APPLICATION FOR FAMILY PLANNING MEDICAL ASSISTANCE (FPMA)

A. Please tell us about the FPMA applicant and where the FPMA applicant lives. *If you are applying for FPMA on behalf of someone else, tell us about that person's information in Section A below, not your own information.*

FPMA Applicant's Legal Name: _____ Primary Language: _____

SSN: _____ ☐ Male ☐ Female DOB: _____

Street Address: _____ Mailing Address: _____
(if different from street address or confidentiality is needed)

City/State/Zip: _____ _____

If no permanent address, please tell us where the FPMA applicant can be reached: _____

Primary Phone: _____ Secondary Phone: _____

E-Mail Address: _____ ☐ The FPMA applicant does not have an E-Mail address.

Is the FPMA applicant a NH resident? ☐ Y ☐ N If female, is the FPMA applicant pregnant? ☐ Y ☐ N

Is the FPMA applicant a US citizen or US national? ☐ Y ☐ N

If no, does the FPMA applicant have eligible immigration status? ☐ Yes. If yes, fill in the document type & ID # below.

a. Immigration document type: _____ b. Document ID number: _____

c. Lived in the US since 1996? ☐ Y ☐ N

d. Is the FPMA applicant, applicant's spouse or parent a veteran or an active-duty member of the U.S. military? ☐Yes ☐No

Does the FPMA applicant have Medicaid? ☐ Y ☐ N Private insurance? ☐ Y ☐ N *If yes, please answer the next questions:*

If yes, Insurance Company Name | Policy/Group Number | Name of Policy Holder | Date Ins. Begins | Date Ins Ends

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If the FPMA applicant got any Family Planning services in the last **90 days before this application date**, the FPMA applicant may qualify for help with unpaid bills for Family Planning services during that time period. He/she does not have to be currently eligible to apply for retroactive Family Planning medical assistance. The FPMA applicant *must provide the same kind of proofs for the retroactive periods that are needed for the current application.* Does the FPMA applicant want to apply for retroactive help? ☐ **Y** ☐ **N**

If **yes**, check all 3 boxes for retroactive coverage for all 3 months, otherwise, just check the boxes for the months the FPMA applicant would like coverage. ☐ **1 - 30 days** ☐ **31 - 60 days** ☐ **61 - 90 days**

B. Please tell us about the people the FPMA applicant lives with. Start with the FPMA applicant and list ALL of the people living with him/her. *You do not have to give the SSN or citizenship status of any individual who is not applying for assistance.*

Name	SSN	DOB	Relation to you	U.S. Citizen?	Student (Yes or No. If Yes, put grade too)
			SELF	☐ **Y** ☐ **N**	
				☐ **Y** ☐ **N**	
				☐ **Y** ☐ **N**	
				☐ **Y** ☐ **N**	
				☐ **Y** ☐ **N**	
				☐ **Y** ☐ **N**	

C. Please tell us about the FPMA applicant's income and federal tax filing status.

Gross Wages $ ☐ Weekly ☐ Bi-Weekly ☐ Monthly Current Employer:

Tips/Other Wages $ ☐ Weekly ☐ Bi-Weekly ☐ Monthly Employer Phone #:

Bonus/Other Wages $ ☐ Weekly ☐ Bi-Weekly ☐ Monthly

Pension $ ☐ Weekly ☐ Bi-Weekly ☐ Monthly Have you recently lost a job? ☐ Y ☐ N

Spousal Support $ ☐ Weekly ☐ Bi-Weekly ☐ Monthly If yes, when? / /

Unemployment $ ☐ Weekly ☐ Bi-Weekly ☐ Monthly Former Employer:

Other $ ☐ Weekly ☐ Bi-Weekly ☐ Monthly

Does the FPMA applicant plan to file a federal income tax return NEXT YEAR?

☐ **Yes. If yes,** please answer questions **a – e**. ☐ **No. If no,** skip to question **d**.

a. Will the FPMA applicant file jointly with a spouse? ☐ Yes ☐ No

If yes, name of spouse:

b. Will the FPMA applicant claim any dependents on the tax return? ☐ Yes ☐ No

If yes, list name(s) and DOB of dependents:

c. Do any of these dependents live with someone else? ☐ Yes ☐ No

If yes, how many dependents live with someone else?

Please list their name(s):

d. Is the FPMA applicant required to file a federal income tax return next year? ☐ Yes ☐ No

e. Will the FPMA applicant be claimed as a dependent on someone's tax return? ☐ Yes ☐ No

If yes, please list the name of the tax filer:

How is the FPMA applicant related to the tax filer?

