

FAMILY PLANNING EXPANSION PROJECT (FPEP) ENROLLMENT FORM



Examples of **Services Covered** by FPEP

- | | | |
|--|---|--|
| <ul style="list-style-type: none"> ▪ Yearly exam and your choice of birth control method ▪ Emergency contraception | <ul style="list-style-type: none"> ▪ Vasectomies | <ul style="list-style-type: none"> ▪ Family planning counseling and education ▪ Follow-up contraceptive care |
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Examples of **Services Not Covered** by FPEP

- | | |
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| <ul style="list-style-type: none"> ▪ Treatment for sexually transmitted infections ▪ Pregnancy confirmation for the Oregon Health Plan | <ul style="list-style-type: none"> ▪ Tubal ligations or Essure® ▪ Treatment for bladder infections |
|--|--|

1 Where did you hear about us? (check all that apply)

<input type="checkbox"/> Ad on the bus, light rail or bus shelter	<input type="checkbox"/> Friend or family
<input type="checkbox"/> Movie theatre	<input type="checkbox"/> Billboard
<input type="checkbox"/> Text message	<input type="checkbox"/> Have been here before
<input type="checkbox"/> facebook	<input type="checkbox"/> MySpace
<input type="checkbox"/> Oregon Family Planning website	<input type="checkbox"/> Other: _____

2 Last Name	3 First Name	4 Middle Initial
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5 Address _____

6 City	7 State	8 Zip
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9 Have you been sterilized for more than 6 months? (tubal ligation, Essure®, hysterectomy, vasectomy) <input type="checkbox"/> Yes <input type="checkbox"/> No	10 Do you live in Oregon? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Are you a: (check one box only)

11 U.S. Citizen **OR** **12** Lawful Permanent Resident who has held this status for at least 5 years

13 Do you have any health insurance that covers contraceptive management? Yes No

14 Household Size:	Wages or Salary \$ _____
	Social Security, Disability, or Unemployment Benefits \$ _____
	Other Income \$ _____
	15 Total Monthly Gross Household Income: \$ _____

16 Date of Birth ____ / ____ / _____	17 Social Security # ____ - ____ - ____
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I declare under penalty of perjury that the information I have provided is correct and complete to the best of my knowledge. I have been told that I may be eligible for the Oregon Health Plan and I have received information about local primary health care insurance and services. I understand and agree that my social security number (SSN), other information on this form, and information I provided to prove my identity and citizenship must be disclosed to DHS for purposes of determining eligibility for the FPEP program. I have been given a copy of a Notice which explains how my SSN and other information will be used.

18 Client Signature _____	19 Date of Signature _____
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20 Client indicates special confidentiality need and, if applicable, private insurance should not be billed. <small>Clinic Staff: Code "NC" in box 17a of CVR regardless of insurance coverage.</small>	Client Initials for Special Confidentiality
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FOR CLINIC STAFF USE ONLY

21 Agency # _____	22 Clinic/Site # _____
23 Primary Care information offered <input type="checkbox"/> Y <input type="checkbox"/> N	24 OHP information offered <input type="checkbox"/> Y <input type="checkbox"/> N
25 Title X: Client pays _____ % per sliding fee scale for non-FPEP-covered service	26 Staff initials _____

FPEP CITIZENSHIP AND IDENTITY VERIFICATION

Document verification of citizenship and identity below. Create new record or update current record in database as needed.

	CITIZENSHIP DOCUMENTATION	IDENTITY DOCUMENTATION	
PENDING	27 <input type="checkbox"/> Oregon Birth Information Form (FPEP103) completed by client <input type="checkbox"/> Enter into FPEP Eligibility Database for electronic check - State staff will update database if citizenship is verified OR 28 <input type="checkbox"/> Out-of-state birth record request completed by client <input type="checkbox"/> Send request to State Family Planning Program - Clinic staff will update database if citizenship is verified OR 29 <input type="checkbox"/> Client will supply citizenship document	33 <input type="checkbox"/> Client will supply identity document <input type="checkbox"/> By date _____	PENDING
VERIFIED	30 <input type="checkbox"/> Citizenship listed as verified in FPEP Eligibility Database OR 31 <input type="checkbox"/> Citizenship document witnessed and copied Check Tier: <input type="checkbox"/> Tier 1 <input type="checkbox"/> Tier 2 <input type="checkbox"/> Tier 3 <input type="checkbox"/> Tier 4 (Tier 1 satisfies identity verification) 32 <input type="checkbox"/> Information entered in FPEP Eligibility Database Date _____ Initials _____	34 <input type="checkbox"/> Identity listed as verified in FPEP Eligibility Database OR 35 <input type="checkbox"/> Identity document witnessed and copied (Required with citizenship document Tier 2, 3, or 4) 36 <input type="checkbox"/> Information entered in FPEP Eligibility Database Date _____ Initials _____	VERIFIED

