

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 \$ _____
	Child Support/Alimony \$ _____
	Other Income \$ _____
15 Total Monthly Gross Household Income: \$ _____	

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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