

FAMILY PLANNING EXPANSION PROJECT (FPEP) ENROLLMENT FORM



¹ Examples of **Services Covered** by FPEP

- Yearly exam and your choice of birth control method
- Emergency contraception
- Family planning counseling and education
- Follow-up contraceptive care
- Vasectomies

Examples of **Services Not Covered** by FPEP

- Treatment for sexually transmitted diseases / infections
- Pregnancy confirmation for the Oregon Health Plan
- Tubal ligations or Essure®
- Treatment for bladder infections

² Last Name	³ First Name	⁴ Middle Initial
⁵ Address		
⁶ City	⁷ State	⁸ Zip
⁹ Have you been sterilized for more than 6 months? (tubal ligation, Essure®, hysterectomy, vasectomy) <input type="checkbox"/> Yes <input type="checkbox"/> No		¹⁰ Do you live in Oregon? <input type="checkbox"/> Yes <input type="checkbox"/> No
¹¹ Are you a U.S. Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If you are NOT a U.S. citizen, please answer the next question</i>		
¹² Are you a Lawful Permanent Resident who arrived in the U.S. 5 years before today? <input type="checkbox"/> Yes <input type="checkbox"/> No		
¹³ Do you have any health insurance that covers contraceptive management? <input type="checkbox"/> Yes <input type="checkbox"/> No		
¹⁴ Household Size: _____	Wages or Salary	\$ _____
	TANF/SSI/Social Security/Disability Income	\$ _____
	Unemployment Benefits	\$ _____
	Alimony	\$ _____
	Other Income	\$ _____
¹⁵ Total Monthly Gross Household Income:		\$ _____
¹⁶ Date of Birth __/__/____	¹⁷ Social Security # __ __ __ / __ __ / __ __ __ __	

I declare under penalty of perjury that the information I have provided is correct and complete to the best of my knowledge. I have been told that I may be eligible for the Oregon Health Plan and I have received information about local primary health care insurance and services. I understand and agree that my social security number (SSN), other information on this form, and information I provided to prove my identity and citizenship must be disclosed to DHS for purposes of determining eligibility for the FPEP program. I have been given a copy of a Notice which explains how my SSN and other information will be used.

¹⁸ Client Signature _____ ¹⁹ Date of Signature _____

²⁰ Client indicates special confidentiality need and, if applicable, private insurance should not be billed. <small>Clinic Staff: Code "NC" in box 17a of CVR regardless of insurance coverage.</small>	Client Initials for Special Confidentiality
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FOR CLINIC STAFF USE ONLY

21 Agency #

22 Clinic/Site #

23 Primary Care information provided Y N

24 OHP information provided Y N

25 Title X: Client pays _____ % per sliding fee scale for non-FPEP-covered service

26 Staff initials

FPEP CITIZENSHIP AND IDENTITY VERIFICATION

Document verification of citizenship and identity below. Create new record or update current record in database as needed.

CITIZENSHIP DOCUMENTATION

IDENTITY DOCUMENTATION

PENDING

PENDING

- 27 Client will supply citizenship document
- At or before next visit
 - By date _____
- OR**
- 28 Oregon Birth Information Form (FPEP103) completed by client
- Enter into FPEP Eligibility Database for electronic check
 - State staff will update record if citizenship is verified
- Date _____ Initials _____

- 32 Client will supply identity document
- At or before next visit
 - By date _____
- OR**
- 33 Oregon Birth Information Form (FPEP103) completed by client
- Enter into FPEP Eligibility Database for electronic check
 - State staff will update record if identity is verified
- Date _____ Initials _____

VERIFIED

VERIFIED

- 29 Citizenship listed as verified in FPEP Eligibility Database
- OR**
- 30 Citizenship document witnessed and copied
- Check Tier Tier 1 Tier 2 Tier 3 Tier 4
- (Tier 1 satisfies identity verification)
- 31 Information entered in FPEP Eligibility Database
- Date _____ Initials _____

- 33 Identity listed as verified in FPEP Eligibility Database
- OR**
- 34 Identity document witnessed and copied
- (Required with citizenship document Tier 2, 3, or 4)
- 35 Information entered in FPEP Eligibility Database
- Date _____ Initials _____

36 **Qualifies for FPEP** Y N

37 **FPEP ID#**

The FPEP ID# is REQUIRED for reimbursement. Complete items 36, 38 and 39 only if citizenship and identity have been verified and client is eligible for full year of FPEP coverage.

