



Health Insurance Application for Extended Family Planning Benefits A Special Medicaid Program

Office Date Received

Name:	First	M.I.	Last	Maiden Name	Area Code	Phone Number
Residence:	Number	Street	Apt. No.	City	County	State
Mailing Address (Required if different from above):					If no home phone, number where you can be reached ()	
					Zip Code	

- Please answer the following questions:
- In the past, have you had one or both of the following services? Hysterectomy: Yes No Tubal ligation: Yes No
 - What was the date of your last menstrual period? Yes No
 - The benefits you will receive are intended to delay pregnancy through family planning services. Do you wish to receive these services? Yes No
 - List all of the people who live in your home (write your name first):

****Only the applicant must provide her Social Security Number and her proof of citizenship and identity.**

First	M.I.	Last	Relationship to Applicant	**Social Security Number	Date of Birth	Race	Sex	US Citizen? Yes No	** If no, give INS ID Number	Date of Entry	Applied for Medicaid? Yes No
		(Self)									

5. Income: Complete the following information on anyone in the home who gets money from any source (include your parents if you are under age 21 and live with them):

Name of Person Receiving Income	Income Source	Gross Income (Before Deduction)	How Often Are You Paid This Amount? (weekly, biweekly, monthly)	Additional Information
Current Job: Employer's Name	Current Job: Employer's Name			Employer's Address/Phone Number:
	Child Support			Employer's Address/Phone Number:
	Contributions from Others			Child Care Cost for Job: Paid by: _____ Paid to: _____
	Unemployment Benefits			Child(ren) paid for: _____
	Social Security/SSI			Armt. Paid: \$ _____
	Other Income - List Type			How often: _____

- Do you have health insurance? Yes No If yes, give the name of the insurance company: _____
- If you are 18 or under, are you enrolled in any KidCare program? Yes No
- If yes, does your insurance have family planning as a benefit? Yes No
- Please attach proof of US citizenship and identity to this application. Evidence of U.S. citizenship includes but is not limited to: a U.S. Passport, a U.S. Birth Certificate, Form FS-240, Report of Birth Abroad of a Citizen of the U.S., or Form FS 545 or Form DS 1350. Certification of Birth Abroad. Only originals or certified copies are acceptable.

CERTIFICATION AND AUTHORIZATION: I certify that the information provided on this application is true and correct to the best of my knowledge. By signing this form, I give consent to the Department of Health to obtain and to release my confidential financial and medical information for the purpose of determining eligibility for the Family Planning Waiver Program. I therefore authorize the following programs under Medicaid, MomCare, WIC, and DCF or their agents to contact me or my healthcare provider(s) for the purpose of coordination of care, payment of claims for services, quality improvement of services concerning my participation in the family planning waiver program. My authorization to release information includes any medical, mental health, alcohol/drug abuse, sexually transmitted disease, tuberculosis, HIV/AIDS, and adult or child abuse information. I understand that the information I have provided shall be kept confidential in accordance with Florida and federal laws. I have read and understand my rights and responsibilities as they apply to the family planning waiver program and that authorization shall remain in effect unless withdrawn in writing.

Signature of Applicant: _____ Date: _____

Eligibility Staff Signature/Date: _____ FMMIS Termination Date: _____

Mail or bring this application and any letter you received to your local county health department (see attached list). DO NOT SEND THIS APPLICATION TO MEDICAID.

Florida Department of Health
Instructions for Completing the
Health Insurance Application for Extended Family Planning Benefits
(Medicaid Family Planning waiver)

The information on the application is needed to help determine if you are approved for the Medicaid Family Planning Waiver program. You are eligible for this program if you have:

- Lost your full Medicaid
- Have not had a hysterectomy or tubal ligation.
- Not pregnant.
- Desires family planning services.
- Income is less than or equal to 185% current federal poverty level.

In order to assist with this determination we need you to complete the application, answer the questions (1-9) and sign and date the form. Failure to complete the application will delay the determination for benefits as well as your duration or time on this program, if eligible. **You must sign and date the form after the date that you lost your full Medicaid.**

Fill in the rows starting with **Name, Residence and Mailing Address**. Please print your information. Please complete or fill in the information requested in these rows on the form. Please include your mailing address if different from your residence (home) address. This contact information is important. You will be contacted by phone if additional information is needed; you will be contacted by mail to let you know about your eligibility for the program.

Questions 1-3 ask for your reproductive history and whether you desire to participate in the Family Planning Waiver program. Please answer questions 1 through 3.

