LOUISIANA DEPARTMENT OF HEALTH
Medicaid

CAJUN submit date: _____ Resubmit date: _____
IMDOC submit date: _____ Resubmit date: _____

BHSF Form 1-DOCE
Rev. 06/2023

DEPARTMENT OF CORRECTIONS
ENROLLMENT SUPPLEMENTAL SIGNATURE FORM

First Name	Middle Initial	Last Name	
SSN or Alien Number	**Date of Birth**	**DOC Inmate Number**	**DOC Location Name**
Are you Hispanic or Latino? ☐ YES ☐ NO		***If eligible for Medicare, complete 1-PM Form***	

Mailing Address Please list a mailing address for LDH to use while you are incarcerated.	Street Address or PO Box
	City State Zip Code

Choosing a Health Plan

Most people on Medicaid need to choose a health plan as well as a dental plan. These plans are groups of doctors, nurses, dentists, and other staff who work together to provide health care. All Health Plans must offer the same medical coverage, as well as all Dental Plans. Some of the plans offer extra benefits. Review the comparison charts that shows the differences in health plans and dental plans. If you know which plans you want, please choose now. If you do not choose, and you need to be in a health plan or dental plan, we will choose for you.

Please select ONE Health Plan:

☐ Aetna Better Health of Louisiana ☐ AmeriHealth Caritas Louisiana ☐ Healthy Blue

☐ Louisiana Healthcare Connections ☐ UnitedHealthcare Community Plan ☐ Humana Healthy Horizons in Louisiana

Please select ONE Dental Plan:

☐ DentaQuest ☐ MCNA Dental

Read And Sign This Application

By signing and submitting this application, I state that I 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.

I 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.

I understand that providing the requested information (including social security numbers) is voluntary. However, failing to provide it may delay or prevent me from getting health coverage through Medicaid or any other insurance affordability program.

I understand that LDH will check the information I give them to make sure it is correct. I give LDH permission to contact any outside source(s) necessary to check this information, process my 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.

I give these outside sources permission to give LDH any information about me, or any person necessary for this application, that it may request. I understand that this permission will end when this application is denied, when my Medicaid eligibility ends, or when I submit a written statement to LDH canceling this permission, whichever comes first. A cancellation may prevent me from being found to be eligible for Medicaid.

I 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.

I know that I must tell Medicaid if anything changes (and is different than) what I wrote on this application. I can visit www.medicaid.la.gov or call1-888-342·6207 to report any changes. I understand that a change in my information could affect the eligibility for member(s) of my household.

I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting www.hhs.gov/ocr/office/file, calling the US DHHS Regional Office for Civil Rights at 1-800-368-1019, or writing to the LDH at PO Box 4818, Baton Rouge, Louisiana 70821.

I confirm that no one applying for health insurance on this application is incarcerated (detained or jailed), and if they are, that I must report it.

Is anyone applying for coverage on this application incarcerated (detained or jailed)?

☐ Yes ☐ No If **YES**, who is incarcerated? _____

Renewal of coverage in future years

To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow Medicaid to use income data, including information from tax returns. Medicaid will send me a notice, let me make any changes, and I can opt out at any time.

☐ Yes, renew my eligibility automatically for the next (choose one): ☐ 5 years ☐ 4 years ☐ 3 years ☐ 2 years ☐ 1 year

☐ No, don't use information from tax returns to renew my coverage.

If anyone on this application is eligible for Medicaid

By signing and submitting this application, I understand that if anyone on this application enrolls in Medicaid, I'm giving LDH our rights to any money owed to us by any other health insurance, legal settlement, a spouse or parent, or other third party.

I know I'll be asked to cooperate with the agency that collects medical support from an absent parent. If I think that cooperating to collect medical support will harm me or my children, I can tell the agency and I may not have to cooperate.

☐ Agree ☐ Disagree (Selecting **DISAGREE** may impact your eligibility for Medicaid.)

Income

Does anyone applying for coverage on this application have income? ☐ Yes ☐ No

If **YES**, employer name/address: _____

Wages are paid: ☐ Hourly ☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly ☐ Yearly

Wages/tips (before taxes): $_____ Average hours worked each week: _____

Will they be filing taxes? ☐ Yes ☐ No

Estate Recovery

I understand that Estate Recovery rules require Louisiana Medicaid to recover the cost of certain Medicaid payments from the applicant's estate. These costs include the total amount of payments for facility services, hospital care, payments to HCBS or PACE providers, and prescription drugs received at age 55 or older. The estate is the property owned at the time of death. Medicaid will not make a claim against the estate while the applicant or his or her legal spouse is still living. Medicaid also will

not make a claim if the applicant has a dependent child who is under age 21, blind, or disabled. Collection may not be made if it is not cost effective for Medicaid to do so, or if it would cause a hardship for the heirs of the estate. 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 convincing situations.

My right to appeal

If I think the Health Insurance Marketplace or Louisiana Medicaid has made a mistake, I can appeal its decision. To appeal means to tell someone at the Health Insurance Marketplace or Medicaid that I think the action is wrong, and ask for a fair review of the action. I know that I can find out how to appeal by contacting Medicaid at 1-888-342-6207. I know that I can be represented in the process by someone other than myself. My eligibility and other important information will be explained to me.

Sign this application

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 is true and correct to the best of my knowledge. I have read or someone has read to me the "Read And Sign This Application" section of the application (starting on page 1), including fraud penalties.

Applicant's Signature	Applicant's Name (printed)	Date

To be completed by DOC Prison, Re-Entry, or Jail Staff			
PRISON ONLY: Is applicant high-needs? ☐ YES – Medical ☐ YES – Mental Health ☐ NO			
Explanation of Release *(if applicable)*			
☐ Adj release Date: _____ ☐ FTD release Date: _____	☐ Parole eligible or board hearing Date: _____	☐ Re-entry Court Judge: _____ Date: _____	☐ Other *(please explain)*
DOC/Jail Representative's Signature		**DOC/Jail Representative's Name (printed)**	
DOC/Jail Representative's E-mail		**Date**	

In the event that the applicant is unable to sign their application, please select one of the following:

☐ Option 1: Applicant communicates his/her desire to apply for Medicaid, but is unable to physically sign.
☐ Option 2: Applicant is not able to communicate his/her desire to apply for Medicaid and is unable to physically sign.

Additionally, fill in the information and sign below:

I, _____ (responsible party's name), _____ (responsible party's title), am signing on behalf of _____ (applicant's name) because he/she is unable to sign for the following reason(s): _____

_____

Responsible Party's Signature	Responsible Party's Name (printed)	Date

Submit this form via fax to LDH at 1-877-672-0324 or by e-mail to IMDOC@la.gov