APPLICATION FOR LOUISIANA'S MEDICARE SAVINGS PROGRAM

For help with Medicare Premiums, Co-pays, and Deductibles

- If you have Medicare, fill out this application to see if you qualify for the Medicare Savings Program.
- If you want to apply for someone who does not have Medicare, please complete the full **Application for Health Coverage**. To get an application, call 1-888-342-6207 or visit online MyMedicaid.la.gov.
- If you need extra space, use a separate sheet of paper or the space provided for you on page 5.
- If you have any questions, call 1-888-342-6207 from Monday–Friday to speak with a Medicaid representative. TTY Text Telephone users call 1-800-220-5404.
- Complete and mail this application to the **Medicaid Application Office, P.O. Box 91278 Baton Rouge, LA 70821-9278** or fax it to 1-877-523-2987.

What is your preferred language? ☐ English ☐ Spanish ☐ Vietnamese ☐ Other: _____

► *Please **PRINT** clearly in black ink.*

1 — Personal Information

First name	Middle initial	Last name	Suffix *(Sr., Jr., etc.)*

Social Security number	Date of birth	Sex ☐ Male ☐ Female

Marital status ☐ Single ☐ Married ☐ Widowed ☐ Divorced/separated	Are you Hispanic or Latino? *(optional)* ☐ Yes ☐ No

Race *(optional – you may mark one or more)*

☐ White ☐ Asian Indian ☐ Japanese ☐ Other Asian ☐ Samoan
☐ Black or African American ☐ Chinese ☐ Korean ☐ Native Hawaiian ☐ Other Pacific Islander
☐ Filipino ☐ Vietnamese ☐ Guamanian or Chamorro
☐ American Indian or Alaska Native – Tribe: _____ ☐ Other: _____

2 — Contact Information

Mailing Address			Home Address *(if different)*		
P.O. box or street address		Apt/Lot #	Street address		Apt/Lot #
City	State	Zip	City	State	Zip
E-mail address *(if you have one)*			Home parish *(where you live)*		

Home phone ( )	Cell phone ( )	Other phone ( )

3 — Spouse's Information

Are you married and living with a spouse? ☐ Yes ☐ No *(If **NO**, skip to section 4)*

First name	Middle initial	Last name	Suffix *(Sr., Jr., etc.)*

Social Security number	Date of birth	Sex ☐ Male ☐ Female

Is he/she Hispanic or Latino? *(optional)* ☐ Yes ☐ No	Race *(optional – you may mark one or more)* ☐ White ☐ Black ☐ Asian ☐ Native Hawaiian or Pacific Islander ☐ American Indian or Alaska Native — Tribe: _____ ☐ Other

Does your spouse want to apply for the Medicare Savings Program? ☐ Yes ☐ No

4 — Medicare Information

	You	Your Spouse *(if married)*
Medicare Claim Number		
Does this person have health insurance (other than Medicare) or a Medicare supplement?	☐ Yes ☐ No	☐ Yes ☐ No

5 — Money from Jobs *(examples: cash, checks, tips, etc.)*

Does anyone in the home work? ☐ Yes ☐ No *(If **NO**, skip to section 6)*

	Job 1	Job 2	Job 3
Worker's name			
Employer name			
Employer phone number	( )	( )	( )
Is this person self-employed?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
How much are they paid? *(gross income before taxes)*	$	$	$
How often paid? *(weekly, biweekly, monthly, etc.)*			

6 — Other Money *(examples: Social Security, pension, worker's comp, etc.)*

Does anyone in the home get money from other sources? ☐ Yes ☐ No *(If **NO**, skip to section 7)*

	Source 1	Source 2	Source 3
Who receives the money?			
Where does it come from?			
How much are they paid? *(gross income before taxes)*	$	$	$
How often paid? *(weekly, biweekly, monthly, etc.)*			

7 — Medical Expenses

Do you or your spouse have medical bills (paid or unpaid) for medical care received in the past 3 months?
☐ Yes ☐ No *(If **NO**, skip to section 8)*

