

TAKE CHARGE

Louisiana Family Planning Waiver Services

Family Planning services are available to many women ages 19-44 through **TAKE CHARGE**, a Louisiana waiver program.



What is family planning?



Family Planning helps a woman avoid an unintended pregnancy. The spacing of childbirths increases a child's chances of survival and allows a mother to better plan for her children and herself. Family planning is one important way women can **TAKE CHARGE** of their lives.

Who can qualify?

Women ages 19-44 who:

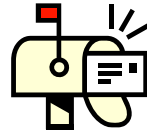
- ★ do not have Medicaid or other insurance that covers family planning;
- ★ are not pregnant; and
- ★ have not had a procedure to prevent pregnancy like a hysterectomy.

If you already get Medicaid, you are eligible for family planning services.

How to Apply

① **Online** –
www.Medicaid.DHH.Louisiana.gov.

② **Mail** –



TAKE CHARGE
P.O. Box 91278
Baton Rouge, LA
70821-9278

③ **Fax** – 1-877-523-2987 (toll-free)

④ **Drop Off** – Go to your local Medicaid Office. Call 1-888-342-6207 for the closest office or visit our web site at www.TAKECHARGE.DHH.Louisiana.gov.

Is income counted?

Yes. Your family's gross income for the month has to be less than the amounts in the chart. We give deductions for things like child support, child care payments, and \$90 for each employed person.

We **do not** count things like bank accounts, cash on hand, vehicles or property.

Number in Family	Income Amounts April 1, 2010 through March 31, 2011	
	Weekly Income	Monthly Income
1	\$452	\$1,805
2	\$608	\$2,429
3	\$763	\$3,052
4	\$919	\$3,675
5	\$1,075	\$4,299
6	\$1,231	\$4,922
More than 6	For each extra person, add \$624 to the monthly amount	

What services are covered?

- ★ Four yearly physical examinations and laboratory tests
- ★ Contraceptive counseling
- ★ Birth control products that require a prescription, such as birth control pills, patches, injections, IUDs, and diaphragms
- ★ Sterilization procedures

Questions

If you need help filling out the application or getting any of the needed proofs, call **1-888-342-6207**. If you are deaf or hard of hearing and use a TTY text telephone, call **1-800-220-5404**.

**NO enrollment fees,
NO premiums, NO co-payments
NO deductibles**

(TEAR OFF THE APPLICATION HERE BEFORE MAILING. KEEP THIS PAGE FOR YOURSELF.)

Your Rights

If you think the decision we make is unfair, not correct, or made too late, you may ask for a fair hearing by:

- ✓ Calling the Family Planning Waiver/**TAKE CHARGE** Program office at 1-888-342-6207, and/or
- ✓ Writing to
LA DHH Bureau of Appeals
P.O. Box 4183
Baton Rouge, LA 70821-4183

TAKE CHARGE is an Equal Opportunity Program.

We can't treat you differently because of your race, color, sex, age, disability, religion, nationality or political belief. If you think we have:

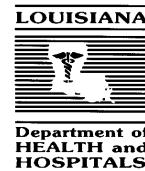
- ✓ Call the U.S. DHHS Regional Office for Civil Rights in Dallas, TX at 1-800-368-1019, and/or
- ✓ Call the Family Planning/**TAKE CHARGE** Program office at 1-888-342-6207, TTY users call 1-800-220-5404, and/or
- ✓ Write to
LA Department of Health & Hospitals
P.O. Box 4818
Baton Rouge, LA 70821-4818

Si ud quiere un solicitud in espanol o quiere a hablar con alguien que habla espaniol, llama
1-877-252-2447.

Nếu quý vị cần đơn tiếng Việt hoặc tham khảo với nhân viên người Việt, Xin gọi số điện thoại miễn phí
1-877-252-2447.

This public document was published at a cost of \$13,018.50. Seventy five thousand (75,000) copies of this public document were published in this first printing at a cost of \$13,018.50. The total cost of all printings of this document, including reprints, is \$13,018.50. This document was published by Office of State Printing, 950 Brickyard Lane, Baton Rouge, LA 70804 to advise applicants, recipients, and other individuals of family planning waiver services from the **TAKE CHARGE** Program through LA DHH under authority of 42 CFR 435.905. This material was printed in accordance with the standards for printing by state agencies established pursuant to R.S. 43:31. Printing of this material was purchased in accordance with provisions of Title 43 of the Louisiana Revised Statutes.

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Rev. 04-10
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Application For



Helping Women Ages 19-44 TAKE CHARGE of their Lives

1-888-342-6207

Apply Online at
www.TAKECHARGE.DHH.Louisiana.gov

Louisiana Department of Health & Hospitals

TAKE CHARGE

Family Planning Waiver Application



Use this form to apply for family planning services for Women age 19-44.

How to apply

1. **Fill out and sign this application. Use black ink.** If you need extra space to answer any questions use a separate sheet of paper.
2. **Get the documents of proof.** Look for a list of things we need beginning on page 6.
3. **Send the application and proofs to us right away. We will give you more time to get the proofs to us if you need it.**

Where to send the application and proofs

Mail to: P.O. Box 91278, Baton Rouge, LA 70821-9278

Fax to: 1-877-523-2987 (toll-free)

Drop off at: Your local 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 (specify) _____

What language do you write best? English Spanish Vietnamese Other (specify) _____

1. Tell Us About You – The woman wanting family planning waiver services.

Name _____
First Middle Initial Maiden Last

Mailing Address _____
Street Address Apartment/Lot Number

City State Zip Code

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

City State Zip Code

Social Security Number _____ - _____ - _____ Date of Birth _____
Month Day Year

Parish Where You Live _____ 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. _____

Marital Status: Married Single Separated Divorced Widowed

Race and Ethnic Background (You do not have to answer. You may mark more than one box.) White Black Asian
 American Indian or Alaska Native Hispanic or Latino Native Hawaiian or Pacific Islander

If you have questions or need help with this application, call Medicaid 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.

