NEW YORK STATE DEPARTMENT OF HEALTH
Office of Health Insurance Programs

Medicaid Presumptive Eligibility (PE) for the Family Planning Benefit Program (FPBP) Provider Screening Form

1. APPLICANT'S PERSONAL INFORMATION

a. Applicant's Legal Name: _____
First Name Middle Initial Last Name

b. Legal Residential Address: _____
Street Apt. # City Zip Code

County of Legal Residence: _____ Resident of New York City (NYC) ☐ Yes ☐ No

Is it OK for us to send a Family Planning Benefit Program benefit card and related mail to your residential address? ☐ Yes ☐ No

If not, please provide us with a confidential mailing address below:

Confidential Mailing Address: _____
Street Apt. # City Zip Code

c. Home Telephone Number: (_____)_____ – _____

Is it OK for you to get calls related to your application at this number? If not, please provide us with a confidential contact number where you can receive calls related to your application below:

Confidential Phone Number: (_____)_____ – _____

d. Social Security Number (optional): _____ – _____ – _____

e. Date of Birth: _____ / _____ / _____
MM DD YYYY

f. Sex: ☐ Female ☐ Male

g. Citizenship/Immigration Status: (1) Are you a U.S. Citizen? ☐ Yes ☐ No

(2) Are you lawfully present in the U.S. and a NYS resident? ☐ Yes ☐ No ☐ I Don't Know

To be eligible for PE for the Family Planning Benefit Program, you must be a US Citizen or be lawfully present and a NYS resident. If you are not documented, or are a temporary non-immigrant who is not a NYS resident, you may be able to get Medicaid for the treatment of an emergency medical condition or a pregnancy, if you are determined to be otherwise eligible. To apply for this coverage, contact your local department of social services (LDSS) or the Human Resources Administration (HRA), if you live in NYC.

If the answer to **both 1 and 2** is either "No" or "I Don't Know", **STOP the Screening Process**

If the answer to **either 1 or 2** is "Yes", **CONTINUE the Screening Process**

2. HEALTH INSURANCE

Public Health Insurance:

Do you have or have you recently applied for:
- Medicaid (MA) ☐ Yes ☐ No
- Child Health Plus (CHPlus) ☐ Yes ☐ No
- Temporary Cash Assistance (TA) ☐ Yes ☐ No

If you are enrolled in Medicaid, or Temporary Cash Assistance, you are not eligible for the FPBP. If you have recently applied for these programs, contact the place where you applied and follow through on the completion of your current application.
If you already have CHPlus, you may still apply for PE for the FPBP if you need confidential family planning services.

If you have received services in the past and you know your CIN, enter it here _____

Do you have Medicare? ☐ Yes ☐ No

Are your Medicare premiums being paid by Medicaid? ☐ Yes ☐ No

Private or Employer Sponsored Health Insurance (Optional):

Are you covered by any other health insurance or plan? ☐ Yes ☐ No

If yes, what is the name of the Health Insurance Plan? _____

What is the policyholder's name and their relationship to you? _____

3. GOOD CAUSE QUESTION

a. Will billing any other health insurance cause harm to your physical or emotional health or safety, and/or will it interfere with the privacy and confidentiality of your application for or receipt of family planning services? ☐ Yes ☐ No

b. Good Cause Authorization

If 3(a) is "Yes", Provider must call 1-800-541-2831 for a Good Cause Authorization

Good Cause Authorization Call Date: _____ Approved? ☐ Yes ☐ No

Name of Call Center Representative: _____

Duration of Good Cause: From _____ to _____

4. HOUSEHOLD SIZE

Count these individuals in your household:

APPLICANT		1
# of parents of applying individual living in HH		_____
# of applicant's siblings living in HH		_____
# of applicant's children (under 21) living in HH		_____
Spouse of applicant living in HH	+	_____
a. HH size	=	_____ **Total HH Size**

Note: If a member of the applicant's household is pregnant, she should be counted as herself plus one.

5. INCOME

a. Applicant's total monthly **gross** income (Before taxes and any deductions) $ _____

Include all wages, tips, commissions, self-employment income, Social Security retirement, survivors, and disability benefits, alimony, unemployment benefits, disability payments, etc.
(Do not include grants or loans of students or any Temporary Cash Assistance or SSI payments).

6. PRESUMPTIVE ELIGIBILITY FOR FPBP DETERMINATION

Compare the monthly income amount on line 5(a) to 223% of the FPL for the applicable HH size on line 4a.

If the Monthly Income is:

***Less than or equal to 223% of the FPL for the applicable HH size:** ☐ Yes

Applicant IS Presumptively Eligible for the FPBP. Give PE Determination Letter and FPBP Document Checklist to the individual.

Provider must submit PE Screening Form, PE Determination Letter and FPBP Document Checklist to the NYSDOH Designated Agent within five (5) business days of the determination date. The PE individual must also sign, date and complete an application for the FPBP (DOH-4282) to have eligibility determined for ongoing FPBP services. If a signed, dated and completed application for FPBP was completed, forward it and any documents provided, that should also be included or later forwarded to the NYSDOH Designated Agent.

***More than 223% of the FPL for the applicable HH size:** ☐ Yes

Applicant IS NOT Presumptively Eligible for the FPBP. No further action is required. Give applicant PE Determination Letter.

7. CONTACT INFORMATION AND DETERMINATION DATE

FPBP Provider Agency Name: _____

Provider Site Address: _____

Screener's Phone Number (with area code): (_____ **)** _____ **ext.**

Screener's Fax Number (with area code): (_____ **)** _____ **ext.**

Screener's Name: _____

Screener's Signature: _____

Date Screening Form/Determination Completed: _____ / _____ / _____
MM DD YYYY