



**Application for
ver08.18.2014
Plan First
Medicaid Family Planning Program**

A program of the Montana Department of Public Health and Human Services

Plan First is a Montana Medicaid family planning health care program for women 19 through 44. Plan First covers family planning services for eligible Montanans.

To find out more about Plan First or get help filling out this application:

Website: dphhs.mt.gov/planfirst
1-855-854-1399 In-State toll Free
1-406-444-6446 Helena Area and Out-of State
MT Relay Service 711
Email: planfirst@mt.gov

This symbol  lets you know you need to provide documents.

Part 1. Applicant Information

I am Female. Yes No

I am able to bear children. Yes No

I am a Montana resident. Yes No

You must be a Montana resident to be eligible for Plan First.

I am between the age 19 through 44. Yes No

Birth date _____

You must be age 19 through 44 to be eligible for Plan First.

If you answered “No” to any of these, you are not eligible for Plan First. You may be eligible for Medicaid. You can apply for Medicaid at any Office of Public Assistance. Call 1-800-332-2272 or email citizensadvocate@mt.gov to find locations of Offices of Public Assistance. Medicaid applications are available online at <https://apply.mt.gov>.

I am pregnant now. Yes No

If you answered “yes” to this question you are also not eligible for Plan First but are likely eligible for pregnancy coverage through Montana Medicaid. Application information is found above.

If you are not pregnant, please move on to the next page.

Part 2. Personal Information

First name	Middle initial	Last name
Mailing address		
City	State and Zip code	County where you live
Home address (if different than mailing)		
City	State and Zip code	County where you live
Birth date	SSN	Maiden name
Home phone number	Work phone number	Cell phone number
Email address		
<p>The Department of Public Health and Human Services will send you correspondence regarding your application and the Plan first program. You have the option to receive this information via U.S. Mail and/or email. You also have the option to be contacted by phone. Please indicate your preferred method of contact below.</p> <p>Preferred Method of Contact (select one or both): <input type="checkbox"/> U S Mail <input type="checkbox"/> Email</p> <p>Additional Method of Contact (select one or more): <input type="checkbox"/> Home Phone <input type="checkbox"/> Work Phone <input type="checkbox"/> Cell Phone <input type="checkbox"/> All</p>		

Additional Contact (Optional): If you prefer Plan First contact someone else if with any additional questions, please provide his or her information. By listing this person it gives us permission to share your Plan First program information with them.

Contact First and Last name		
Mailing address		
City	State and Zip code	Gender <input type="checkbox"/> Female <input type="checkbox"/> Male
Home phone number	Work phone number	Cell phone number
Email address		

Do you want us to send letters and follow-up information to:

Applicant only Contact only Both Applicant AND Contact

Part 3. Health insurance

Do you have health insurance? Yes No
 If yes, include a copy of the front and back of your insurance cards.

Insurance company name, address, and phone number

Policyholder's Name

Policyholder's SSN

Policy number

Group number

Effective date of coverage

Part 4. Citizenship and Identity

Are you a U S citizen? Yes No
 If yes, include proof of U.S. citizenship or alien status and proof of identity (original documents or certified copies must be provided).
 If no, include a copy of the document that proves legal U.S. status.

Proof of U S citizenship and identity or legal immigration status is only needed for the Plan First applicant, not for other family members. The complete list of acceptable documents can be found at dphhs.mt.gov/planfirst.

Please provide **one** of these four documents:

- U. S. Passport
- Certificate of Naturalization (N-550 or N-570)
- Certificate of U S Citizenship (N-560 or N-561)
- Tribal Documents

If you do not have a U.S. Passport, a Certificate of Naturalization, a Certificate of U.S. Citizenship, or Tribal Documents please provide **one** of the Alternate Documents and **one** of the Photo ID Documents below:

Alternate Citizenship Documents (provide one):

- Birth record from the State, territory or local jurisdiction where you were born
- Certification of Report of Birth Abroad (DS-1350)
- Consular Report of Birth Abroad of a Citizen of the USA (FS-240)
- Certification of Birth Abroad (FS-545)
- US Citizen ID Card (I-197 or I-179)
- American Indian Card (I-872)
- Northern Mariana Card (I-873)
- Final Adoption Decree
- Evidence of US Government Civil Service Employment
- Official Military Record of Service (DD-214 or similar official document showing US place of birth)
- Department of Homeland Security's SAVE (Systematic Alien Verification for Entitlement)

Alternate Photo Identity Documents (provide one):

- Driver's license with photograph or personal identifying information (current or not more than three months since expiration)

- School ID with photograph
- U S military card or draft record
- U S military dependent card
- Federal, State, or Local government ID card with photograph or other personal identifying information (Federal, State, or local government)
- Certificate of Degree of Indian Blood, or other US American Indian/Alaskan Native tribal document with photograph or other personal identifying information

If you are not a U S citizen, enter your Alien Registration Number:

If you entered your Alien Registration Number on the line above, provide a copy of one of the items listed below as proof of the Alien Registration Number:

- Alien Registration Receipt Card, Permanent Resident Card, or Green Card
- Passport with the following unexpired stamps or attachments: Arrival-Departure Record (I-94) including the stamp showing status, Resident Alien Form (I-551) or Temporary Resident Card (I-688B or I-766)
- A court-ordered notice for asylum
- Other proof of lawful immigration status

Note: Federal law requires Plan First to see the original or a certified copy. Plan First will make a copy of any original documents provided and return the originals to you. You do not need to give the document to Plan First in person; Plan First will accept an original document or certified copy in person, by mail, or from a person authorized by the applicant to bring or send the document to Plan First.

