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

1-DOCE
Revised 7/2018

DOC ENROLLMENT SUPPLEMENTAL SIGNATURE FORM

First Name	M.I.	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***	

Choosing a Health Plan

Most people on Medicaid need to choose a health plan. A health plan is a group of doctors, nurses, and other staff who work together to provide health care. All of Healthy Louisiana's health plans must offer the same medical coverage. Some of the health plans offer extra benefits. Review the comparison chart that shows the differences in health plans.

If you know which health plan you want, please choose now. If you do not choose, and you need to be in a health plan, we will choose for you.

Please select one:

☐ **Aetna Better Health of Louisiana** ☐ **Louisiana Healthcare Connections** ☐ **Healthy Blue**

☐ **UnitedHealthcare Community Plan** ☐ **AmeriHealth Caritas Louisiana**

Read & Sign This Application

- I'm signing this application under penalty of perjury which means I've provided true answers to all the questions on this form to the best of my knowledge. I know that I may be subject to penalties under federal law if I provide false or untrue information. I understand that the information being requested is used to check my eligibility for help paying for health coverage. What I provide will be checked using information in LDH electronic databases and databases from the Internal Revenue Service (IRS), Social Security, the Department of Homeland Security, and/or a consumer reporting agency. If the information doesn't match, I may be asked to send proof. I agree to help Medicaid by letting them obtain the information they need from government agencies, employers, medical providers, and others.
- I know that I must tell Medicaid if anything changes in my situation within 10 days of that change. I can visit http://ldh.la.gov/index.cfm/subhome/48 or call **1-888-342-6207** 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, 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 Louisiana LDH at PO Box 4818, Baton Rouge, Louisiana 70821.

Authorization to Release or Obtain Health Information for Eligibility in Program Enrollment and Service Delivery:

- I authorize this application for Medicaid benefits.
- I authorize the release and transfer of the following protected health information to the Louisiana Department of Health/Medicaid Program, the Medicaid Managed Care Health Plan in which I am enrolled, or their contractors, agents, or representatives, from the Louisiana Department of Public Safety and Corrections, its contractors, agents, or representatives, and I further authorize the release and transfer the following protected health information to the Louisiana Department of Public Safety and Corrections, its contractors, agents, or representatives, from the Louisiana Department of Health/Medicaid Program, the Medicaid Managed Care Health Plan in which I am enrolled, or their contractors, agents or representatives:
  - Any and all of my medical records, medical history, examinations, reports, surgical reports, treatment, tests, prescriptions, immunizations, hospital records and reports, laboratory testing and reports, x-rays and reports, and MR/DD reports; and
  - Records pertaining to alcoholism, drug abuse, mental health, behavioral health, vocational rehabilitation, HIV (AIDS), sexually transmitted diseases, and genetics described or specified in the 2DOC and 3DOC forms (in compliance with state and/or federal laws which require special permission to release otherwise privileged information).
- Information used or disclosed pursuant to this authorization may be re-disclosed by the recipient and will no longer be protected by the HIPAA Privacy Rule or LDH privacy policies.
- This authorization is for the purpose of Eligibility Determination by the Louisiana Medicaid Program and Medical Service Delivery/Provision and case management by the Louisiana Medicaid Program or the Medicaid Managed Care Plan in which I am enrolled. I understand that generally I am not required to sign this authorization as a condition of receiving medical treatment, but I may be denied eligibility for Medicaid benefits or enrollment in a Medicaid Managed Care Health Plan if I do not sign it.
- This authorization is for paper, oral and electronic information.
- This authorization will expire twelve (12) months from the date on which it was signed, unless I cancel it earlier. I may cancel it in writing at any time, but the cancellation will not affect any actions that have already been taken in reliance on the authorization, including any uses or disclosures of my information that have already been made.

APPLICANT NAME (PRINTED)	APPLICANT SIGNATURE	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 Name	DOC/Jail Representative Signature	DOC/Jail Representative Email	DATE

SEND COMPLETED FORM TO EMAIL IMDOC@LA.GOV or FAX 1-877-672-0324