

# LOUISIANA MEDICAID ELIGIBILITY

## FORMS CATALOG

This is a catalog of printed BHSF publications available for order from the Department of Administration Office of State Printing.



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STATE OF LOUISIANA  
OFFICE OF STATE PRINTING

www.doa.louisiana.gov/stateprinting

WAREHOUSE REQUISITION

(this block for internal use only)

PLEASE FILL OUT THIS FORM COMPLETELY. YOUR ORDER CANNOT BE PROCESSED WITHOUT A PHYSICAL STREET ADDRESS, PHONE NUMBER AND UPS NUMBER.

1

**DELIVER TO**

DHH—Medicaid Region 10  
1313 Mockinabird Lane  
Woodlawn, LA 71313

ATTENTION: Morticia A. DELIVERY ADDRESS PHONE NUMBER: (504)-635-1604

REQUISITIONED BY AND PHONE NUMBER OR IDENTIFY FROM DELIVER TO PERSON

UPS ACCOUNT NUMBER

2

7119E0

\*\*MUST HAVE UPS ACCOUNT NUMBER. FAILURE TO PROVIDE NUMBER WILL DELAY YOUR SHIPMENT UNTIL ONE IS PROVIDED\*\*

Check here if job is to be picked up from State Printing Warehouse. UPS account # not required if so.

5

07/04/2010

3

Herman Munster 225-749-1793

4

LINE #	FORM NUMBER	UNITS/PACKS ORDERED	REVISION DATE	FORM NAME
1	BHSF Flyer LTC	50	7-09	LTC Program flyer—Vietnamese
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				

6

SEND ORDERS TO

OFFICE OF STATE PRINTING  
P.O. BOX 94095  
BATON ROUGE, LA 70804-9095  
(225) 219-9570 • FAX (225) 219-9573

ORDERS MAY BE PICKED UP AT

OFFICE OF STATE PRINTING  
950 BRICKYARD LANE  
BATON ROUGE, LA 70802  
(225) 219-9570

DA 202 - BHSF  
Rev. 5/10

**DO NOT USE THE FORM POSTED ON THE DOA WEBSITE.** The form was revised specifically for BHSF. Always access the form through the BHSF Portal or this Catalog.

1

**DELIVER TO:** Fill in the information on the person who should receive the printed documents. Fill in the office name, complete physical address (no P. O. Boxes), attention line and recipient's phone number.

2

**UPS ACCOUNT NUMBER:** Always use: 7119E0. Do not use this account for any purpose other than ordering forms.

3

**REQUISITIONED BY AND PHONE NUMBER:** Fill in name and phone number of person placing the order.

4

All items in this section are found in the FORMS CATALOG.

**NOTE: UNITS/PACKS ORDERED** – This is the quantity of forms packaged together as a unit. **EXAMPLE:** If the order is for 1,000 total forms, and the catalog shows that the form comes packaged 50 per UNITS/PACKS then the number to be entered in this field is  $1,000 \div 50$  or "20."

