

LOUISIANA MEDICAID ELIGIBILITY

FORMS CATALOG

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



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

D E L I V E R T O

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

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

2 **UPS ACCOUNT NUMBER**
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 **DATE**
07/04/2010

3 REQUISITIONED BY AND PHONE NUMBER (IF DIFFERENT FROM DELIVER TO PERSON)
 Herman Munster 225-749-1793

LINE #	FORM NUMBER	UNITS&PACKS ORDERED	REVISION DATE	FORM NAME
4 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

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.


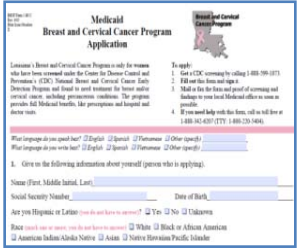


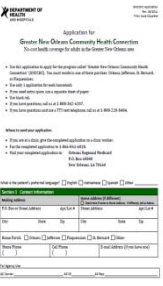


NOTE: UNITS/PACKS ORDERED – This is the quantity of forms packaged together as a unit. **EXAMPLE:** If the order is for 1,000 total forms, and the catalog shows that the form comes packaged 50 per UNITS/PACKS then the number to be entered in this field is $1,000 \div 50$ or "20."








5





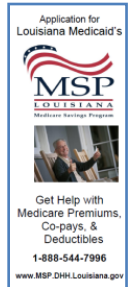


DATE: Fill in date you fax the order to DOA.

6

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

	<p>BREAST AND CERVICAL CANCER FLYER FORM NUMBER: BHSF B/CC Program UNITS/PACKS ORDERED: 100 Breast and Cervical Cancer Flyer—English Rev. Mar 2009</p>
	<p>BREAST/CERVICAL CANCER PROGRAM—APPLICATION FORM NUMBER: BHSF 1 BCC UNITS/PACKS ORDERED: 50 Breast and Cervical Cancer Application—English Rev. Jun 2005</p>
 <p>(black & white)</p>	<p>FAMILY OPPORTUNITY ACT MEDICAID BUY-IN PROGRAM—COVER AND APPLICATION (B&W) FORM NUMBER: BHSF 1 FOA UNITS/PACKS ORDERED: 50 FOA BUY-IN Program—Cover & Application—English Rev. April 2010 FOA BUY-IN Program—Cover & Application—Spanish Rev. Jul 2009 FOA BUY-IN Program—Cover & Application—Vietnamese Rev. Jul 2009</p>
	<p>FRIENDS AND FAMILY TRANSPORTATION FLYER FORM NUMBER: BHSF FLYER FRIEN/FAM UNITS/PACKS ORDERED: 100 Friends & Family Transportation Program Flyer – English Rev. Feb 2008</p>
	<p>GNOCHC APPLICATION FORM NUMBER: GNOCHC APPLICATION - English UNITS/PACKS ORDERED: 100 GNOCHC Application – English Rev. Jun 2011</p>
	<p>HIPAA 101 NOTICE OF PRIVACY PRACTICES FORM NUMBER: BHSF FORM HIPPA 101P UNITS/PACKS ORDERED: 50 Notice of Privacy Practices – English Rev. Aug 2008</p>
	<p>LACHIP APPLICATION FORM NUMBER: BHSF 1 CH UNITS/PACKS ORDERED: 50 LaChip Application—English Rev. April 2010 LaChip Application—Spanish Rev. April 2010 LaChip Application—Vietnamese Rev. April 2010</p>

 <p>Application for LaMOMS Helping Pregnant Women Have Healthier Babies</p> <p>Apply Online at www.LaMOMS.org</p> <p>1-888-342-6207</p>	<p>LAMOMS—COVER AND APPLICATION FORM NUMBER: BHSF 1-PW UNITS/PACKS ORDERED: 50 LaMOMS Cover and Application—English Rev. April 2010 LaMOMS Cover and Application—Spanish Rev. April 2010 LaMOMS Cover and Application—Vietnamese Rev. April 2010</p>
 <p>Medicaid Application for Long Term Care Services</p> <p>1. Person Applying for Medicaid (the applicant)</p>	<p>LONG TERM CARE—APPLICATION FORM NUMBER: BHSF 1 L UNITS/PACKS ORDERED: 400 LONG TERM CARE Application Rev. Nov 2007</p>
 <p>Facility or Home Care</p> <p>The choice is yours to make.</p> <p>www.Medicaid.org</p>	<p>LONG TERM CARE CHOICE FLYER FORM NUMBER: BHSF Fly/LTC Choice UNITS/PACKS ORDERED: 100 LONG TERM CARE CHOICE FLYER—English Rev. Sept 2007</p>
 <p>Louisiana Medicaid's Long Term Care Program</p>	<p>LONG TERM CARE PROGRAM FLYER FORM NUMBER: BHSF Flyer LTC UNITS/PACKS ORDERED: 50 LTC Program flyer—English Rev. April 2008</p>
 <p>Louisiana's Medicaid Program</p> <p>Health Care for You and Your Family</p> <p>1-888-342-6207</p>	<p>LOUISIANA'S MEDICAID PROGRAM FLYER FORM NUMBER: BHSF Flyer Med. Prog UNITS/PACKS ORDERED: 100 La's Medicaid Program flyer—English Rev. Oct. 2008</p>
 <p>Give Your Child Health Coverage At Low Cost or No Cost To You.</p> <p>LaCHIP</p> <p>Apply today! www.lachip.org</p>	<p>LACHIP LUNCH FLYER FORM NUMBER: BHSF LUNCH FLYER UNITS/PACKS ORDERED: 500 BHSF Lunch Flyer – English Rev. Apr. 2011</p>
 <p>LOUISIANA MEDICAID General Application</p> <p>1. Where did you get your Medicaid application?</p> <p>2. Tell us about yourself.</p>	<p>MEDICAID PROGRAM GENERAL APPLICATION FORM NUMBER: BHSF 1 G UNITS/PACKS ORDERED: 200 Medicaid Program General Application—English Revised July 2007 Medicaid Program General Application—Spanish Revised Sept 2007 Medicaid Program General Application—Vietnamese Revised May 2008</p>

