Maryland Department of Health and Mental Hygiene
Maryland Medical Assistance
Family Planning Program
Application

The **Maryland Medical Assistance Family Planning (FP) Program** provides family planning benefits for certain low income eligible women. Applicants must be under 51 years of age, a Maryland resident, and a U.S. citizen or a qualified alien who meets all requirements for benefits.

- The FP Program does not cover any other health care services except family planning services.
- **This program does not cover services related to abortion and infertility.**
- If you are currently enrolled in the Medical Assistance Program, the Maryland Children's Health Program, Medical Assistance for Families or the Primary Adult Care (PAC), you already have family planning benefits and are considered ineligible for this program. Call your Managed Care Organization (MCO) if you need help finding a family planning provider.
- If you have Medicare you are not eligible to enroll in this program.
- If you already had a permanent sterilization you are not eligible to enroll in this program.
- If you want a permanent sterilization and are eligible, it will be covered (must be age 21 or over).
- The FP Program does not cover prenatal services. If you are pregnant and need health care coverage for prenatal care, apply for the Maryland Children's Health Program at your local health department. For more information call 1-800-456-8900.

There are no fees to enroll, no deductibles, no monthly premium, and no annual benefit limit. There are no copays for contraceptive prescriptions (birth control). If you qualify for the program, and you do not already have a FP Program Card, you will receive one which will allow you to choose any family planning provider that accepts Maryland Medical Assistance. You will not be required to join a Managed Care Organization (MCO). If you have a primary care provider contact them to see if they participate. Most local health departments, community health centers, federally qualified health centers, and Planned Parenthood also accept the card. If you have questions about what is covered or need help finding a provider, call 1-800-456-8900.

If you have any questions, please see our website, www.dhmh.state.md.us/mma/mmahome. If you have questions about the application, call toll free at 1-855-692-4993. If you do not speak English, translation services are available. The application is also available in Spanish. Maryland Relay Service is available at 1-800-735-2258 for individuals with disabilities.

Important Application Information and General Instructions

- **Read all the instructions before completing the application**.
- **Print** clearly in blue or black ink or type the required information. All information must be readable.
- The process to determine eligibility takes up to 45 days. Notification of the eligibility determination will be sent by mail.
- Women who are determined eligible will be enrolled for 12 months.
- Before the period of eligibility ends, a notice and re-application packet will be mailed to the address provided on the original application.
- Please mail your application to:

Department of Health & Mental Hygiene
Family Planning Program
P.O. Box 296
Baltimore, MD 21298-9795

Or fax to: 410-333-0134

Instructions for Completing the Maryland Medical Assistance Family Planning Application

Important: Print with black or blue ink or type the required information

Section 1:

A. Print your first name, middle initial, last name, and suffix.

B. Fill in your complete home street address for where you live. **You must be a Maryland resident.** Check whether the program may send mail to this address. If you are homeless, please write "homeless" in the home address line and fill in the state and county. Fill in your home, cell or work phone number including area code. If you do not want mail sent to your home address do the following: (1) provide an alternate address or phone number for messages in section C, and (2) check that you do not want mail sent to your home address. The program will then contact you at your alternate address and message number only.

C. If you want a representative or someone else to get your mail, complete that person's name and address in the box. If you enter "homeless" in section B, you must enter a mailing address in section C. If you have a post office box to get mail, list it here. You can include a message phone number in the message phone box.

D. Write your date of birth and social security number. Social security numbers are required. If the program may contact you by email, provide your email address.

E. Check U.S. Citizenship status "YES" or "NO". If you check "NO", fill in your alien registration number in the box.

F. Check the box next to your current marital status.

G. Check the box to indicate if you are currently pregnant. If no, check the box to indicate if you have had a permanent sterilization ("tubes tied" or ESSURE). **If you are pregnant or have had a permanent sterilization you are not eligible.**

Section 2:

H. Check whether you have any other form of health insurance, including Medical Assistance, Medicare, insurance through your employer, or as a retirement benefit. If yes, include the name of the insurance company or program through which you have coverage. You will also need to provide the Policy or ID number. **If you currently have Medical Assistance or Medicare, you are considered ineligible for this program.** However if you lose Medical Assistance or Medicare, you may be eligible**.**

Section 3:

I. Check whether your ethnicity is Hispanic or Latino.

J. Check your race. You may check more than one race.

K. Primary and secondary language information is optional. Indicate if a translation service is needed for us to speak to you.

