

Medicaid Application for Long Term Care Services

Use this application for persons who are planning to live or now live in a nursing facility, group home, or developmental center in Louisiana or who have been offered an opportunity for Waiver or PACE in Louisiana.

We need to know about:

- The applicant,(the person in need of Medicaid)
- Applicant's spouse,
- Applicant's dependents who are under 18 and who live in the applicant's home, and
- For applicants under age 18, we will need information about their parents.

START HERE – Please use a black ink pen.

Check what you are applying for:

- Nursing Facility Services
- Intermediate Care/Developmental Disability Facility Services (group homes and developmental centers)
- HCBS Waiver (Home and Community Based Services)
- PACE (Program of All Inclusive Care for the Elderly)

What language do you speak best? English Spanish Vietnamese Other (specify) _____

What language do you write best? English Spanish Vietnamese Other (specify) _____

1. Person Applying for Medicaid (the applicant)

Name _____ Male Female
First Middle Initial Last Maiden Name

Home Address _____
Street Address Apartment/Lot Number

City State Zip Code

Mailing Address (if different) _____
P.O. Box or Street Address Apartment/Lot Number

City State Zip Code

Parish _____ Home Phone Number (_____)

Daytime Phone Number (_____) Cell Phone Number (_____)

E-mail Address _____

Date of Birth _____ Single Married Separated Divorced Widowed

Social Security Number _____ Medicare Claim Number _____

Louisiana Resident? Yes No Veteran? Yes No U.S. Citizen? Yes No

If **not a U.S. citizen**, are they a lawful permanent resident? Yes No Date Granted Residency _____

Permanent Resident Card Number : A _____

Race or Ethnic Background (you do not have to answer; you may mark one or more): White Black Asian

Hispanic American Indian or Alaska Native Native Hawaiian or Pacific Islander

Latino? (optional) Yes No

2. A. Does the applicant have someone helping them with their business affairs including this Medicaid application? Yes – Fill Out Below No – Go to Question B

Name _____

E-mail Address _____

Mailing Address _____
P.O. Box or Street Address Apartment/Lot Number

City State Zip Code

Daytime Phone Number (_____) Cell Phone Number (_____)

Relationship to Applicant _____

Questions - Call 1-888-342-6207

(TTY text telephone for deaf and hard of hearing: 1-800-220-5404)

B. Does anyone have power of attorney for handling the applicant's business affairs, or is anyone the curator or under curator? Yes – Fill Out Below No – Go to Question 3

Give us information about this person. Check one: Power of Attorney Curator or Under Curator
If they are the same person listed in Question A above, check this box and go to Question 3.

Name _____

E-mail Address _____

Mailing Address _____

P.O. Box or Street Address

Apartment/Lot Number

City

State

Zip Code

Daytime Phone Number (_____) _____ Cell Phone Number (_____) _____

Relationship to Applicant _____

3. To what address should Medicaid send the applicant's mail? Applicant Someone Listed in Question 2
(give name) _____

Answer Question 4 if applying for nursing facility services or Intermediate Care/Developmental Disability Facility Services (group homes and developmental centers).

4. A. Check box that fits the applicant's current situation – Lives in a Facility Plans to Enter a Facility

B. Facility Name _____

Date Entered or Date Planning to Enter _____

C. Is the applicant expected to be in the facility for at least 30 days? Yes No

D. Where was the applicant living **before** they entered the facility?

Their Home Someone Else's Home Rented Other (specify) _____

E. Does the applicant own their home? Yes No If yes, does anyone live in the home? Yes No

If yes, who lives in the home: Spouse Child Parent Brother/Sister

Someone Else (give name) _____

Is this person paying rent to live there? Yes No How much is paid every month? \$ _____

F. If the applicant is medically able to leave the facility, where would they live? Return to Their Home

Somewhere Else (specify) _____

Answer Question 5 if applying for HCBS waiver services (Home and Community Based Services).

5. Has the applicant been offered a Home and Community Based Waiver Slot? Yes No **If yes**, what type of HCBS waiver is the applicant applying for? Adult Day Health Care Children's Choice New Opportunities Elderly/Disabled Adult Other (specify) _____

Name of Support Coordination Agency _____

Is the applicant expected to get HCBS waiver services for at least 30 days? Yes No

Answer Question 6 if applicant is under age 65 and has a disability.

6. Was the disability caused by an accident? Yes No

When did the disability start? _____

What is the disability? Give us information about it. _____

Has the applicant ever applied for Social Security Disability or Supplemental Security Income (SSI) benefits?
 Yes No If yes, has a decision been made? Yes No

List the doctors, hospitals or other medical providers who give care to the applicant and can give us medical records to support their medical condition. **If more space is needed, use another sheet of paper.**

Name of Doctor, Hospital or Other Medical Provider	Medical Provider's Address and Phone Number

7. Did the applicant move to Louisiana from another state? Yes No If yes, when did the applicant move to Louisiana _____ Does the applicant plan to stay in Louisiana? Yes No
8. **A.** Was the applicant living with their legal spouse prior to entering the nursing home? Yes No **If yes, do you wish to apply for Medicaid for this spouse?** Yes No
- B.** Give us information about the applicant's living, deceased, or divorced spouse(s).

