FAMILY PLANNING SERVICES – A PROGRAM OF THE PENNSYLVANIA DEPT OF Human Services

NAME (LAST, FIRST, MIDDLE INITIAL)		TODAY'S DATE
ADDRESS (STREET # & STREET NAME)	ADDRESS (CITY)	
ADDRESS (STATE)	ADDRESS (ZIP)	COUNTY IN WHICH YOU LIVE

SELECT ONE:

☐ I agree to have mail regarding this program come from the PA Dept. of Human Services to the above address.

☐ Mail to the above address would violate my confidentiality; please use the address below instead.

ALTERNATE CONFIDENTIAL ADDRESS (STREET # & STREET NAME)	ALTERNATE CONFIDENTIAL ADDRESS (CITY)
ALTERNATE CONFIDENTIAL ADDRESS (STATE)	ALTERNATE CONFIDENTIAL ADDRESS (ZIP)

PREFERRED CONTACT PHONE #	SCHOOL DISTRICT IN WHICH YOU LIVE
( )________-______________ ☐ Home ☐ Work ☐Cell	
BEST TIME TO CALL ☐ Anytime ☐ Morning ☐ Afternoon ☐ Evening	

DATE OF BIRTH	SOCIAL SECURITY #	CITIZENSHIP / IMMIGRATION STATUS
		☐ US Citizen ☐Perm Resident - (must be resident 5 years or more) **Green Card #** _A___________________ ☐ Parolee/Refugee/Asylee ☐ Other ______________________

FAMILY MEMBERS – LIST ONLY YOUR Spouse (IF MARRIED) AND CHILDREN / STEP-CHILDREN WHO LIVE WITH YOU

☐Spouse ☐Child ☐Step Child	LAST NAME, FIRST NAME, MIDDLE INITIAL	☐ Male ☐ Female	☐Married ☐Single	BIRTH DATE	☐US Citizen ☐Perm Resident
☐Child ☐Step Child	LAST NAME, FIRST NAME, MIDDLE INITIAL	☐Male ☐ Female	☐Married ☐Single	BIRTH DATE	☐US Citizen ☐Perm Resident
☐Child ☐Step Child	LAST NAME, FIRST NAME, MIDDLE INITIAL	☐Male ☐ Female	☐Married ☐Single	BIRTH DATE	☐US Citizen ☐Perm Resident
☐Child ☐Step Child	LAST NAME, FIRST NAME, MIDDLE INITIAL	☐Male ☐ Female	☐Married ☐Single	BIRTH DATE	☐US Citizen ☐Perm Resident

MARITAL STATUS
☐ Never Married ☐ Married ☐ Divorced ☐ Separated ☐ Widowed
IF MARRIED, LIST YOUR HUSBAND'S SOCIAL SECURITY #: ________________________

PLEASE TURN OVER! APPLICATION CONTINUES ON BACK.

☐ I am not currently working ☐ But I have worked in the past month.

☐ I am currently working and my employer is_____.

My salary – ***before taxes*** – is: $_____☐weekly ☐bi-weekly ☐monthly ☐annually.

I began my job on____(date) and my job is located in ☐ Pennsylvania ☐New Jersey ☐_____.

My hourly pay is $_____/hour and I work_____hours per week. My last paycheck was dated_____

My spouse is employed by_____.

Their salary – ***before taxes*** – is: $_____☐weekly ☐bi-weekly ☐monthly ☐annually.

They began their job on____(date) and it is located in ☐Pennsylvania ☐New Jersey ☐_____.

His/her hourly pay is $_____/hour and he/she works_____hours per week. Their last paycheck was dated_____

A child who lives with me, and is financially dependent, is employed by_____.

Their salary ***before taxes*** – is: $_____☐weekly ☐bi-weekly ☐monthly ☐annually.

They began their job on_____(date) and it is located in ☐Pennsylvania ☐New Jersey ☐_____.

