Application for SelectPlan for Women

Si necesita esta información en español, llame al teléfono: ***1-800-842-2020***

This is an application for family planning services. If you need help translating it, please contact your County Assistance Office. Translation services will be provided free of charge.

នេះជាពាក្យដាក់សុំសំរាប់សេវាការគំរោងការណ៍គ្រួសារ។ បើលោកអ្នកត្រូវការជំនួយបកប្រែ សូមទាក់ទងទៅការិយាល័យវែលហ្វែរបស់លោកអ្នក។ សេវាការបកប្រែនឹងផ្តល់អោយដោយឥតគិតថ្លៃ។

这是关于家庭计划服务的申请。 如果你需要翻译协助，请联络你所在地方的郡县援助办事处。可免费提供翻译服务。

Настоящий документ представляет собой заявление на получение обслуживания по планированию семьи. Если вам нужна помощь в его переводе, обращайтесь в Окружное бюро помощи (County Assistance Office). Переводческие услуги будут предоставлены вам бесплатно.

Esta es una solicitud de servicios de planificación familiar. Si necesita ayuda con la traducción comuníquese con la Oficina de Asistencia del Condado (CAO) que le corresponde. Los servicios de traducción son gratuitos.

Đây là mẫu đơn về các dịch vụ kế hoạch hoá gia đình. Nếu bạn cần phiên dịch mẫu này, xin tiếp xúc với Phòng Trợ Cấp Quận Hạt. Dịch vụ phiên dịch sẽ được cung cấp miễn phí.

All information you provide on this form will be kept confidential.

SelectPlan for Women provides family planning services for a woman who:

- Is between the ages of 18 through 44
- Is a resident of Pennsylvania
- Is a U.S. citizen or has satisfactory immigration status for Medical Assistance
- Has no family planning insurance coverage
- Is not eligible for any other Medical Assistance category
- Is not pregnant or sterilized
- Is income eligible (income does not exceed 185% of Federal Poverty Income Guidelines)

SelectPlan for Women provides:

- Women's health exams, routine health screenings and birth control methods.
- Education, family planning counseling and referrals to other health care providers and social services.

Are you pregnant? ☐ Yes ☐ No (If **YES**, you may be eligible for other health care coverage - see box below.)

Have you had any surgical procedures which would prevent you from becoming pregnant, such as a tubal ligation or a hysterectomy? ☐ Yes ☐ No

If you answered **YES** to either question, please **STOP**. You are not eligible for SelectPlan for Women.

I understand I may be eligible for other Medical Assistance coverage, but at this time I only wish to apply for SelectPlan for Women. Please initial:______

1. Fill out the form (please print) and sign this application.
2. Attach proof of all income listed in Section C page 3.
   - The information you attach should show what the income is *before* taxes and deductions.
   - Proof includes pay stubs, award letters, pay checks or current tax return.
   - Make sure the pay stubs represent a full month's income. One pay stub may be sent in if it is a typical pay period. An employer's letter that states your monthly gross pay is also acceptable.
   - If self-employed, copies of tax returns or other business financial records may be used as proof.
3. Attach proof of your identity and that you are a U.S. citizen or in satisfactory immigration status. (for example, birth certificate or immigration documents)
4. Attach proof that you are a PA resident (for example, driver's license or state ID)
5. Mail this form and required documentation to:

DPW - Central Unit, 1401 N. 7th St. P.O. Box 2675, Harrisburg, PA 17105-2675

If you need help completing this application, please call **1-800-842-2020**, or if you are hearing impaired call **TDD 1-800-451-5886**.

To apply on-line, go to **www.compass.state.pa.us**. This site also allows you to apply for other health care coverage, cash assistance and food stamps.