 <p>Do you have a disability? Do you work? Do you need healthcare coverage?</p> <p>Medicaid Purchase Plan for workers with disabilities</p> <p>1-888-544-7996</p>	<p>MEDICAID PURCHASE PLAN—COVER & APPLICATION FORM NUMBER: BHSF 1MPP UNITS/PACKS ORDERED: 50 MPP-Medicaid Purchase Plan—Cover & App—English Rev. June 2009</p>
	<p>MEDICAID 7 PROGRAM FLYER FORM NUMBER: BHSF 7 PROGRAM FLYER UNITS/PACKS ORDERED: 200 Medicaid 7 Program Flyer Rev. June 2010</p>
<p>Get the Medical Services You Need From...</p>  <p>Louisiana's Medicaid Program</p> <p>www.Medicaid.DH.Louisiana.gov 1-888-544-7997</p>	<p>MEDICAL SERVICES FLYER FORM NUMBER: BHSF Flyer – Medical Services UNITS/PACKS ORDERED: 100 (Currently out of Stock) Medical Serices flyer – English Rev. April 2007</p>
	<p>MEDICAL TRANSPORTATION SERVICES FLYER FORM NUMBER: BHSF Flyer – NEMT UNITS/PACKS ORDERED: 100 Medical Transportation Serices flyer (NEMT) – English Rev. July 2008</p>
 <p>Get Help with Medicare Premiums, Co-pays, & Deductibles</p> <p>1-888-544-7996 www.MSP.DH.Louisiana.gov</p>	<p>MEDICARE SAVINGS PROGRAM—COVER AND APPLICATION FORM NUMBER: BHSF 1-MB UNITS/PACKS ORDERED: 50 MSP-Medicare Savings Program—Cover & App—English Rev. Oct. 2008</p>
	<p>MIG AFTER HIGH SCHOOL FLYER FORM NUMBER: MIG After High School UNITS/PACKS ORDERED: 100 MIG After High School Flyer - English Rev. Dec. 2010</p>
	<p>MIG BENEFITS FLYER FORM NUMBER: BHSF MIG Benefits UNITS/PACKS ORDERED: 100 MIG Benefits Flyer - English Rev. Dec. 2010</p>

 <p>Knowing Your Rights</p> <p>WORK PAY</p>	<p>MIG KNOWING YOUR RIGHTS FLYER FORM NUMBER: MIG Knowing Your Rights UNITS/PACKS ORDERED: 100 MIG Rights Flyer - English Rev. Dec. 2010</p>
 <p>Taxes</p> <p>WORK PAY</p>	<p>MIG TAXES FLYER FORM NUMBER: MIG Taxes UNITS/PACKS ORDERED: 100 MIG Taxes Flyer - English Rev. Dec. 2010</p>
 <p>Ticket to Work</p> <p>WORK PAY</p>	<p>MIG TICKET TO WORK FLYER FORM NUMBER: MIG Ticket UNITS/PACKS ORDERED: 100 MIG Ticket Flyer - English Rev. Dec. 2010</p>
 <p>LOUISIANA Department of HEALTH AND HOSPITALS Notice of Privacy Practices</p> <p>©2005-2006 April 20, 2005</p>	<p>NOTICE OF PRIVACY PRACTICE FLYER FORM NUMBER: HIPAA 101P UNITS/PACKS ORDERED: 50 HIPAA Notice of Privacy Practice flyer—English Rev. Apr. 2003 HIPAA Notice of Privacy Practice flyer—Spanish Rev. Apr. 2004 HIPAA Notice of Privacy Practice flyer—Vietnamese Rev. Feb. 2005</p>
 <p>OSUP ISIS PRIOR PERIOD ADJUSTMENT FORM</p>	<p>OSUP ISIS PRIOR PERIOD ADJ FORM FORM NUMBER: OSUP F036 UNITS/PACKS ORDERED: 50 OSUP ISIS Prior Period Adj Rev. Jan. 2002</p>
 <p>LOUISIANA MEDICAID PROGRAM Renewal Form</p> <p>Use this form to renew Medicaid coverage. If you <u>do not</u> renew, Medicaid services will end. After we get the information from you, we will let you know if you and/or your family still qualify.</p> <p>How to renew.</p> <ol style="list-style-type: none"> 1. Fill out and sign this form to renew by mail or call your worker to renew by phone. 2. Start getting the documents of proof. Look for the picture of a mailbox next to each document we need. If you need more time to get any proofs, let us know right away. 3. Send this renewal form and the proofs we already have right away, so we can start working to see if you and/or your family qualify. Bring or fax the renewal form and proofs to us or mail them to the envelope that came with this form. 4. When you get the rest of the proofs, send us bring them to us. If you need the address or fax number to your closest Medicaid office, call 1-800-342-4287, TTY: 1-800-220-5416. There are hot calls. <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>RENEWAL FORM FOR ANY PROGRAM FLYER FORM NUMBER: BHSF 2 (G) UNITS/PACKS ORDERED: 200 Renewal Form for any Program—English Rev. Jan. 2007</p>

