200% FPL

FAMILY PLANNING AND REPRODUCTIVE HEALTH
DETERMINATION OF CLIENT ELIGIBILITY FOR STATE FUNDED SURGICAL SERVICES
Effective March 2, 2009

Client Name ______________________________ Client ID Number __________________

Date of Visit __________________ Date of Birth ______________ Age _____________

Gross Monthly Income _________________ Family Size _________________

Family Size	1	2	3	4	5	6	7	8	Each Additional Person
Maximum* Monthly Income	**$1,806**	**$2,428**	**$3,052**	**$3,676**	**$4,298**	**$4,922**	**$5,546**	**$6,168**	**$312**

SERVICE CLIENT IS ELIGIBLE FOR ___________________________________

FROM ______________________ **TO** ______________________

"I am not covered by a private insurance or Title XIX (Public Assistance) plan which covers this service."
"I have been offered a written statement of the results of this eligibility determination."
"I hereby agree that all facts stated above are true and accurate to the best of my knowledge."

_______________________________________ _______________________________________
Client's Signature Date Witness' Signature Date

CLIENT ELIGIBILITY DETERMINATION FOR NEW SERVICE WHEN FAMILY SIZE AND INCOME HAVE NOT CHANGED

SERVICE CLIENT IS ELIGIBLE FOR ___________________________________

ELIGIBILITY PERIOD FROM ______________________ **TO** ______________________

"My family size and income have not changed since the last eligibility determination."

_______________________________________ _______________________________________
Client's Signature Date Witness' Signature Date

Eligibility for state funded services does not guarantee/ensure that services will be provided with those funds. Provision of service with state funds is dependent upon availability of funds.

*** Instructions for computing monthly income and completing this form are on the back.**