2. Pregnancy

A. Are you pregnant? Yes No

B. Were you pregnant in any of the last three months? Yes No

3. Citizenship/Immigration Status

A. Are you a U.S. citizen? Yes – Go to B No – Answer next questions

Are you a lawful permanent resident? Yes No Date you came to the U.S. _____

Permanent Resident Card Number (green card #): A _____

B. Tell us where you were born.

City _____ State _____ Country _____

Mother's Full Name (first, middle initial, last) _____

Mother's Maiden Name _____

4. Tell Us 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 5.

*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.*

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 _____

5. Health Insurance

Do you have health insurance? Yes – Fill Out Below No – Go to Question 6

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

6. Medical Procedures

Have you had any medical procedures which would keep you from getting pregnant like having your tubes tied or a hysterectomy? Yes No

If yes, you cannot get family planning waiver services through the TAKE CHARGE program.

7. Income from Working

Does anyone work (you, your husband, or children under age 18)? Yes – Fill out below No – Go to Question 9

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

Who works?	Employer/Business Name and Phone Number	Self Employed	How much? (show gross, not take home pay)	How often paid?
		<input type="checkbox"/> Yes <input type="checkbox"/> No		
		<input type="checkbox"/> Yes <input type="checkbox"/> No		
		<input type="checkbox"/> Yes <input type="checkbox"/> No		

8. Other Income

Tell us about any income that you, your husband, and children under age 18 get, like the kinds listed below.

Income Type		Tell us where this money is from or who pays this money. (name, address, and phone)	Who gets this income?	How much?	How often?
Social Security	<input type="checkbox"/> Yes <input type="checkbox"/> No			\$	
SSI	<input type="checkbox"/> Yes <input type="checkbox"/> No			\$	
Unemployment	<input type="checkbox"/> Yes <input type="checkbox"/> No			\$	
Worker's Compensation	<input type="checkbox"/> Yes <input type="checkbox"/> No			\$	
Child Support	<input type="checkbox"/> Yes <input type="checkbox"/> No			\$	
Alimony	<input type="checkbox"/> Yes <input type="checkbox"/> No			\$	
Money from Friends/Relatives	<input type="checkbox"/> Yes <input type="checkbox"/> No			\$	
Other (tell us what it is) _____	<input type="checkbox"/> Yes <input type="checkbox"/> No			\$	

9. Child Support and Alimony Paid to Someone Outside the Home

Do you or does your husband pay **court-ordered** child support or alimony to someone **outside your home**?

Yes No

If **yes**, to whom? _____ Monthly Amount \$ _____

10. Child Care/Adult Care

Do you or does your husband pay for child care or pay for care for an adult **with a disability** in order to work, go to school, or get training? Yes No If **yes**, tell us about it below.

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 No How much? _____

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

11. Where did you get this TAKE CHARGE application form?

- Medicaid office hospital/clinic pharmacy doctor's office school Internet
- Office of Family Support friend/relative business church festival/health fair
- Toll Free hotline number Social Security Office other _____

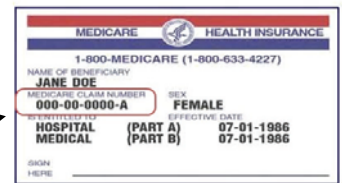
12. Disability Benefits and Medicare

A. Are you unable to work because of a disability? Yes No

B. Did you ever get Medicare? Yes No

The Medicare Card looks like this.

C. Did you ever receive Social Security Disability payments or SSI? Yes No



↓ THIS IS THE END OF THE APPLICATION. YOU MUST SIGN BELOW ↓

By signing this application I am giving my permission to the State of Louisiana and its agents to make contacts to verify the information given on this application. Under penalty of perjury I certify all information I have given is true. I also acknowledge that I have received and read the Rights and Responsibilities on the next page.

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

If someone working for Medicaid helped you fill out this form, they will sign below.

_____ **Date:** _____

Please send the application to the TAKE CHARGE program office right away. The address is P.O. Box 91278, Baton Rouge, LA 70821-9278, and the fax number is 1-877-523-2987. We will give you more time to get the proofs to us if you need it.

YOUR RIGHTS AND RESPONSIBILITIES

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

CITIZENSHIP AND IMMIGRATION STATUS: You state that the information about citizenship and immigration status given on this application form is true and correct.

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

VERIFICATION OF INFORMATION: You understand that the information you give about you and/or the person(s) applying will be checked. You agree to help do that and let 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 on eligibility for you and/or the person(s) applying for Medicaid/family planning waiver services.

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 Medicaid/**TAKE CHARGE** Program has paid for you and/or the person(s) applying.

REPORTING CHANGES: You agree to tell 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 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 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

Send Us These Things

Copies of all health insurance cards (front and back.)

If you are **not** a U.S. citizen send copies of Permanent Resident Card (green card) or other proof from U.S. Citizenship and Immigration Services.

If you were **not** born in Louisiana **AND** you have never received benefits from Social Security Disability, Supplemental Security Income (SSI), or Medicare, send proof of U.S. Citizenship such as birth certificate or U.S. Passport. If you don't have these, ask us about other things you may use.

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.

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.

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.