STEPS FOR COMPLETING AN APPLICATION FOR STATE FUNDED ABORTION

1. Submit the application via fax to (804) 864-7771. Email reproductivehealth@vdh.virginia.gov to inform VDH that the fax has been sent so that the fax machine may be monitored.
2. Staff will review the form for completeness. Upon receipt of the completed application, VDH will process the application within two business days.

   Sections 1, 2A, and the first part of Section 3 must be completed. Application must include the Medicaid number. If the client has no insurance, the referring facility must complete the process by referring the client to their local Department of Social Services (DSS) to apply for Medicaid, and then obtaining a Medicaid number.

Section 1: Patient Applicant Information
To be completed by Certifying Physician/Abortion Facility

Date of Application: _____ Name of Patient Applicant: _____

Date of Birth: _____ Address: _____

Medicaid Number: _____ _____

Date of Procedure: _____ City/County of Residence: _____

Name of Abortion Facility: _____

Name of Certifying Physician: _____

Section 2: Medical Information and Certification
All Certifying Physicians must complete section 2A
Certifying Physicians must choose and complete either 2B or 2C
All Certifying Physicians must print name, sign and date

Required Certification

2A: I certify that my examination of the patient applicant and/or her medical record indicates that she is _____ weeks pregnant as of _____ (date)

Section 3: Verification

Certifying physician license #: _____ License expiration date: _____

Either Section 2B OR 2C must be completed. When the indication for abortion is due to gross and totally incapacitating deformity, Section 2C specifies which additional test results will be included. Test results to support diagnosis **must** be sent with application.

Section 32.1-92.1: Cases of Rape or Incest

2B: I hereby request state funds under the provisions of § 32.1-92.1 of the **Code of Virginia**, as amended. This pregnancy is the direct result of either rape or incest. The patient has verified that this event has been reported to a law enforcement or public health agency.

Date of Occurrence: _____ Date Reported: _____

Reported to: _____

Section 32.1-92.2: Cases of gross and totally incapacitating physical and/or mental deformity

2C: I hereby request state funds under the provisions of § 32.1-92.2 of the **Code of Virginia**, as amended.
Attach all diagnostic procedure results:

☐ Amniocentesis ☐ Ultrasound ☐ Blood Test ☐ Other

Summary of diagnostic procedure results:

_____

_____

_____

I certify that my examination of the patient applicant and review of diagnostic tests indicate that the fetus will be born with a gross and totally incapacitating physical deformity and/or a gross and totally incapacitating mental deformity.

The form must then be signed and dated by the certifying physician.

Required Signature

Certifying physician (Print name): _____

Certifying physician (Signature): _____ Date: _____

3. If the application is incomplete, VDH will contact the referring facility for clarification and/or additional documents as needed.

4. The completed application will be reviewed by two VDH physicians. Once a completed application is received, VDH has two full business days to review the application and communicate the application decision to the facility submitting the application.

5. The signed application will be sent back to the referring facility.

   a) The application will be faxed to the number identified on the original application fax.

   b) As a courtesy, VDH will alert the contact person indicated on the faxed application that the application has been faxed.