U. S. Citizenship Documents

The National Center for Health Statistics can help the applicant find out where to get their birth certificate if they were born in a state other than Montana. Call 1-866-441-6247. The call is free or visit www.cdc.gov/nchs. Select “Births” and then select “Links to State Health Departments”. If the applicant is unable to get the documents they need, please call Plan First at 1-855-854-1339 In-State Toll Free or 1-406-444-6446 Helena Area/Out-of-State (For TTY, call MT Relay Service 711).

Race and Ethnicity Information (Optional)

You do not have to answer, but this information helps Plan First find out if we are serving all ethnic groups and races in our state.

Select one:	
<input type="checkbox"/> Hispanic/Latino	<input type="checkbox"/> Non-Hispanic/Latino
Select one:	
<input type="checkbox"/> American Indian or Alaskan Native	<input type="checkbox"/> Asian
<input type="checkbox"/> Native Hawaiian or Pacific Islander	<input type="checkbox"/> Black or African American
<input type="checkbox"/> White/Caucasian	<input type="checkbox"/> Unknown

Part 5. Additional Household Members

Tell us about all the people who live with you. If you file taxes, we need to know about everyone on your tax return. (You don't need to file taxes to get coverage). How many of your household members fall in the categories below?

Include:

- Your spouse,
- Your children under 21 who live with you,
- Anyone you include on your tax return, even if they do not live with you,
- Anyone else under 21 who you take care of and lives with you,
- Your parents if they live with you and claim you on their taxes,
- Anyone who lives with you and claims you on their taxes.

Please list all the people in your household who fit the categories above. Do not include yourself.

Name	Relationship

Part 6. Expenses

Please provide copies of documents to verify payments you list.

Does anyone in your household have expenses that would normally be a tax deduction
 Yes No (if no, go to Part 7.)
 If yes, identify the expenses for which you are responsible to pay. If you do not report and verify expenses, the expense deduction will not be allowed. If anyone outside the household pays any expenses for the household, please enter their name in the applicable fields below.

Deduction Type	Name	Amount
Alimony Paid		\$
Moving Expenses		\$
Student Loan Interest		\$
Tuition and Educational Fees		\$
Health Savings Account Deposits		\$
IRA Deposits		\$
Other		\$

Part 7. Income

Provide income information for each household member.

☞ Please provide copies of documents to support the incomes you list.

☞ The following is a list of documents that can be used:

- Pay stubs, pay envelopes, earnings statements from employers
- Award letters for Social Security, Unemployment Insurance benefits, Workers Compensation, pensions, etc.
- Alimony stubs or payment records
- Bank statements for checking accounts and savings accounts
- Federal income tax returns, bookkeeping records, expense records if self-employed
- Rental income or sales contract records/ledgers

Employment Income

NAME	EMPLOYER	YEARLY AMOUNT BEFORE TAXES
		\$
		\$
		\$
		\$
		\$

Other Income Not From Employment

Note: You don't need to tell us about child support, veteran's payment, worker's compensation or Supplemental Security Income (SSI).

	NAME	YEARLY AMOUNT BEFORE TAXES OR OTHER DEDUCTIONS
Social Security		\$
Annuity		\$
Capital Gains		\$
Unemployment Insurance		\$
IRA/Retirement Distribution		\$
Assistance Payments from a Tribe or Other State		\$
Alimony		\$
General Assistance (includes County or BIA)		\$
Interest/Dividends		\$
Military Allotment		\$
Retirement Benefits/Pensions		\$
State Income Tax Refunds		\$
Lease Income		\$
Jury Duty		\$
Rental/Royalties		\$

Foster Care Payments		\$
Temporary Disability Insurance		\$
Scholarships, awards, and fellowship grant dollars above and beyond the cost of tuition and fees		\$
Other		\$

Part 8. Signature

Please read and sign.

Plan First will keep what you tell us private as required by law. Plan First services are limited to family planning and birth control services for eligible women who need family planning services.

I declare under penalty of perjury that I have read all statements on this form and the information I give is true, correct, and complete to the best of my knowledge. I understand I can be penalized if I knowingly give false information.

Applicant's Signature _____ Date _____

(If you cannot sign your name, make a mark and have an adult sign next to your mark.)

Final checklist

- Did you answer all the questions on the application?
- Did you sign and date the application?
- Do you have all the documents you need?

Submit completed application and copies of documents, if needed, to:

**Plan First
PO Box 202951
Helena MT 59620**

Next steps

- If information on your application changes after you send the application, call or email:
1-855-854-1399 In-State Toll Free
1-406-444-6446 Helena Area and Out-of State
MT Relay Service 711
Email: planfirst@mt.gov
- We will review your application as quickly as possible. Please allow up to four weeks for us to make a decision.
- If information is missing, we will send you a letter telling you what else you need to send.
- We will send you a letter to tell you if you get Plan First services. If you are not eligible, we will send you a letter to tell you why.

Effective date of Plan First Enrollment

If determined eligible for enrollment, Plan First becomes effective on the first day of the month in which Plan First received your application.

If determined eligible for enrollment, you are covered for 12 months from the date your coverage begins unless you turn 45, move out of state, or are no longer fertile (have a sterilization procedure). You will receive a renewal application to renew your coverage before the end of the 12 month coverage period.

Complaints:

Plan First is operated under ARM 37.82.701, 37.86.1701, 37.86.1705/6, and MCA 53-4-212/1105, 53-6-113.

If you are not satisfied with the actions taken on your application for Plan First, you have the right to a fair hearing. You can ask for a fair hearing by calling 1-800-362-8312. If you use a TTY, call 711. The call is free. You can also ask for a fair hearing by writing to:

Department of Public Health and Human Services, Office of Fair Hearings, PO Box 202953, Helena MT 59620-2953.