5


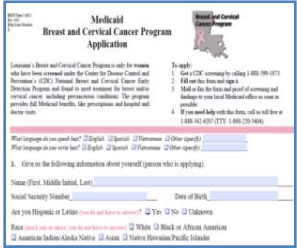




**DATE:** Fill in date you fax the order to DOA.


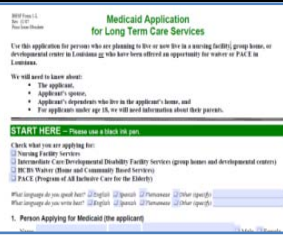



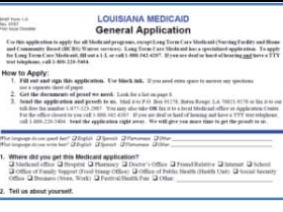
6



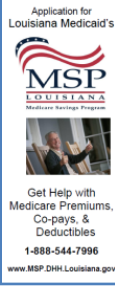

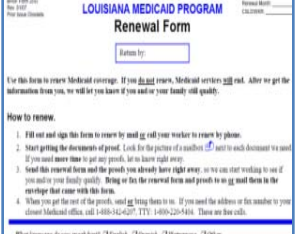
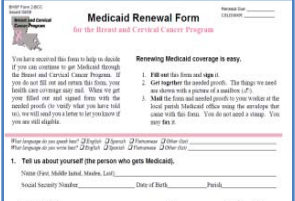
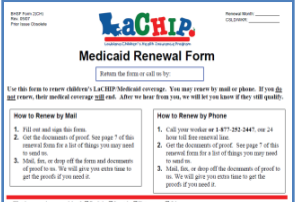
**SEND ORDERS TO:** Fax the order form to: 225.219.9573.

- Local Medicaid Eligibility offices should place orders directly with DOA Office of State Printing. Orders should only be placed by designated staff.
- Effective July 1, 2010, local Offices are not billed for the cost of forms or shipping.
- Revisions to the *Forms Catalog* will not be formally issued. It is recommended that you always access the catalog through the Portal or a saved link (e.g. from “My Favorites”).
- Please minimize the number of orders by placing periodic orders (monthly or bi-monthly). This reduces shipping costs.
- If outreach partners contact you for a large quantity of forms please contact the State Outreach Coordinator at: [coveringkids@la.gov](mailto:coveringkids@la.gov).
- Maximum order thresholds will be placed on some forms. You will be notified by DOA to seek approval from the Policy Section for these orders. Contact [Eligibility Policy Section](#) to seek approval for these large orders.
- Questions about orders placed or availability of forms:
  - Betty Zumo: 225.219.9582.
  - Backup: 225.219.9589.
- Forms that are not found in this Forms Catalog may also be printed. To check availability, contact:
  - [Eligibility Policy Section](#) OR
  - Edward Fowler: 225-342-3002

*Suggestions for this Catalog?*  
Send to [Eligibility Policy Unit](#)

	<p><b>BREAST AND CERVICAL CANCER FLYER</b>                  FORM NUMBER: BHSF B/CC Program                  UNITS/PACKS ORDERED: 100  <a href="#">Breast and Cervical Cancer Flyer—English</a> Rev. Mar 2009</p>
	<p><b>BREAST/CERVICAL CANCER PROGRAM—APPLICATION</b>                  FORM NUMBER: BHSF 1 BCC                  UNITS/PACKS ORDERED: 50  <a href="#">Breast and Cervical Cancer Application—English</a> Rev. Jun 2005</p>
	<p><b>CHANGE OF ADDRESS FORM</b>                  FORM NUMBER: BHSF ADDRESS CHANGE                  UNITS/PACKS ORDERED: 100  <a href="#">Change of Address—English</a> Rev. Sept 2007</p>
 <p>(black &amp; white)</p>	<p><b>FAMILY OPPORTUNITY ACT MEDICAID BUY-IN PROGRAM—COVER AND APPLICATION (B&amp;W)</b>                  FORM NUMBER: BHSF 1 FOA                  UNITS/PACKS ORDERED: 50  <a href="#">FOA BUY-IN Program—Cover &amp; Application—English</a> Rev. April 2010  <a href="#">FOA BUY-IN Program—Cover &amp; Application—Spanish</a> Rev. Jul 2009  <a href="#">FOA BUY-IN Program—Cover &amp; Application—Vietnamese</a> Rev. Jul 2009</p>
	<p><b>FRIENDS AND FAMILY TRANSPORTATION FLYER</b>                  FORM NUMBER: BHSF FLYER FRIEN/FAM                  UNITS/PACKS ORDERED: 100  <a href="#">Friends &amp; Family Transportation Program Flyer – English</a> Rev. Feb 2008</p>
	<p><b>LACHIP APPLICATION</b>                  FORM NUMBER: BHSF 1 CH                  UNITS/PACKS ORDERED: 50  <a href="#">LaChip Application—English</a> Rev. April 2010  <a href="#">LaChip Application—Spanish</a> Rev. April 2010  <a href="#">LaChip Application—Vietnamese</a> Rev. April 2010</p>

