

**Maryland Department of Health  
Maryland Medicaid  
Family Planning Program  
Application**

The **Maryland Medicaid Family Planning (FP) Program** provides family planning benefits for certain low income eligible women and men. Applicants can be of any age. Applicants must be a Maryland resident, and a U.S. citizen or a qualified alien who meets all requirements for benefits.

- **The FP Program does not cover any other health care services except family planning services.** Family planning services include: advice about birth control methods; physical exams, including pelvic and breast exams; screenings, such as pap smears and for sexually transmitted infections, when done as part of the family planning visit; birth control pills and devices, such as IUDs; emergency contraception; and permanent sterilization (must be aged 21 or over).
- The FP Program does not cover enough services to be a health insurance plan. Visit [www.MarylandHealthConnection.gov](http://www.MarylandHealthConnection.gov) or call 1-855-642-8572 to find out if you qualify for full Medicaid benefits or to get help paying for a health insurance plan.
- **This program does not cover services related to abortion and infertility.**
- If you are currently enrolled in Medicaid or the Maryland Children's Health Program, you already have family planning benefits and are considered ineligible for this program. Call your Managed Care Organization (MCO) if you need help finding a family planning provider.
- If you have Medicare, you are not eligible to enroll in this program.
- Individuals who have had a permanent sterilization procedure or a hysterectomy are not covered for the family planning services/supplies provided through this program.
- If you want a permanent sterilization and are eligible, it will be covered (must be age 21 or over).
- The FP Program does not cover prenatal services. If you are pregnant and need health care coverage for prenatal care, apply for Medicaid with the Maryland Health Connection (MHC) or at your local health department. For more information, call MHC at 1-855-642-8572 or the FP Program at 1-855-692-4993.

There are no fees to enroll, no deductibles, no monthly premium, and no annual benefit limit. There are no copays for contraceptive prescriptions (birth control). If you qualify for the FP Program and you do not already have a FP Program Card, you will receive one, which will allow you to choose any family planning provider that accepts Medicaid. You will not be required to join a Managed Care Organization (MCO). If you have a primary care provider, contact them to see if they participate. Most local health departments, community health centers, federally qualified health centers, and Planned Parenthood also accept the card. If you have questions about what is covered or need help finding a provider, call 1-800-456-8900.

If you have any questions, please see our website, <https://mmcp.health.maryland.gov/familyplanning/Pages/Home.aspx>. If you have questions about the application, call toll free at 1-855-692-4993. If you do not speak English, interpretation services are available, at no cost. The application is also available in Spanish. Maryland Relay Service is available at 1-800-735-2258 for individuals with disabilities.

**Important Application Information and General Instructions:**

- **Read all the instructions before completing the application.**
- **Print** clearly in blue or black ink or type the required information. All information must be readable.
- **Applicants who are married should apply using separate application forms.**
- The process to determine eligibility takes up to 45 days. Notification of the eligibility determination will be sent by mail.
- Applicants who are determined eligible will be enrolled for 12 months.
- Before the period of eligibility ends, a notice and re-application packet will be mailed to the address provided on the original application.

Please mail your completed application to:

**Maryland Department of Health  
Family Planning Program  
P.O. Box 296  
Baltimore, MD 21298-9795  
Or fax to: 410-333-0134**

**Instructions for Completing the Maryland Medicaid Family Planning Application**  
**Important: Print with black or blue ink or type the required information**

Section 1:

- A. Print your first name, middle initial, last name, and suffix.
- B. Fill in your complete home street address for where you live. **You must be a Maryland resident.** Check whether the FP Program may send mail to this address. If you are homeless, please write “homeless” in the home address line and fill in the state and county. Fill in your home, cell, or work phone number including area code. If you do not want mail sent to your home address you must: (1) provide an alternate address or phone number for messages in section C, and (2) check that you do not want mail sent to your home address. The FP Program will then contact you at your alternate address and message number only.
- C. If you want a representative or someone else to get your mail, complete that person’s name and address in the box. If you enter “homeless” in Section B, you must enter a mailing address in Section C. If you have a post office box to get mail, list it here. You can include a message phone number in the message phone box.
- D. Write your date of birth and Social Security number. Social Security numbers are required. Select whether you are male or female. (Both males and females may apply.)
- E. Check U.S. Citizenship status “YES” or “NO”. If you check “NO”, fill in your alien registration number in the box.
- F. Check the box next to your current marital status.
- G. Check the box to indicate if you are currently pregnant. If you are pregnant you are not eligible. Individuals who have had a permanent sterilization procedure or a hysterectomy are not covered for the family planning services/supplies provided through this program.

Section 2:

- H. Check whether you have any other form of health insurance, including Medicaid, Medicare, insurance through your employer, or as a retirement benefit. If yes, include the name of the insurance company or program through which you have coverage. You will also need to provide the Policy or ID number. **If you currently have Medicaid or Medicare, you are considered ineligible for this program.** However if you lose Medicaid or Medicare, you may be eligible.