	Expense 1	Expense 2	Expense 3
Who received care?			
Name of doctor, clinic, or other medical provider			
Phone number	( )	( )	( )
Dates of service			
Total cost	$	$	$

8 — Things You Own

Do you have any of these?	Who owns it?	Describe it *(include names of banks, insurance companies, etc.)*	How much is it worth?
Checking accounts ☐ Yes ☐ No			$
Savings accounts ☐ Yes ☐ No			$
Direct express accounts ☐ Yes ☐ No			$
Vehicle *(cars, trucks, boats, motorcycles, RVs, ATVs, etc.)* ☐ Yes ☐ No			$
Other vehicles ☐ Yes ☐ No			$
Property other than where you live ☐ Yes ☐ No			$
Certificates of Deposit (CD) ☐ Yes ☐ No			$
Annuities, trusts, stocks, bonds, retirement accounts ☐ Yes ☐ No			$
Life or burial insurance ☐ Yes ☐ No			$
Money set aside for burial or pre-need contract ☐ Yes ☐ No			$
Safe deposit box ☐ Yes ☐ No			$
Other ☐ Yes ☐ No			$

YOUR RIGHTS AND RESPONSIBILITIES

- By signing and submitting this application, you state that you have permission from all of the people listed on the application to both submit their information to the Louisiana Department of Health (LDH), and receive any information about their eligibility and health coverage.
- You understand that LDH is authorized to gather the information requested in this application and any supporting documentation, including social security numbers, under the Patient Protection and Affordable Care Act (Public Law No. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law No. 111-152), and the Social Security Act.
- You understand that providing the requested information (including social security numbers) is voluntary. However, failing to provide it may delay or prevent you from getting health coverage through Medicaid or any other insurance affordability program.
- You understand that LDH will check the information you give us to make sure it is correct. You give LDH permission to contact any outside source(s) necessary to check this information, process your application, determine eligibility, and otherwise operate the Medicaid program. These outside sources may include:
  - Federal agencies (such as the Internal Revenue Service, Social Security Administration, and Department of Homeland Security), other state agencies, and/or local government agencies.
  - Banks, financial institutions, and consumer reporting agencies.
  - Employers identified on applications for eligibility determinations.
  - Doctors or other medical providers.
  - Applicants/enrollees, and authorized representatives of applicants/enrollees.
  - LDH contractors engaged to perform a function for the Medicaid program.
  - Anyone else as required or allowed by law.
- You give these outside sources permission to give LDH any information about you, or any person necessary for this application, that it may request. You understand that this permission will end when this application is denied, when your Medicaid eligibility ends, or when you submit a written statement to LDH canceling this permission, whichever comes first. A cancellation may prevent you from being found to be eligible for Medicaid.
- You understand the social security numbers will only be used to get information from these outside sources to verify income, make eligibility determinations, or for other purposes directly connected to the administration of the Medicaid program.
- You must tell Medicaid if anything changes or is different than what you've written on this application. Call 1-888-342-6207 to report any changes. You also understand that a change in your information could affect the eligibility for member(s) of your household. You agree to tell Medicaid within 10 days if any of the following change: mailing or home addresses, things you own, health insurance coverage or premiums, income, if anyone moves in or out of your home, or if anyone moves out of state.
- You state that answers you gave on this application are true and correct. If you purposely gave information that is not true or if you withheld information, you have committed fraud. If you commit fraud, you may have to pay back money that Medicaid pays for care that you receive.
- You state that the information given in this application about your citizenship and immigration status is true and correct.
- By signing and submitting this application, you understand that if anyone on this application enrolls in Medicaid, you are giving LDH your rights to any money owed to you by any other health insurance, legal settlement, a spouse or parent, or other third party.
- You understand that Medicaid will only send case information to Child Support Enforcement for medical support if you ask them to. LDH will only make a referral if parents of children under age 19 receive Medicaid. You can request that Medicaid not refer you if you feel you have good cause not to cooperate with Child Support Enforcement.
- You understand that Estate Recovery rules require LDH to recover the cost of certain Medicaid payments from your estate in the event of your death. These costs include the total amount of payments for facility services, hospital care, waiver services, payments to Home and Community Based Services (HCBS) or Program for All-Inclusive Care for the Elderly (PACE) providers, and prescription drugs received at age 55 or older. LDH will not make a claim against the estate while you or your legal spouse is still living. LDH will also not make a claim if you have a dependent child who is under age 21, blind, or disabled. Collection may not be made if it is not cost effective for LDH to do so, or if your heirs apply for a hardship waiver after your death. A hardship may exist if the estate property is the only source of income for the heirs, if that income is limited, or if there are other extenuating circumstances.
- You agree that by accepting Medicaid, the State of Louisiana or its assignee will be named as the remainder beneficiary of all annuities purchased on or after Feb. 8, 2006 for the total amount of medical assistance paid on your behalf, unless you have a spouse, minor child, or a child with a disability. In these cases, the State of Louisiana must be named as beneficiary after these individuals. You agree to tell Medicaid about any annuity you and your spouse own or co-own regardless if the annuity is irrevocable (cannot be changed) or Medicaid counts it. You understand that you must tell Medicaid about changes made to any annuity which may affect when payments begin, the amount paid, frequency of payments, and additions to the principal.
- You can ask for a Fair Hearing if you think any decision made on the case is unfair, incorrect, or made too late.
- LDH cannot treat you differently because of race, color, sex, age, disability, religion, nationality, or political belief. If you think it has, you can call the U.S. DHHS Regional Office for Civil Rights in Dallas, TX at 1-800-368-1019 or write to the Louisiana Department of Health, Human Resources at P. O. Box 4818, Baton Rouge, LA 70821-4818.

