LOUISIANA DEPARTMENT OF HEALTH
Medicaid

BHSF Form 1-A
Revised 9/9/2022

Application for Health Coverage

THINGS TO KNOW

Use this application to see what coverage choices you qualify for

- Affordable private health insurance plans that offer comprehensive coverage to help you stay well
- A new tax credit that can immediately help pay your premiums for health coverage
- Free or low-cost insurance from Medicaid or the Louisiana Children's Health Insurance Program (LaCHIP)

You may qualify for a free or low-cost program even if you earn as much as $94,000 a year (for a family of 4).

Who can use this application?

- Use this application to apply for anyone in your family.
- Apply even if you or your child already has health coverage. You could be eligible for lower-cost or free coverage.
- Families that include immigrants can apply. You can apply for your child even if you aren't eligible for coverage. Applying won't affect your immigration status or chances of becoming a permanent resident or citizen.

Apply faster online

Apply faster online at www.medicaid.la.gov.

What you may need to apply

- Social Security Numbers (or document numbers for any legal immigrants who need insurance)
- Employer and income information for everyone in your family (for example, from paystubs, W-2 forms, or wage and tax statements)
- Policy numbers for any current health insurance
- Information about any job-related health insurance available to your family

Why do we ask for this information?

We ask about income and other information to let you know what coverage you qualify for and if you can get any help paying for it. **We'll keep all the information you provide private and secure, as required by law.**

What happens next?

Send your complete, signed application to the address on page 12. **If you don't have all the information we ask for, sign and submit your application anyway.** We'll follow-up with you within 1–2 weeks. You'll get instructions on any further steps to take. If you don't hear from us, visit www.medicaid.la.gov or call **1-888-342-6207**. Filling out this application doesn't mean you have to buy health coverage.

Get help with this application

- **Online:** www.medicaid.la.gov
- **Phone:** Call us at **1-888-342-6207.**
- **In person:** Visit our website or call **1-888-342-6207** to find the Medicaid office closest to you.
- ¿Necesita traductor de español? Llame al **1-888-342-6207.**
- Quí vị có cần thông dịch viên người Việt không? Nếu cần xin gọi số **1-888-342-6207.**

NEED HELP WITH YOUR APPLICATION? Visit www.medicaid.la.gov or call us at **1-888-342-6207**. If you need help in a language other than English, call **1-888-342-6207** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-800-220-5404**.

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STEP 1 Tell us about yourself

(We need one adult in the family to be the contact person for your application.)

1. First name, Middle name, Last name, & Suffix

2. Home address (Leave blank if you don't have one) | 3. Apartment or suite number

4. City | 5. State | 6. ZIP code | 7. Parish

8. Mailing address (if different from home address) | 9. Apartment or suite number

10. City | 11. State | 12. ZIP code | 13. Parish

14. Phone number | 15. Other phone number

16. Do you want to get information about this application by e-mail? ☐ Yes ☐ No

E-mail address: _____

17. What is your preferred spoken or written language (if not English)?

STEP 2 Tell us about your family

Who do you need to include on this application?

Tell us about all the family members who live with you. If you file taxes, we need to know about everyone on your tax return. (You don't need to file taxes to get health coverage).

DO Include:

- Yourself
- Your spouse
- Your children under 21 who live with you
- Your unmarried partner who needs health coverage
- Anyone you include on your tax return, even if they don't live with you
- Anyone else under 21 who you take care of and lives with you

You DON'T have to include:

- Your unmarried partner who doesn't need health coverage
- Your unmarried partner's children
- Your parents who live with you, but file their own tax return (if you're over 21)
- Other adult relatives who file their own tax return

The amount of assistance or type of program you qualify for depends on the number of people in your family and their incomes. This information helps us make sure everyone gets the best coverage they can.

Complete Step 2 for each person in your family. Start with yourself, then add other adults and children. If you have more than 4 people in your family, you'll need to make a copy of the pages and attach them. You don't need to provide immigration status or a Social Security Number (SSN) for family members who don't need health coverage. We'll keep all the information you provide private and secure as required by law. We'll use personal information only to check if you're eligible for health coverage.

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STEP 2: PERSON 1 (Start with yourself)

Complete Step 2 for yourself, your spouse/partner, and children who live with you and/or anyone on your same federal income tax return if you file one. See page 1 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you.

1. First name, Middle name, Last name, & Suffix

2. Date of birth (mm/dd/yyyy)

3. Sex ☐ Male ☐ Female

4. Social Security number (SSN)

We need this if you want health coverage and have an SSN. We only use SSNs to check income and other information from other government agencies, financial institutions, and other sources to see who's eligible for help with health coverage costs. Providing your SSN can be helpful even if you don't want health coverage, and can speed up the application process. If someone wants help getting an SSN, call **1-800-772-1213** or visit **www.socialsecurity.gov**. TTY users should call **1-800-325-0778**.

5. **If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)**

☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

6. **Race (OPTIONAL—check all that apply.)**

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

7. **Do you plan to file a federal income tax return NEXT YEAR?**
(You can still apply for health insurance even if you don't file a federal income tax return.)

