Florida Medicaid Family Planning Waiver

1115 Research and Demonstration Waiver

Extension Request July 1, 2013

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What is the Florida Medicaid Family Planning Waiver?

The FPW expands the provision of family planning and family planning-related services to women ages 14 through 55, losing their Medicaid coverage, who:

- Have family income at or below 185 percent of the Federal poverty level (FPL);
- Are not otherwise eligible for Medicaid, Children's Health Insurance Program (CHIP) or health insurance coverage that provides family planning services.

**Eligibility is limited to 2 years after losing Medicaid coverage, subject to an annual redetermination.*

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Services that are Available

- Physical exams
- Family planning counseling and pregnancy tests
- Birth control supplies
- Colposcopies and treatment for sexually transmitted diseases
- Related pharmaceuticals and laboratory tests

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Family Planning Waiver Application

FLORIDA DEPARTMENT OF HEALTH

Health Insurance Application for Extended Family Planning Benefits
A Special Medicaid Program

Office Date Received

Name: First	M.I.	Last	Maiden Name	Area Code ( )	Phone Number
Residence: Number	Street	Apt. No.	City	County	State / Zip Code
Mailing Address (Required if different from above):				If no home phone, number where you can be reached ( )	

Please answer the following questions:
1. In the past, have you had one or both of the following services? Hysterectomy: ☐ Yes ☐ No Tubal ligation: ☐ Yes ☐ No
2. What was the date of your last menstrual period? ______________ ☐ Yes ☐ No
3. The benefits you will receive are intended to delay pregnancy through family planning services. Do you wish to receive these services? ☐ Yes ☐ No
4. List all of the people who live in your home (write your name first):

****Only the applicant must provide her Social Security Number and her proof of citizenship and identity.**

First M.I. Last	Relationship to Applicant	**Social Security Number	Date of Birth	Race	Sex	US Citizen? Yes	US Citizen? No	** If no, give INS ID Number	Date of Entry	Applied for Medicaid? Yes	Applied for Medicaid? No
	(Self)										

5. Income: Complete the following information on anyone in the home who gets money from any source (include your parents if you are under age 21 and live with them):

Name of Person Receiving Income	Income Source	Gross Income (Before Deduction)	How Often Are You Paid This Amount? (weekly, biweekly, monthly)	Additional Information
	Current Job: Employer's Name			Employer's Address/Phone Number:
	Current Job: Employer's Name			Employer's Address/Phone Number:
	Child Support			**Child Care Cost for Job:**
	Contributions from Others			Paid by:
	Unemployment Benefits			Paid to:
	Social Security/SSI			Child(ren) paid for:
	Other Income – List Type			Amt. Paid: $ How often:

6. Do you have health insurance? ☐ Yes ☐ No If yes, give the name of the insurance company: ____________________
7. If you are 18 or under, are you enrolled in any KidCare program? ☐ Yes ☐ No
8. If yes, does your insurance have family planning as a benefit? ☐ Yes ☐ No
9. Please attach proof of US citizenship and identity to this application. Evidence of U.S. citizenship includes but is not limited to: a U.S. Passport, a U.S. Birth Certificate, Form FS-240, Report of Birth Abroad of a Citizen of the U.S. or Form FS 545 or From DS1350, Certification of Birth Abroad. Only originals or certified copies are acceptable.

CERTIFICATION AND AUTHORIZATION: I certify that the information provided on this application is true and correct to the best of my knowledge. By signing this form, I give consent to the Department of Health to obtain and to release my confidential financial and medical information for the purpose of determining eligibility for the Family Planning Waiver Program. I therefore authorize the following programs under Medicaid, MomCare, WIC, and DCF or their agents to contact me or my healthcare provider(s) for the purpose of coordination of care, payment of claims for services, quality improvement of services concerning my participation in the family planning waiver program. My authorization to release information includes any medical, mental health, alcohol/drug abuse, sexually transmitted disease, tuberculosis, HIV/AIDS, and adult or child abuse information. I understand that the information I have provided shall be kept confidential in accordance with Florida and federal laws. I have read and understand my rights and responsibilities as they apply to the family planning waiver program and that authorization shall remain in effect unless withdrawn in writing.

Signature of Applicant: ______________________________ Date: ____________

Eligibility Staff Signature/Date: ______________________________ FMMIS Termination Date: ____________

Mail or bring this application and any letter you received to your local county health department (see attached list). DO NOT SEND THIS APPLICATION TO MEDICAID.

DH 3212, 11/06 Stock No. 5744-000-3212-0

May be accessed from the Department of Health website at http://www.doh.state.fl.us/family/famplan/waiver.html.

What Objectives does the Agency Expect to Promote with this Waiver?

- Increasing access to family planning services;
- Increasing child spacing intervals through effective contraceptive use; and
- Reducing the number of unintended pregnancies in Florida.

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What is the impact of this extension on other parts of the Florida Medicaid Program?

- The extension does not impact any other eligibility or service provision of the Medicaid or CHIP programs.
- Extension of the waiver will allow the Agency to continue providing family planning services to the eligible population.

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Why is the Family Planning Waiver Discussed at Public Meetings?

- Agency must obtain federal approval to extend the Family Planning Waiver, which currently expires December 31, 2013
- The extension application must be submitted six months prior to the expiration date.

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Florida Medicaid Family Planning Waiver Extension

Public Comment Period:

- June 1, 2013 – June 30, 2013

Public Meeting Locations:

- June 4: Medicaid Area Office 6, Tampa, Florida – via webinar
- June 6: Agency for Health Care Administration, Tallahassee, Florida

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Public Comments

Interested parties may provide comments for 30 days, from June 1, 2013 – June 30, 2013

Members of the Media:

- Contact the Office of Communications at AHCACommunications@ahca.myflorida.com or by calling 850-412-3623

Members of the Public:

- Email comments pertaining to the Family Planning Waiver to FamilyPlanningWaiver@AHCA.MYFLORIDA.COM

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