	<p><b>LAMOMS—COVER AND APPLICATION</b>                  FORM NUMBER: BHSF 1-PW                  UNITS/PACKS ORDERED: 50  <a href="#">LaMOMS Cover and Application—English</a> Rev. April 2010  <a href="#">LaMOMS Cover and Application—Spanish</a> Rev. April 2010  <a href="#">LaMOMS Cover and Application—Vietnamese</a> Rev. April 2010</p>
	<p><b>LONG TERM CARE—APPLICATION</b>                  FORM NUMBER: BHSF 1 L                  UNITS/PACKS ORDERED: 400  <a href="#">LONG TERM CARE Application</a> Rev. Nov 2007</p>
	<p><b>LONG TERM CARE CHOICE FLYER</b>                  FORM NUMBER: BHSF Fly/LTC Choice                  UNITS/PACKS ORDERED: 100  <a href="#">LONG TERM CARE CHOICE FLYER—English</a> Rev. Sept 2007</p>
	<p><b>LONG TERM CARE PROGRAM FLYER</b>                  FORM NUMBER: BHSF Flyer LTC                  UNITS/PACKS ORDERED: 50  <a href="#">LTC Program flyer—English</a> Rev. April 2008</p>
	<p><b>LOUISIANA'S MEDICAID PROGRAM FLYER</b>                  FORM NUMBER: BHSF Flyer Med. Prog                  UNITS/PACKS ORDERED: 100  <a href="#">La's Medicaid Program flyer—English</a> Rev. Oct. 2008</p>
	<p><b>MEDICAID PROGRAM GENERAL APPLICATION</b>                  FORM NUMBER: BHSF 1 G                  UNITS/PACKS ORDERED: 200  <a href="#">Medicaid Program General Application—English</a> Revised July 2007  <a href="#">Medicaid Program General Application—Spanish</a> Revised Sept 2007  <a href="#">Medicaid Program General Application—Vietnamese</a> Revised May 2008</p>