L. Check the box to indicate if you are visually impaired. If yes, indicate if large print notices are needed.

M. Check the box to indicate if you are hearing impaired. If yes, indicate if Maryland Relay Services are needed.

Section 4:

N. If you are married and living with your spouse, print the first name, middle initial, last name, suffix, date of birth and social security number of your spouse. Social security numbers are required.

Section 5:

O. Print the number of children under 19 years of age that live in your household. Print the first name, middle initial, last name, date of birth and social security number of any children that live with you that are under 19 years of age. Social security numbers are required. If you need more space please complete Attachment 1.

Instructions for Completing the Maryland Medical Assistance Family Planning Application (Continued)

Section 6:

Section 6 applies to you and your spouse, if you are married and living with your spouse.

P. Check whether you or your spouse receives any income from employment. If yes, complete the name and address of the employer. Then list the GROSS amount (before any deductions) and frequency of all income received. You must provide information about your income. If you are married and living with your spouse, you must also provide information about your spouse's income. You may be contacted to provide proof of income. If you are under 19 years of age and not married, the program collects information about your income but income will not be considered.

Q. Check whether you and / or your spouse receive any income other than employment. If yes, list the source, amount, and frequency of all other income.

R. Check whether you and / or your spouse pay for child or dependent care. If yes, list the name of the provider, telephone number, the name of the person who receives care and the amount paid per month.

S. Check whether you and / or your spouse pay child support or alimony. If yes, list the name of the person making payments, the name of the person who receives the payments, and the amount paid per month.

Section 7:

T. Please read the Maryland Medical Assistance Family Planning Rights and Responsibilities on the last page of this packet before signing and dating the application.

U. If an Authorized Representative completed the application on your behalf, he or she must print, sign and date the application.

Please remember to sign and date your application. An unsigned application is not valid and will be returned.

Mail applications to:

Department of Health & Mental Hygiene
Family Planning Program
P.O. Box 296
Baltimore, MD 21298-9795

Or fax to: 410-333-0134

Maryland Medical Assistance Family Planning Program
RIGHTS AND RESPONSIBILITIES
Please read and save these rights and responsibilities for your records.

- I understand that this application is for family planning services only.

- I understand that this program does not cover primary care services for the treatment of any diseases or infections that may be identified during a family planning service visit except those expressly covered. Should you need assistance in obtaining primary care services go to your nearest Federally Qualified Health Center; locations can be found at the Health Resources and Service Administration, http://findahealthcenter.hrsa.gov/Search_HCC.aspx, or call 800-456-8900.

- I understand this program cannot provide coverage if I am already pregnant or have had a permanent sterilization.

- **I understand this program does not provide coverage for services related to abortion and infertility.**

- I certify that I am a US citizen or qualified alien. I understand that my social security number will be used to verify my eligibility. My social security number may also be used to cross-match information in federal, state, and local government files. I understand that the information given on this application form is confidential and will only be used for the purpose of program administration, except as permitted by state and federal law.

- I understand that the Maryland Department of Health and Mental Hygiene may conduct independent verification of the statements made by me on this application and agree to the release of personal and financial information from any financial institution, insurance company, present or past employer, federal, state, or local government agency, private or public organization to the Department for eligibility determination.

- I understand that if I have other insurance I must use the other insurance prior to accessing the Maryland Medical Assistance Family Planning Program benefit.

- I must notify the Department within 10 business days if any of the following changes occur: change in address, contact information, health insurance coverage; any change in my income or my husband's income if married and living together, or any other changes in my household.

- I agree that my family planning service providers may release medical information related to services I have received to program administrators. Both the family planning service providers and the Department will ensure the confidentiality of my protected health information as required by state and federal law.

- I understand that if the FP program pays for my family planning services and later identifies that another insurance should have paid for the services, the FP program has the right to recover costs from the responsible third party. I understand that if I get more benefits than I am entitled to, through my fault, I may have to repay the program for any extra benefits received.

- I understand that I have the right to appeal a decision made by the program administrators related to my eligibility for participation or the scope of services that I am entitled to receive.

- My signature certifies that I understand my rights and responsibilities related to enrollment in the Maryland Medical Assistance Family Planning Program.

Your application must be complete and signed. If you have questions you may call our office at 1-855-692-4993 **before you send your application.**

This space is for Family Planning office use only.	Date Stamp Received

Maryland Medical Assistance Family Planning Program Application

Section 1 Complete with your information.

