BHSF Form 2-FP
Rev 07/07
Prior Issue Obsolete

TAKE CHARGE
Family Planning Waiver Renewal

Renewal Month: _____

CSLD/WKR: _____

Return this form or call us by:

Use this form to renew your coverage for family planning waiver services. If you **do not** renew, your coverage will end. You may renew by mail, fax, phone, or in person.

How to Renew:

By mail: Fill out and sign this form. Return the form and needed proofs (see page 3) in the envelope provided. If you need extra space on any question, use a separate sheet of paper.
By fax: Fill out and sign this form. Fax it and needed proofs (see page 3) to the fax number on the notice that came with this form or fax it to 1-877-523-2987.
By phone: Call the worker who sent you this form or call (toll-free) 1-888-342-6207 Monday through Friday 8:00 A.M. to 4:00 P.M. Press 1 for English and then 0 for an operator who can transfer you to your worker. You must speak to your worker to renew by phone.
In person: Visit your closest Medicaid office or Application Center. For the office closest to you, call 1-888-342-6207. If you are deaf or hard of hearing and have a TTY text telephone, call 1-800-220-5404.

What language do you speak best? ☐ *English* ☐ *Spanish* ☐ *Vietnamese* ☐ *Other (list)* _____
What language do you write best? ☐ *English* ☐ *Spanish* ☐ *Vietnamese* ☐ *Other (list)* _____

1. Tell us about you – The woman who gets family planning waiver services.

Your Name _____
First *Middle Initial* *Maiden* *Last*

Home Address _____
Street Address *Apartment/Lot Number*

_____
City *State* *Zip Code*

Mailing Address *(if different)* _____
P.O. Box or Street Address *Apartment/Lot Number*

_____
City *State* *Zip Code*

Your Social Security Number _____ - _____ - _____ Parish Where You Live _____

Marital Status: ❑ Married ❑ Single ❑ Separated ❑ Divorced ❑ Widowed

E-mail Address _____

Home Phone (_____) _____ Cell Phone (_____) _____ Daytime Phone (_____) _____

Best Day/Time to Call Monday through Friday Between 8 a.m. and 4:30 p.m. _____

2. Tell Us On the Next Page About the Other People Living With You – List your husband first (if married) and then all children under age 18. If no one lives with you, go to Question 3.

If there are more than 4 people, use a separate sheet of paper. Social Security numbers must be given for spouse, children, and anyone who gets Medicaid.

**If you have questions or need help filling out this form, call our office at 1-888-342-6207.
If you are deaf or hard of hearing and have a TTY text telephone, call 1-800-220-5404.
These calls are free.**

Name (first, middle initial, last) _____

Date of Birth (month, day, year) _____ Social Security Number _____ - _____ - _____

Relationship to You: ❑ Husband ❑ Child ❑ Step-Child ❑ Grandchild ❑ Other _____

Name (first, middle initial, last) _____

Date of Birth (month, day, year) _____ Social Security Number _____ - _____ - _____

Relationship to You: ❑ Child ❑ Step-Child ❑ Grandchild ❑ Other _____

Name (first, middle initial, last) _____

Date of Birth (month, day, year) _____ Social Security Number _____ - _____ - _____

Relationship to You: ❑ Child ❑ Step-Child ❑ Grandchild ❑ Other _____

Name (first, middle initial, last) _____

Date of Birth (month, day, year) _____ Social Security Number _____ - _____ - _____

Relationship to You: ❑ Child ❑ Step-Child ❑ Grandchild ❑ Other _____

3. Health Insurance

Do you have Medicare? ❑ Yes ❑ No

Do you have health insurance? ❑ Yes – Fill Out Below ❑ No – Go to Question 4

Policyholder's Name _____ Coverage Start Date _____

Insurance Company Name and Phone Number _____

Policy Number _____ Group Number _____

It covers: ❑ Hospital ❑ Doctor ❑ Medicine ❑ Dental ❑ Ambulance ❑ Pregnancy ❑ Family Planning

4. Pregnancy

Are you pregnant? ❑ Yes ❑ No Expected Due Date _____

Are you expecting more than one baby? ❑ Yes ❑ No

5. Income from Working

Does anyone work (you, your husband, or children under age 18)? ❑ Yes – Fill Out Below ❑ No – Go to Question 6

Tell us about **each** full-time job, part-time job, or business.