D. Signatures

Initials

I certify that I understand "My Rights and Responsibilities," on the next page. _____

I understand that DHHS will keep my eligibility and case information confidential and only persons involved in administering DHHS' programs or as otherwise permitted by Federal regulations or State law will review it. _____

I understand that I may be required to provide proof of my eligibility for family planning medical assistance, including proof of what I have written on the application and what I have told DHHS and people administering this program. _____

I understand that the information I have provided will be verified by collateral contacts and/or Federal, State, and local officials and that if any information is found to be incorrect or false, or if I have deliberately withheld information related to my receipt of assistance, now or in the future, I may lose my benefits and may be prosecuted for fraud. _____

I understand that my signature below permits DHHS and any contracted third party entity to verify my income, identity, and other eligibility information. Failure to give permission to conduct these verifications or revoking permission to conduct these verifications will result in denial or termination of assistance. _____

I understand that my signature below authorizes DHHS to obtain verification that I meet the eligibility requirements for assistance, and authorizes release of such information to DHHS. My authorization to release information to DHHS remains in effect for as long as I receive any kind of DHHS assistance. _____

REQUEST FOR WAIVER OF COOPERATING WITH THIRD PARTY MEDICAL LIABILITY REQUIREMENT

Checking this box and signing below means that the Family Planning medical assistance applicant requests a waiver from cooperating with the third party medical liability requirement because cooperating would result in reprisal against and cause physical and emotional harm to the applicant.

☐ I cannot cooperate with the third party medical liability requirement because I believe cooperating would result in reprisal against and cause physical and emotional harm to me.

I certify, under penalty of perjury, that I have reviewed the information above; it is true and complete to the best of my knowledge, including the information concerning citizenship status.

Applicant Signature **Date**

If someone helped you complete this form, that individual must sign below.

Signature **Legal relationship to applicant** **Date**

CMU Fax: 271-8604 CMU phone: 1-877-464-2447 CMU email: ChildrensMedicaid.DCS@dhhs.state.nh.us

MY RIGHTS AND RESPONSIBILITIES

Nondiscrimination Notice

In accordance with Federal law and U.S. Department of Agriculture (USDA) and U.S. Department of Health and Human Services (HHS) policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. Under the Food Stamp Act and USDA policy, discrimination is also prohibited on the basis of religion or political beliefs.

To file a complaint of discrimination, contact USDA or HHS. Write USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410 or call (202) 720-5963 (voice & TDD). Write HHS, Director, Office of Civil Rights, Room 506-F, 200 Independence Avenue, S.W., Washington, D.C. 20201 or call (202) 619-0403 (voice) or (202) 619-3257 (TTY). USDA and HHS are equal opportunity providers and employers. Or you may also write to the Ombudsman, NH DHHS, 129 Pleasant St., Concord, NH 03301-3857; or call (603) 271-6941 or 1-800-852-3345 ext 6941. TDD Access: Relay NH 1-800-735-2964 or 711.

Administrative Appeal

You, or someone representing you, may request an Administrative Appeal if you are not satisfied with any decision regarding eligibility made by DHHS. You may be represented by an attorney yourself, or another person, such as a relative or friend, at an Administrative Appeal. DHHS will not pay for the cost of any legal services, but there are free and reduced cost legal services available in NH. An Administrative Appeal may be requested either verbally or in writing by contacting a District Office or DHHS, 105 Pleasant Street, Concord, NH 03301-6521. Telephone (603) 271-4292 or 1-800-852-3345 ext 4292; TDD Access: Relay NH 1-800-735-2964 or 711.

Quality Control

Your case may be selected for a quality control or other governmental review. Such a review entails an in-depth investigation into your financial or medical situation, living arrangements and other circumstances. **Failure to cooperate in these reviews could result in the loss of your benefits**.

Social Security Number (SSN)

The Federal Privacy Act of 1974 as amended, requires that we tell you the laws that allow us to ask you for your SSN. RSA 167:4-c, 42 CFR 435.910, 42 CFR 435.920, & 42 USC 1320b-7 mandate that you give us your SSN or that you apply for one. It will be used to verify income, on-going and continued eligibility, and in investigations for possible fraud. You will not get assistance without giving us your SSN.

Reporting Changes

Periodically, you will be required to complete a review of your circumstances. Your assistance will end if you do not completely fill out the review form, return it by the due date, and come in for a personal interview, if required.

Also, within 10 calendar days after the change happens, you must notify DHHS about any factors that affect eligibility, such as:

- any changes in source of income or hours worked;
- any time you apply for another category of Medicaid;
- any changes in amount of any of your income;
- any receipt of any lump sum payment or settlement; or
- a pregnancy.

ATTENTION!

Anything you tell or give to us will be verified & shared:

- **at the federal, state and local levels; and also**
- **through collateral contacts and/or computer matching with other electronic verification tools such as, but not limited to, USCIS, IEVS, Vital Records, SSA, financial institutions, & employment databases.**

We do this to confirm your eligibility for our programs and determine your benefits. If any information we get from using these sources doesn't match the information you provided to us, you may be denied assistance and you may be subject to criminal prosecution for knowingly providing false information.

Intentional False Statements

Any person who intentionally makes a false statement or misrepresents his/her circumstances or intentionally fails to disclose the receipt of property, wages, income or any change in circumstances that would affect his/her initial or continued eligibility for assistance may be found guilty of violating state law. The penalties are: Class A felony where the value of the monetary award or goods or services exceeds $1,000; Class B felony where the value exceeds $100; & misdemeanor where the value does not exceed $100.
RSA 167:17-b and 17-c.

Benefits Received in Error

You are required to pay back any benefits or services received in error, regardless of whether you made a mistake in the information you provided, or failed to provide, to us.