Spouse's Name (First, Maiden, Last)	Social Security Number	Date of Birth	Date of Death	Divorced from Applicant
_____ Is this individual a: <input type="checkbox"/> Railroad Retiree <input type="checkbox"/> Veteran	____-____-____		Date of Death: Has a succession been opened? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No Date and Parish/County of Divorce:
_____ Is this individual a: <input type="checkbox"/> Railroad Retiree <input type="checkbox"/> Veteran	____-____-____		Date of Death: Has a succession been opened? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No Date and Parish/County of Divorce:

C. If the applicant is under age 18, does he live with his parents (or did he live with them before going to the nursing home, group home, or developmental center)? Yes No Give us information about the parents below.

Name _____ Social Security Number _____
first, maiden, last

Name _____ Social Security Number _____
first, maiden, last

Is any parent listed above a veteran? Yes No Who? _____

Answer Questions D and E if applying for nursing facility services or Intermediate Care/Developmental Disability Facility Services (group homes and developmental centers).

D. Does the applicant have children under age 18 living with them now or before going to the nursing home, group home, or developmental center? Yes No Give us information about the children below.

Full Name _____ Social Security Number _____ Date of Birth _____

Full Name _____ Social Security Number _____ Date of Birth _____

E. Does the applicant wish to give any of his income to anyone listed in **B** and/or **D**? Yes No

9. Tell us about the income of the applicant, the applicant's spouse, the applicant's parents or the applicant's children under age 18.

Income Type	Who is the income for?	Where is it from? Who pays it?	How often is it received?	Gross Amount
Social Security	<input type="checkbox"/> Yes <input type="checkbox"/> No			
SSI	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Veteran's Benefits	<input type="checkbox"/> Yes <input type="checkbox"/> No	VA File Number:		
Railroad Retirement	<input type="checkbox"/> Yes <input type="checkbox"/> No	Claim Number:		
Retirement/Pension	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Annuities	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Royalties	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Money from Friends/ Relatives	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Reverse Annuity Mortgage	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Rental Income	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Worker's Comp Unemployment	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Alimony/ Child Support	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Other (specify):	<input type="checkbox"/> Yes <input type="checkbox"/> No			

10. Has the applicant, applicant's spouse, applicant's parents or applicant's children under age 18 applied for income, such as Social Security or Veteran's benefits, but did not get it yet? Yes No
 If yes, who applied Applicant Spouse Parent Child What type of income? _____

11. Is the applicant eligible to get benefits like Social Security, Veteran's benefits, or another type of income from anyone living or deceased? Yes – Fill Out Below No - Go to Question 12
 From who? Spouse Parent **To show more than one spouse or parent, use another sheet of paper.**
 Name _____ Social Security Number _____
 Date of Birth _____ Veteran: Yes No Deceased: Yes No Date of Death _____

12. Does the applicant, applicant's spouse, applicant's parents or applicant's children under age 18 work or are they self-employed? Yes – Fill Out Below No – Go to Question 13

Name of Employee	Employer's Name and Phone Number	Self-employed?	Gross Amount	How often is it received?
		<input type="checkbox"/> Yes <input type="checkbox"/> No		
		<input type="checkbox"/> Yes <input type="checkbox"/> No		

13. Has the applicant, their parents, or spouse ever received any lump sum of money like an insurance or lawsuit settlement, worker's compensation settlement, inheritance, or a Social Security payment or are they expecting to receive a lump sum? Yes – Fill Out Below No – Go to Question 14
 Who? _____ Amount \$ _____
 When? _____ From whom? _____
 For what reason? _____
 Attorney's Name, Address, and Phone Number _____

14. Tell us if the applicant, applicant's spouse, or the applicant's parents have any of the things listed or if they have access to these things. **You must answer questions A through N and provided the requested information.**

A. Bank Accounts and Certificates of Deposit (CDs): Yes – Fill Out Below No – Go to B
If more than 4, use another sheet of paper.

Type of Account	Who does it belong to?	Name of Bank or Credit Union	Account Number	How much is in it?
<input type="checkbox"/> checking <input type="checkbox"/> savings <input type="checkbox"/> Christmas club <input type="checkbox"/> CD				
<input type="checkbox"/> checking <input type="checkbox"/> savings <input type="checkbox"/> Christmas club <input type="checkbox"/> CD				
<input type="checkbox"/> checking <input type="checkbox"/> savings <input type="checkbox"/> Christmas club <input type="checkbox"/> CD				
<input type="checkbox"/> checking <input type="checkbox"/> savings <input type="checkbox"/> Christmas club <input type="checkbox"/> CD				

B. Annuities and/or Retirement Accounts (IRA, Keogh, 401-K): Yes – Fill Out Below No – Go to C

Who does it belong to? Applicant Spouse Applicant and Spouse Parent(s)
 Account Number(s) _____
 How much is in it? _____
 Are regular payments being received? Yes No
 How much? \$ _____ How often? _____
 If **no**, are regular payments available? Yes No Don't Know
 Can a lump sum withdrawal of these funds be made? Yes No Don't Know
 Date of Purchase of Annuity _____
 Who is the beneficiary of the annuity? _____
 Who is the remainder beneficiary of the annuity? _____

