STATE OF OKLAHOMA
Oklahoma Health Care Authority

Application for Family Planning Services

This Family Planning Services/SoonerPlan application is used for individuals 19 years of age and older. Please complete every item on this form. If more space is needed, use a separate sheet of paper. Mail the completed application form to Oklahoma Health Care Authority, Attention: FPW SoonerPlan, PO Box 18276, Oklahoma City, OK 73154. If you need assistance completing this form, contact your local Oklahoma Department of Human Services (OKDHS) county office.

1. Tell us about everyone living in the household. Show the names as they appear on their Social Security card.
   Race - Please use one or more of the following codes to describe your race(s) and or ethnic group: A = Asian; B = Black; H = Hawaiian/Pacific Islander; I = American Indian/Alaskan Native; S = Hispanic; W = White Sex: M = Male; F = Female

Name (first, middle, last)	Relation-ship to person 1	Social Security number	Date of Birth	Marital Status	Sex	Race	Hispanic or Latino	Okla. resident	U.S. citizen	Tribal name or alien registration number
Person 1					M ☐ F ☐		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
					M ☐ F ☐		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
					M ☐ F ☐		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
					M ☐ F ☐		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
					M ☐ F ☐		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	

2. How do we contact the above household? (Please print)

Street or P.O. Box mailing address	City	State	Zip
Finding address, if different Street address	City	State	Zip

Area code	Home phone number	Area code	Day time phone number	Area code	Number for messages

Office Use Only

Case name	Case no.	County	Supervisor	District

3. For all U.S. citizens needing family planning services, identity must be verified. Please mail a **copy** of each person's drivers license or government issued ID card with picture, school ID with picture, tribal CDIB card, or U.S. military ID card.

4. For all U.S. citizens needing family planning services, citizenship must also be verified. Complete the information below. If available, mail a **copy** of each person's birth certificate with this application.

Name (first, middle, last) of the household member needing family planning services	Name as shown on their birth certificate (first, middle, last)	County of birth	State of birth	Mother's maiden name (first, middle, last) as shown on the applicant's birth certificate
Person 1				

5. Is anyone in the household employed? Yes ☐ No ☐ Self-employed? Yes ☐ No ☐ If yes, complete the following about each full-time or part-time job or business. Show gross earnings - NOT take home pay.

Employer's name, address and phone number or self employment information	Who earns this money?	Gross earnings per pay period?	How often paid? (weekly, every other week, twice a month, monthly?)

6. Does anyone in the household get any other money or income? Yes ☐ No ☐ Some examples of other income are:

Social Security/SSI	Other Pensions	Support (alimony or child support)	Annuities/Trust
Worker's Compensation	Veteran's Benefits	Interest, such as C.D., stocks, bonds	Railroad Retirement
Military Allotment	Royalties/Gas/Oil	Money from friends, relatives, etc.	Unemployment
Rental	Other, specify _____		

If yes, give us the following information.

Name of person money is for?	Source of money?	How much money?	How often received?

7. Does anyone needing family planning services have health insurance? Yes ☐ No ☐ If yes, answer the following:

Insurance company name, address and phone number	Group or policy number	Person covered	Type of coverage (major medical, dental, HMO, etc.)	Effective date	Policy holder's name and Social Security number	Relationship of policy holder to insured

Rights and Responsibilities

- The information I give on this form is true and correct to the best of my knowledge. I realize if I give information that isn't true OR if I withhold information, I can be lawfully punished for fraud or perjury. I may also have to re-pay SoonerCare for any medical bills, which were not paid correctly. (28 USC 1746)
- I understand that the information I give on this application both verbally and in writing will be checked. I agree to help do that and to let SoonerCare get needed information from government agencies, employers, medical providers and other sources.
- I know that our Social Security numbers will be given to other government agencies to get information needed to prove eligibility.
- I know I am required to help the Oklahoma Department of Human Services (OKDHS) or the Oklahoma Health Care Authority (OHCA) to identify and locate those absent parents who might be liable for the costs of medical care to me or others in my family receiving SoonerCare.
- I give permission for SoonerCare to: (1) collect payments from anyone who is supposed to pay for medical care, (2) share necessary medical information with any insurance company, person or entity who is responsible for paying the bill, and (3) inspect any of my medical records to determine the compensability of claims for services. I also give permission to any of my medical providers or home care providers to give information to the OKDHS or the OHCA to make payment or overpayment decisions.
- I agree to tell SoonerCare within 10 days if there are any changes in our income, the people who live in our home, where we live or get our mail, and/or our health insurance.
- I know that I can ask for a fair hearing if I think the decision made on my case is unfair, incorrect or made too late.
- I also know that my application for SoonerCare cannot be denied because of race, color, sex, age, disability, religion, nationality or political belief.

13. ASSIGNMENT: I do hereby transfer, assign and authorize payment to the Oklahoma Health Care Authority (OHCA) all claims I have or may have against health insurance or liability insurance companies, or other third parties. This covers all payments for medical services made by OHCA.

Yes ☐ No ☐
This Application will be denied if you check NO to this question.

14. Your Signature_____ Date _____

For office use only

Date received _____

ELIGIBLE Yes ☐ No ☐

Signature _____

Date _____

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