WEST VIRGINIA DEPARTMENT OF HEALTH
BUREAU FOR PUBLIC HEALTH
OFFICE OF MATERNAL, CHILD, AND FAMILY HEALTH
BUREAU FOR PUBLIC HEALTH
FAMILY PLANNING PROGRAM

VOLUNTARY STERILIZATION IN-TAKE FORM

All areas must be completed prior to submission.

CLIENT NAME: _____ **TODAY'S DATE:** _____
(LAST) (FIRST) (MI) MM DD YYYY

DATE OF BIRTH: _____
MM DD YYYY

PREGNANT: _____ **EDC:** _____
MM DD YYYY

S.S. NO.: _____-____-_____ **GROSS MONTHLY INCOME:** _____ **FAMILY SIZE:** _____

SURGEON REFERRAL: _____

FACILITY REFERRAL: _____

OTHER SERVICE: _____

FAMILY PLANNING SITE: _____

CLINIC NUMBER: _____

REMARKS: _____

I ATTEST THAT:

1. **I understand that my decision, at any time, not to be sterilized will not result in the withdrawal or withholding of any benefits provided by programs or projects receiving federal funds.**
2. **I am not covered by any public (Medicaid) or private insurance for voluntary sterilization procedures.**
3. **I understand the charges for the surgical sterilization will be paid by the Family Planning Program.**
4. **I will pay attention to the covered period for having the surgery completed.**
5. **I will voluntarily request financial assistance for a surgical sterilization.**
6. **I understand that this authorization is valid for seven (7) months from the date of signature.**

CLIENT'S SIGNATURE: _____ **DATE:** _____
MM DD YYYY

FOR OFFICE USE ONLY:

DENIED: _____ **REASON:** _____

APPROVED: _____ **COVERED PERIOD: FROM** _____ **TO** _____

BY: _____ **DATE:** _____

RETURN INTAKE FORMS TO: 350 CAPITOL STREET, ROOM 427, CHARLESTON, WV 25301
ATTN: WVFPP BILLING SPECIALIST. OR SEND VIA FAX TO: (304) 957-7505.
THIS FAX IS ENCRYPTED FOR SAFE TRANSMISSION OF INFORMATION.