Question 4 asks for a list of all of the people who live with you or live in your home. Please complete the information requested of yourself as well as the other people or persons that live with you or in your home. Please note that only you, the applicant will need to provide your:

- social security number
- certified proof of your citizenship and identity, if claiming to be a U.S. Citizen and
- proof of your income, pay stubs from the last four weeks, if employed.

Question number 5 asks for the name, income sources, and relationship for not only yourself but the people living with you or in your home. Please complete the information requested of yourself as well as the other people or persons that live with you or in your home including current job, employer's address and phone number.

Please fill out the column with the heading **Child Care Cost for Job**.

Questions 6-8 ask for insurance information. Please answer questions 6-8

Read the **Certification and Authorization** section and sign and date the form. You need to mail or bring this application to your local health department.



Florida Medicaid Agency for Health Care Administration *Champions of Health Care*

is CHCUP Financial Managed Care Provider **Recipient** Reference TPL CCMS Site
Search **information** buyin edb search case search service usage

Search By: Recipient ID [redacted] SSN [redacted]

Recipient Information

Recipient ID	[redacted]	Name	[redacted]	Primary ID	Yes
PHI Ind	[redacted]	Prew Name	[redacted]	Linked ID	
Medicare ID	[redacted]	Payee Name	[redacted]	Medicare Coverage	
Medicare ID Ind	[redacted]	Address	[redacted]	Medicare Buy-In	
SSN	[redacted]	Address 2	[redacted]	Benefit Plan	[redacted]
Gender	[redacted]	Address 3	[redacted]	Man Exempt Ind	
Birth Date	[redacted]	City	[redacted]	Managed Care	TXIX 07/01/2005 - 03/31/2007 PEPW 06/06/2005 - 06/30/2006
Age	37	State	FL	TPL	TXIX 01/01/2005 - 06/30/2005 TXIX 06/01/2004 - 12/31/2004
Death Date		Zip	[redacted]	Opt Out Ind	
Death Date Ind		Phone	[redacted]	Lockin	
Race	[redacted]	Phone Type	Unknown	MK Pend Choice Ind	
Race 2	[redacted]	ALT Phone		Unborn Ind	
Ethnicity	Not Applicable	ALT Phone Type	No Phone	Expected Birth Date	
Citizen	US Citizen	Residence County	[redacted]	Mem ID	
Language	ENGLISH	Area	[redacted]	CHCUP Ind	No
Language Ind	Conversion	Caseworker County	[redacted]	CHCUP Ind Source	Conversion
		District	[redacted]	CHCUP Date	



**MEDICAID FAMILY PLANNING
WAIVER BENEFITS
ADDITIONAL INFORMATION LETTER**

Date:

Medicaid No.:

Recipient's name:

Your application for Medicaid family planning waiver benefits requires additional information to be processed. We must receive the information requested on the attached form **within 30 days** or your application will be denied. **If we deny your application due to lack of information, it will be necessary to reapply to be eligible for this special program.**

The attached form must be returned to the following address within 30 days.

RETURN FORM TO:

If you have concerns or questions about program services, please contact your local county health department's eligibility staff member _____ at _____.



REQUEST FOR ADDITIONAL INFORMATION
FOR
MEDICAID FAMILY PLANNING
WAIVER BENEFITS APPLICATION

DATE: _____

FROM: _____

TO:

Client's Name: _____

Mailing Address: _____

We have reviewed your application for extended family planning waiver services. In order to complete the application process, we need additional information from you. The statements below will prompt you where to look on the application for the information that is incomplete. If the area is not highlighted, you do not need to complete. We have kept your original application and only need the requested information. **Please sign the enclosed application for it to be valid and mail to the address above.**

- You did not complete question(s) _____ by checking the yes or no box. The entire question left blank is highlighted in yellow for you.
- You did not write the date of your last menstrual period in question 2. Please add the date in the space after question 2.
- Question 5 is not completed correctly. The area(s) highlighted in yellow need(s) to be completed. You must attach proof of all incomes listed.
- You did not include proof of US citizenship. Please look at question 9 for what to attach.
- You did not include proof of identity. Please attach.
- Additional information requested: _____
- Sign enclosed application.