After reading, please continue to the next page to complete your application.

Read and sign below

By signing this application I am giving my permission to the State of Louisiana and its agents to verify the information given on this application. Under penalty of perjury, I certify that all information contained in this application, including U.S. citizenship or lawful immigrant status of all persons applying for benefits, is true and correct to the best of my knowledge. I have read or someone has read to me the "Rights and Responsibilities" section of the application (located on page 4), including fraud penalties.

Sign here:	Date:
Spouse sign here *(if applying)*:	Date:

Use this space for any comments or information that you could not fit on your application.

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MEDICAID AUTHORIZED REPRESENTATIVE FORM

For Medicaid Applicant or Enrollee

You can choose an authorized representative

You can give a trusted person permission to talk about your Medicaid eligibility with us, see your information, and act for you on matters related to your application/renewal. This person is called an "authorized representative." You are not required to name any person or organization as your authorized representative. If you ever need to change your authorized representative, contact Medicaid. If you are a legal representative of an applicant/enrollee, submit proof to Medicaid.

Select what you would like your authorized representative to be able to do (check all that apply):

- ☐ Sign an application on your behalf.
- ☐ Complete and submit a renewal form on your behalf.
- ☐ Receive notices and other communications from Medicaid on your behalf. (If this option is selected, then all mail will be sent to the authorized representative's address only.)
- ☐ Act on your behalf in all matters regarding your Medicaid case and receive information about your Medicaid case

1. Name of authorized representative (First, Middle, Last, & Suffix) or name of organization		
2. Address		3. Apartment or suite number
4. City	5. State	6. ZIP code
7. Phone number (__ __ __) __ __ __ – __ __ __ __	8. ID number (if applicable)	

By signing below, I understand that I am designating the authorized representative listed above to perform the actions that I have selected above. I understand that this will remain in effect until it is canceled.