Section 3:

- I. If the FP Program may contact you by email, provide your email address. Check whether your ethnicity is Hispanic or Latino.
- J. Check your race. You may check more than one race.
- K. Primary and secondary language information is optional. Indicate if a translation service is needed for us to speak to you.
- L. Check the box to indicate if you are visually impaired. If yes, indicate if large print notices are needed.
- M. Check the box to indicate if you are hearing impaired. If yes, indicate if Maryland Relay Services are needed.

Section 4:

- N. Check whether you receive any income from employment. If yes, complete the name and address of the employer. Then list the GROSS amount (before any deductions) and frequency of all income received. You must provide information about your income. You may be contacted to provide proof of income. If you are married, you do not need to provide information regarding your spouse’s income.

## **Instructions for Completing the Maryland Medicaid Family Planning Application (Continued)**

- O. Check whether you receive any income other than employment. If yes, list the source, amount, and frequency of all other income.
- P. Check whether you had any medical bills you want help paying in the past three (3) months. If yes, list the type of medical expense and the amount of the bill.
- Q. Check whether you are American Indian or Alaska Native (AI/AN). If no, continue to section R. If yes, please complete this section.

Check whether you are a member of a federally recognized tribe. If yes, please provide the tribe name and the state where the tribe is located.

Check whether you have ever gotten a service from or if you are eligible to get services from the Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs.

If you are AI/AN, certain money received may be exempt from Medicaid consideration. Additionally, you may be exempt from prescription copays. Check whether you received income that includes money from: per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties; payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations); money from selling things that have cultural significance. If yes, list the amount received and how often you receive the payment.

- R. Check whether you pay for certain things that can be deducted on a federal income tax return, including student loan interest. If yes, list the frequency you paid the deduction and the amount paid. If you have other types of deductions that can be deducted on a federal income tax return to report, please specify the deduction type, list the frequency you paid the deduction and the amount paid.

### Section 5:

- S. Please read the Maryland Medicaid Family Planning Rights and Responsibilities on the last page of this packet before signing and dating the application.
- T. If an Authorized Representative completed the application on your behalf, he or she must print, sign and date the application.

**Please remember to sign and date your application. An unsigned application is not valid and will be returned.**

**Mail applications to:**

**Maryland Department of Health  
Family Planning Program  
P.O. Box 296  
Baltimore, MD 21298-9795**

Or fax to: 410-333-0134

**Maryland Medicaid Family Planning Program (FP Program)**  
**RIGHTS AND RESPONSIBILITIES**  
**Please read and save these rights and responsibilities for your records.**

- I understand that this application is for family planning services only. (Both males and females can apply.)
- I understand that this program does not cover primary care services for the treatment of any diseases or infections that may be identified during a family planning service visit except those expressly covered. Should you need assistance in obtaining primary care services go to your nearest Federally Qualified Health Center; locations can be found at the Health Resources and Service Administration, [http://findahealthcenter.hrsa.gov/Search\\_HCC.aspx](http://findahealthcenter.hrsa.gov/Search_HCC.aspx), or call 1-800-456-8900.
- I understand this program cannot provide coverage if I am already pregnant.
- I understand that if I have had a permanent sterilization procedure or a hysterectomy, I am not covered for the family planning services/supplies provided through this program.
- **I understand this program does not provide coverage for services related to abortion and infertility.**
- I certify that I am a US citizen or qualified alien. I understand that my Social Security number will be used to verify my eligibility. My Social Security number may also be used to cross-match information in federal, state, and local government files. I understand that the information given on this application form is confidential and will only be used for the purpose of program administration, except as permitted by state and federal law.
- I understand that the Maryland Department of Health may conduct independent verification of the statements made by me on this application and agree to the release of personal and financial information from any financial institution, insurance company, present or past employer, federal, state, or local government agency, private or public organization to the Department for eligibility determination.
- I understand that if I have other insurance, I must use the other insurance prior to accessing the Maryland Medicaid Family Planning Program benefit.
- I must notify the Department within 10 business days if any of the following changes occur: change in address, contact information, health insurance coverage; any change in my income.
- I agree that my family planning service providers may release medical information related to services I have received to FP Program administrators. Both the family planning service providers and the Department will ensure the confidentiality of my protected health information as required by state and federal law.
- I understand that if the Maryland Medicaid Family Planning Program pays for my family planning services and later identifies that another insurance should have paid for the services, the FP Program has the right to recover costs from the responsible third party. I understand that if I get more benefits than I am entitled to, through my fault, I may have to repay the FP Program for any extra benefits received.
- I understand that I have the right to appeal a decision made by the FP Program administrators related to my eligibility for participation or the scope of services that I am entitled to receive.
- My signature certifies that I understand my rights and responsibilities related to enrollment in the Maryland Medicaid Family Planning Program.