A	First Name	MI	Last Name	Suffix
B	Home Street Address (Include Apt) Do you want mail sent to this address? ◯Yes ◯No			Telephone ☐ **Home** ☐ **Cell** ☐ **Work**
	City	State	Zip Code	County
C	First Name (alternative contact or authorized representative)		Last Name	
	Mailing Address (Include Apt) or P.O. Box			Message Phone
	City	State	Zip Code	County
D	Your Date of Birth:	Your social security number:	E-mail address:	
E	Are you a U.S. Citizen? ◯Yes ◯ No	If you are not a citizen please provide your immigrant documentation number:		
F	What is your Marital Status: ◯ Never Married ◯Married ◯Separated ◯Divorced ◯Widowed	**G**	Are you Pregnant? ◯Yes ◯No	If no, Have you had a permanent sterilization? ◯ Yes ◯ No

Section 2 Other Insurance including Maryland Medical Assistance or Medicare.

H Do you have other insurance, including **Medical Assistance or Medicare,** which pays for your health care?
◯Yes ◯ No
If yes, please write the name of the insurance company or program and your Policy/ID number on the line below:
Insurance Company :_____ Policy/ID Number:_____

Section 3 Optional Information.

I	Are you Hispanic/ Latino? ◯Yes ◯ No		
J	What is your race?	☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian / Pacific Islander ☐ White	
K	What is your primary language?	What is your secondary language?	Are translation services needed? ◯Yes ◯No
L	Are you visually impaired? ◯Yes ◯No	If yes, do you want large print notices? ◯Yes ◯No	
M	Are you hearing impaired? ◯Yes ◯No	If yes, should we use Maryland Relay Services? ◯Yes ◯No	

Section 4 Complete if applicable. List your Spouse's information, if spouse is living with you.

N	Spouse First Name	MI	Spouse Last Name	Suffix
	Spouse Date of Birth:		Spouse Social Security Number:	

Section 5 Complete if applicable. List the names of your children under 19 years of age and living with you.

O	How many children under 19 years of age live in your household? _____		
	Child First Name	MI	Child Last Name
	Child Date of Birth :		Child Social Security Number:

Please Turn Page and Complete The Other Side

FAMILY PLANNING FINANCIAL INFORMATION

Section 6 Complete the financial information for yourself and your spouse if living with you.

P

Do you or your spouse receive any income from employment? ◯ **Yes** ◯ **No**
If yes, complete Section P.

Your Employer Name	**Your Employer Address**
Spouse Employer Name	**Spouse Employer Address**

List all gross income before tax from full or part time employment, self employment, etc.

Earned Income	**Self**	**How Often**	**Spouse**	**How Often**
Wages	$		$	
Self Employment	$		$	
Other:	$		$	
Other:	$		$	

Q

Do you or your spouse receive any other income not from employment? ◯ **Yes** ◯ **No**
If yes, list any other income received such as unemployment, child support, SSDI, alimony, pensions, workers compensation, etc.

Unearned Income - Type	**Self**	**How often**	**Spouse**	**How Often**
	$		$	
	$		$	
	$		$	

R

Do you or your spouse pay for child or dependent care? ◯ **Yes** ◯ **No**

Name of care provider:	**Telephone**	**Who receives care?**	**Amount Paid Monthly**
			$
			$

S

Do you or your spouse pay child support or alimony? ◯ **Yes** ◯ **No**

Name of Person Paying	**Name of person receiving these payments**	**Amount Paid Monthly**
		$
		$

Section 7 Signature Section.

T

I have read and agree to the rights and responsibilities listed elsewhere in this application packet. I swear and affirm under penalty of perjury that all the information I gave is true, correct, and complete to the best of my ability, belief, and knowledge.

Applicant's Signature: **Date: ____ /____ /____**

U

Representative's Name (printed) and Signature (if applicable):

Date : ____/____/____

When finished: Please remove instructions and keep rights and responsibilities for future reference. Mail the application pages and required documentation to: **Department of Health & Mental Hygiene**

Family Planning Program
P.O. Box 296
Baltimore, MD 21298-9795
Or fax to: 410-333-0134

Attachment 1

Your First Name	MI	Your Last Name	Suffix

Section 5-Continued List the names of your children under 19 years of age and living with you.		
Child First Name	MI	Child Last Name
Child Date of Birth :		Child Social Security Number:
Child First Name	MI	Child Last Name
Child Date of Birth :		Child Social Security Number:
Child First Name	MI	Child Last Name
Child Date of Birth :		Child Social Security Number:
Child First Name	MI	Child Last Name
Child Date of Birth :		Child Social Security Number:
Child First Name	MI	Child Last Name
Child Date of Birth :		Child Social Security Number:
Child First Name	MI	Child Last Name
Child Date of Birth :		Child Social Security Number:

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