



Plan First

Virginia's Family Planning Program for Men and Women

Agency use only:
 Application:
 New Renewal
 Case # _____
 Eligibility Worker _____

Plan First pays for family planning services only. You may be eligible for full health care coverage if you are pregnant, or if you are age 18 or under. If this applies to you, please complete the Health Insurance for Children and Pregnant Women application available online at www.famis.org.

Step 1 Tell us who is completing the application, where you live, and where you get your mail.

First Name	MI	Last Name	Phone Numbers		Preferred Language (See Instructions)
		(Suffix)	H () W ()	Other ()	
Address	Apt. No.	City	State	Zip	City/County of Residence
(Street)					
(Mailing)					

Step 2 Tell us about yourself, your spouse (if you are married & living together), and any children under 21 years of age who live in your home. If you are under age 21 and living with your parents, list your parents.

	Person 1	Person 2	Person 3	Person 4
Name (first, MI, last)	(Suffix)	(Suffix)	(Suffix)	(Suffix)
Relationship to Person in Step 1	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Step-child <input type="checkbox"/> Other (Parent, grandchild, sibling, etc.)	<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Step-child <input type="checkbox"/> Other (Parent, grandchild, sibling, etc.)	<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Step-child <input type="checkbox"/> Other (Parent, grandchild, sibling, etc.)
Date of Birth & Sex	Month/day/year <input type="checkbox"/> M <input type="checkbox"/> F	Month/day/year <input type="checkbox"/> M <input type="checkbox"/> F	Month/day/year <input type="checkbox"/> M <input type="checkbox"/> F	Month/day/year <input type="checkbox"/> M <input type="checkbox"/> F

Step 3 Provide the following information only for persons applying for Plan First.

	Applicant #1	Applicant #2
Name		
Social Security # (required)		
Does this person have health insurance? (See instructions for further explanation)	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please provide: Type of Policy: _____ Company Name: _____ Policy ID#: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please provide: Type of Policy: _____ Company Name: _____ Policy ID#: _____
Have you had a family planning service in the last 3 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, when? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, when? _____
Person's Race, see codes below:	Race Code # _____	Race Code # _____
Race Codes: 1 White; 2 Black or African American; 3 American Indian/Alaskan Native; 4 Asian; 5 Spanish American/Hispanic; 6 Native Hawaiian or Other Pacific Islander; 7 Asian & White; 8 Black/African American & White; 9 Other or Unknown; or A Asian & Black/African American		
Is this person a U.S. citizen?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If the person is not a U.S. citizen complete this section.	Alien/INS# _____ Date entered U.S. _____ Country of Birth: _____	Alien/INS# _____ Date entered U.S. _____ Country of Birth: _____

Step 4

Tell us about your income, the income of your spouse (if you are married and living together), and the income of any children under 21 years of age who live in your home. If you are under the age of 21 and live with your parents, list your parents' income.

Person Receiving Income	Employer's Name or Source of Income	How Often is Income Received?	How Much Gross Income is Received?
_____ (First Name, MI, Last Name, Suffix)	_____ Name of Employer	<input type="checkbox"/> weekly <input type="checkbox"/> twice a month <input type="checkbox"/> every two weeks <input type="checkbox"/> monthly <input type="checkbox"/> yearly	\$ _____
_____ (First Name, MI, Last Name, Suffix)	_____ Name of Employer	<input type="checkbox"/> weekly <input type="checkbox"/> twice a month <input type="checkbox"/> every two weeks <input type="checkbox"/> monthly <input type="checkbox"/> yearly	\$ _____
_____ (First Name, MI, Last Name, Suffix)	_____ Name of Employer	<input type="checkbox"/> weekly <input type="checkbox"/> twice a month <input type="checkbox"/> every two weeks <input type="checkbox"/> monthly <input type="checkbox"/> yearly	\$ _____
_____ (First Name, MI, Last Name, Suffix)	_____ Name of Employer	<input type="checkbox"/> weekly <input type="checkbox"/> twice a month <input type="checkbox"/> every two weeks <input type="checkbox"/> monthly <input type="checkbox"/> yearly	\$ _____

Step 5

Tell us about childcare or adult daycare expenses: Do you pay someone to provide childcare or adult daycare while you work?

Yes No

Full Name of person in daycare	How much do you pay? _____ How often? _____	How much do you pay? _____ How often? _____	How much do you pay? _____ How often? _____	How much do you pay? _____ How often? _____
_____	_____	_____	_____	_____

Step 6

Voter Registration (See instructions for Step 6)

As a citizen of the Commonwealth of Virginia, we are required to provide you with the opportunity to register to vote when applying for benefits. Please check one of the following.