☐ **YES. If yes,** answer questions a–c. ☐ **NO. If no,** skip to question c.

a. Will you file jointly with a spouse? ☐ Yes ☐ No
If yes, name of spouse: _____

b. Will you claim any dependents on your tax return? ☐ Yes ☐ No
If yes, list name(s) of dependents: _____

c. Will you be claimed as a dependent on someone's tax return? ☐ Yes ☐ No
If yes, please list the name of the tax filer: _____
How are you related to the tax filer? _____

8. Are you pregnant? ☐ Yes ☐ No **If yes,** how many babies are expected during this pregnancy? _____

9. **Do you need health coverage?**
(Even if you have insurance, there might be a program with better coverage or lower costs.)

☐ **YES. If yes,** answer all the questions below. ☐ **NO. If no,** SKIP to the income questions on page 3.

10. Do you have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.)? ☐ Yes ☐ No **If yes,** you'll need to complete and include Appendix D.

11. Do you live in a medical facility or nursing home? ☐ Yes ☐ No **If yes,** you'll need to complete and include Appendix D.

12. Do you want help paying for medical bills (paid or unpaid) for medical care received in the past 3 months? ☐ Yes ☐ No

13. Do you live with at least one child under the age of 19, and are you the main person taking care of this child? ☐ Yes ☐ No

14. Were you in foster care at age 18 or older? ☐ Yes ☐ No
a. **If yes,** in which state? _____ b. Were you on Medicaid? ☐ Yes ☐ No c. How old were you when you left foster care? _____

15. Did you have insurance through a job and lose it within the past 6 months? ☐ Yes ☐ No
a. **If yes,** end date: _____ b. Reason the insurance ended: _____

16. Are you a full-time student? ☐ Yes ☐ No

17. Are you a U.S. citizen or U.S. national? ☐ Yes ☐ No
If yes, were you born in the U.S. or a U.S. territory? ☐ Yes ☐ No **If no,** fill in your information below (if it applies to you).
a. Alien number _____ b. Certificate type _____ c. Certificate number _____
If no, do you have eligible immigration status? ☐ Yes ☐ No **If yes,** fill in your information below (if it applies to you).
a. Document type _____
b. Document expiration date (mm/dd/yyyy) _____
c. Alien, I-94, or SEVIS ID number _____
d. Card or Passport number _____
e. Have you lived in the U.S. since 1996? ☐ Yes ☐ No
f. Are you or your spouse or parent a veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

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STEP 2: PERSON 1 (Continue with yourself)

Current Job & Income Information

☐ **Employed**
If you're currently employed, tell us about your income. Start with question 18.

☐ **Not employed**
Skip to question 28.

☐ **Self-employed**
Skip to question 27.

CURRENT JOB 1:

18. Employer name and address

19. Employer phone number

20. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

$ _____

21. Average hours worked each WEEK

CURRENT JOB 2: (If you have more jobs and need more space, attach another sheet of paper.)

22. Employer name and address

23. Employer phone number

24. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

$ _____

25. Average hours worked each WEEK

26. **In the past year, did you:** ☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

27. **If self-employed, answer the following questions:**

a. Type of work

_____

b. How much net income (profits or losses once business expenses are paid) will you get from this self-employment this month?

$ _____

28. **OTHER INCOME THIS MONTH:** Check all that apply, and give the amount and how often you get it.

☐ None

☐ Unemployment	$ _____	How often? _____	☐ Child support	$ _____	How often? _____
☐ Pensions	$ _____	How often? _____	☐ Veteran's payments	$ _____	How often? _____
☐ Social Security	$ _____	How often? _____	☐ Scholarships/Grants	$ _____	How often? _____
☐ Retirement accounts	$ _____	How often? _____	☐ Capital Gains	$ _____	How often? _____
☐ Investments	$ _____	How often? _____	☐ Net farming/fishing	$ _____	How often? _____
☐ Alimony received	$ _____	How often? _____	☐ Net rental/royalty	$ _____	How often? _____
☐ Supplemental Security Income (SSI)	$ _____	How often? _____	☐ Other income	Type: _____ $ _____	How often? _____

29. **DEDUCTIONS:** Check all that apply, and give the amount and how often you get it. If you pay for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.

NOTE: You shouldn't include a cost that you already considered in your answer to net self-employment (question 27b).

☐ Alimony paid	$ _____	How often? _____	☐ Other deductions	Type: _____	
☐ Student loan interest	$ _____	How often? _____		$ _____	How often? _____

30. **YEARLY INCOME:** Complete only if your income changes from month to month. If you don't expect changes to your monthly income, skip to the next person.

Your total income **this year**	Your total income **next** year (if you think it will be different)
$	**$**

THANKS! This is all we need to know about you.

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STEP 2: PERSON 2

Complete Step 2 for yourself, your spouse/partner, and children who live with you and/or anyone on your same federal income tax return if you file one. See page 1 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you.

