT WORK?

YES ☐ NO ☐

FOR INITIAL APPLICATION YOU NEED TO SEND:

1) Copy of State issued ID
   Example: copy of a driver's license or school ID
2) **AND** a copy of a Certified Birth Certificate

ARE YOU A U.S.CITIZEN?
YES ☐ NO ☐

If "NO" are you a permanent legal resident who arrived in the U.S. prior to 5 years before this application? YES ☐ NO ☐

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 ☐ NO ☐	☐	☐
2. Are you pregnant?	☐	☐
3. Have you had a hysterectomy or tubal ligation? YES ☐ NO ☐ ***IF "YES" STOP HERE***	☐	☐
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.**	☐	☐
5. My family size is. (This includes myself, spouse, children)______________ If you are under age 19, does this number include your parent(s)?	☐	☐
6. Do you have Health/Hospital Insurance?	☐	☐

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 10-01-2008)

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

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

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

From: ______________________________

____

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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

Fold Here
DO NOT TAPE
DO NOT STAPLE

THIS IS THE BACK FLAP

DO NOT STAPLE
DO NOT TAPE
Fold Here

DO NOT STAPLE DO NOT TAPE

(Peel and Stick Tape Here)

AND STICK
USE PEEL
DO NOT TAPE
DO NOT STAPLE

THIS IS THE INSIDE FLAP

Revised 10.01.2008