I understand that all information gathered on my situation and those persons for whom I am legally responsible is personal and confidential. My decision to appoint an authorized representative is optional, made freely, and does not relieve me of my responsibility to actively participate in the Medicaid eligibility process. I understand that the function of the authorized representative is to accompany, assist, and represent me in the eligibility determination process, and to aid in obtaining financial, medical, and/or other documentation necessary for Medicaid to determine my eligibility for Medicaid. I understand that while some of the information gathered may have no impact on my Medicaid eligibility, it may affect my liability to a third party if this information is disclosed to the third party by my authorized representative. I hereby hold the Louisiana Department of Health harmless for any claim resulting from disclosure of information to a third party by my authorized representative. I understand that if this authorization is not signed in the presence of Medicaid staff, Medicaid staff may verify this designation.

9. Your name (First, Middle, Last, & Suffix)	
10. Name of applicant/enrollee (First, Middle, Last, & Suffix) (if you are signing as their legal representative)	
11. Your relationship to applicant/enrollee (if you are signing as their legal representative)	12. SSN or Case ID for applicant/enrollee
13. Your signature	14. Date (mm/dd/yyyy)

Continued on the following page...

MEDICAID AUTHORIZED REPRESENTATIVE FORM (continued)

For the Authorized Representative

By signing below, the authorized representative agrees to: 1) Accept responsibility for fulfilling all responsibilities encompassed within the scope of the authorized representation to the same extent as the individual represented; 2) Maintain, or be legally bound to maintain, the confidentiality of any information regarding the individual represented provided by the Louisiana Department of Health; and 3) Adhere to the regulations in 42 CFR Part 431, Subpart F and at 45 CFR 155.260(f) (relating to the confidentiality of information), 42 CFR 447.10 (relating to the prohibition against reassignment of provider claims as appropriate for a facility or an organization acting on the facility's behalf), as well as other relevant state and federal laws concerning conflicts of interest and confidentiality of information. If the authorized representative is an organization, this section must be completed and signed by all individuals who will act on behalf of the organization and agree to be bound the conditions of this agreement. By signing below, you certify under the penalty of perjury that any information provided on behalf of the individual represented is true and correct to the best of your knowledge.

15. Name of authorized representative (First, Middle, Last, & Suffix) or name of organization	16. ID number (if applicable)
17. Name of individual acting on behalf of organization (First, Middle, Last, & Suffix) (if applicable)	
18. Signature of Authorized representative or individual acting on behalf of organization	19. Date (mm/dd/yyyy)

Name of additional individual(s) who will act on behalf of the organization (if applicable):

20. Name of individual acting on behalf of organization (First, Middle, Last, & Suffix)	
21. Signature of individual acting on behalf of organization	22. Date (mm/dd/yyyy)
23. Name of individual acting on behalf of organization (First, Middle, Last, & Suffix)	
24. Signature of individual acting on behalf of organization	25. Date (mm/dd/yyyy)
26. Name of individual acting on behalf of organization (First, Middle, Last, & Suffix)	
27. Signature of individual acting on behalf of organization	28. Date (mm/dd/yyyy)
29. Name of individual acting on behalf of organization (First, Middle, Last, & Suffix)	
30. Signature of individual acting on behalf of organization	31. Date (mm/dd/yyyy)

STATE OF LOUISIANA
VOTER REGISTRATION AGENCIES
DECLARATION FORM

If you are not registered to vote where you live now, would you like to apply to register to vote here today? (Check one)

☐ I want to register to vote. ☐ I do not want to register to vote.

IF YOU DO NOT CHECK EITHER BOX, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME.

Applying to register or declining to register to vote **will not** affect the amount of assistance that you will be provided by this agency. Voter eligibility requirements are found on the voter registration application form.

Note: If you do register to vote, the location where your application was submitted will remain confidential. If you decline to register to vote, this fact will remain confidential. Applying to register or declining to register to vote will be used **only** for voter registration purposes.

If you would like help in filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private. (Check one)

☐ **Yes, I would like help.** ☐ **No, I do not want help.**

For assistance in completing the voter registration application form outside our office, contact Louisiana Department of Health and hospitals at 1-888-342-6207.

If completed outside our office, this declaration form and your completed voter registration application form (if you filled one out) should be returned to P.O. Box 91278 Baton Rouge, LA 70821-9278.