1. First name, Middle name, Last name, & Suffix

2. Date of birth (mm/dd/yyyy)

3. Sex ☐ Male ☐ Female

4. Social Security number (SSN)
We need this if PERSON 2 wants health coverage and has an SSN.

5. Relationships
(examples: mother, father, daughter, son, etc.)
This person's relationship to:
PERSON 1: _____

6. Does PERSON 2 live at the same address as you? ☐ Yes ☐ No
If no, list address: _____

7. **If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)**
☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

8. **Race (OPTIONAL—check all that apply.)**

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

9. **Does PERSON 2 plan to file a federal income tax return NEXT YEAR?**
(You can still apply for health insurance even if you don't file a federal income tax return.)
☐ **YES. If yes,** answer questions a–c. ☐ **NO. If no,** skip to question c.
a. Will PERSON 2 file jointly with a spouse? ☐ Yes ☐ No
If yes, name of spouse: _____
b. Will PERSON 2 claim any dependents on their tax return? ☐ Yes ☐ No
If yes, list name(s) of dependents: _____
c. Will PERSON 2 be claimed as a dependent on someone's tax return? ☐ Yes ☐ No
If yes, please list the name of the tax filer: _____
How is PERSON 2 related to the tax filer? _____

10. Is PERSON 2 pregnant? ☐ Yes ☐ No **If yes,** how many babies are expected during this pregnancy? _____

11. **Does PERSON 2 need health coverage?**
(Even if you have insurance, there might be a program with better coverage or lower costs.)
☐ **YES. If yes,** answer all the questions below. ☐ **NO. If no,** SKIP to the income questions on page 5.

12. Does PERSON 2 have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.)? ☐ Yes ☐ No **If yes,** you'll need to complete and include Appendix D.

13. Does PERSON 2 live in a medical facility or nursing home? ☐ Yes ☐ No **If yes,** you'll need to complete and include Appendix D.

14. Does PERSON 2 want help paying for medical bills (paid or unpaid) for medical care received in the past 3 months? ☐ Yes ☐ No

15. Does PERSON 2 live with at least one child under the age of 19, and are they the main person taking care of this child? ☐ Yes ☐ No

16. Was PERSON 2 in foster care at age 18 or older? ☐ Yes ☐ No
a. **If yes,** in which state? _____ b. Were they on Medicaid? ☐ Yes ☐ No c. How old was PERSON 2 when they left foster care? _____

17. Did PERSON 2 have insurance through a job and lose it within the past 6 months? ☐ Yes ☐ No
a. **If yes,** end date: _____ b. Reason the insurance ended: _____

18. Is PERSON 2 a full-time student? ☐ Yes ☐ No

19. Is PERSON 2 a U.S. citizen or U.S. national? ☐ Yes ☐ No
If yes, was PERSON 2 born in the U.S. or a U.S. territory? ☐ Yes ☐ No **If no,** fill in their information below (if it applies to them).
a. Alien number _____ b. Certificate type _____ c. Certificate number _____
If no, does PERSON 2 have eligible immigration status? ☐ Yes ☐ No **If yes,** fill in their information below (if it applies to them).
a. Document type _____ b. Document expiration date (mm/dd/yyyy) _____
c. Alien, I-94, or SEVIS ID number _____ d. Card or Passport number _____
e. Has PERSON 2 lived in the U.S. since 1996? ☐ Yes ☐ No f. Is PERSON 2 or their spouse or parent a veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

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STEP 2: PERSON 2 (Continue with PERSON 2)

Current Job & Income Information

☐ **Employed**
If PERSON 2 is currently employed, tell us about their income. Start with question 20.

☐ **Not employed**
Skip to question 30.

☐ **Self-employed**
Skip to question 29.

CURRENT JOB 1:

20. Employer name and address

21. Employer phone number

22. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

$ _____

23. Average hours worked each WEEK

CURRENT JOB 2: (If PERSON 2 has more jobs and you need more space, attach another sheet of paper.)

24. Employer name and address

25. Employer phone number

26. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

$ _____

27. Average hours worked each WEEK

28. **In the past year, did PERSON 2:** ☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

29. **If self-employed, answer the following questions:**

a. Type of work

_____

b. How much net income (profits or losses once business expenses are paid) will PERSON 2 get from this self-employment this month?

$ _____

30. **OTHER INCOME THIS MONTH:** Check all that apply, and give the amount and how often PERSON 2 gets it.

☐ None

☐ Unemployment **$** _____ How often? _____
☐ Pensions **$** _____ How often? _____
☐ Social Security **$** _____ How often? _____
☐ Retirement accounts **$** _____ How often? _____
☐ Investments **$** _____ How often? _____
☐ Alimony received **$** _____ How often? _____
☐ Supplemental Security Income (SSI) **$** _____ How often? _____
☐ Child support **$** _____ How often? _____
☐ Veteran's payments **$** _____ How often? _____
☐ Scholarships/Grants **$** _____ How often? _____
☐ Capital Gains **$** _____ How often? _____
☐ Net farming/fishing **$** _____ How often? _____
☐ Net rental/royalty **$** _____ How often? _____
☐ Other income Type: _____ **$** _____ How often? _____

31. **DEDUCTIONS:** Check all that apply, and give the amount and how often PERSON 2 gets it. If PERSON 2 pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.

NOTE: You shouldn't include a cost that you already considered in PERSON 2's answer to net self-employment (question 29b).