His/her hourly pay is $_____/hour and he/she works_____hours per week. Their last paycheck was dated_____

I receive the following additional forms of income ***per month***:

Child Support $_____Alimony $_____Worker's Compensation $_____Social Security $ _____

Unemployment $_____Pension $_____Other ***Cash*** Support $_____(type_____)

When did you last receive this income:_____

Does anyone plan to file a **federal income tax return**? ☐Yes ☐No If Yes, please complete the table below:

Name of Each person who will file		
Will this person file jointly w/a spouse? (yes/no)		
If yes, list name of spouse		
Will this person claim dependent(s)? (yes/no)		
If yes, list name of dependent(s)		

Does anyone have a **tax deductible** expense they will claim? ☐Yes ☐No If Yes, please complete the table below:

Does anyone have expense from (check yes):	**YES**	**Whose expense is this?**	**How often is this expense paid?**	**Amount**
Student Loan Interest Deduction				
Self-Employed health insurance deduction				
Deductible part of self-employment tax				

PLEASE TAKE THIS PAGE HOME WITH YOU AFTER SPEAKING WITH YOUR COUNSELOR ABOUT THE PENNSYLVANIA DEPARTMENT OF Human Services *FAMILY PLANNING SERVICES PROGRAM*

PA DEPT OF Human Services *FAMILY PLANNING SERVICES PROGRAM* RIGHTS AND RESPONSIBILITIES

- I understand the information I've provided on this form will be kept confidential and used only to administer benefits.
- I authorize the release of personal, financial, and medical information for the purpose of determining eligibility for the *Family Planning Services* program.
- I understand that I must report all changes in my household or financial situation to the County Assistance Office, Central Office or Change Center within 10 days.
- I understand that I can request a hearing if I do not agree with the decision made on this application.
- I understand that the information reported on this application is subject to verification from employers, financial sources and other third parties.
- I understand that a *Family Planning Services* applicant must provide her Social Security Number (42 U.S. C. § 1320b-7). This number may be used to check the information on this application.
- I certify that all information on this application is true under penalty of perjury.
- I certify that I am a U.S. citizen or have satisfactory immigration status for Medical Assistance.
- I certify to the best of my knowledge that I understand my rights and responsibilities.

YOU'RE ALMOST DONE! – LAST STEPS OF THE APPLICATION PROCESS

Congratulations for signing up for *Family Planning Services*! In order to finalize your application, **copies** of the following items are required to be shared with the Department of Human Services (DHS):

☐ pay stubs that show a typical **month's** salary **OR** your most recent Federal Tax Return

☐ proof of other income (Spousal Income, Unemployment, Child support) – copies of checks or eligibility notices

☐ your birth certificate **OR** United States passport

Within SEVEN DAYS, please bring checked items above **back to this Center, or fax or mail copies to**:

Planned Parenthood of Western PA
933 Liberty Avenue
Piittsburgh, PA 15222
Fax: 412-434-8974

We highly suggest that all documentation be sent through us so we can track it for you.

⇒ You should receive a letter from DHS in a few weeks saying that you are enrolled or that documentation is still needed. If you do provide documentation, and meet all the criteria, you'll get a second letter saying you're enrolled. If you fail to provide documentation, you'll get a notice saying your case has been closed.

⇒ If you are enrolled, and have never had an Access card before, you'll get a card in the mail. **Receipt of this card does not mean you've been enrolled**. If you previously had an Access card, you won't get a new one.

⇒ Your enrollment is good for one year. DHS will contact you in twelve months about how to renew.

⇒ If your application has been denied and you believe it is an error contact the case worker listed on the letter or your County Assistance Office (CAO).

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ADDENDUM FORM

Have you been in foster care at the age of 18 or older? ☐Yes ☐No

Is anyone in the household currently in prison or another correctional facility? (Incarcerated) ☐Yes ☐No

If yes, who: County: Date of Admission:

I pay for child/adult care so that I can work. ☐Yes ☐No

Name of Child/Adult	Monthly Care Expense	How Many Months Per Year Is This Paid?

MEDICAL INSURANCE COVERAGE

☐ I have no medical insurance

☐ Using my current insurance would cause me physical, emotional, or other harm

☐ I give permission for my *Family Planning Services* application to be submitted / signed electronically by Planned Parenthood.

☐ I understand I may be eligible for other Medical Assistance, but now wish to only apply for *Family Planning Services*.

☐ I have read the *Family Planning Services* Rights and Responsibilities and agree to provide the necessary documentation.

Signature_____ **Date:** _____

Staff use only

Paper application completed by: _____ Date: _____

□ Photo ID copied □ Birth Certificate/passport copied □ Income verification/Zero Income Statement

Compass Application completed by: _____ Date: _____

W# _____ Date Documentation faxed/ Scanned to CAO or DHS _____