37 Qualifies for FPEP <input type="checkbox"/> Y <input type="checkbox"/> N	38 FPEP ID# _____	<i>The FPEP ID# is REQUIRED for reimbursement. Complete items 37, 39 and 40 only if citizenship and identity have been verified and client is eligible for full year of FPEP coverage.</i>
39 Eligible FROM date _____	40 Eligible TO date _____	

41 Record client request for special confidentiality (be sure notation meets legal standard "at risk of emotional or physical harm")

42 Clinic use (optional)

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Ejemplos de los Servicios Cubiertos por FPEP

- | | |
|--|---|
| <ul style="list-style-type: none"> ▪ Exámenes anuales y su opción de métodos de planificación familiar ▪ Pastillas anticonceptivas de emergencia (las PAE) | <ul style="list-style-type: none"> ▪ Información y educación de planificación familiar ▪ Consultas regulares de métodos anticonceptivos ▪ Vasectomía |
|--|---|

Ejemplos de Servicios No Cubiertos por FPEP

- | | |
|--|--|
| <ul style="list-style-type: none"> ▪ Tratamiento para infecciones transmitidas sexualmente ▪ Confirmación del embarazo para el Plan de Salud de Oregon | <ul style="list-style-type: none"> ▪ Ligadura de trompas o Essure® ▪ Tratamiento para las infecciones de la vejiga |
|--|--|

1 ¿Cuándo se entero de nosotros? (**marque todas las que apliquen**) Amigo o familiar

Un anuncio en el camion, el tren o en la caseta de la parada del camion En la cartelera

En el cine Mensaje de texto facebook MySpace Han estado aquí antes

Sitio de Internet de la Proyecto de Planificación Familiar El otro: _____

2 Apellido	3 Primer Nombre	4 Segundo Nombre
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5 Domicilio: (Dirección de calle)

6 Ciudad	7 Estado	8 Zona Postal
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9 ¿Ha estado esterilizada(o) por más de seis meses? (ligadura de trompas, Essure®, histerectomía, vasectomía) <input type="checkbox"/> Sí <input type="checkbox"/> No	10 ¿Vive en Oregon? <input type="checkbox"/> Sí <input type="checkbox"/> No
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Estatus de ciudadanía: (**verifique sólo una caja**)

11 Ciudadano(a) de los Estados Unidos **O** 12 Residente legal permanente para por lo menos cinco años

13 ¿Tiene seguro de salud que cubre servicios de planificación familiar? Sí No

14 Número de personas en el hogar:	15	Salario \$ _____	
Seguro Social, Ingreso de Incapacidad, o, Beneficios de Desempleo		\$ _____	
		Otros Ingresos \$ _____	
		Ingreso Mensual Bruto: \$ _____	

16 Fecha de Nacimiento ____ / ____ / ____	17 Número de Seguro Social # ____ ____ / ____ ____ / ____ ____
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Declaro bajo penalidad de castigo que la información que he provehido es correcta y completa de acuerdo a mi conocimiento. He sido informado/da que posiblemente califique para Medical (OHP) y he recibido información acerca de servicios locales de cuidado primario y cobertura médica. Entiendo y verifico que mi número de seguro social (SSN), otra información en esta forma e información que he provehido para verificar mi identidad y ciudadanía será entregada al Departamento de Servicios Humanos (DHS) para el propósito de determinar elegibilidad para el programa de Planificación Familiar (FPEP). He recibido una copia de la Notificación que explica como será usado mi número de seguro social (SSN) y otra información.

18 Firma del paciente	19 Fecha de la Firma
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20 El cliente indica necesidad de confidencialidad, y si es pertinente al seguro medico privado no se le cobrará <small>Clinic Staff: Code "NC" in box 17a of CVR regardless of insurance coverage.</small>	Iniciales del cliente indicando confidencialidad
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IDENTITY DOCUMENTATION

PENDING

PENDING

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 Enter into FPEP Eligibility Database for electronic check
 - State staff will update database if citizenship is verified

OR

28 Out-of-state birth record request completed by client
 Send request to State Family Planning Program
 - Clinic staff will update database if citizenship is verified

OR

29 Client will supply citizenship document

33 Client will supply identity document
 By date _____

VERIFIED

VERIFIED

30 Citizenship listed as verified in FPEP Eligibility Database

OR

31 Citizenship document witnessed and copied
 Check Tier: Tier 1 Tier 2 Tier 3 Tier 4
 (Tier 1 satisfies identity verification)

32 Information entered in FPEP Eligibility Database

Date _____ Initials _____

34 Identity listed as verified in FPEP Eligibility Database

OR

35 Identity document witnessed and copied
 (Required with citizenship document Tier 2, 3, or 4)

36 Information entered in FPEP Eligibility Database

Date _____ Initials _____

37 **Qualifies for FPEP** Y N

38 **FPEP ID#**

The FPEP ID# is REQUIRED for reimbursement. Complete items 37, 39 and 40 only if citizenship and identity have been verified and client is eligible for full year of FPEP coverage.

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