

## 2.3 STERILIZATION:

### Procedure for Submitting Request for Sterilization Funding – Public Health Offices

Eligibility criteria: the client...	<ul style="list-style-type: none"> <li>• Is 21 years of age or older.</li> <li>• Does not have Medicaid/other insurance and is not eligible for Medicaid.</li> <li>• Is a Title X FP client with a Priority A rating for tubal ligations or Priority A or B for vasectomy.</li> </ul>
Client's medical record includes...	<ul style="list-style-type: none"> <li>• Documentation of either:             <ul style="list-style-type: none"> <li>○ A Title X visit within the last 12 months that includes a comprehensive client health history and physical exam, as described in the FPP Protocol Section 1, Subsection 1.2.H.A "Contraceptive Services", <b>or</b></li> <li>○ PHO clinician reviews the outside records that the client had a comprehensive visit described in the FPP Protocol Section 1, Subsection 1.2.H.A "Contraceptive Services" and documentation <u>that the client is a suitable candidate for sterilization surgical procedure that may require general anesthesia.</u></li> </ul> </li> <li>• An assessment of contraindication and, if present, documentation that a Surgical Provider was notified and agrees to perform the procedure.</li> <li>• Documentation of non-coercive sterilization counseling and education (STEP 3 of Section 1, Subsection 1.2.H.A and Section 2, Subsection 2.3.D below), including the permanent nature of sterilization and the alternative reversible methods such as IUDs (comparable effectiveness) and implants (more effective).</li> <li>• Justification of Priority Level Rating (see FPP Protocol Sterilization section), for tubal ligation/vasectomy.</li> <li>• Clinician's documentation of sterilization referral order.</li> </ul>
Forms required include...	<ul style="list-style-type: none"> <li>• Current Income Assessment Worksheet, completed, signed, and dated by the client and staff.</li> <li>• Current Consent for FP Services form, signed and dated by the client.</li> <li>• Current Sterilization Request/Consent for Sterilization forms, with all required areas filled in.             <ul style="list-style-type: none"> <li>○ Each form must be scanned and filed in the client's MR.</li> </ul> </li> </ul>
Only after all the above criteria are met, send secure email with the following documents to the FP State Office:	<ul style="list-style-type: none"> <li>• The completed Sterilization Request Form.</li> <li>• The completed Consent for Sterilization Form.</li> </ul>
When the PHO receives the approved request:	<ul style="list-style-type: none"> <li>• The client is entered into the PHO internal tracking system (approved, not approved, pending);</li> <li>• The client is notified; and,</li> <li>• Arrangements are made for the client to pick up their approved paperwork.</li> </ul>
During the appointment for paperwork pick-up, the PHO clerk will...	<ul style="list-style-type: none"> <li>• Assist the client with making an appointment for their procedure.</li> <li>• Scan a copy of the approved paperwork into the medical record.</li> <li>• Give the client copies of:             <ul style="list-style-type: none"> <li>○ Approved sterilization request</li> <li>○ Consent for sterilization</li> <li>○ Instruction letter</li> <li>○ Printed copies of the annual physical exam/health history</li> <li>○ Other pertinent information</li> </ul> </li> <li>• Review with the client the consent's expiration date, appointment date, clinic location/phone number, and next steps.</li> <li>• Enter the charge and collect the percentage pay, if due, from the client.</li> <li>• Inform the FPP State Office of the client's name and procedure appointment date.</li> </ul>

Name:		Phone#:		PHO Name:	
DOB:					
MRN:					
	YES	NO	Comments		
Consent for Sterilization			Date consent signed by client:	Are all areas complete?	Consent scanned into BEHR?
			Surgical Provider:		
Sterilization Request form			Date signed (matches Federal form consent date?):	If Priority A is there Justification?	Request scanned into BEHR?
			Are all areas complete?		
Eligible for Medicaid			Checked Portal:	Not Found <input type="checkbox"/>	Not Eligible <input type="checkbox"/>
			Eligible <input type="checkbox"/>		
			Medicaid/Insurance Benefits:		
Federal Sterilization form current					
21 Years old or older			Age:	Male	Female
Family Planning Consent Signed and Scanned			Date signed:		
Income Worksheet			Date signed:	_____ % Percent Pay	
Physical Exam Complete			Date:	BP	BMI
				G	P
			PMH <input type="checkbox"/> Social History <input type="checkbox"/> Family History <input type="checkbox"/>		
NO Contraindications NONE			<p>Clients with the following medical problems are generally NOT appropriate for outpatient surgery with general anesthesia:</p> <ul style="list-style-type: none"> <li>• History of umbilical hernia repair with(out) mesh or large unrepaired umbilical hernia,</li> <li>• Unstable angina or angina at rest,</li> <li>• Symptomatic cardiac vascular disease,</li> <li>• Symptomatic congenital heart disease (CHD),</li> <li>• CHF requiring treatment in the ER or hospital admission within the last 3-6 months,</li> <li>• Myocardial Infarction within the last 3 - 6 months,</li> <li>• Morbid Obesity (BMI &gt;45-50), a BMI over 45 can significantly increase anesthetic risk</li> <li>• Sleep apnea where home CPAP is used or has been recommended,</li> <li>• Pneumonia within the past 2-4 weeks,</li> <li>• Acute intoxication (with drugs or alcohol) or active cocaine abuse,</li> <li>• Serious, potentially life-threatening diseases that are not optimally managed (e.g., brittle diabetes, unstable angina, symptomatic asthma, uncontrolled hypertension).</li> </ul>		
Counseling/Education			RLP (required) <input type="checkbox"/> Sterilization (required) <input type="checkbox"/>		
Priority Rating:  Female: G   P  Male			<p>Priority A</p> <ul style="list-style-type: none"> <li>• Problems with birth control method (specify)</li> <li>• High risk pregnancy (present or past) or risk of poor pregnancy outcome or significant health risk to the mother</li> <li>• Genetic problems in the family</li> <li>• History of physical abuse in the family</li> <li>• Substance abuse (alcohol or other drugs)</li> <li>• Inability to care for more children because:                             <ul style="list-style-type: none"> <li>o Either of the parents have a severe medical condition</li> <li>o The family already had a child with a severe medical condition</li> </ul> </li> <li>• Multiparity (greater than or equal to 4 live births)</li> </ul> <p>Priority B</p> <ul style="list-style-type: none"> <li>• Unable to handle more children due to economics or unstable job situation</li> <li>• Religious objections to other types of contraception</li> </ul>		
Reviewed by clinician			Date	Provider	
F/U Needed			Nurse contact info:		
F/U completed			Date:		
Approved Date			Date to billing:	Denied/Withdrawn <input type="checkbox"/> Date: _____ Lack F/U <input type="checkbox"/> Criteria Not Met <input type="checkbox"/> Has Benefits <input type="checkbox"/> Medical Risk <input type="checkbox"/> Other <input type="checkbox"/> _____	