**MEDICAID FAMILY PLANNING WAIVER
ELIGIBILITY WORKSHEET**

SECTION I – General Information (Completion of Section I is required)

- STEP 1.** Does the client have Medicaid or Temporary Aid to Needy Families (TANF) coverage?
 No Yes **IF YES, STOP!**
- STEP 2.** Did the client provide proof of U.S. citizenship and identity? No Yes **IF NO, STOP!**
- STEP 3.** Answer the following questions and proceed accordingly:
- a) Has the client had a hysterectomy or tubal ligation? No Yes **IF YES, STOP!**
- b) What was the date of the client's last menstrual period? _____
- c) Does the client wish to receive family planning services? No Yes **IF NO, STOP!**
- STEP 4.** Does the client have health insurance? No Yes
 If yes, did they provide the name of the insurance company? No Yes **IF NO, STOP!**
- Does the client have KidCare? No Yes **IF YES, STOP!**
- STEP 5.** a) How many members are in the filing unit? _____
 b) Did the client provide verification of income for the appropriate members of the filing unit?
 No Yes **IF NO, STOP!**

SECTION II – Budget Computations (use HMS to calculate eligibility)

STEP 1.	Total Monthly EARNED Income (before deductions) for the filing unit.	\$ _____
STEP 2.	Subtract \$90.00 for EACH employed member of the filing unit.	- \$ _____
	BALANCE	\$ _____
STEP 3.	Subtract childcare as billed to families up to \$175 per child age two or older or \$200 per child under age two.	\$ _____
	TOTAL NET MONTHLY EARNED INCOME	\$ _____
STEP 4.	Total Monthly UNEARNED Income for the filing unit. (VA, SSA, contributions, unemployment comp., child support, etc.)	\$ _____
STEP 5.	Subtract up to \$50.00 per month of total child support received.	\$ _____
	TOTAL NET MONTHLY UNEARNED INCOME	\$ _____
STEP 6.	Add Total Net Monthly Earned Income and Total Net Monthly Unearned Income and Multiply by 12 for Total Net Annual Income.	
	TOTAL NET ANNUAL INCOME FOR FILING UNIT	\$ _____

SECTION III – Compare Total Net Income for Filing Unit to the Current Federal Poverty Level.

TOTAL NET INCOME IS: Greater than 185% of poverty level INELIGIBLE
 Less than or equal to 185% of poverty level ELIGIBLE

 Date Staff Signature / Title County Health Department Site / County

IF ELIGIBLE, complete Family Planning Waiver Input Document and forward to Medicaid fiscal agent.
 IF INELIGIBLE, provide Denial Letter, offering other family planning options.

Name: _____
 I.D. No: _____
 D.O.B.: _____

Show Family Members : 

TEST V1.7 COUNTY HEALTH DEPARTMENT
FACE SHEET

Name : MYNN,CAITLIN	Client ID : 230-98-7645	DOB : 06/15/1975
Family Id : 370041544-01	Client Status : ACTIVE	
Race : HAWAIIAN NATIVE	Gender : FEMALE	Migrant :
Cntry Origin :	Hispanic : YES	Marital Status: MARRIED
HIPAA Privacy : NP Good Faith-DH3205v4/03	Language : ENGLISH	Billing Consent/Date : N -
Street Addr : 2564 APPLGATE WAY TALLAHASSEE 32308 LEON		
Mail Addr : 2564 APPLGATE WAY TALLAHASSEE 32308 LEON		
Phone # :	Registration Date : 02/16/2005	
Medical Rec # : 101ABC203	Location : LEON COUNTY HEALTH DEPARTMENT	

FAMILY MEMBER INFORMATION

MYNN,MICHAEL	09/07/73	HEAD OF HOUSEHOLD
MYNN,FRED	09/08/89	
MYNN,TEEN	06/28/91	

FINANCIAL INFORMATION

First Ins : BLUE CROSS BLUE SHIELD OF FLA	Coverage dates 06/24/2005 To
Second Ins : MEDICARE2	Coverage dates 10/01/2006 To

Payor : SMITH,WILL X
Address : 45 LESSLIE ROW
City : ARRAN
Phone # :
State : FL

Family Size : 4	Wage Earners : 2	Yearly Gross : \$ 43137.60
Net Yearly Income : \$ 40977.60(yr)	\$ 3414.00(mth)	
Empl Deduction : \$ 2160.00		
# Children in Childcare : 0		Deduction : \$ 0
# Children receiving Childcare : 0		Deduction : \$ 0
Child Support Expense : \$ 0		
Sliding Fee Scale : 83%		Date last determined : 12/20/2007
BPL : 198%		

NO HOUSEHOLD DATA

I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF. I GIVE MY CONSENT TO THE DEPARTMENT OF HEALTH TO MAKE INQUIRY AND VERIFY THE INFORMATION. I UNDERSTAND THAT I MAY BE PROSECUTED UNDER STATE LAW IF I HAVE DELIBERATELY SUPPLIED THE WRONG INFORMATION.