C. Patient Fund Account at Nursing Facility: Yes – Balance \$ _____ No – Go to **D**

D. Cash on Hand or Held by Someone Else: Yes – Fill Out Below No – Go to **E**

Amount \$ _____ Who does it belong to? Applicant Spouse Applicant and Spouse Parent(s)
Who is holding this cash? _____
Where did this cash come from? _____

E. Safe-Deposit Box(es): Yes – Fill Out Below No – Go to **F**

Who does it belong to? Applicant Spouse Applicant and Spouse Parent(s)
Name of the Bank or Credit Union _____
What is inside the box or boxes? _____

What are the things inside the box worth? _____

F. Stocks: Yes – Fill Out Below No – Go to **G**

Who does it belong to? Applicant Spouse Applicant and Spouse Parent(s)
How much is the stock(s) worth? _____
What is the name of the company? _____

G. Bonds: Yes – Fill Out Below No – Go to **H**

Who does it belong to? Applicant Spouse Applicant and Spouse Parent(s)
What is the bond worth? _____
Bond Number(s) _____
What type of bond is it? _____

H. Cars, Trucks, Boats, Campers, Motorcycles, ATVs (All Terrain Vehicles): Yes – Fill Out Below
 No – Go to **I** *If more than 3, use another sheet of paper.*

Owner	What is it?	Make, Model, Year	What is it worth?	How much is owed on it?

I. Home Property: Yes – Fill Out Below No – Go to **J**

Who does it belong to? Applicant Spouse Applicant and Spouse Parent(s) Others
Give us information about it like the address, lot size or number of acres, and if there are buildings on it:

How much is it worth? _____
How much is owed on it? _____

J. Property that is Not the Primary Home – such as a second home, land, out of state property, or inherited property (divided or undivided share): Yes – Fill Out Below No – Go to **K**

Who does it belong to? Applicant Spouse Applicant and Spouse Parent(s)
How much is it worth? _____
Who gets the tax notice? _____
What is their interest or share in the divided/undivided property? _____
How much is owed on it? _____
Give us information about it like the address, lot size, number of acres, and if there are buildings on it. _____

K. Money in a Bank Account(s) set aside for Burial Yes – Fill Out Below No
Pre-arranged Burial Contract with a Funeral Home: Yes – Fill Out Below No – Go to L

Who owns it?	Whose burial?	Bank/Credit Union/Funeral Home	How much is it worth?

If more than 2, use another sheet of paper.

L. Life or Burial Insurance: Yes – Fill Out Below No – Go to M *If more than 6, use another sheet of paper.*

Name of Insured	Owner of Policy	Insurance Company	Face Value	Policy Number

M. Burial Space Items (cemetery plot, grave site, crypt, mausoleum, vault, casket, urn, niche or other repository, burial markers, headstones, and costs for opening/closing grave that are not covered in a pre-arranged burial contract): Yes – Fill Out Below No – Go to N

Who owns it? Applicant Spouse Applicant and Spouse Parent(s)

What is it? _____

Whose burial is it for? Applicant Spouse Parent(s) Is it paid in full? Yes No

N. Is there anything else that is owned? Yes – Fill Out Below No – Go to Question 15

Who owns it? Applicant Spouse Applicant and Spouse Parent(s)

What is it? _____

How much is it worth? _____

Give us information about it. _____

15. A. Does the applicant, the applicant’s spouse, or the applicant’s parents have their name on **someone else’s** bank or credit union account? Yes No

B. Does **anyone else** have a bank or credit union account that has money in it belonging to the applicant, the applicant’s spouse, or the applicant’s parents? Yes No

If **yes** to **A** or **B**, answer the questions below.

Whose name is on the account? _____

Whose money is in the account? _____

How much money is in the account? _____ Account Number: _____

How much belongs to the applicant? _____

How much belongs to the applicant’s spouse? _____

How much belongs to the applicant’s parent(s)? _____

What is the name of the bank or credit union? _____

16. Has the applicant, their spouse, or parents ever created a trust, placed any items in trust, or had a trust set up for them? Yes No **(What is a trust?** – A trust is a legal relationship in which a person called a “trustee” holds money or other assets for the benefit of another, the “beneficiary”. The trust must be valid under State law. The trust document will specify how the assets and money in trust will be handled. It can be set up by a will.)

17. Does the applicant, their spouse, or children under age 18 have any paid or unpaid medical bills for services received in the last 3 months? Yes No If yes, how much? \$ _____

How much does the applicant, their spouse, or children under age 18 pay for prescriptions each month (best guess or average)? \$ _____

18. Has the applicant, their spouse, or anyone acting for them **ever** given away, sold, cashed in, or changed the name listed on a policy or deed for any item of value such as land, houses, home property, life or burial insurance, vehicles, or bank accounts? Yes – Fill Out Below No – Go to Question **19**
If more than 2 things or if more space is needed, use another sheet of paper.