 <p>Do you have a <b>disability</b>? Do you <b>work</b>? Do you need <b>healthcare coverage</b>?</p> <p><b>Medicaid Purchase Plan</b> for workers with disabilities 1-888-544-7996</p>	<p><b>MEDICAID PURCHASE PLAN—COVER &amp; APPLICATION</b> FORM NUMBER: BHSF 1MPP UNITS/PACKS ORDERED: 50 <a href="#">MPP-Medicaid Purchase Plan—Cover &amp; App—English</a> Rev. June 2009</p>
	<p><b>MEDICAID 7 PROGRAM FLYER</b> FORM NUMBER: BHSF 7 PROGRAM FLYER UNITS/PACKS ORDERED: 200 <a href="#">Medicaid 7 Program Flyer</a> Rev. June 2010</p>
 <p>Application for Louisiana Medicaid's <b>MSP LOUISIANA</b> Medicare Savings Program</p> <p>Get Help with Medicare Premiums, Co-pays, &amp; Deductibles 1-888-544-7996 www.MSP.DHH.Louisiana.gov</p>	<p><b>MEDICARE SAVINGS PROGRAM—COVER AND APPLICATION</b> FORM NUMBER: BHSF 1-MB UNITS/PACKS ORDERED: 50 <a href="#">MSP-Medicare Savings Program—Cover &amp; App—English</a> Rev. Oct. 2008</p>
 <p><b>Notice of Privacy Practices</b></p> <p>©Louisiana Blue April 20, 2009</p>	<p><b>NOTICE OF PRIVACY PRACTICE FLYER</b> FORM NUMBER: HIPAA 101P UNITS/PACKS ORDERED: 50 <a href="#">HIPAA Notice of Privacy Practice flyer—English</a> Rev. Apr. 2003 <a href="#">HIPAA Notice of Privacy Practice flyer—Spanish</a> Rev. Apr. 2004 <a href="#">HIPAA Notice of Privacy Practice flyer—Vietnamese</a> Rev. Feb. 2005</p>
 <p><b>LOUISIANA MEDICAID PROGRAM Renewal Form</b></p> <p>How to renew:</p> <ol style="list-style-type: none"> <li>Fill out and sign this form to renew by mail or call your provider to renew by phone.</li> <li>Start getting the documents of proof. Look for the picture of a mailbox. Send to each document we send. If you need more time to get our proofs, let us know right away.</li> <li>Send this renewal form and the proofs you already have right away, so we can start working to send if you and/or your family qualify. Being or less the renewal form and proofs to us go mail them in the envelope that came with this form.</li> <li>When you get the rest of the proofs, send us things later to us. If you need the address or the number to your closest Medicaid office, call 1-888-544-7996, TTY: 1-888-229-5416. There are fax calls.</li> </ol> <p>What language do you speak best? <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other</p>	<p><b>RENEWAL FORM FOR ANY PROGRAM FLYER</b> FORM NUMBER: BHSF 2 (G) UNITS/PACKS ORDERED: 200 <a href="#">Renewal Form for any Program—English</a> Rev. Jan. 2007</p>
 <p><b>Medicaid Renewal Form for Breast and Cervical Cancer Program</b></p> <p>Renewing Medicaid coverage is easy.</p> <ol style="list-style-type: none"> <li>Fill out this form and sign it.</li> <li>Get together the needed proofs. The things we need are shown with a picture of a mailbox (P. 1).</li> <li>Mail the form and needed proofs to your broker or the local parish Medicaid office using the envelope that came with this form. You do not need a stamp. You are not charged.</li> </ol> <p>1. Tell us about yourself (the person who gets Medicaid): Name (First, Middle Initial, Middle Last, Last) _____ Social Security Number _____ Date of Birth _____ Period _____ Mailing Address _____ City _____ State _____ Zip _____</p>	<p><b>RENEWAL FORM FOR BREAST AND CERVICAL CANCER PROGRAM</b> FORM NUMBER: BHSF 2BCC UNITS/PACKS ORDERED: 50 <a href="#">Renewal form—Breast &amp; Cervical Cancer Prog.—English</a> Rev. Apr. 2006</p>
 <p><b>Medicaid Renewal Form</b></p> <p>How to Renew by Mail:</p> <ol style="list-style-type: none"> <li>Fill out and sign this form.</li> <li>Get the documents of proof. See page 1 of this renewal form for a list of things you may need to provide.</li> <li>Mail, fax, or drop off the form and documents of proof to us. We will give you extra time to get the proofs if you need it.</li> </ol> <p>How to Renew by Phone:</p> <ol style="list-style-type: none"> <li>Call your broker at 1-877-352-2447, ext. 24 from toll free number line.</li> <li>Get the documents of proof. See page 1 of this renewal form for a list of things you may need to provide.</li> <li>Mail, fax, or drop off the documents of proof to us. We will give you extra time to get the proofs if you need it.</li> </ol> <p>What language do you speak best? <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other</p>	<p><b>RENEWAL FORM FOR LaCHIP/CHAMP CHILD</b> FORM NUMBER: BHSF 2CH UNITS/PACKS ORDERED: 100 <a href="#">Renewal Form for LaCHIP/CHAMP Child—English</a> Rev. May 2007</p>

**Medicaid Purchase Plan**  
Renewal Form

What language do you speak best?  English  Spanish  Vietnamese  Other (specify) \_\_\_\_\_  
What language do you write best?  English  Spanish  Vietnamese  Other (specify) \_\_\_\_\_

"We can provide an interpreter at no cost to you, if you do not speak English!"

