GreenMountainCare
A HEALTHIER STATE OF LIVING

202FP

Access Plan Program Provider Screening form

1. Applicant's Personal Information

a. Name:_____ Date of Birth:_____ Social Security Number:_____

b. Home Address:_____ City:_____ State:_____ Zip Code:_____

c. Mailing Address:_____ City:_____ State:_____ Zip Code:_____

(Please provide an address you are comfortable having documents sent to if not your home address.)

☐ Home and Mailing address are the same

d. Gender:_____

e. To be eligible for Presumptive Eligibility for the Access Plan Program, you must be a U.S. Citizen or have satisfactory immigration status. For more information visit: *https://www.healthcare.gov/immigrants/lawfully-present-immigrants/.*

1. Are you a U.S. Citizen? ☐ Yes ☐ No

2. If no, are you a lawfully present immigrant? ☐ Yes ☐ No

f. Are you pregnant? ☐ Yes ☐ No

2. Health Insurance

a. Do you have insurance that covers family planning or family planning related services? ☐ Yes ☐ No

3. Income

a. Applicant's monthly income: $_____

Income eligibility requires that the applicant has income at or below 208% of the Federal Poverty Level. Presumptive Eligibility is based on only the applicant's income.

b. Does this meet the income criteria of being ≤ 208% FPL? ☐ Yes ☐ No

4. Eligibility

a. Is the applicant eligible? ☐ Yes ☐ No

If yes, date eligible:_____

5. Contact Information and Screening Date

Agency Name:_____

Agency Address:_____

Date Screening form/determination Completed:_____