If you are not registered to vote where you live now, would you like to apply to register to vote today?

- Yes, I would like to register to vote. (If you would like help filling out the voter registration application form, we will help you. The decision to accept help is yours. You also have the right to fill out your voter registration application form in private.)
- I do not want to apply to register to vote today.

If you do not check either box, you will be considered to have decided not to register to vote at this time.

Applying to register or declining to register to vote will not affect the amount of assistance or services that you will be provided by this agency. If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with: Secretary of the Virginia State Board of Elections, Washington Building, First Floor, 1100 Bank Street, Richmond, VA 23219. Telephone: (804) 864-8901, toll free (800) 552-9745.

Agency Use Only:

Face-to-face interview not required.

A voter registration form was mailed. Date mailed: _____

Step 7

Tell us if you have given permission for someone else to follow up on this application.

If you would like to have someone else contact us for you, please complete the following:

I authorize (name) _____
 and/or (organization name) _____
 Address _____ City _____ State _____ Zip _____
 Telephone _____

to receive eligibility and enrollment information relating to this application. I also authorize the LDSS and the Department of Medical Assistance Services or its contractors to release information about this application to this person/organization.

Step 8

Signature of Applicant(s)

Note: We cannot process this application for you unless it is signed.

By signing below, I certify that I have read my Rights and Responsibilities (located on the instructions page) and agree to all the conditions and terms. I also agree that all the information I have given on this application is true and correct to the best of my knowledge and belief. I also understand that if I give false information, withhold information, or fail to report required changes promptly or on purpose, health insurance coverage may be denied or ended and I could be prosecuted for perjury, larceny and/or fraud.

Applicant #1 _____ Applicant #2 _____

SIGNATURES (REQUIRED)

Date _____

Application Instructions & Rights and Responsibilities

This application may be used for men and women applying for benefits through Plan First.

How do I apply?

To get started, simply complete this application and mail, drop off, or fax to the **local department of social services (LDSS)** in the city or county in which you live. If you need assistance completing the application, please contact your LDSS.

If you are age 18 or under or pregnant:

The Health Insurance for Children and Pregnant Women Application is used to apply for full benefit medical assistance for children age 18 or under and pregnant women. This application is available on-line at www.famis.org or at your LDSS.

If you are age 19 or older:

The Plan First Application is used to apply for medical assistance limited to family planning services. You may use this application to apply for Plan First for yourself and/or your spouse with whom you live. You may also designate someone to apply on your behalf (authorized representative).

Step 1: Information on person completing application

Complete this section listing your name, address, city/county of residence and phone number. Please list the address you want Plan First information to be mailed to in the mailing section. Please indicate a phone number where you can be reached if needed, regarding your Plan First application. Please tell us the language you speak. Write the name of the language in the space provided, such as: English, Spanish, Vietnamese, Farsi, Korean, Kurdish, Arabic, Urdu, Russian, or any other language.

Step 2: Information on applicant and other family members in the home

Provide information on you, your spouse (if you are married & living together), and all children under 21 who live in the home with you even if they are not applying for Plan First. Although you can only apply for persons 19 years and older on this form, we need information on all children under 21 living in your home to correctly determine the size of the family. If there are more than 3 children under age 21 in the home, complete Step 2 on another application and attach it to this one. For each child under age 21 in the home, please write the child's name, the child's relationship to you, the child's date of birth, and check if the child is male or female.

Step 3: Information about persons applying for insurance

Answer all the questions in the column, if you are applying for Plan First for this person.

Enter the **Social Security number** for each person applying for Plan First. A Social Security number is required for all persons applying for Plan First. For each person, check

whether or not he or she has other health insurance coverage now. If the person has health insurance now, list the type of policy. Provide the name of the insurance company and the policy number.

If the person has had a family planning expense in the last 3 months, Plan First may be able to help with the bill. Check yes if anyone applying for Plan First had any family planning service in the last 3 months and list the month the service was received. The person will have to show proof of income for that month.

Enter the correct code number for each person's race. Codes are listed below the question on the application. Then check yes or no if he/she is of Hispanic/Latino ethnic origin.

If the person is a U.S. citizen check yes. If the person is a legal immigrant, provide the person's Alien/INS #, country of birth, and the date the person entered the U.S. You must provide a copy of the front and back of the person's Resident Alien Card or other proof of immigration status with this application. If the person is a U.S. citizen and qualifies for Plan First, you may be asked to provide proof of his/her citizenship and identity.

