

## CONFIDENTIALITY STATEMENT

*All of the information you provide on this application will remain confidential. The only people who will see this information are the enrollment facilitators and the state or local agencies and family planning providers who need to know this information in order to determine if you (the applicant) and your applying household members are eligible. The person helping you with this application cannot discuss the information with anyone, except a supervisor or the state or local agencies or family planning providers who need this information.*

## INSTRUCTIONS

These are the instructions for completing the Family Planning Benefit Program application. This application is for people applying for the Family Planning Benefit Program (FPBP) only.

Applicants must sign the declination on the application stating that they do not want their eligibility determined for Medicaid or Family Health Plus. You may apply for Medicaid or Family Health Plus any time in the future. These programs cover many other health care services in addition to family planning services. If you want your eligibility determined for Medicaid or Family Health Plus, you must complete the "Access NY Health Care" (DOH-4220) application.

**Please read** the entire application and instructions before you fill out the application. You may attach an additional sheet of paper if there is not enough room for your answers on the application.

## SECTION A CONTACT INFORMATION

In this section, we ask for the applicant's name and information about how to contact the applicant. The home address is where the persons applying for the FPBP live. The mailing address, if different, is where the Common Benefit card, all notices and other information will be sent.

If you wish to use a different mailing address for confidential purposes, please tell the person who is interviewing you, and complete the section entitled "Mailing Address (if different)" to assure all correspondence will be sent to the address you request.

Also, please answer whether anyone in the household is a veteran.

## SECTION B HOUSEHOLD INFORMATION

List the names of people living with you *who are applying* for the FPBP. However, you must list your spouse even if your spouse is not applying. If you live with other people, such as your children, you may list them even if they are not applying. Listing the other household members may allow us to give you a higher eligibility level. Fill out the information requested for each household member listed:

- Answer whether the person listed on the line is also applying for FPBP (enter "yes" or "no").
- A social security number must be provided only for all persons who are applying. If anyone applying does not have a social security number, they must apply for one.
- Race/Ethnic Group: This information is optional. It is asked to make sure all people have access to the program. If you fill out this information, use one of the codes shown on the application that best describes the person's race or ethnic background.

## SECTION C HOUSEHOLD INCOME

In this section, list all types of income and the amount received by the people you listed in Section B. Be sure to include current earnings from work, child support payments, and unemployment benefits, interest, Social Security Benefits, pensions, disability payments, money from relatives or friends or any other type of payments received. Note if applicant is a student.

- If the household has no income, please explain how the applicants are being supported.
- Answer if you have to pay for child care or for care of a disabled or elderly adult in order to work or go to school. Check the appropriate box. If yes, give the name of the individual(s) who receives the care, how much you pay for the care, and how often you pay the amount listed (for example weekly, monthly).

**SECTION D****CITIZENSHIP**

This information is required for all people applying for family planning benefits. The State will not report any information on this application to the USCIS, formerly the INS. All applicants must provide original documentation of citizenship and identity according to Federal guidelines. The person helping you with your interview will tell you what are considered acceptable forms of documentation. You will not need to provide this proof at renewal if you have done it at application.

**SECTION E****HEALTH INSURANCE**

It is important to tell us whether anyone in your household has health insurance or is covered by someone else's insurance, because:

- For certain applicants, we will subtract the cost of the health insurance from your income;
- For future medical bills, it helps us determine which insurance should pay first.

If anyone in the household has Medicaid, Medicare, Family Health Plus or Child Health Plus, please give the name(s) of those household member(s). This may help us reduce paperwork for you.

If anyone in the household has other health insurance coverage, please provide the information requested. If you do not know or cannot get the health insurance information, please check "I don't know."

If you want this application and receipt of FPBP to be kept confidential from the health insurance policyholder, please check "yes" in the box after the last question in Section E: Health Insurance.

You should also tell the person interviewing you why you do not want any health insurance you may be covered under to be billed.

Please be sure to supply us with a confidential mailing address and contact number so we are able to keep all information regarding your application and any subsequent notices (including renewal packets) private if you are found eligible. If either your residence or mailing addresses change, please be sure to let your worker know as soon as possible.