Signature _____ Date: _____
(client/parent/guardian) Date Printed: Jan 29, 2008



MEDICAID FAMILY PLANNING WAIVER DENIAL NOTICE

Date: _____

Dear Ms: _____

Your application dated _____ for family planning waiver benefits under Medicaid has been **DENIED** as of _____ for the following reason(s):

- | | |
|--|---|
| <input type="checkbox"/> no proof of U.S. citizenship | <input type="checkbox"/> no proof of identity |
| <input type="checkbox"/> over income | <input type="checkbox"/> income not verified |
| <input type="checkbox"/> services declined | <input type="checkbox"/> tubal ligation or hysterectomy |
| <input type="checkbox"/> PEPW or Emergency Medicaid only | <input type="checkbox"/> eligibility period expired |
| <input type="checkbox"/> other: _____ | |

We do want to encourage you to maintain your health by seeking health care services. Your doctor's office may have a plan that can fit your needs. You may also contact your local county health department for free or reduced-cost family planning services.

If you think that this action is incorrect or you disagree with a decision, your local county health department eligibility worker or your worker's supervisor will be glad to discuss it with you. You also have the right to request in writing a hearing before a state hearings officer. Requests for hearings must be filed with the agency clerk within twenty-one (21) days of receipt of this notice. Written requests must be sent to: Department of Health, Agency Clerk, Office of the General Counsel, 4052 Bald Cypress Way, Bin #A-02, Tallahassee, FL 32399-1703. You may bring with you or be represented at the hearing by anyone you choose, such as a lawyer, relative or friend. Your hearing will occur within ninety (90) days of the request.

In accordance with Federal law and our policy, the Department of Health is prohibited from discriminating on the basis of race, color, national origin, sex, age, disability, religion, political belief or martial status.

Name: _____
I.D. No: _____
D.O.B.: _____



Family Planning Waiver Input Document

This form is to be used by Qualified Designated Personnel who determine family planning waiver eligibility only. All of the information **must** be completed to add coverage. **Please print clearly.** Mail this form to the Medicaid fiscal agent at ACS State Healthcare, Recipient Services Department, P.O. Box 7092, Tallahassee, FL 32314-7092.

Recipient Medicaid ID: _____
(must match FMMIS)

SSN: ____-____-_____
(must match FMMIS*)

Recipient Name: _____
(must match FMMIS) Last First MI

Address: _____
Number Street Apt. #

City/Town FL State Zip

Date of Birth: __/__/____
(must match FMMIS)

*If SSN does not match FMMIS, contact AHCA, Recipient File Management Unit, 850-922-4497

Family Planning Waiver Eligibility Span: __/__/____ to __/__/____ FP
Begin (mmddccyy) End (mmddccyy) Category

Date Application Signed: __/__/____
MM DD CCYY

Authorization

Before requesting this coverage be added to the file, the person completing this form checked FMMIS by Recip ID SSN

Print name of DOH eligibility staff _____

Date _____

Signature of DOH Supervisor _____

(____) _____
Area Code Phone Number

Print name of DOH Supervisor _____

Fiscal Agent Use Only

Name of person entering data on FMMIS

Date Entered: __/__/____
MM DD CCYY

FAMILY PLANNING WAIVER BATCH TRANSMITTAL

TO: ACS State Healthcare
 Recipient Services Department
 P.O. Box 7092
 Tallahassee, FL 32314-7092

Return to:

FROM: _____ **DATE:** _____

Quantity Submitted: _____

For ACS Use Only:

	NAME	PIN/Recip.# / SSN	OK	RTD	COMMENTS	√
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
11.						
12.						
13.						
14.						

