LOUISIANA DEPARTMENT OF HEALTH LACARTE PROGRAM
CARDHOLDER ENROLLMENT FORM

(Cardholder and Supervisor/Approver must take Certification Course and score a minimum of 90%. Proof should be attached to this form.)

☐ NEW   ☐ CHANGE(Complete Name, Personnel # and fields that require changes)   ☐ DELETE/CANCEL

Section I: To be completed by Cardholder:

Cardholder Name: _____   Personnel #: **P**_____
                  (maximum of 23 spaces)

Job Title: _____   Employee Date of Birth: _____

Department: _____   Facility: _____

Office/Program/Region/Group: _____

Sub Office/Program/Region/Group: _____

Office Delivery Address: _____

Office Mailing Address: _____

City, State, & Zip:_____   Work Phone#:_____   E-mail Address:_____

Employee Signature: _____

Section II: To be completed by Supervisor/Approver with final approval by Program Administrator. Supervisor/Approver will be responsible for reviewing and approving monthly statements and supporting documentation and assuring that expenditures are valid and that all expenditures are coded in the Bank of America Works Workflow system. All fields must be completed.

Cycle Card Limit ($ Amount that can be spent during cycle which runs from 6th to 5th) : _____

Single Transaction Limit:_____
                          (Max $5000)

Number of Purchases Allowed per **day**: _____
                          (6TH TO 5TH each month)(Can be unlimited)

Agency/Organization Business Area Code: _____   Cost Center: _____
                          (Will be used if allocations are not completed)

*MCC Restrict/Add Codes: **11992TRAVL** Justification: Policy Requirement: No travel related expenditures
                         11992CASH   Justification: Policy Requirement: No cash transactions
                         11992REST   Justification: Policy Requirement: DOA restrictions

Supervisor/Approver Signature: _____   Print Name: _____

Supervisor/Approver E-mail address: _____

Alternate Supervisor/Approver:_____   Print Name: _____

Alternate Supervisor/Approver E-mail address: _____

APPROVED BY: _____   DATE: _____

Date Application processed by ProgAdm:_____   Submitted to Bank By:_____

NOTE: This form is to be forwarded to the LDH LaCarte Program Administrators, c/o Division of Safety/Security & Administrative Services; LDHPCardProgramAdmin@la.gov