☐ Alimony paid **$** _____ How often? _____
☐ Student loan interest **$** _____ How often? _____
☐ Other deductions Type: _____ **$** _____ How often? _____

32. **YEARLY INCOME:** Complete only if PERSON 2's income changes from month to month. If you don't expect changes to PERSON 2's monthly income, skip to the next person.

PERSON 2's total income **this year**
$

PERSON 2's total income **next** year (if you think it will be different)
$

THANKS! This is all we need to know about PERSON 2.

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STEP 2: PERSON 3

Complete Step 2 for yourself, your spouse/partner, and children who live with you and/or anyone on your same federal income tax return if you file one. See page 1 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you.

1. First name, Middle name, Last name, & Suffix

2. Date of birth (mm/dd/yyyy)

3. Sex ☐ Male ☐ Female

4. Social Security number (SSN)
We need this if PERSON 3 wants health coverage and has an SSN.

5. Relationships
(examples: mother, father, daughter, son, etc.)
This person's relationship to:
PERSON 1: _____
PERSON 2: _____

6. Does PERSON 3 live at the same address as you? ☐ Yes ☐ No
If no, list address: _____

7. **If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)**
☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

8. **Race (OPTIONAL—check all that apply.)**

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

9. **Does PERSON 3 plan to file a federal income tax return NEXT YEAR?**
(You can still apply for health insurance even if you don't file a federal income tax return.)
☐ **YES. If yes,** answer questions a–c. ☐ **NO. If no,** skip to question c.
a. Will PERSON 3 file jointly with a spouse? ☐ Yes ☐ No
If yes, name of spouse: _____
b. Will PERSON 3 claim any dependents on their tax return? ☐ Yes ☐ No
If yes, list name(s) of dependents: _____
c. Will PERSON 3 be claimed as a dependent on someone's tax return? ☐ Yes ☐ No
If yes, please list the name of the tax filer: _____
How is PERSON 3 related to the tax filer? _____

10. Is PERSON 3 pregnant? ☐ Yes ☐ No **If yes,** how many babies are expected during this pregnancy? _____

11. **Does PERSON 3 need health coverage?**
(Even if you have insurance, there might be a program with better coverage or lower costs.)
☐ **YES. If yes,** answer all the questions below. ☐ **NO. If no,** SKIP to the income questions on page 7.

12. Does PERSON 3 have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.)? ☐ Yes ☐ No **If yes,** you'll need to complete and include Appendix D.

13. Does PERSON 3 live in a medical facility or nursing home? ☐ Yes ☐ No **If yes,** you'll need to complete and include Appendix D.

14. Does PERSON 3 want help paying for medical bills (paid or unpaid) for medical care received in the past 3 months? ☐ Yes ☐ No

15. Does PERSON 3 live with at least one child under the age of 19, and are they the main person taking care of this child? ☐ Yes ☐ No

16. Was PERSON 3 in foster care at age 18 or older? ☐ Yes ☐ No
a. **If yes,** in which state? _____ b. Were they on Medicaid? ☐ Yes ☐ No c. How old was PERSON 3 when they left foster care? _____

17. Did PERSON 3 have insurance through a job and lose it within the past 6 months? ☐ Yes ☐ No
a. **If yes,** end date: _____ b. Reason the insurance ended: _____

18. Is PERSON 3 a full-time student? ☐ Yes ☐ No

19. Is PERSON 3 a U.S. citizen or U.S. national? ☐ Yes ☐ No
If yes, was PERSON 3 born in the U.S. or a U.S. territory? ☐ Yes ☐ No **If no,** fill in their information below (if it applies to them).
a. Alien number _____ b. Certificate type _____ c. Certificate number _____
If no, does PERSON 3 have eligible immigration status? ☐ Yes ☐ No **If yes,** fill in their information below (if it applies to them).
a. Document type _____ b. Document expiration date (mm/dd/yyyy) _____
c. Alien, I-94, or SEVIS ID number _____ d. Card or Passport number _____
e. Has PERSON 3 lived in the U.S. since 1996? ☐ Yes ☐ No f. Is PERSON 3 or their spouse or parent a veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

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STEP 2: PERSON 3 (Continue with PERSON 3)

Current Job & Income Information

☐ **Employed**
If PERSON 3 is currently employed, tell us about their income. Start with question 20.

☐ **Not employed**
Skip to question 30.

☐ **Self-employed**
Skip to question 29.

CURRENT JOB 1:

20. Employer name and address	21. Employer phone number

22. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

$ _____

23. Average hours worked each WEEK

CURRENT JOB 2: (If PERSON 3 has more jobs and you need more space, attach another sheet of paper.)

24. Employer name and address	25. Employer phone number

26. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

$ _____

27. Average hours worked each WEEK

28. **In the past year, did PERSON 3:** ☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

29. **If self-employed, answer the following questions:**

a. Type of work

_____

b. How much net income (profits or losses once business expenses are paid) will PERSON 3 get from this self-employment this month?

$ _____

30. **OTHER INCOME THIS MONTH:** Check all that apply, and give the amount and how often PERSON 3 gets it.