What was it? What was it worth?	Why?	When did this happen?	Who received the item?	If recorded, tell us when and where.	What was received in return? (Amount of money or value of item.)	What happened to the money or item that was received?

19. Give us information about the applicant’s health insurance, Medicare supplement, and Medicare Prescription Drug Plan. No Insurance
For more space, use another sheet of paper.

What is it?	Policyholder	Insurance Name and Phone Number	Coverage Start Date	What does it cover?	Policy Number	Group Number	Cost per Month
<input type="checkbox"/> Medicare supplement <input type="checkbox"/> Medicare drug plan <input type="checkbox"/> Health insurance				<input type="checkbox"/> Hospital <input type="checkbox"/> Doctor <input type="checkbox"/> Dental <input type="checkbox"/> Ambulance <input type="checkbox"/> Medicine <input type="checkbox"/> Cancer only			
<input type="checkbox"/> Medicare supplement <input type="checkbox"/> Medicare drug plan <input type="checkbox"/> Health insurance				<input type="checkbox"/> Hospital <input type="checkbox"/> Doctor <input type="checkbox"/> Dental <input type="checkbox"/> Ambulance <input type="checkbox"/> Medicine <input type="checkbox"/> Cancer only			
<input type="checkbox"/> Medicare supplement <input type="checkbox"/> Medicare drug plan <input type="checkbox"/> Health insurance				<input type="checkbox"/> Hospital <input type="checkbox"/> Doctor <input type="checkbox"/> Dental <input type="checkbox"/> Ambulance <input type="checkbox"/> Medicine <input type="checkbox"/> Cancer only			

20. Does the applicant have Long Term Care Partnership Insurance? Yes No

Comments from Medicaid Staff/Applicant/Applicant’s Representative:

Person Making Comments Signs Here: _____ **Date** _____

Your Rights and Responsibilities

WHAT MEDICAID HAS THE RIGHT TO EXPECT OF YOU (the person applying for Medicaid)

CITIZENSHIP AND IMMIGRATION STATUS: You state that the information about citizenship and immigration status given at the beginning of this application form is true and correct.

REPORTING THE TRUTH: You state that the information you give on this application form is true and correct. You understand if you purposely give information that is not true or if you purposely do not tell information that you are supposed to, you may get health benefits that you should not get. If that happens, you can by law be punished for fraud. Also, you may have to pay money back to Medicaid for the bills it paid by mistake.

VERIFICATION OF INFORMATION: You understand that the information you give will be checked. You agree to help with this and let Medicaid get information it needs from government agencies, employers, medical providers, and others.

SOCIAL SECURITY NUMBERS: You understand Social Security numbers will only be used to get information from other government agencies to make a decision about your eligibility for Medicaid.

PAYMENT OF MEDICAL CARE BY A THIRD PARTY: You understand by accepting Medicaid, the Department has the right to get money received by you from other sources like insurance payments or lawsuit settlements for services that Medicaid has paid for you.

REPORTING CHANGES: You agree to tell Medicaid within 10 days of these changes: 1) if you move out of state; 2) changes in mailing or home address; 3) if anyone moves in or out of your home; 4) changes in health insurance and premiums; 5) changes in income; and 6) changes in things you own.

CHILD SUPPORT ENFORCEMENT: You understand that Medicaid will only send information to Child Support Enforcement for medical support if you ask them to.

ANNUITIES: You agree that by accepting Medicaid, the State of Louisiana will be named as the remainder beneficiary of all annuities purchased on or after Feb. 8, 2006 for the total amount of medical assistance paid on your behalf, unless you have a spouse, minor child, or a child with a disability. In these cases, the State must be named as beneficiary after these individuals. You agree to tell Medicaid about any annuity you and your spouse own or co-own regardless if the annuity is irrevocable (cannot be changed) or Medicaid counts it. You understand that you must tell Medicaid about changes made to any annuity which may affect when payments begin, the amount paid, frequency of payments, and additions to the principal.

WHAT YOU (the person applying for Medicaid) HAVE THE RIGHT TO EXPECT FROM MEDICAID

RIGHT TO A FAIR HEARING: You understand that you can ask for a Fair Hearing if you think any decision made on the case is unfair, incorrect, or made too late.

NO DISCRIMINATION: You understand Medicaid cannot treat you differently because of race, color, sex, age, disability, religion, nationality, or political belief. If you think it has, you can call the U.S. DHHS Regional Office for Civil Rights in Dallas, TX at 1-800-368-1019 or write to Louisiana's Department of Health & Hospitals, Human Resources at P. O. Box 4818 Baton Rouge, LA 70821-4818.

OTHER SERVICES: You understand Medicaid will send you information about WIC, KIDMED, and other Medicaid services.