Medicaid Renewal Form
for the Breast and Cervical Cancer Program

You have received this form to help us decide if you are eligible to get Medicaid through the Breast and Cervical Cancer Program. If you do not, we will contact you to let you know. If you do, we will send you a letter to let you know if you are still eligible.

Renewing Medicaid coverage is easy.

- Fill out this form and sign it.
- Get together the needed proofs. The steps we need are listed on page 2. You may need a picture of a suitable ID.
- Mail the form and needed proofs to the address at the end of this form. We will check them and let you know if you are still eligible.

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

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

1. Tell us about yourself (the person who gets Medicaid).

Name (First, Middle Initial, Maiden Last) _____
Date of Birth _____
Home Address _____
City _____ State _____ Zip _____

RENEWAL FORM FOR BREAST AND CERVICAL CANCER PROGRAM

FORM NUMBER: BHSF 2BCC

UNITS/PACKS ORDERED: 50

[Renewal form—Breast & Cervical Cancer Prog.—English](#) Rev. Apr. 2006

LaCHIP
Medicaid Renewal Form

Use this form to renew children's LaCHIP Medicaid coverage. You may need to mail or phone. If you do, call your local coverage office. After we hear from you, we will let you know if they still qualify.

How to Renew by Mail

- Fill out and sign this form.
- Get the documents of proof. See page 1 of this renewal form for a list of things you may need to mail.
- 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.

How to Renew by Phone

- Call your number at 877-352-2447 ext 24. Have all the documents of proof.
- Get the documents of proof. See page 1 of this renewal form for a list of things you may need to mail.
- 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.

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

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

RENEWAL FORM FOR LaCHIP/CHAMP CHILD

FORM NUMBER: BHSF 2CH

UNITS/PACKS ORDERED: 100

[Renewal Form for LaCHIP/CHAMP Child—English](#) Rev. May 2007

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 getting a waiver in order of a "cash" transfer, PLEASE indicate which waiver is needed by checking USE A SEPARATE SHEET.

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

Name _____
Mailing Address _____ City _____ State _____ Zip Code _____
Home Address _____ City _____ State _____ Zip Code _____
Phone _____ 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

Use this form to renew your coverage for family planning waiver services. If you do not renew, your coverage will end. You may need to mail, fax, phone, or phone.

How to Renew:

By mail: Fill out and sign this form. Return the form and needed proofs (see page 1) in the envelope provided. If you need extra time to get needed proofs, see page 1 of this form for the address that you may use to get extra time.

By fax: Fill out and sign this form. Fax it and needed proofs (see page 1) to the fax number on the notice that you will receive with this form or to 877-352-2447.

By phone: Call the number who use this form or call toll-free 1-888-424-2427 Monday through Friday, 9:00 a.m. to 5:00 p.m. For health and care (H&C) services, the call transfer you to your provider. If you need to get more information, call 1-888-424-2427.

By person: Visit your chosen Medicaid office or Application Center. For the office closest to you, call 1-888-424-2427. From our toll-free number, call 1-888-424-2427.

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):

Name (First, Middle Initial, Maiden Last) _____
Date of Birth _____
Home Address _____
City _____ State _____ Zip Code _____

Is the person a resident of long-term care or a veteran? Yes No (If "Yes," is a Veteran) _____

Residence address: _____
City _____ State _____ Zip code _____
Mailing address: _____
City _____ State _____ Zip code _____

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

Helping Women
Ages 19-44
TAKE CHARGE
of their Lives

1-888-342-6237

Apply Online at
www.Medicaid.la.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