BHSF Form 1-FP
Rev. 02/09
Prior Issue Obsolete

TAKE CHARGE
Family Planning Waiver Application

Use this form to apply for family planning services for Women age 19-44.

How to apply

1. **Fill out and sign this application. Use black ink.** If you need extra space to answer any questions use a separate sheet of paper.
2. **Get the documents of proof.** Look for a list of things we need beginning on page 4.
3. **Send the application and proofs to us right away. We will give you more time to get the proofs to us if you need it.**

Where to send the application and proofs

Mail to: P.O. Box 91278, Baton Rouge, LA 70821-9278
Fax to: 1-877-523-2987 (toll-free)
Drop off at: Your local Medicaid office or Application Center. For the office closest to you, call 1-888-342-6207. If you are deaf or hard of hearing and have a TTY text telephone, call 1-800-220-5404.

What language do you speak best? ❑ *English* ❑ *Spanish* ❑ *Vietnamese* ❑ *Other (specify)* _____
What language do you write best? ❑ *English* ❑ *Spanish* ❑ *Vietnamese* ❑ *Other (specify)* _____

1. Tell Us About You – The woman wanting family planning waiver services.

Name _____
First *Middle Initial* *Maiden* *Last*

Mailing Address _____
Street Address *Apartment/Lot Number*

_____
City *State* *Zip Code*

Home Address *(if different)* _____
P.O. Box or Street Address *Apartment/Lot Number*

_____
City *State* *Zip Code*

Social Security Number _____ - _____ - _____ Date of Birth _____
Month *Day* *Year*

Parish Where You Live _____ E-mail Address _____

Home Phone (____) _____ Cell Phone (____) _____ Daytime Phone (____) _____

Best Day/Time to Call Monday through Friday between 8 a.m. and 4:30 p.m. _____

Marital Status: ❑ Married ❑ Single ❑ Separated ❑ Divorced ❑ Widowed

Race and Ethnic Background *(You do not have to answer. You may mark more than one box.)* ❑ White ❑ Black ❑ Asian ❑ American Indian or Alaska Native ❑ Hispanic or Latino ❑ Native Hawaiian or Pacific Islander

If you have questions or need help with this application, call Medicaid at 1-888-342-6207. If you are deaf or hard of hearing and have a TTY text telephone, call 1-800-220-5404. THESE CALLS ARE FREE.

2. Pregnancy

A. Are you pregnant? ❑ Yes ❑ No
B. Were you pregnant in any of the last three months? ❑ Yes ❑ No

3. Citizenship/Immigration Status

A. Are you a U.S. citizen? ❑ Yes – Go to B ❑ No – Answer next questions

Are you a lawful permanent resident? ❑ Yes ❑ No Date you came to the U.S. _____

Permanent Resident Card Number (green card #): A_____

B. Tell us where you were born.

City _____ State _____Country _____

Mother's Full Name (first, middle initial, last) _____

Mother's Maiden Name _____

4. Tell Us About the Other People Living With You – List your husband first (if married) and then all children under age 18. If no one lives with you, go to Question 5.

*If there are more than 4 people, use a separate sheet of paper. Social Security numbers **must** be given for spouse, children, and anyone who gets Medicaid.*

Name (first, middle initial, last) _____
Date of Birth (month, day, year) _____ Social Security Number _____ - _____ - _____
Relationship to You: ❑ Husband ❑ Child ❑ Step-Child ❑ Grandchild ❑ Other _____

Name (first, middle initial, last) _____
Date of Birth (month, day, year) _____ Social Security Number _____ - _____ - _____
Relationship to You: ❑ Child ❑ Step-Child ❑ Grandchild ❑ Other _____

Name (first, middle initial, last) _____
Date of Birth (month, day, year) _____ Social Security Number _____ - _____ - _____
Relationship to You: ❑ Child ❑ Step-Child ❑ Grandchild ❑ Other _____