Signature or Mark **Name Typed or Printed** **Date**

Signatures of Two Witnesses If Signed With Mark:

1) _____ 2) _____

COMPLAINTS

If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with the Louisiana Secretary of State, Commissioner of Elections, P.O. Box 94125, Baton Rouge, LA 70804-9125 or by calling (225) 922-0900 or 1-800-883-2805.

Comments/Remarks (for official use only):

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Louisiana Voter Registration Application
(LA-VRA - Rev. 6/19)

SEE THE OTHER SIDE OF THIS PAGE FOR INSTRUCTIONS ➔

QUESTIONS? - Call your parish Registrar of Voters Office or call the Secretary of State at 1-800-883-2805 or (225) 922-0900.

OFFICIAL USE ONLY: WD: _____ PCT: _____ REG. TYPE: _____ IN/OUT: _____ REG # _____

Please print clearly in ink, preferably black.

Reason for Application: ☐ New Voter Registration ☐ Updating Voter Registration

Eligibility

1. Are you a citizen of the United States of America? ☐ Yes ☐ No
   Will you be 18 years of age on or before election day? ☐ Yes ☐ No

If you checked **'No'** in response to either of these questions, do not complete this form. You are not eligible to vote at this time. **(Please see application instructions for information regarding eligibility to register prior to age 18.)**

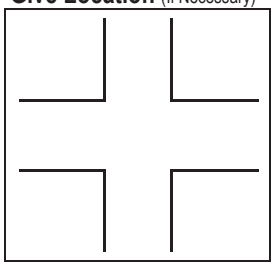
Name

2. LAST NAME: _____ FIRST NAME: _____
   FULL MIDDLE OR MAIDEN NAME: _____ SUFFIX (Sr., Jr., II): _____

Residence Address (Where you live and claim homestead exemption, if any)

HOUSE # & STREET (NO P.O. BOX): _____ UNIT/APT #: _____
CITY/TOWN: _____ STATE LA ZIP CODE: _____

Give Location (If Necessary)



Mailing Address (If different from Residence Address)

3. ☐ Check if no postal service at your residence address above and supply mailing address here.
   HOUSE # & STREET/P.O. BOX: _____ UNIT/APT #: _____
   CITY/TOWN: _____ STATE: _____ ZIP CODE: _____

Date of Birth

4. ____/____/____ (MM DD YYYY)

5. ***SSN** _____ - _____ - _____ (XXX XX XXXX)

6. **Sex** ☐ M ☐ F

7. **Race** (Optional) ☐ WHITE ☐ BLACK ☐ ASIAN ☐ HISPANIC ☐ AMERICAN INDIAN ☐ OTHER _____

Party Affiliation

8. ☐ DEMOCRAT ☐ GREEN ☐ INDEPENDENT ☐ LIBERTARIAN ☐ REPUBLICAN ☐ NO PARTY ☐ OTHER (Specify) _____

Place of Birth

9. CITY/TOWN: _____ STATE: _____
   PARISH/COUNTY: _____ COUNTRY: _____

Mother's Maiden Name

10. _____

Email

11. _____

Phone

12. Home: (_____) _____ - _____
    Other: (_____) _____ - _____

LA DL/ID Card #

13. _____
☐ I do not have a LA DL/ID card.

Do you need assistance in voting?

14. ☐ No ☐ Yes, Reason: _____

Last Residence Address

15. HOUSE # & STREET: _____
CITY: _____ STATE: _____

Place of Last Registration

16. STATE: _____ PARISH/ COUNTY: _____

Former Registered Name, if any

17. _____

Affirmation and Signature (Read and sign or make your mark.)

