LOUISIANA
DEPARTMENT OF HEALTH
Medicaid

BHSF Form AVS
Rev. 05/19

Authorization for Verification of Resources

Applicant's name *(print)* | Applicant's Social Security Number

To determine whether an applicant or their legal spouse can receive or continue to receive Medicaid Healthcare Coverage, we must verify information about them and the amount of resources owned by them. This form authorizes Medicaid to request records from financial institutions for an individual and their spouse when one or both apply for Medicaid. **Please read and fill out this form.**

By signing this form you authorize verification of your resources (as well as those of your spouse, if applicable) with financial institutions for the purpose of determining eligibility for Medicaid. This authorization will end if your application for Medicaid is denied, you are no longer eligible for Medicaid, or if you revoke this authorization in a written statement to the Louisiana Department of Health (LDH).

You agree to allow organizations such as the following to give records about you or your spouse to LDH:

- Employers
- Insurance companies
- Real estate companies
- Government agencies
- Building associations
- Banks/Other financial institutions

This agreement does not include getting personal health information from doctors or healthcare providers.

Applicant's name *(print)* | Applicant's Social Security Number

Applicant's signature | Date

Applicant's spouse's name *(print)* | Spouse's Social Security Number

Spouse's signature | Date

Guardian/power of attorney/authorized representative's name *(print)* **– if applicable**

Representative's signature **– if applicable** | Date **– if applicable**

You can return this form by faxing it to **1-877-523-2987**.
You can also mail it to **Medicaid/LaCHIP Office, P.O. Box 91283, Baton Rouge, LA 70821-9278**.