This form is used to continue getting Medicaid through the Medicaid Purchase Plan. Please fill out EVERY item on this form. If you are unable to answer a question in terms of "Yes" "No" "FRAGILE" please a receipt for ANY item, USE A SEPARATE SHEET.

1. Tell us where YOU are, where YOU live, and where YOU get your mail:

Name \_\_\_\_\_  
Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Parish \_\_\_\_\_ Home Phone # \_\_\_\_\_ Daytime Phone # \_\_\_\_\_

**RENEWAL FORM FOR MEDICAID PURCHASE PLAN**

FORM NUMBER: BHSF 2MPP

UNITS/PACKS ORDERED: 100

[Renewal Form for Medicaid Purchase Plan—English](#) Rev. Dec. 2004

**TAKE CHARGE**  
Family Planning Waiver Renewal

Renewal Form

Fill out this form to renew your coverage for family planning waiver services. If you do not renew, your coverage will end. You may request to reach this office, via phone.

**How to Renew:**

Do not: Fill out and sign this form. Return the form and signed proof (see page 2) in the envelope provided. If you cannot sign on any services, use a separate sheet of paper.

Do not: Fill out and sign this form. Fill out and mail (proof) (see page 2) to the fax number on the letter that came with this form or to 1-877-452-2467.

Do not: Call the number on the top of this form or call (504)635-4247 (toll-free) through Friday 8:00 A.M. to 4:00 P.M. From 1 to 4 English and then for no operators who can transfer you to your number. You may speak to your number directly.

To renew: Call the above Medicaid office or Application Center. For the office closer to you, call 1-800-452-2467. From an out-of-state location, call 1-800-452-2467.

What language do you speak best?  English  Spanish  Vietnamese  Other (specify) \_\_\_\_\_  
What language do you write best?  English  Spanish  Vietnamese  Other (specify) \_\_\_\_\_

**RENEWAL FORM FOR TAKE CHARGE**

FORM NUMBER: BHSF 2 FP

UNITS/PACKS ORDERED: 100

[Family Planning Take Charge Renewal](#) Rev. July 2007

**Louisiana Medicaid Program**  
SSI Recipient Application

Long Term Facility Care, Home and Community Based Services (HCBS), or Program of All Inclusive Care for the Elderly (PACE)

What language do you speak best?  English  Spanish  Vietnamese  Other (specify) \_\_\_\_\_  
What language do you write best?  English  Spanish  Vietnamese  Other (specify) \_\_\_\_\_

1. Name of Applicant (person who needs long-term facility care, Home and Community Based services or PACE): \_\_\_\_\_

Home State (include federal, state, and territory): \_\_\_\_\_ Date of birth: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Married (single)  Single  Married  Divorced  Widowed

Is the person in need of long-term care a Veteran?  Yes  No  Yes, VA Claim

Residential status: \_\_\_\_\_

Residence address: \_\_\_\_\_

**SSI RECIPIENT—LONG TERM CARE—APPLICATION**

FORM NUMBER: BHSF 1L SSI

UNITS/PACKS ORDERED: 200

[SSI Recipient—Long Term Care—Care Application](#) Rev. Dec. 2005

**Application For**

**TAKE CHARGE**

Family Planning Waiver Services

Helping Women Ages 19-44 TAKE CHARGE of Their Lives

1-800-342-6207

Apply Online at [www.louisiana.gov](#)

Louisiana Department of Health & Hospitals

**TAKE CHARGE Cover and Application**

FORM NUMBER: BHSF1-FP

UNITS/PACKS ORDERED: 50

[TAKE CHARGE—Cover & App—English](#) Rev. April 2010

[TAKE CHARGE—Cover & App—Spanish](#) Rev. May 2010

[TAKE CHARGE—Cover & App—Vietnamese](#) Rev. April 2010