☐ None

☐ Unemployment **$** _____ How often? _____
☐ Pensions **$** _____ How often? _____
☐ Social Security **$** _____ How often? _____
☐ Retirement accounts **$** _____ How often? _____
☐ Investments **$** _____ How often? _____
☐ Alimony received **$** _____ How often? _____
☐ Supplemental Security Income (SSI) **$** _____ How often? _____
☐ Child support **$** _____ How often? _____
☐ Veteran's payments **$** _____ How often? _____
☐ Scholarships/Grants **$** _____ How often? _____
☐ Capital Gains **$** _____ How often? _____
☐ Net farming/fishing **$** _____ How often? _____
☐ Net rental/royalty **$** _____ How often? _____
☐ Other income Type: _____ **$** _____ How often? _____

31. **DEDUCTIONS:** Check all that apply, and give the amount and how often PERSON 3 gets it. If PERSON 3 pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.

NOTE: You shouldn't include a cost that you already considered in PERSON 3's answer to net self-employment (question 29b).

☐ Alimony paid **$** _____ How often? _____
☐ Student loan interest **$** _____ How often? _____
☐ Other deductions Type: _____ **$** _____ How often? _____

32. **YEARLY INCOME:** Complete only if PERSON 3's income changes from month to month. If you don't expect changes to PERSON 3's monthly income, skip to the next person.

PERSON 3's total income **this year**	PERSON 3's total income **next** year (if you think it will be different)
$	**$**

THANKS! This is all we need to know about PERSON 3.

NEED HELP WITH YOUR APPLICATION? Visit www.medicaid.la.gov or call us at **1-888-342-6207**. If you need help in a language other than English, call **1-888-342-6207** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-800-220-5404**.

STEP 2: PERSON 4

Complete Step 2 for yourself, your spouse/partner, and children who live with you and/or anyone on your same federal income tax return if you file one. See page 1 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you.

1. First name, Middle name, Last name, & Suffix

2. Date of birth (mm/dd/yyyy)

3. Sex ☐ Male ☐ Female

4. Social Security number (SSN)
We need this if PERSON 4 wants health coverage and has an SSN.

5. Relationships
(examples: mother, father, daughter, son, etc.)
This person's relationship to:
PERSON 1: _____
PERSON 2: _____
PERSON 3: _____

6. Does PERSON 4 live at the same address as you? ☐ Yes ☐ No
If no, list address: _____

7. **If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)**
☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

8. **Race (OPTIONAL—check all that apply.)**
☐ White
☐ Black or African American
☐ American Indian or Alaska Native
☐ Asian Indian
☐ Chinese
☐ Filipino
☐ Japanese
☐ Korean
☐ Vietnamese
☐ Other Asian
☐ Native Hawaiian
☐ Guamanian or Chamorro
☐ Samoan
☐ Other Pacific Islander
☐ Other _____

9. **Does PERSON 4 plan to file a federal income tax return NEXT YEAR?**
(You can still apply for health insurance even if you don't file a federal income tax return.)
☐ **YES. If yes,** answer questions a–c. ☐ **NO. If no,** skip to question c.
a. Will PERSON 4 file jointly with a spouse? ☐ Yes ☐ No
If yes, name of spouse: _____
b. Will PERSON 4 claim any dependents on their tax return? ☐ Yes ☐ No
If yes, list name(s) of dependents: _____
c. Will PERSON 4 be claimed as a dependent on someone's tax return? ☐ Yes ☐ No
If yes, please list the name of the tax filer: _____
How is PERSON 4 related to the tax filer? _____

10. Is PERSON 4 pregnant? ☐ Yes ☐ No **If yes,** how many babies are expected during this pregnancy? _____

11. **Does PERSON 4 need health coverage?**
(Even if you have insurance, there might be a program with better coverage or lower costs.)
☐ **YES. If yes,** answer all the questions below. ☐ **NO. If no,** SKIP to the income questions on page 9.

12. Does PERSON 4 have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.)? ☐ Yes ☐ No **If yes,** you'll need to complete and include Appendix D.

13. Does PERSON 4 live in a medical facility or nursing home? ☐ Yes ☐ No **If yes,** you'll need to complete and include Appendix D.

14. Does PERSON 4 want help paying for medical bills (paid or unpaid) for medical care received in the past 3 months? ☐ Yes ☐ No

15. Does PERSON 4 live with at least one child under the age of 19, and are they the main person taking care of this child? ☐ Yes ☐ No

16. Was PERSON 4 in foster care at age 18 or older? ☐ Yes ☐ No
a. **If yes,** in which state? _____ b. Were they on Medicaid? ☐ Yes ☐ No c. How old was PERSON 4 when they left foster care? _____

17. Did PERSON 4 have insurance through a job and lose it within the past 6 months? ☐ Yes ☐ No
a. **If yes,** end date: _____ b. Reason the insurance ended: _____

