

FAMILY PLANNING EXPANSION PROJECT (FPEP) ENROLLMENT FORM



¹ Examples of **Services Covered** by FPEP

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

Examples of **Services Not Covered** by FPEP

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

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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¹¹ Are you a U.S. Citizen? Yes No *If you are NOT a U.S. citizen, please answer the next question*

¹² Are you a Lawful Permanent Resident who arrived in the U.S. 5 years before today? Yes No

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

¹⁴ Household Size: _____	Wages or Salary \$ _____ TANF/SSI/Social Security/Disability Income \$ _____ Unemployment Benefits \$ _____ Alimony \$ _____ Other Income \$ _____ ¹⁵ Total Monthly Gross Household Income: \$ _____
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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 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)