Name (first, middle initial, last) _____
Date of Birth (month, day, year) _____ Social Security Number _____ - _____ - _____
Relationship to You: ❑ Child ❑ Step-Child ❑ Grandchild ❑ Other _____

5. Health Insurance

Do you have health insurance? ❑ Yes – Fill Out Below ❑ No – Go to Question 6
Policyholder's Name _____Coverage Start Date _____
Insurance Company Name and Phone Number _____
Policy Number _____Group Number _____
It covers: ❑ Hospital ❑ Doctor ❑ Medicine ❑ Dental ❑ Ambulance ❑ Pregnancy ❑ Family Planning

6. Medical Procedures

Have you had any medical procedures which would keep you from getting pregnant like having your tubes tied or a hysterectomy? ❑ Yes ❑ No

If yes, you cannot get family planning waiver services through the TAKE CHARGE program.

7. Income from Working

Does anyone work (you, your husband, or children under age 18)? ❑ Yes – Fill out below ❑ No – Go to Question 9

Tell us about **each** full-time job, part-time job, or business.

Who works?	Employer/Business Name and Phone Number	Self Employed	How much? (show gross, not take home pay)	How often paid?
		❑ Yes ❑ No		
		❑ Yes ❑ No		
		❑ Yes ❑ No		

8. Other Income

Tell us about any income that you, your husband, and children under age 18 get, like the kinds listed below.

Income Type		Tell us where this money is from or who pays this money. (name, address, and phone)	Who gets this income?	How much?	How often?
Social Security	❑ Yes ❑ No	[redacted]		$	
SSI	❑ Yes ❑ No	[redacted]		$	
Unemployment	❑ Yes ❑ No			$	
Worker's Compensation	❑ Yes ❑ No			$	
Child Support	❑ Yes ❑ No			$	
Alimony	❑ Yes ❑ No			$	
Money from Friends/Relatives	❑ Yes ❑ No			$	
Other (tell us what it is) _____	❑ Yes ❑ No			$	

9. Child Support and Alimony Paid to Someone Outside the Home

Do you or does your husband pay **court-ordered** child support or alimony to someone **outside your home**?
❑ Yes ❑ No
If **yes**, to whom? _____ Monthly Amount $ _____

10. Child Care/Adult Care

Do you or does your husband pay for child care or pay for care for an adult **with a disability** in order to work, go to school, or get training? ❑ Yes ❑ No If **yes**, tell us about it below.

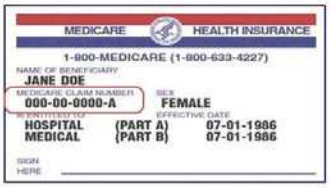
Name of Child(ren) or Adult Who Gets Care _____
Who pays for the care? _____How much is paid each month? _____
Is help received with paying it from anyone or another program? ❑ Yes ❑ No How much? _____
Name of Center or Caregiver _____Phone Number (_____) _____

11. Where did you get this TAKE CHARGE application form?

❑ Medicaid office ❑ hospital/clinic ❑ pharmacy ❑ doctor's office ❑ school ❑ Internet
❑ Office of Family Support ❑ friend/relative ❑ business ❑ church ❑ festival/health fair
❑ Toll Free hotline number ❑ Social Security Office ❑ other _____

12. Disability Benefits and Medicare

A. Are you unable to work because of a disability? ❑ Yes ❑ No
B. Did you ever get Medicare? ❑ Yes ❑ No
The Medicare Card looks like this.



C. Did you ever receive Social Security Disability payments or SSI? ❑ Yes ❑ No

THIS IS THE END OF THE APPLICATION. YOU MUST SIGN BELOW

By signing this application I am giving my permission to the State of Louisiana and its agents to make contacts to verify the information given on this application. Under penalty of perjury I certify all information I have given is true. I also acknowledge that I have received and read the Rights and Responsibilities on the next page.

Sign Your Name Here:_____ **Date:** _____

If someone working for Medicaid helped you fill out this form, they will sign below.