ESTATE RECOVERY: You understand that Estate Recovery rules require the Department to recover the cost of certain Medicaid payments from your estate. These costs include the total amount of payments for facility services, waiver services, hospital care, and prescription drugs received at age 55 or older by LTC and/or HCBS recipients. The Department will not make a claim against the estate while you or your legal spouse is still living or if you have a dependent child who is under age 21, blind, or disabled. Collection may not be made if it is not cost effective for the Department to do so, or if your heirs apply for a hardship waiver after your death and the hardship waiver is granted by the Department. A hardship may exist if the estate property is the only source of income for the heirs, if that income is limited, or other extenuating circumstances.

↓ **SIGN BELOW** ↓

Applicant or Representative Signs Here: _____ **Date** _____

Applicant's Spouse Signs Here: _____ **Date** _____

If anyone signs with an "X", two witnesses must sign.

_____ **Date** _____ **Date** _____

If Medicaid filled out this application, they will sign here. _____ **Date** _____

See next page for a list of documents you may need to send us.

Documents of Proof We May Need From You

If someone from Medicaid interviewed you, then...

Please send the documents of proof marked with a check ✓ to the Medicaid office at:

_____ by _____. *You may keep this page and the next page.*

If you filled out the application, then...

Keep in mind **not** everything will apply. To help you decide what to send, enter a check ✓ next to each document of proof you think does apply. *You may keep this page and the next page.*

Let us know if you do not have or cannot get any of these documents of proof, because we may be able to get them or help you get them. Please trust that the information you give us on your application and everything you send us will be kept confidential. We are required by law to keep it private.

✓	What to send:	See Question
	Proof of applicant's marriage such as a marriage certificate (not needed if applicant's spouse gets Long Term Care Medicaid)	1
	Copy of Permanent Resident Card (green card) or other forms from U.S. Citizenship and Immigration Services - for applicant who <u>is not</u> a U.S. citizen	1
	Copy of legal documents to show power of attorney, curator, or interdiction	2
	If applicant is widowed, copy of succession documents	8
	Proof of income such as the 1099 from the last tax year, a check stub, or award letter showing amount of gross income (before withholdings) from retirement, pension, Veteran's Benefits, annuities, mineral rights, worker's compensation, child support, reverse annuity mortgages, and royalties - for applicant, applicant's spouse, applicant's parents (if applicant is under 18), and applicant's dependents under age 18	9
	If the applicant, applicant's spouse, or applicant's parents (if applicant is under 18) own property that is rented out, send proof of the amount of rental income received (letter from renters or cancelled check) and proof of expenses of rental property.	9
	Statement from friends and/or relatives who give money to applicant and/or their spouse	9
	For anyone who works, send pay stubs or letter from employer showing gross pay (before taxes) for the last month. If self-employed, send copies of tax return and all schedule attachments - for applicant, applicant's spouse, applicant's parents (if applicant is under 18), and applicant's dependents under age 18	12
	Proof of any lump sum payments received in the last three years from an insurance or lawsuit settlement, inheritance, worker's compensation settlement, or Social Security - for applicant, applicant's spouse, and applicant's parents (if applicant is under 18)	13
	Copies of bank statements for the last month. Send ALL pages showing the check images, account numbers, name and address of bank, all deposits and withdrawals, and all names on the accounts. - for applicant, applicant's spouse, and applicant's parents (if applicant is under 18)	14 A
	Copy of annuity and last bank statement - for applicant, applicant's spouse, and applicant's parents (if applicant is under 18)	14 B
	Last statement for certificates of deposit (CDs), IRAs, 401-Ks, Keoghs, and retirement accounts - for applicant, applicant's spouse, and applicant's parents (if applicant is under 18)	14 A, 14 B
	A list of what is inside any safe-deposit box. This must be a written statement by a bank employee or a sworn statement from someone who looked inside. - for applicant, applicant's spouse, and applicant's parents (if applicant is under 18)	14 E

✓	What to send:	See Question
	Copies of stocks and bonds, including any account statements - for applicant, applicant's spouse, and applicant's parents (if applicant is under 18)	14 F, 14 G
	Copies of vehicle registrations or titles if more than one vehicle is owned and proof of what is owed on each vehicle like a statement from creditor - for applicant, applicant's spouse, and applicant's parents (if applicant is under 18)	14 H
	For property that is owned (not their home) or property that has been inherited (can be undivided), send proof to show what it is worth and how much of a share they have - for applicant, applicant's spouse, and applicant's parents (if applicant is under 18)	14 J
	Copy of the last bank statement for burial or funeral accounts - for applicant, applicant's spouse, and applicant's parents (if applicant is under 18)	14 K
	Copies of pre-arranged burial contracts with funeral homes which includes a list of services - for applicant, applicant's spouse, and applicant's parents (if applicant is under 18)	14 K
	Copies of life or burial insurance policies if the face value for all is more than \$10,000 for each person - for applicant, applicant's spouse, and applicant's parents (if applicant is under 18)	14 L
	For any burial space items such as a mausoleum or cemetery plot that are not paid in full, send proof of how much is owed and how much the item(s) is worth - for applicant, applicant's spouse, and applicant's parents (if applicant is under 18)	14 M
	Copies of trust documents filed at the courthouse - for applicant, applicant's spouse, and applicant's parents (if applicant is under 18)	16
	Copies of paid or unpaid medical bills for services received in the last 3 months (if applying for Medicaid for those months) - for applicant, applicant's spouse, and applicant's parents (if applicant is under 18)	17
	Copy of the Act of Donation, Bill of Sale, or some other document to show items that were given away, sold, or deed was changed - for applicant, applicant's spouse, and applicant's parents (if applicant is under 18)	18
	Copies of front and back of all health insurance cards, including Medicare, long term care insurance, Medicare prescription drug plans, and Medicare supplements - for applicant Also, send proof of monthly premium amount.	19
	Other:	
	Other:	
	Other:	

Please mail, fax, or drop off the application and documents of proof to your local Medicaid office.