Step 4: Income

Please list the name and the source of income for yourself and your spouse (if married and living together). If you are under age 21 and live with your parents, you will need to include your parents' income information along with your own.

If the income is from a job, list the name of the employer. If the income is from another source (such as unemployment compensation, Social Security, veteran's benefits etc), write the type or source of the income.

For each type of income listed, check how often it is received (each week, every two weeks, twice a month, once a month, or yearly) and write the gross amount of income received each time. Be sure to write the amount of income before any taxes or other deductions are taken (gross income).

You also need to provide **proof of each type of income** for each source listed above. You will need to provide proof of all income received in the prior month before you apply or the most recent 4 week period. (For example, if you were applying in June, you would need to attach proof of all income received in the month of May.)

To provide proof of income from a job, please attach a copy of all paycheck stubs for the month before you apply or the most recent 4 week period showing gross pay. If you do not have paycheck stubs, you can send a signed letter from an employer stating how much (gross pay) the employee was paid for each pay period for that month, or you may contact your LDSS agency to request a special form for reporting employment income. If you are self-employed, provide your most current tax return and all schedules or provide business records. You may be asked to provide records from the last three months up to the last year.

If income is different from month to month, you may provide proof of the last 3 months of income to show an average income. If you have questions about what income to report or what proof is needed, please call your LDSS.

Step 5: Childcare or Adult Daycare Expenses

Certain child and adult daycare expenses may help a person qualify for Plan First. Tell us if you **pay for childcare or adult daycare while you work**. If the answer is yes, write the name of each person in daycare, how much you pay for their care, and how often you pay it. (For example: \$50 a week or \$200 a month.) You can even report this expense if you are paying a relative to care for the children. The adult daycare expenses must be for an incapacitated spouse or parent of the person applying for health insurance.

Step 6: Voter Registration

Please follow instructions on the application. **Warning: Intentionally making a materially false statement on this form constitutes the crime of election fraud, which is punishable under Virginia law as a felony. Violators may be sentenced to up to 10 years in prison, or up to 12 months in jail and/or fined up to \$2,500.**

Step 7: Release of Information

If you would like someone else to be able to receive information about this application, **clearly print the person's name** or the name of an **organization, the address, and phone number** in this section. We will not release any information about this application to anyone except you or your spouse living in the home, unless you tell us who you want to be able to receive this information.

Step 8: Signature

Each applicant must sign the application, even if it is filled out by another person. Before you sign this application, make sure all the information is correct and read the section on your **Rights and Responsibilities** carefully. When you sign the application you are agreeing to all the statements under the Rights and Responsibilities. **Sign and date the application.** We cannot process an application without a signature.

Final checklist:

Did you answer all the questions?
Did you attach proof of all of last month's income?
Did you attach any other necessary documents?
Did you sign the application?

Mail, fax or drop off the application at your LDSS today.

YOUR RIGHTS AND RESPONSIBILITIES

(Read this section before signing the application)

I have the right to:

- ▲ Be treated fairly and equally regardless of my race, color, religion, national origin, gender, political beliefs, or disability consistent with state and federal law.
- ▲ File a complaint if I feel I have been discriminated against.
- ▲ Request, in writing, a hearing or review of any negative action that affects eligibility for or receipt of Plan First benefits. This includes timely decisions made on this application.

I further understand and agree that:

- ▲ The State and its contractors may contact other State and Federal agencies to verify any information that affects eligibility for coverage of the persons applied for on this application.
- ▲ The State and its contractors may exchange information on this application and medical, health, or other information relating to the person's coverage with other agencies and contractors to assist with application, enrollment, administration, quality control, and quality assurance.
- ▲ The Commonwealth of Virginia or its designee has the right to receive payments for services and supplies from insurance companies and other liable sources as reimbursement for medical services received by the persons.
- ▲ Each provider of medical services to the person may release any medical or other information necessary for the provider to be paid.
- ▲ If I am found eligible for full benefit Medicaid, I must cooperate in pursuing paternity and medical support for my children. I understand that my failure to cooperate may cause my ineligibility for full benefit Medicaid.

As an enrollee in Plan First, I understand:

- ▲ I may be held responsible for payment of any service not covered by Plan First.
- ▲ I must report any changes in the information provided on this application within 10 calendar days to my LDSS.
- ▲ Plan First must be renewed at least **every 12 months**. It is very important that you report any change in your address to the LDSS agency that is managing the case. If we do not have a correct address, we will not be able to notify you when it is time to renew coverage and the person(s) will be cancelled from the program.

Help us maintain coverage - tell us if you move!