Who works?	Employer/Business Name and Phone Number	Self Employed	How much? (gross, not take home pay)	How often paid?
		❑ Yes ❑ No		
		❑ Yes ❑ No		
		❑ Yes ❑ No		

6. Other Income - Not from Working

Do you or does anyone in your home get any money that is not from a job like:
• Social Security • SSI • Unemployment • Retirement • Worker's Compensation • Child Support • Alimony
• Money From Friends and Relatives • Anything Else
❑ Yes – Tell Us About It Below ❑ No – Go to Question 7

Who gets it?	What is it?	How much? (gross, not take home)	How often?
			❑ weekly ❑ every 2 weeks ❑ twice a month ❑
			❑ weekly ❑ every 2 weeks ❑ twice a month ❑
			❑ weekly ❑ every 2 weeks ❑ twice a month ❑

7. Child Care and Adult Care

Do you or does your husband pay for child care or care for an adult **with a disability** in order to work, go to school, or get training? ❑ Yes – Fill Out Below ❑ No – Go to Question 8

Name of Child(ren) or Adult Who Gets Care _____

Who pays for the care? _____ How much is paid each month? _____

Is help received with paying it from anyone or another program? ❑ Yes - How much? _____ ❑ No

Name of Daycare Center or Caregiver _____ Phone Number (_____) _____

8. Child Support and Alimony

Does anyone pay court-ordered child support or alimony to someone not living in your home? ❑ Yes ❑ No

If **yes**, to whom? _____ Person in Your Home Who Pays It _____

How much and how often? _____

Send Us These Things
Pay stubs from last month showing gross pay (before taxes) or a letter from the employer. If self-employed, send copies of last year's tax return and all schedule attachments – for you, your husband, and children under 18.
Proof of gross income (before taxes) from Veteran's Benefits, worker's comp, alimony, and any other income that is not from working. Proof could be award letters and 1099 tax statements from last year's tax return - for you, your husband, and children under 18.
Statement from friends or relatives who give money to you, your husband, or children
Proof of child care payments from the day care center. Proof of payments for adult care from the caregiver.
Court order and proof of alimony or child support that you or your husband **PAYS** to someone **outside your home**. If it is paid through Louisiana Support Enforcement Services (SES), you **do not** have to send proof – let us know.

YOUR RIGHTS AND RESPONSIBILITIES

WHAT THE MEDICAID/TAKE CHARGE PROGRAM HAS THE RIGHT TO EXPECT OF YOU

CITIZENSHIP AND IMMIGRATION STATUS: You state that you and/or the person(s) renewing coverage for Medicaid/Take Charge are U.S. citizens or they are in this country legally.

REPORTING THE TRUTH: You state that the information you give on this renewal form is true and correct. You understand if you purposely give information that is not true OR if you purposely do not tell information that you are supposed to, you may get health benefits you should not get. If that happens, by law you can be punished for fraud. Also, you may have to pay money back to the Medicaid/**TAKE CHARGE** Program for the bills it paid by mistake.

VERIFICATION OF INFORMATION: You understand that the information you give about yourself and/or the person(s) applying will be checked. You agree to help do this and to let the Medicaid/**TAKE CHARGE** Program get information it needs from government agencies, employers, medical providers, and others.

SOCIAL SECURITY NUMBERS: You understand Social Security numbers will only be used to get information from other government agencies to make a decision about eligibility for you and/or the person(s) applying for Medicaid/**TAKE CHARGE**.

PAYMENT OF MEDICAL CARE BY A THIRD PARTY: You understand by accepting Medicaid/family planning waiver services, the Department has the right to get money received by you and/or the person(s) applying from other sources like insurance payments or lawsuit settlements for services that the Medicaid/**TAKE CHARGE** Program has paid for you and/or the person(s) applying.

REPORTING CHANGES: You agree to tell the Medicaid/**TAKE CHARGE** Program within 10 days of these changes: 1) if anyone getting family planning waiver services moves out of state; 2) if there are any changes in your mailing or home address; 3) if anyone getting family planning gets health insurance or Medicare; and 4) if anyone getting family planning becomes pregnant.

CHILD SUPPORT ENFORCEMENT: You understand that the Medicaid/**TAKE CHARGE** Program will only send case information to Child Support Enforcement for medical support if you ask them to.

WHAT YOU HAVE THE RIGHT TO EXPECT FROM THE MEDICAID/TAKE CHARGE PROGRAM

RIGHT TO A FAIR HEARING: You understand that you can ask for a Fair Hearing if you think any decision made on the case is unfair, incorrect, or made too late.

NO DISCRIMINATION: You understand that Medicaid/**TAKE CHARGE** Program cannot treat you differently because of race, color, sex, age, disability, religion, nationality, or political belief. If you think it has, you can call the U.S. DHHS Regional Office for Civil Rights in Dallas, TX at 1-800-368-1019 or write to Louisiana's Department of Health & Hospitals, Human Resources at P. O. Box 4818 Baton Rouge, LA 70821-4818

⬇ YOU MUST SIGN BELOW ⬇

Sign Your Name Here: _____ **Date** _____

If someone from Medicaid or a Medicaid Application Center helped you fill out this form, they will sign below.

_____ **Date** _____

Please return this renewal form right away. We will give you more time to get the documents of proofs if you need it. If you need the address or fax number to your local Medicaid office, call 1-888-342-6207. If you are deaf or hard of hearing and have a TTY text telephone, call 1-800-220-5404. These calls are free.