**Your application must be complete and signed. If you have questions you may call our office at 1-855-692-4993 before you send your application**

<b>Maryland Medicaid Family Planning Program Application</b>			
<b>Section 1 Complete your information</b>			
<b>A</b>	First Name	MI	Last Name Suffix
<b>B</b>	Home Street Address (Include Apt)		Telephone <input type="checkbox"/> Home: <input type="checkbox"/> Cell: <input type="checkbox"/> Work:
	City	State	ZIP Code County
	Do you want mail sent to this address? Yes <input type="checkbox"/> No <input type="checkbox"/>		
<b>C</b>	First Name (alternative contact or authorized representative)		Last Name
	Mailing Address (Include Apt) or P.O. Box		Message Phone
	City	State	ZIP Code County
<b>D</b>	Date of Birth:	Social Security Number:	Sex: M <input type="checkbox"/> F <input type="checkbox"/>
<b>E</b>	Are you a U.S. Citizen? Yes <input type="checkbox"/> No <input type="checkbox"/>	If you are not a citizen please provide your immigrant documentation number:	
<b>F</b>	What is your marital status: Never Married <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/>		
<b>G</b>	(If you are female) Are you pregnant? Yes <input type="checkbox"/> No <input type="checkbox"/>		
<b>Section 2 Other insurance including Medicaid or Medicare</b>			
<b>H</b>	Do you have other insurance, including <b>Medicaid or Medicare</b> , which pays for your health care? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please write the name of the insurance company or program and your Policy/ID number below: Insurance Company: _____ Policy/ID number: _____		
<b>Section 3 Optional information</b>			
<b>I</b>	Email address:	Are you Hispanic/Latino? Yes <input type="checkbox"/> No <input type="checkbox"/>	
<b>J</b>	What is your race? American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/>		
<b>K</b>	What is your primary language?	What is your secondary language, if any?	Are translation services needed? Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>L</b>	Are you visually impaired? Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, do you want large print notices? Yes <input type="checkbox"/> No <input type="checkbox"/>	
<b>M</b>	Are you hearing impaired? Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, should we use Maryland Relay Services? Yes <input type="checkbox"/> No <input type="checkbox"/>	
<b>FAMILY PLANNING FINANCIAL INFORMATION</b>			
<b>Section 4 Complete the financial information for yourself.</b>			
<b>N</b>	Do you receive any income from employment? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, complete Section Q.		
	Your Employer Name		Your Employer Address
	List all gross income before tax from full or part time employment, self-employment, etc.		
	<b>Earned Income</b>	<b>Amount</b>	<b>How Often</b>
	Wages	\$	
Self-Employment	\$		
Other:	\$		

<b>O</b>	<b>Do you receive any other income not from employment? Yes <input type="checkbox"/> No <input type="checkbox"/></b> If yes, list any other income received, such as unemployment, child support, SSDI, alimony, pensions, workers' compensation, etc.		
	<b>Unearned Income - Type</b>	<b>Amount</b>	<b>How often</b>
		\$	
		\$	

<b>P</b>	<b>Did you have any medical bills you want help paying in the past three (3) months? Yes <input type="checkbox"/> No <input type="checkbox"/></b> If yes, list the type of medical expense and the amount of the bill.	
	<b>Medical Expense</b>	<b>Amount</b>
		\$

<b>Q</b>	<b>Are you an American Indian or Alaskan Native (AI/AN)? Yes <input type="checkbox"/> No <input type="checkbox"/></b> If no, continue to section R. If yes, please complete the following questions.	
	<b>Are you a member of a federally recognized tribe? Yes <input type="checkbox"/> No <input type="checkbox"/></b> If yes, provide the tribe name and state where the tribe is located in the space below.	
	Tribe Name	State
	<b>Have you ever gotten a service from the Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs? Yes <input type="checkbox"/> No <input type="checkbox"/></b>	
	<b>If no, are you eligible to get services from the Indian Health Service, a tribal health program, or urban Indian health programs, or through a referral from one of these programs? Yes <input type="checkbox"/> No <input type="checkbox"/></b>	
	<b>Did you receive any AI/AN specific income? Yes <input type="checkbox"/> No <input type="checkbox"/></b>	

<b>Amount</b>	<b>How Often</b>
\$	
\$	

<b>R</b>	<b>Do you pay any of the following deductible expenses? Yes <input type="checkbox"/> No <input type="checkbox"/></b>		
	<b>Deduction</b>	<b>Amount</b>	<b>How often</b>
	Student Loan Interest	\$	
	Other:	\$	

**Section 5 Signature Section.**

<b>S</b>	I have read and agree to the rights and responsibilities listed elsewhere in this application packet. I swear and affirm under penalty of perjury that all the information I gave is true, correct, and complete to the best of my ability, belief, and knowledge.	
	<b>Applicant's Signature:</b>	<b>Date:</b>
<b>T</b>	<b>Representative's Name (printed) and Signature:</b>	<b>Date :</b>

Please submit your completed application by mail to: Maryland Department of Health  
 Family Planning Program  
 P.O. Box 296  
 Baltimore, MD 21298-9795  
**Or by fax to: 410-333-0134**