38 **Eligible FROM date**

39 **Eligible TO date**

40 Record client request for special confidentiality (be sure notation meets legal standard "at risk of emotional or physical harm")

41 Clinic use (optional)

FAMILY PLANNING EXPANSION PROJECT (FPEP) ENROLLMENT FORM



1 Ejemplos de los Servicios Cubiertos por FPEP

- | | |
|--|---|
| <ul style="list-style-type: none"> ▪ Exámenes anuales y su opción de métodos de planificación familiar ▪ Pastillas anticonceptivas de emergencia (las PAE) | <ul style="list-style-type: none"> ▪ Información y educación de planificación familiar ▪ Consultas regulares de métodos anticonceptivos ▪ Vasectomía |
|--|---|

Ejemplos de Servicios No Cubiertos por FPEP

- | | |
|--|---|
| <ul style="list-style-type: none"> ▪ Tratamiento para infecciones transmitidas sexualmente ▪ Confirmación del embarazo para el Plan de Salud de Oregon | <ul style="list-style-type: none"> ▪ Ligadura de trompas o Essure®(metodo de anticoncepción permanente) ▪ Tratamiento para las infecciones de la vejiga |
|--|---|

2 Apellido	3 Primer Nombre	4 Segundo Nombre
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5 Domicilio: (Dirección de calle)

6 Ciudad	7 Estado	8 Zona Postal
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9 ¿Ha estado esterilizada(o) por más de seis meses? (ligadura de trompas, Essure®(metodo de anticoncepción permanente), histerectomía, vasectomia) <input type="checkbox"/> Sí <input type="checkbox"/> No	10 ¿Vive en Oregon? <input type="checkbox"/> Sí <input type="checkbox"/> No
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11 ¿Es Ud. Ciudadano (a) de los Estados Unidos? Sí No *Si ud. NO es un Ciudadano de los Estados Unidos, por favor contestar la siguiente pregunta*

12 ¿Es Ud. residente legal permanente que llegó a los Estados Unidos hace 5 años? Sí No

13 ¿Teine seguro de salud que cubre servicios de planificación familiar? Sí No

14 Número de personas en el hogar:	Salario \$ _____
	TANF/SSI/Seguro Social/Ingreso de Incapacidad \$ _____
	Beneficios de Desempleo \$ _____
	Pensión por Divorcio \$ _____
	Otros Ingresos \$ _____
	15 Ingreso Mensual Bruto: \$ _____

16 Fecha de Nacimiento ___/___/___	17 Número de Seguro Social # ___ ___ ___ / ___ ___ / ___ ___ ___
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Declaro bajo penalidad de castigo que la información que he provehido es correcta y completa de acuerdo a mi conocimiento. He sido informado/da que posiblemente califique para Medical (OHP) y he recibido información acerca de servicios locales de cuidado primario y cobertura médica. Entiendo y verifico que mi número de seguro social (SSN), otra información en esta forma e información que he provehido para verificar mi identidad y ciudadanía será entregada al Departamento de Servicios Humanos (DHS) para el propósito de determinar elegibilidad para el programa de Planificación Familiar (FPEP). He recibido una copia de la Notificación que explica como será usado mi número de seguro social (SSN) y otra información.

18 Firma del paciente _____	19 Día de la Firma _____
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20 El cliente indica necesidad de confidencialidad, y si es pertinente al seguro medico privado no se le cobrará <small>Clinic Staff: Code "NC" in box 17a of CVR regardless of insurance coverage.</small>	Iniciales del cliente indicando confidencialidad
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