For the office closest to you, call 1-888-342-6207.

(TTY text telephone for deaf and hard of hearing: call 1-800-220-5404)

Department of Health and Hospitals
Voter Registration Declaration (Optional)

If you fill it out, your answers will not affect the benefits you get from the
Louisiana Department of Health and Hospitals.

If you are not registered to vote where you live now, would you like to apply to register to vote here today? Yes No

- If you checked "Yes," please complete the attached form called the "Louisiana Mail Voter Registration Application." You may mail your completed Voter Registration Application to your local Registrar of Voters listed on the application or mail it to the Department of Health and Hospitals.
- **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.

If you would like help in filling out the voter registration application form, we will help you. **You may call us toll-free at 1-888-342-6207.** The decision whether to seek or accept help is yours. You may fill out the application form in private.

If you choose to register to vote at this time, the information about the location where you completed the application to register will remain confidential and will only be used for voter registration purposes. If you choose not to register to vote, that information will also be kept confidential.

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:

Louisiana Secretary of State
Commissioner of Elections
P.O. Box 94125
Baton Rouge, LA 70804-9125
Phone: (toll-free) 1-800-883-2805

Print Your Name

Social Security Number

Date of Birth

Sign Your Name

Today's Date

ACADIA

Courthouse #115
Crowley, LA 70526-4363
(337) 788-8841

ALLEN

P. O. Box 150
Oberlin, LA 70655-0150
(337) 639-4966

ASCENSION

828 S. Irma Blvd. #205
Gonzales, LA 70737-3631
(225) 621-5780

ASSUMPTION

P. O. Box 578
Napoleonville, LA 70390-0578
(985) 369-7347

AVOYELLES

312 N. Main St. #E
Marksville, LA 71351-2409
(318) 253-7129

BEAUREGARD

P. O. Box 952
DeRidder, LA 70634-0952
(337) 463-7955

BIENVILLE

P. O. Box 697
Arcadia, LA 71001-0697
(318) 263-7407

BOSSIER

P. O. Box 635
Benton, LA 71006-0635
(318) 965-2301

CADDO

P.O. Box 1253
Shreveport, LA 71153-1253
(318)226-6891

CALCASIEU

1000 Ryan St. #7
Lake Charles, LA 70601-5250
(337)437-3572

CALDWELL

P. O. Box 1107
Columbia, LA 71418-1107
(318) 649-7364

CAMERON

P. O. Box 1
Cameron, LA 70631-0001
(337) 775-5493

CATAHOULA

P. O. Box 215
Harrisonburg, LA 71340-0215
(318) 744-5745

CLAIBORNE

507 W. Main Suite 1
Homer, LA 71040-3914
(318) 927-3332

CONCORDIA

4001 Carter St. #4
Vidalia, LA 71373-3021
(318) 3367770

DESOTO

105 Franklin St.
Mansfield, LA 71052-2046
(318) 872-1149

E. BATON ROUGE

222 St. Louis #201
Baton Rouge, LA 70802-5860
(225) 389-3940

E. CARROLL

P. O. Box 708
Lake Providence, LA 71254-0708
(318) 559-2015

E. FELICIANA

P. O. Box 488
Clinton, LA 70722-0488
(225) 683-3105

EVANGELINE

200 Court St. Ste. 102
Ville Platte, LA 70586-4463
(337) 363-5538

FRANKLIN

Courthouse
6560 Main St.
Winnsboro, LA 71295-2750
(318) 4354489

GRANT

Courthouse
200 Main St.
Colfax, LA 71417-1828
(318) 627-9938

IBERIA

300 S. Iberia St. #110
New Iberia, LA 70560-4543
(337) 369-4407

IBERVILLE

P. O. Box 554
Plaquemine, LA 70765-0554
(225) 687-5201

JACKSON

500 E. Court St. #102
Jonesboro, LA 71251-3400
(318) 259-2486

JEFFERSON

P. O. Box 10494
Jefferson, LA 70181-0494
(504) 736-6191

JEFFERSON DAVIS

302 N. Cutting Ave.
Jennings, LA 7054-65361
(337) 824-0834

LAFAYETTE

1010 Lafayette #313
Lafayette, LA 70501-6885
(337) 291-7140

LAFOURCHE

307 W. 4th St. #101
Thibodaux, LA 70301-3105
(985) 447-3256

LASALLE

P. O. Box 2439
Jena, LA 71342-2439
(318) 992-2254

LINCOLN

100 W. Texas Ave.
Ruston, LA 71270-4463
(318) 251-5110

LIVINGSTON

P. O. Box 968
Livingston, LA 707540968
(225) 686-3054

MADISON

100 N. Cedar St.
Tallulah, LA 71282-3892
(318) 574-2193