18. Is PERSON 4 a full-time student? ☐ Yes ☐ No

19. Is PERSON 4 a U.S. citizen or U.S. national? ☐ Yes ☐ No
If yes, was PERSON 4 born in the U.S. or a U.S. territory? ☐ Yes ☐ No **If no,** fill in their information below (if it applies to them).
a. Alien number _____ b. Certificate type _____ c. Certificate number _____
If no, does PERSON 4 have eligible immigration status? ☐ Yes ☐ No **If yes,** fill in their information below (if it applies to them).
a. Document type _____ b. Document expiration date (mm/dd/yyyy) _____
c. Alien, I-94, or SEVIS ID number _____ d. Card or Passport number _____
e. Has PERSON 4 lived in the U.S. since 1996? ☐ Yes ☐ No f. Is PERSON 4 or their spouse or parent a veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

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STEP 2: PERSON 4 (Continue with PERSON 4)

Current Job & Income Information

☐ **Employed**
If PERSON 4 is currently employed, tell us about their income. Start with question 20.

☐ **Not employed**
Skip to question 30.

☐ **Self-employed**
Skip to question 29.

CURRENT JOB 1:

20. Employer name and address	21. Employer phone number

22. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

$ _____

23. Average hours worked each WEEK

CURRENT JOB 2: (If PERSON 4 has more jobs and you need more space, attach another sheet of paper.)

24. Employer name and address	25. Employer phone number

26. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

$ _____

27. Average hours worked each WEEK

28. **In the past year, did PERSON 4:** ☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

29. **If self-employed, answer the following questions:**

a. Type of work

_____

b. How much net income (profits or losses once business expenses are paid) will PERSON 4 get from this self-employment this month?

$ _____

30. **OTHER INCOME THIS MONTH:** Check all that apply, and give the amount and how often PERSON 4 gets it.

☐ None

☐ Unemployment **$** _____ How often? _____
☐ Pensions **$** _____ How often? _____
☐ Social Security **$** _____ How often? _____
☐ Retirement accounts **$** _____ How often? _____
☐ Investments **$** _____ How often? _____
☐ Alimony received **$** _____ How often? _____
☐ Supplemental Security Income (SSI) **$** _____ How often? _____
☐ Child support **$** _____ How often? _____
☐ Veteran's payments **$** _____ How often? _____
☐ Scholarships/Grants **$** _____ How often? _____
☐ Capital Gains **$** _____ How often? _____
☐ Net farming/fishing **$** _____ How often? _____
☐ Net rental/royalty **$** _____ How often? _____
☐ Other income Type: _____ **$** _____ How often? _____

31. **DEDUCTIONS:** Check all that apply, and give the amount and how often PERSON 4 gets it. If PERSON 4 pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.

NOTE: You shouldn't include a cost that you already considered in PERSON 4's answer to net self-employment (question 29b).

☐ Alimony paid **$** _____ How often? _____
☐ Student loan interest **$** _____ How often? _____
☐ Other deductions Type: _____ **$** _____ How often? _____

32. **YEARLY INCOME:** Complete only if PERSON 4's income changes from month to month. If you don't expect changes to PERSON 4's monthly income, skip to the next person.

PERSON 4's total income **this year**	PERSON 4's total income **next** year (if you think it will be different)
$	**$**

THANKS! This is all we need to know about PERSON 4.

If you have more than four people to include, visit www.medicaid.la.gov to download and print additional pages or make a copy of pages 8 and 9 and complete.

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STEP 3 American Indian or Alaska Native (AI/AN) family member(s)

1. **Are you or is anyone in your family American Indian or Alaska Native?**

☐ **NO. If no,** skip to Step 4.

☐ **YES. If yes,** you'll need to complete and include Appendix B.

STEP 4 Your Family's Health Coverage

Answer these questions for anyone who needs health coverage.

1. **Is anyone enrolled in health coverage now from the following?**

☐ **YES. If yes**, check the type of coverage and write the person(s)' name(s) next to the coverage they have. ☐ **NO.**

☐ Medicaid _____

☐ CHIP _____

☐ Medicare _____

☐ TRICARE (Don't check if you have direct care or Line of Duty)

_____

☐ VA health care programs _____

☐ Peace Corps _____

☐ Employer insurance _____

Name of health insurance: _____

Policy number: _____

Is this COBRA coverage? ☐ Yes ☐ No

Is this a retiree health plan? ☐ Yes ☐ No

☐ Other _____

Name of health insurance: _____

Policy number: _____

Is this a limited-benefit plan (like a school accident policy)?

☐ Yes ☐ No

2. **Is anyone listed on this application offered health coverage from a job?** This could be from their own job or from someone else's job, such as a parent or spouse.

☐ **YES. If yes,** you'll need to complete and include Appendix A.

Is this a state employee benefit plan? ☐ Yes ☐ No **If yes,** who can get coverage from it? _____

☐ **NO. If no,** continue to Step 5.

STEP 5 Read & sign this application

- I understand that I am 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 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.

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STEP 5 Read & sign this application (continued)

- 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 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, 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.)*

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

The person who filled out Step 1 should sign this application. If you're an authorized representative you may sign here, as long as you provide the information required in Appendix C.

Signature	Date (mm/dd/yyyy)

NEED HELP WITH YOUR APPLICATION? Visit www.medicaid.la.gov or call us at **1-888-342-6207**. If you need help in a language other than English, call **1-888-342-6207** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-800-220-5404**.