Provider Use Only

Provider Name	MA Provider Number	Date

A. Applicant Information

Last Name	First Name	Middle Initial	Social Security Number

Sex	Date of Birth	Are you:	Driver's License or ID (State/Number)	Are you a U.S. Citizen?
FEMALE	*mm/dd/yyyy*	☐ Single ☐ Married		☐ Yes ☐ No

Birthplace: *State, County, City*	Name on Birth Certificate: *Last, First, Middle*	Mother's Maiden Name: *Last, First, Middle*

Do you have a copy of your Birth Certificate? ☐ Yes ☐ No

Birth Certificate Verification - Official Use Only

State File Number	Date Filed	Signature/Date	☐ No Record

Race *(check all that apply)* (***Optional***)

☐ African American ☐ Native Alaskan/American Indian ☐ Native Hawaiian/Pacific Islander
☐ Asian ☐ Caucasian ☐ Asian (Indian subcontinent)

Ethnicity (***Optional***)

☐ Hispanic ☐ Non Hispanic

Home Street Address	City	State	Zip Code
Mailing Address *(if needed for confidentiality purposes)*	City	State	Zip Code

County	School District	Home Phone	Work Phone	Best time to call

B. Family Members *(List only your husband (if married), children and step-children who live with you.)*

*Social Security Number is optional for non-applicants

Last name, first name, middle initial **Person 2**	Sex M or F	☐ Married ☐ Single	Date of Birth	Social Security Number*	☐ Spouse ☐ Child ☐ Step Child
Last name, first name, middle initial **Person 3**	Sex M or F	☐ Married ☐ Single	Date of Birth	Social Security Number*	☐ Spouse ☐ Child ☐ Step Child
Last name, first name, middle initial **Person 4**	Sex M or F	☐ Married ☐ Single	Date of Birth	Social Security Number*	☐ Spouse ☐ Child ☐ Step Child
Last name, first name, middle initial **Person 5**	Sex M or F	☐ Married ☐ Single	Date of Birth	Social Security Number*	☐ Spouse ☐ Child ☐ Step Child

C. Income and Expenses

(Remember to send proof.)

Do you or your family members listed in Section "B" have income from: *(Please check yes or no)*	Yes	No	Whose income is this?	How often is the income received? *(Weekly, Bi-weekly, Monthly, etc.)*	Amount of income for each period before taxes and deductions
Employment					
Employer's Name					
Employment					
Employer's Name					
Self Employment *(Including babysitting and room and board paid to you)*					
Social Security Income					
Pension/Retirement					
Worker's Compensation					
Unemployment Benefits					
Dividends/Interest					
Child Support/Alimony					
Other *(specify)*					

Tell us what you pay for child/adult care so that you can work.

(May be used as a deduction to help you qualify - may require proof.)

Name of Child/Adult	Monthly Expense Amount	Name of Child/Adult	Monthly Expense Amount

D. Health Insurance

Do you have health insurance? ☐ Yes ☐ No

If yes, please tell us about this insurance. If no, skip this section.

What is covered by this policy?

☐ Family Planning Services ☐ Prescriptions, including contraceptives

If yes, will filing a claim on that insurance cause physical, emotional or other harm from your spouse, parents or other person? ☐ Yes ☐ No

If yes, please explain:

If you have any additional information or comments that you feel are necessary for us to know, please list them in SECTION E - ADDITIONAL INFORMATION.

Rights and Responsibilities

I understand that the information 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 **SelectPlan for Women** 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 **SelectPlan for Women** 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.

Signature of Applicant
or person applying for applicant:_____Date:_____

Please mail this form and required documentation *(copies are acceptable)* to:
DPW - Central Unit, 1401 N. 7th St. P.O. Box 2675, Harrisburg, PA 17105-2675

E. Additional Information

This area may be used to add family members or provide other information or comments that you feel are necessary for us to know.

F. For Office Use Only

Date Received	Category	File Cleared By/Date
Screened By/Date	AP Registration Number	Provider Number
County	District	Record Number
☐ Eligible ☐ Not Eligible		Reason Code