For ACS Use Only:

Date Received	Date Due	Verifier ID





is CHCUP Financial Managed Care Provider Recipient Reference TPL GCMS Site
Search information buyin edb search case search service usage
Search By: Recipient ID [redacted] SSN [redacted]

Recipient Information

Recipient ID	[redacted]	Name	[redacted]	Primary ID	Yes
PHI Ind	[redacted]	Prev Name	[redacted]	Linked ID	[redacted]
Medicare ID	[redacted]	Payee Name	[redacted]	Medicare Coverage	[redacted]
Medicare ID Ind	[redacted]	Address	[redacted]	Medicare Buy-in	[redacted]
SSN	[redacted]	Address 2	[redacted]	Benefit Plan	WFP 04/01/2007 - 03/31/2009
Gender	Female	Address 3	[redacted]	Man Exempt Ind	[redacted]
Birth Date	07/29/1971	City	[redacted]	Managed Care	WHS 07/01/2006 - 03/31/2007
Age	37	State	FL	TPL	No
Death Date	[redacted]	Zip	[redacted]	Opt Out Ind	[redacted]
Death Date Ind	[redacted]	Phone	[redacted]	Lockin	[redacted]
Race	[redacted]	Phone Type	Unknown	MK Pend Choice Ind	[redacted]
Race 2	[redacted]	ALT Phone	[redacted]	Unborn Ind	[redacted]
Ethnicity	Not Applicable	ALT Phone Type	No Phone	Expected Birth Date	[redacted]
Citizen	US Citizen	Residence Count	[redacted]	Mom ID	[redacted]
Language	ENGLISH	Area	[redacted]	CHCUP Ind	No
Language Ind	Conversion	Caseworker County	15 DADE	CHCUP Ind Source	Conversion
		District	[redacted]	CHCUP Date	[redacted]

2009 MEDICAID BENEFIT (eligibility) CODES ON FMMIS

To be eligible for the Family Planning Waiver, recipient file should indicate:

1. *SSI – Supplemental Security Income or*
2. *TXIX – Title XIX (SOBRA)*

Other Benefit Plan Codes that are ineligible:

ALIEN – Emergency Medicaid for Aliens
EBA – Medicaid Reform-Enhanced Benefit Account
IBSCI – Traumatic Brain/spinal Cord Injury Waiver
IWACF – Adult Cystic Fibrosis Waiver
IWADA – Aged/Disabled Adult
IWALE – Assisted Living Waiver
IWCDC – Consumer Directed Care Research/Demo Waiver
IWCHL – Channeling Waiver
IWDD – Developmental Disabilities Waiver
IWDD1 – DD Tier 1
IWDD2 – DD Tier 2
IWDD3 – DD Tier 3
IWFSL – family Supported Living Waiver
IWPAC – Project AIDS Care
LTC – Long Term Care
MKIDS – MediKids
MN – Medically Needy
PARTD – Medicare Part D FFS
PEPW – Presumptive Eligible Pregnant Women
QI1 – QI 1
QMB – Qualified medicare Beneficiaries
QMBSS – Silver Saver
RXEXP – Drug Assistance Expense Program
SLMB – Specified Low-Income Medicare Beneficiaries
WADH – Adult Day Health Care Waiver
WALZ – Alzheimers Disease Waiver
WAO – Aging Out
WD – Working Disabled
WFD – Familiar Dysautonomia Waiver
WFP – Family Planning Waiver
WFSC – Florida Senior Care Waiver
WMON – Model Waiver

BENEFIT PLANS IN THE NEW FMMIS

Benefit Plan: The benefit plan defines the service package an individual is able to receive under Medicaid.

The benefit plans with full Medicaid benefits are Title XIX, SSI, and LTC.

WFP is the benefit plan for family planning waiver participants who receive family planning services only – no other benefits.

The benefit plans for QMB, SLMB and QI1 are for the respective Medicare Savings Programs (MSP) aid categories. (Remember, someone may be QMB only or QMB + full Medicaid; SLMQ only or SLMB only + full Medicaid; or QI1 only or QI1 with Medically Needy.)

The MN benefit plan is for Medically Needy; they receive all Medicaid benefits EXCEPT long term care. (Do not confuse the MN *aid* category for newborns with the MN benefit plan for the Medically Needy aid categories of NS, NA R, etc.)

PEPW is the benefit plan for the MU aid category; Medicaid benefits are limited to pregnancy-related services.

The ALIEN benefit plan is for emergency Medicaid for aliens whose only Medicaid benefit is the coverage of the emergency service (no pharmacy or other benefits that aren't defined as emergency service).

The EBA benefit plan corresponds to a special new aid category (EBA) for qualified persons in the Medicaid reform areas and is currently limited to over-the-counter drugs; it does not entitle the person to Medicaid benefits.

With the exception of WFP, all of the W* benefit plans and I* benefit plans do not entitle the person to benefits UNLESS they are also in SSI, LTC, or Title XIX.