_____ **Date:** _____

Please send the application to the TAKE CHARGE program office right away. The address is P.O. Box 91278, Baton Rouge, LA 70821-9278, and the fax number is 1-877-523-2987. We will give you more time to get the proofs to us if you need it.

YOUR RIGHTS AND RESPONSIBILITIES

WHAT MEDICAID/TAKE CHARGE PROGRAM HAS THE RIGHT TO EXPECT OF YOU

CITIZENSHIP AND IMMIGRATION STATUS: You state that the information about citizenship and immigration status given on this application form is true and correct.

REPORTING THE TRUTH: You state that the information you give on the application form is true and correct. You understand if you on purpose give information that is not true OR if you on purpose do not tell information that you are supposed to, you and/or the person(s) applying may get health benefits that you or they should not get. If that happens, you can by law be punished for fraud. Also, you may have to pay money back to Medicaid/ **TAKE CHARGE** Program for the bills it paid by mistake.

VERIFICATION OF INFORMATION: You understand that the information you give about you and/or the person(s) applying will be checked. You agree to help do that and let Medicaid/**TAKE CHARGE** Program get information it needs from government agencies, employers, medical providers, and others.

SOCIAL SECURITY NUMBERS: You understand Social Security numbers will only be used to get information from other government agencies to make a decision on eligibility for you and/or the person(s) applying for Medicaid/family planning waiver services.

PAYMENT OF MEDICAL CARE BY A THIRD PARTY: You understand by accepting Medicaid/family planning waiver services, the Department has the right to get money received by you and/or the person(s) applying from other sources like insurance payments or lawsuit settlements for services that Medicaid/**TAKE CHARGE** Program has paid for you and/or the person(s) applying.

REPORTING CHANGES: You agree to tell Medicaid/**TAKE CHARGE** Program within 10 days of these changes: 1) if anyone getting family planning waiver services moves out of state; 2) if there are any changes in your mailing or home address; 3) if anyone getting family planning gets health insurance or Medicare; and 4) if anyone getting family planning becomes pregnant.

CHILD SUPPORT ENFORCEMENT: You understand that Medicaid/**TAKE CHARGE** Program will only send case information to Child Support Enforcement for medical support if you ask them to.

WHAT YOU HAVE THE RIGHT TO EXPECT FROM MEDICAID/TAKE CHARGE PROGRAM

RIGHT TO A FAIR HEARING: You understand that you can ask for a Fair Hearing if you think any decision made on the case is unfair, incorrect, or made too late.

NO DISCRIMINATION: You understand that Medicaid/**TAKE CHARGE** Program cannot treat you differently because of race, color, sex, age, disability, religion, nationality, or political belief. If you think it has, you can call the U.S. DHHS Regional Office for Civil Rights in Dallas, TX at 1-800-368-1019 or write to Louisiana's Department of Health & Hospitals, Human Resources at P. O. Box 4818 Baton Rouge, LA 70821-4818

Send Us These Things
Copies of all health insurance cards (front and back.)
If you are not a U.S. citizen send copies of Permanent Resident Card (green card) or other proof from U.S. Citizenship and Immigration Services.
If you were **not** born in Louisiana **AND** you have never received benefits from Social Security Disability, Supplemental Security Income (SSI), or Medicare, send proof of U.S. Citizenship such as birth certificate or U.S. Passport. If you don't have these, ask us about other things you may use.
Pay stubs from last month showing gross pay (before taxes) or a letter from the employer. If self-employed, send copies of last year's tax return and all schedule attachments – for you, your husband, and children.
Proof of gross income (before taxes) from Veteran's Benefits, worker's comp, alimony, and any other income that is not from working. Proof could be award letters and 1099 tax statements from last year's tax return - for you, your husband, and children.
Statement from friends or relatives who give money to you, your husband, or children.
Proof of child care payments from the day care center. Proof of payments for adult care from the caregiver.
Court order and proof of alimony or child support that you or your husband **PAYS** to someone **outside your home**. If it is paid through Louisiana Support Enforcement Services (SES), you **do not** have to send proof – let us know.