MOREHOUSE

129 N. Franklin
Bastrop, LA 71220-3815
(318) 281-1434

NATCHITOCHE

P. O. Box 677
Natchitoches, LA 71458-0677
(318) 357-2211

ORLEANS

1300 Perdido #1W23
New Orleans, LA 70112-2127
(504) 658-8300

OUACHITA

122 St John St #114
Monroe, LA 71201-7342
(318) 3271436

PLAQUEMINES

P. O. Box 989
Port Sulphur, LA 70083-0989
(504) 564-6957

POINTE COUPEE

211 E. Main St.
New Roads, LA 70760-3661
(225) 638-5537

RAPIDES

701 Murray St.
Alexandria, LA 71301-8099
(318) 473-6770

RED RIVER

P. O. Box 432
Coushatta, LA 71019-0432
(318) 932-5027

RICHLAND

P. O. Box 368
Rayville, LA 71269-0368
(318) 728-3582

SABINE

400 Capitol St. #107
Many, LA 71449-3099
(318) 256-3697

ST. BERNARD

8201 W. Judge Perez Rm. 104
Chalmette, LA 70043-1696
(504) 278-4231

ST. CHARLES

P. O. Box 315
Hahnville, LA 70057-0315
(985) 783-2731

ST. HELENA

P. O. Box 543
Greensburg, LA 70441-0543
(225) 222-4440

ST. JAMES

P. O. Box 179
Convent, LA 70723-0179
(225) 562-2330

ST. JOHN

1801 W. Airline Hwy
LaPlace, LA 70068-3344
(985) 652-9797

ST. LANDRY

P. O. Box 818
Opelousas, LA 70571-0818
(337) 948-0572

ST. MARTIN

Courthouse
415 S. Martin St.
St. Martinville, LA 70582-4549
(337) 394-2204

ST. MARY

500 Main St. #301
Franklin, LA 70538-6144
(337) 828-4100

ST. TAMMANY

701 N. Columbia St.
Covington, LA 70433-2709
(985) 809-5500

TANGIPAHOA

P. O. Box 895
Amite, LA 70422-0895
(985) 748-3215

TENSAS

P. O. Box 183
St. Joseph, LA 71366-0183
(318) 766-3931

TERREBONNE

P. O. Box 9189
Houma, LA 70361-9189
(985) 873-6533

UNION

P. O. Box 235
Farmerville, LA 71241-0235
(318) 368-8660

VERMILION

100 N. State St. #120
Abbeville, LA 70510
(337) 898-4324

VERNON

P. O. Box 626
Leesville, LA 71496-0626
(337) 239-3690

WASHINGTON

Courthouse Bldg.
900 Washington St.
Franklinton, LA 70438
(985) 839-7850

WEBSTER

P. O. Box 674
Minden, LA 71058-0674
(318) 377-9272

W. BATON ROUGE

P. O. Box 31
Port Allen, LA 70767-0031
(225) 336-2421

W. CARROLL

P. O. Box 71
Oak Grove, LA 71263-0071
(318) 428-2381

W. FELICIANA

P. O. Box 2490
St. Francisville, LA 70775-2490
(225) 635-6161

WINN

Courthouse Room 105
Winnfield, LA 71483-3238
(318) 628-6133

OFFICIAL USE ONLY**Address Change**

Name Change

Party Change

Remarks

Circle One: PA MV RG SDA SS

Received by: _____

PLACE IN AN ENVELOPE AND MAIL TO YOUR
REGISTRAR OF VOTERS

USE THIS FORM TO: 1) register to vote 2) change your address 3) request a name change 4) change party affiliation

TO REGISTER TO VOTE AND BE ELIGIBLE TO VOTE YOU MUST: 1) be a United States citizen 2) be at least 17 years old to register but must be 18 years old to vote 3) not be under an order of imprisonment for conviction of a felony 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 FOR COMPLETING THIS FORM: All information except your signature should be printed clearly in ink, preferably black, or typed. Fill in all boxes that apply to you.

Box 1: Indicate whether you are a citizen of the United States of America. Indicate whether you will be 18 years of age on or before election day.

Box 2: Provide full name. Do not use initials for middle or maiden name.

Box 3: 'Residence Address' means the address where you live and are registering to vote. If you claim a homestead exemption, you must list the address of that residence. Do not use a post office box for your 'Residence Address'. If you use a rural route and box number, draw a map in the space labeled 'Give Location.' Write in the names of the crossroads (streets) nearest to where you live. Draw an X to show where you live. Use a dot to show any schools, churches, stores or landmarks near where you live and write the name of the landmark. Check the box provided if mail is not delivered to your residence address by the post office. Complete 'Mailing Address' only if it is different from the 'Residence Address' or if mail is not delivered to your residence address.