LTC is the benefit plan for Long Term Care aid categories, i.e., MI*.

The QMBSS benefit plan is for the old Silver Saver participants (program ended 12/31/05).

The RXEXP benefit plan corresponds to the special aid category (5007) referring to House Bill 5007; this benefit plan covers only transplant and chemotherapy drugs for individuals who were on Medically Needy December 2005, prior to Medicare Part D.

PARTD is really the Part D FFS benefit plan which means the person has been given a fee for service span for Medicaid covered drugs for a period for which he or she has Medicare coverage. It tells FMMIS to override the Medicare present edit and allow Medicaid to pay for Medicaid covered drugs that would otherwise have to be covered by a Medicare Part D plan.

MKIDS is the benefit plan for Title XXI (SCHIP) MediKids.



MEDICAID FAMILY PLANNING WAIVER APPROVAL NOTICE

Date: _____

Dear Ms: _____

Your application for family planning waiver benefits under Medicaid has been **APPROVED**.
Your eligibility is approved from _____ through _____, not to exceed one year.

Under this program, Medicaid will pay for:

- Physical exams including a pap smear
- Birth control supplies such as pills, depo (the shot), condoms and diaphragms
- Pregnancy tests and treatment for sexually transmitted diseases for up to six weeks after your exam.

You can receive these family planning services from any Medicaid provider, such as, a doctor (family practitioner, OB/GYN), certified nurse midwife, nurse practitioner, physician assistant, or a county health department, family planning clinic, a birthing center, or a rural or federal health clinic.

If you have concerns or questions about program services, please contact your local county health department.

Name: _____
I.D. No: _____
D.O.B.: _____



**NOTIFICATION OF
MEDICAID FAMILY PLANNING WAIVER
BENEFITS CHANGE**

Date:

Medicaid No.:

Recipient's name:

Your application for family planning waiver benefits under Medicaid was previously approved. However, upon further review of your application, we must revoke your participation in the program. **Your termination is effective immediately.**

We do want to encourage you to maintain your health by seeking health care services. Your doctor's office may have a plan that can fit your needs. You may also contact your local county health department for free or reduced-cost family planning services.

If you think that this action is incorrect or you disagree with a decision, your local county health department eligibility worker or your worker's supervisor will be glad to discuss it with you. You also have the right to request in writing a hearing before a state hearings officer. Requests for hearings must be filed with the agency clerk within twenty-one (21) days of receipt of this notice. Written requests must be sent to: Department of Health, Agency Clerk, Office of the General Counsel, 4052 Bald Cypress Way, Bin #A-02, Tallahassee, FL 32399-1703. You may bring with you or be represented at the hearing by anyone you choose, such as a lawyer, relative or friend. Your hearing will occur within ninety (90) days of the request.

In accordance with Federal law and our policy, the Department of Health is prohibited from discriminating on the basis of race, color, national origin, sex, age, disability, religion, political belief or martial status.



**MEDICAID FAMILY PLANNING WAIVER
ELIGIBILITY REVIEW SHEET**

Client Name:		County Health Department Site/ County:		Name of Eligibility Staff:	
Date of Eligibility Determination:		Date Reviewed:		Signature of Reviewing Staff:	
A. BASIC PROGRAM REQUIREMENTS		<input checked="" type="checkbox"/> CHECK CORRECT RESPONSE (YES) (NO) (N/A)		EXPLANATION OF ERROR	
1. Required documentation attached to application. (proof of U.S. citizenship and identity, and verification of income)					
B. INCOME / DEDUCTIONS					
1. Earned income: (used HMS to calculate)					
a. Wages figured correctly?					
b. Income disregard (\$90) applied correctly?					
c. Appropriate amount of childcare deducted?					
2. Non-Earned Income: (used HMS to calculate)					
a. Income figured correctly?					
b. Deduction for child support figured correctly?					
C. ADMINISTRATIVE					
1. Administrative file contains appropriate forms:					
a. Application with required documentation to include progress notes?					
b. Eligibility worksheet attached to HMS printout of eligibility?					
c. Copy of Family Planning Waiver Input Document?					
d. Copy of approval or denial letter?					
2. Family Planning Waiver eligibility process should be initiated within 5 work days?					
3. Tracking log completed?					
D. DETERMINATION DECISION					
1. Correct Decision Made?					
a. Eligibility approved?					
b. Eligibility denied?					