18. I do hereby solemnly swear or affirm that I am a United States citizen, that I am of eligible age to register to vote, that I have not been incarcerated pursuant to an order of imprisonment for conviction of a felony within the past five years, nor am I under an order of imprisonment for a felony offense of election fraud or other election offense pursuant to R.S. 18:1461.2, that I am not currently under a judgment of full interdiction or limited interdiction where my right to vote has been suspended, that I am a bona fide resident of this state and parish, and that the facts given by me on this application are true to the best of my knowledge and belief. If I have provided false information, I may be subject to a fine of not more than $2,000 ($5,000 for subsequent offense) or imprisonment for not more than 2 years (5 years for subsequent offense), or both.

Applicant Signature: ⊠ _____ Date: _____

Witnesses (If your signature is a mark, you must have two witnesses sign.)

19. Witness #1 Signature: ⊠ _____ Witness #1 Print Name: _____
    Witness #2 Signature: ⊠ _____ Witness #2 Print Name: _____

*** If you do not have a LA driver's license or LA special ID, the last four digits of your social security number are required if you have one. Full SSN is preferred but optional.**

Note: If you decline to register to vote, this fact will remain confidential and will be used only for voter registration purposes. If you register to vote, the office where your application was submitted will remain confidential and will be used only for voter registration purposes. You may request a copy of your voter registration form at any time from the registrar of voters.

OFFICIAL USE ONLY

☐ New Registration Updated Registration: ☐ Address Change ☐ Name Change ☐ Party Change ☐ Change to Assistance in Voting ☐ Other

REMARKS:

CIRCLE ONE:
PA MV RG SDA SS (Disability) Received by: _____ Date: _____

Louisiana Voter Registration Application
(LA-VRA - Rev. 6/19)

QUESTIONS? - Call your parish Registrar of Voters Office or call the Secretary of State at 1-800-883-2805 or (225) 922-0900.

APPLICATION INSTRUCTIONS

USE THIS LOUISIANA VOTER REGISTRATION APPLICATION TO: 1) register to vote; 2) change your address; 3) request a name change; 4) change party affiliation; or 5) request assistance in voting.

TO REGISTER AND BE ELIGIBLE TO VOTE, AN APPLICANT MUST: 1) be a U.S. citizen; 2) be at least 17 years old (16 years old if registering to vote in person at the Registrar's Office or with an application for a Louisiana driver's license) but must be 18 years old before actually voting; 3) not be under an order of imprisonment for conviction of a felony or, if under such an order, not have been incarcerated pursuant to the order within the last five years and not be under an order of imprisonment related to a felony conviction for election fraud or any other election offense pursuant to R.S. 18:1461.2; 4) not be under a judgment of full interdiction or limited interdiction where your right to vote has been suspended; 5) reside in the state and parish in which you seek to register and vote.

Instructions: the gray section numbers on this page correspond to the gray section numbers on the application.

Reason for Application: Check "New Voter Registration" if this is a first time registration or if a new registration in a new parish after moving. Check "Updating Voter Registration" if you are making any change to your present registration. If new registration, fill out the form completely.

1. *Eligibility* - Federal law requires you to affirm that you are a citizen of the United States of America and that you will be 18 years of age on or before the election day in which you are eligible to vote. If you checked **'No'** in response to either of these questions, do not complete this form. You are not eligible to vote at this time. If you are registering as a 16 or 17 year old, you may check "Yes" because you will not be allowed to vote until you are 18.

2. *Name* - You **must** provide your full name. Do not use nicknames or initials for middle or maiden name. *If this application is for a change of name, please also complete section 17: "Former Registered Name."*

3. *Residence Address* - "Residence Address" means the address (number, street, city, state, and zip) where you live and are registering to vote. Residence address **must** be the address where you claim homestead exemption, if any, except for a resident in a nursing home or veterans' home who may choose to use the address of the nursing home or veterans' home or the home where they have a homestead exemption. A college student may elect to use their home address or their address at school while attending. Do not use a post office box for your "Residence Address." If you use a rural route and box number, you may draw a map in box labeled "Give Location" to provide the exact location. Write in the names of the crossroads (streets) nearest to residence. Draw an X to show residence. Use a dot to show any schools, churches, stores, or landmarks near residence and write the name of the landmark.