STEP 6 Submit completed application

Mail your signed application to:

Medicaid Application Office
P.O. Box 91278
Baton Rouge, LA 70821-9893

Fax your signed application to:

1-877-523-2987

NEED HELP WITH YOUR APPLICATION? Visit www.medicaid.la.gov or call us at **1-888-342-6207**. If you need help in a language other than English, call **1-888-342-6207** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-800-220-5404**.

APPENDIX A

Health Coverage from Jobs

You **DON'T** need to answer these questions unless someone in the household is eligible for health coverage from a job. Attach a copy of this page for each job that offers coverage.

Tell us about the **job** that offers coverage.

Take the Employer Coverage Tool on the next page to the employer who offers coverage to help you answer these questions. You only need to include this page when you send in your application, not the Employer Coverage Tool.

EMPLOYEE Information

1. Employee name (First, Middle, Last)	2. Employee Social Security number

EMPLOYER Information

3. Employer name		4. Employer Identification Number (EIN)
5. Employer address		6. Employer phone number
7. City	8. State	9. ZIP code

10. Who can we contact about employee health coverage at this job?

11. Phone number (if different from above)	12. E-mail address

13. **Are you currently eligible for coverage offered by this employer, or will you become eligible in the next 3 months?**

☐ **Yes** (Continue)

13a. If you're in a waiting or probationary period, when can you enroll in coverage? _____ (mm/dd/yyyy)

List the names of anyone else who is eligible for coverage from this job.

Name: _____ Name: _____ Name: _____

☐ **No** (Stop here and go to Step 5 in the application)

Tell us about the **health plan** offered by this employer.

14. Does the employer offer a health plan that meets the minimum value standard*? ☐ Yes ☐ No

15. For the lowest-cost plan that meets the minimum value standard* offered **only to the employee** (don't include family plans):
If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? **$** _____

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Once a month ☐ Quarterly ☐ Yearly

16. What change will the employer make for the new plan year (if known)?

☐ Employer won't offer health coverage.

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much will the employee have to pay in premiums for that plan? **$** _____

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Once a month ☐ Quarterly ☐ Yearly

Date of change (mm/dd/yyyy): _____

* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

EMPLOYER COVERAGE TOOL

Use this tool to help answer questions in Appendix A about any employer health coverage that you're eligible for (even if it's from another person's job, like a parent or spouse). The information in the numbered boxes below match the boxes on Appendix A. For example, the answer to question 14 on this page should match question 14 on Appendix A.

Write your name and Social Security number in boxes 1 and 2 and ask the employer to fill out the rest of the form. Complete one tool for each employer that offers health coverage.

EMPLOYEE Information

The **employee** needs to fill out this section.

1. Employee name (First, Middle, Last)	2. Employee Social Security number

EMPLOYER Information

Ask the **employer** for this information.

3. Employer name		4. Employer Identification Number (EIN)
5. Employer address		6. Employer phone number
7. City	8. State	9. ZIP code

10. Who can we contact about employee health coverage at this job?

11. Phone number (if different from above)	12. E-mail address

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☐ **Yes** (Continue)

13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? (mm/dd/yyyy) _____

☐ **No** (STOP and return this form to employee)

Tell us about the **health plan** offered by this **employer**.

Does the employer offer a health plan that covers an employee's spouse or dependent?

☐ Yes ☐ No **If yes,** which people? ☐ Spouse ☐ Dependent(s)

14. Does the employer offer a health plan that meets the minimum value standard*?

☐ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* offered **only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? **$** _____

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Once a month ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?

☐ Employer won't offer health coverage

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much will the employee have to pay in premiums for that plan? **$** _____

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Once a month ☐ Quarterly ☐ Yearly

Date of change (mm/dd/yyyy): _____

* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

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APPENDIX B

American Indian or Alaska Native (AI/AN) Family Member(s)

Complete this appendix if you or any family members are American Indian or Alaska Native. Submit this with your Application for Health Coverage.

Tell us about your American Indian or Alaska Native family member(s).

American Indians and Alaska Natives may not have to pay cost sharing and may get special monthly enrollment periods. Answer the following questions to make sure your family gets the most help possible.

NOTE: If you have more people to include, make a copy of this page and attach.

	AI/AN PERSON 1	AI/AN PERSON 2
1. Name	First Middle Last	First Middle Last
2. Member of a federally recognized tribe?	☐ Yes **If yes**, what is the tribe's name? _____ ☐ No	☐ Yes **If yes**, what is the tribe's name? _____ ☐ No
3. Has this person ever gotten a service from the Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs?	☐ Yes ☐ No **If no**, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? ☐ Yes ☐ No	☐ Yes ☐ No **If no**, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? ☐ Yes ☐ No
4. Certain money received may not be counted. List any income (amount and how often) reported on your application that includes money from these sources. Check all that apply, and give the amount and how often.	☐ Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties **$** _____ How often? _____ ☐ Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations) **$** _____ How often? _____ ☐ Money from selling things that have cultural significance **$** _____ How often? _____	☐ Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties **$** _____ How often? _____ ☐ Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations) **$** _____ How often? _____ ☐ Money from selling things that have cultural significance **$** _____ How often? _____

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APPENDIX C

Assistance with Completing this Application

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...

