

FAMILY PLANNING EXPANSION PROJECT (FPEP) ENROLLMENT FORM



Examples of **Services Covered** by FPEP

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| <ul style="list-style-type: none"> ▪ Yearly exam and your choice of birth control method ▪ Emergency contraception | <ul style="list-style-type: none"> ▪ Vasectomies | <ul style="list-style-type: none"> ▪ Family planning counseling and education ▪ Follow-up contraceptive care |
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Examples of **Services Not Covered** by FPEP

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| <ul style="list-style-type: none"> ▪ Treatment for sexually transmitted infections ▪ Pregnancy confirmation for the Oregon Health Plan | <ul style="list-style-type: none"> ▪ Tubal ligations or Essure® ▪ Treatment for bladder infections |
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1 Where did you hear about us? (check all that apply)

<input type="checkbox"/> Ad on the bus, light rail or bus shelter	<input type="checkbox"/> Friend or family
<input type="checkbox"/> Movie theatre	<input type="checkbox"/> Billboard
<input type="checkbox"/> Text message	<input type="checkbox"/> Have been here before
<input type="checkbox"/> facebook	<input type="checkbox"/> MySpace
<input type="checkbox"/> Oregon Family Planning website	<input type="checkbox"/> Other: _____

2 Last Name	3 First Name	4 Middle Initial
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5 Address _____

6 City	7 State	8 Zip
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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
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Are you a: (check one box only)

11 U.S. Citizen **OR** **12** Lawful Permanent Resident who has held this status for at least 5 years

13 Do you have any health insurance that covers contraceptive management? Yes No

14 Household Size:	Wages or Salary \$ _____
	Social Security, Disability, or Unemployment Benefits \$ _____
	Other Income \$ _____
	15 Total Monthly Gross Household Income: \$ _____

16 Date of Birth ____ / ____ / _____	17 Social Security # ____ - ____ - ____
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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 _____
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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 offered <input type="checkbox"/> Y <input type="checkbox"/> N	24 OHP information offered <input type="checkbox"/> Y <input type="checkbox"/> 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	27 <input type="checkbox"/> Oregon Birth Information Form (FPEP103) completed by client <input type="checkbox"/> Enter into FPEP Eligibility Database for electronic check - State staff will update database if citizenship is verified OR 28 <input type="checkbox"/> Out-of-state birth record request completed by client <input type="checkbox"/> Send request to State Family Planning Program - Clinic staff will update database if citizenship is verified OR 29 <input type="checkbox"/> Client will supply citizenship document	33 <input type="checkbox"/> Client will supply identity document <input type="checkbox"/> By date _____	PENDING
VERIFIED	30 <input type="checkbox"/> Citizenship listed as verified in FPEP Eligibility Database OR 31 <input type="checkbox"/> Citizenship document witnessed and copied Check Tier: <input type="checkbox"/> Tier 1 <input type="checkbox"/> Tier 2 <input type="checkbox"/> Tier 3 <input type="checkbox"/> Tier 4 (Tier 1 satisfies identity verification) 32 <input type="checkbox"/> Information entered in FPEP Eligibility Database Date _____ Initials _____	34 <input type="checkbox"/> Identity listed as verified in FPEP Eligibility Database OR 35 <input type="checkbox"/> Identity document witnessed and copied (Required with citizenship document Tier 2, 3, or 4) 36 <input type="checkbox"/> Information entered in FPEP Eligibility Database Date _____ Initials _____	VERIFIED

37 Qualifies for FPEP <input type="checkbox"/> Y <input type="checkbox"/> N	38 FPEP ID# _____	<i>The FPEP ID# is REQUIRED for reimbursement. Complete items 37, 39 and 40 only if citizenship and identity have been verified and client is eligible for full year of FPEP coverage.</i>
39 Eligible FROM date _____	40 Eligible TO date _____	

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

42 Clinic use (optional)