Mailing Address - If you check that you do not receive postal service at your residence address, you **must** provide your mailing address (number, street, city, state, and zip). Otherwise, a mailing address may be provided and you may use a post office box for a mailing address.

4. *Birthdate* - Print your date of birth. *The month and day of your birth remains confidential by law.*

5. *Social Security Number* - If you do not have a LA driver's license or LA special identification card, you **must** provide the last four digits of your social security number, if issued. The full social security number is preferred and may be provided on a voluntary basis and will be kept confidential. If you were not issued a social security number or a LA DL or ID and this form is submitted by mail, and you are registering to vote for the first time, in order to avoid additional identification requirements for first time voters you **must** attach one or more documents to prove your identity, residence, and date of birth. Documents may be: a) a copy of current and valid photo identification and/or b) a copy of a current utility bill, bank statement, government check, paycheck, or other government document. *Your SSN remains confidential and is only used for registration purposes.*

6. *Sex* - Check male or female *(for statistical purposes only).*

7. *Race* - Race/Ethnic origin is optional *(for statistical purposes only).*

8. *Party Affiliation* - If you are registering for the first time, you may choose a party affiliation of Democrat, Green, Independent, Libertarian, or Republican parties. You may specify any other party affiliation by checking "other" and then listing the party with which you wish to affiliate. If you do not want to register with a political party affiliation check "No Party," or if you do not complete this section, your party affiliation will be listed as "No Party." If you are already registered with a party affiliation and no political party change is being made with this application, you may leave this section blank or re-enter your political party affiliation.

9. *Place of Birth* - Print the city/town, parish/county, state, and country of your birth place *(for statistical purposes only).*

10. *Mother's Maiden Name* - Print your mother's maiden name, which is her last name at her birth. If unknown, write "unknown."

11. *Email* - Give your email address for election officials to contact you if there is a problem with your registration. *Email addresses are protected from disclosure by law and are for official use only.*

12. *Phone* - Give your phone numbers for election officials to contact you if there is a problem with your registration. *Phone numbers are optional and a public record unless you make a request for your phone numbers to be kept confidential by election officials.*

13. *LA DL/ID Card #* - Print your LA driver's license or LA special identification card number, if issued. If you do not have one, check "I do not have a LA DL/ID card." *This ID number remains confidential and is for official use only.*

14. *Assistance in Voting Needed?* - Indicate if you will need assistance in voting by checking either the "No" or "Yes" box. If "Yes," write the reason for needing assistance. The registrar of voters in your parish may contact you for proof of disability.

15. *Place of Last Residence* - Print the address (number, street, city, and state) of your prior residence, if different from residence address in section 3 or write "Same."

16. *Place of Last Registration* - Print the state and parish (or county) of your last registration if you were registered in another parish or state prior to completing this application. ***Important:*** *Contact the local election office in your prior state and cancel your prior registration. Registering in Louisiana does not automatically cancel or transfer your voter registration from another state.*

17. *Former Registered Name* - If you are using this application to make a name change to your registration, print your former registered name (name you are changing) in this section. If name changed by court order, provide a copy of the order with this application.

18. *Affirmation and Signature* - Read the affirmation and sign your full name or make your mark and print the date this application was signed and completed. *If assistance in registering is being provided, make sure the applicant understands what they are affirming and that they meet the requirements to register to vote.*

19. *Witnesses* - If you are unable to sign your name, you may make your mark, but it **must** be witnessed by two people or it is not valid.

Mailing Instructions - If returned by mail, place in an envelope and mail to your Registrar of Voters Office. You can find your registrar of voters mailing address on the Registrar of Voters Address Page, by visiting our website at www.geauxvote.com or by calling toll free at 1-800-883-2805. Your application or envelope **must** be postmarked 30 days prior to the first election in which you seek to vote.

Online Voter Registration - Voter registration is also available at www.geauxvote.com and you may register online before the 20th day prior to the election. Please call your registrar of voters if you do not receive your voter information card two weeks after registering.