APPENDIX C (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)

APPENDIX D

Personal Assets *(optional)*

Complete this optional appendix if anyone applying has a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.), lives in a medical facility or nursing home, or is 65 years of age or older.

DOES ANYONE IN YOUR HOME OWN...	ASSET VALUE (closest possible estimate)	DESCRIBE THIS ASSET (include names of banks and other companies)
Checking accounts ☐ Yes ☐ No Who owns this? _____	$ _____	
Savings accounts ☐ Yes ☐ No Who owns this? _____	$ _____	
Vehicles ☐ Yes ☐ No Who owns this? _____	$ _____	
Property other than your home ☐ Yes ☐ No Who owns this? _____	$ _____	
Certificates of Deposit (CDs) ☐ Yes ☐ No Who owns this? _____	$ _____	
Annuities, Trusts, Stocks, Bonds, or Retirement Accounts ☐ Yes ☐ No Who owns this? _____	$ _____	
Life or burial insurance. ☐ Yes ☐ No Who owns this? _____	$ _____	
Money set aside for burial or pre-need contract ☐ Yes ☐ No Who owns this? _____	$ _____	
Safe deposit boxes ☐ Yes ☐ No Who owns this? _____	$ _____	
Other (Please describe in detail) ☐ Yes ☐ No Who owns this? _____	$ _____	

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APPENDIX E

Choosing a Health and Dental Plan

Most people on Medicaid or LaCHIP 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. You can look at information about the different Health and Dental Plans at **www.healthy.la.gov**. If you know which Health Plan or Dental Plan you want, please choose now. If you do not choose, and you need to be in a Health or Dental Plan, we will choose for you.

Which Plan is Right for You?

All Health Plans must offer the same medical coverage, as well as all Dental Plans. Some of the plans offer extra benefits. You can choose a different Health Plan and Dental Plan for each person approved for full Medicaid.

Choosing a Plan

1. When choosing a plan the first thing to consider is if your current provider is in that plan. Contact your doctors to find out what plans they accept.
2. For more information about the plans you can choose, visit **www.healthy.la.gov** or call **1-855-229-6848**.

NOTE: If you chose a Health Plan or Dental Plan for anyone please include this appendix with your application.

I choose the following plans for each person applying:

NAME OF PERSON APPLYING	SELECT A HEALTH AND DENTAL PLAN FOR THE PERSON APPLYING (Please select only ONE Health Plan and ONE Dental Plan per person)
	HEALTH PLANS ☐ Aetna Better Health of Louisiana ☐ AmeriHealth Caritas Louisiana ☐ Healthy Blue ☐ Humana Healthy Horizons in Louisiana ☐ Louisiana Healthcare Connections ☐ UnitedHealthcare Community Plan **DENTAL PLANS** ☐ DentaQuest ☐ MCNA Dental
	HEALTH PLANS ☐ Aetna Better Health of Louisiana ☐ AmeriHealth Caritas Louisiana ☐ Healthy Blue ☐ Humana Healthy Horizons in Louisiana ☐ Louisiana Healthcare Connections ☐ UnitedHealthcare Community Plan **DENTAL PLANS** ☐ DentaQuest ☐ MCNA Dental
	HEALTH PLANS ☐ Aetna Better Health of Louisiana ☐ AmeriHealth Caritas Louisiana ☐ Healthy Blue ☐ Humana Healthy Horizons in Louisiana ☐ Louisiana Healthcare Connections ☐ UnitedHealthcare Community Plan **DENTAL PLANS** ☐ DentaQuest ☐ MCNA Dental
	HEALTH PLANS ☐ Aetna Better Health of Louisiana ☐ AmeriHealth Caritas Louisiana ☐ Healthy Blue ☐ Humana Healthy Horizons in Louisiana ☐ Louisiana Healthcare Connections ☐ UnitedHealthcare Community Plan **DENTAL PLANS** ☐ DentaQuest ☐ MCNA Dental

If you have more people to include, visit www.medicaid.la.gov to download and print additional pages or make a copy of this page and complete.

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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.

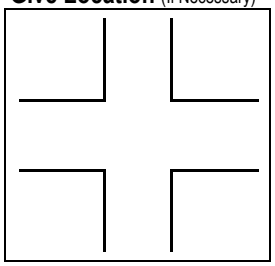
Reason for Application: ☐ New Voter Registration ☐ Updating Voter Registration

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) _____

9. Place of Birth CITY/TOWN: _____ STATE: _____ PARISH/COUNTY: _____ COUNTRY: _____

Mother's Maiden Name **10.** _____

11. Email _____

12. Phone Home: _____ Other: _____

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

14. Do you need assistance in voting? ☐ No ☐ Yes, Reason: _____

Last Residence Address **15.** HOUSE # & STREET: _____ CITY: _____ STATE: _____

16. Place of Last Registration STATE: _____ PARISH/ COUNTY: _____

17. Former Registered Name, if any _____

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.