Box 4: Provide your age.

Boxes 6 & 14: You must provide your Louisiana driver's license number, if issued. If not issued, you must provide at least the last four digits of your social security number, if issued. The full social security number may be provided on a voluntary basis. If neither a social security number nor a Louisiana driver's license number has been issued, 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, attach either a) a copy of a current and valid photo identification or b) a copy of a current utility bill, bank statement, government check, paycheck, or other government document that shows your name and address.

Boxes 8, 12 & 13: The items 'race/ethnic origin', 'home phone' and 'daytime phone' are not required but are helpful.

Box 9: If you do not complete this item, your party affiliation will be listed as 'none', unless you are presently registered with a party affiliation and no change is being made today. If you are not registering with a political party, circle 'none'. The recognized political parties are Democrat, Green, Libertarian, Reform and Republican or you may specify any other party affiliation.

Box 18: If you are using this form to request a change of name, you must print the name to be changed here.

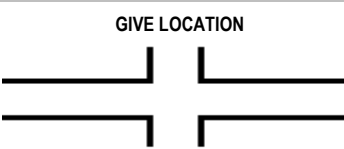
Box 19: Date and sign the card with your signature or mark.

If returned by mail, place in an envelope and mail to the appropriate registrar of voters at the address found on the reverse side of this card. If you have not been issued a social security number or Louisiana driver's license number, you must mail the required documentation with your application. Your application or envelope must be postmarked 30 days prior to the first election in which you seek to vote based on the residence listed on this application.

NOTE: 1. 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. 2. Your social security number will also remain confidential and is intended to be used for voter registration purposes only.

QUESTIONS? Call your Parish Registrar of Voters OR call the Department of State at 1-800-883-2805 or (225) 922-0900.

COMPLETE AND CHECK ALL APPLICABLE BOXES AND TEAR ALONG PERFORATED LINE BEFORE MAILING.

LOUISIANA MAIL VOTER REGISTRATION APPLICATION FORM #04				OFFICIAL USE ONLY COMP REG # _____ Reg Type _____ Wd/ Dist _____ Pct _____ In _____ Out _____			
1 Are you a citizen of the United States of America? YES <input type="checkbox"/> NO <input type="checkbox"/> Will you be 18 years of age on or before election day YES <input type="checkbox"/> NO <input type="checkbox"/> If you checked no in response to either of these questions, DO NOT COMPLETE THIS FORM.							
2 NAME OF APPLICANT (PLEASE PRINT NAME)						GIVE LOCATION 	
LAST		First		FULL MIDDLE OR MAIDEN			
3 RESIDENCE ADDRESS (MUST BE ADDRESS WHERE YOU CLAIM HOMESTEAD EXEMPTION, IF ANY)							
HOUSE OR APT. NO. & STREET				CITY OR TOWN		STATE ZIP	
IF NO mail delivery to residential address, check here: ()				MAILING ADDRESS IF DIFFERENT			
4 AGE		5 DATE OF BIRTH		6 * SOCIAL SECURITY #(CIRCLE ONE)		7 SEX (CIRCLE ONE)	
		MONTH DAY YEAR		NO YES # _____		MALE FEMALE	
8 ** RACE/ ETHNIC ORIGIN (CIRCLE ONE)							
WHITE BLACK ASIAN HISPANIC AMER. INDIAN OTHER: _____							
9 PARTY AFFILIATION (CIRCLE ONE)				10 APPLICANTS'S PLACE OF BIRTH			11 MOTHERS MAIDEN NAME
DEM GRN LBT RFM REP NONE OTHER (SPECIFY) _____				CITY OR TOWN		PARISH OR COUNTY	STATE COUNTRNY
12 ** HOME PHONE			13 ** DAYTIME PHONE		14 LA DRIVERS LICENSE / I.D. #(CIRCLE ONE)		15 Will you require assistance at the polls?(CIRCLE ONE)
()			()		NO YES # _____		NO YES IF YES, GIVE REASON
16 LAST RESIDENCE ADDRESS			17 PLACE OF REGISTRATION			18 FOMER REGISTERED NAME, IF APPLICABLE	
ADDRESS			PARISH OR COUNTY			STATE	
AFFIRMATION : I do hereby solemnly swear or affirm that I am a United States citizen, that I am at least 17 years old, that I am not currently under an order of imprisonment for conviction of a felony, 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 \$1,000 (\$2,500 for subsequent offense) or imprisonment for not more than 1 year.							
19 SIGN YOUR NAME IN BOX AT RIGHT							
DATE: _____ / _____ / _____							
20 IF YOU ARE UNABLE TO SIGN YOUR NAME, TWO WITNESSES TO YOUR MARK MUST SIGN HERE							
WITNESS SIGNATURE				WITNESS SIGNATURE			
* Last 4 digits of the social security number required if no LA driver's license issued; social security number is intended to be used for voter registration purposes only Full # Optional ** OPTIONAL							
LR-1M (REV. 1/11, 7/11) R.S. 18:104 FORM #04							