

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 11. **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**.
- Quý 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**.

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? <input type="checkbox"/> Yes <input type="checkbox"/> 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. Providing your SSN can be helpful even if you don't want health coverage, and can speed up the application process. We use SSNs to check income and other information to see who's eligible for help with health coverage costs. 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 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 _____

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.

- | | | | | |
|---|----------|------------------|--|--|
| <input type="checkbox"/> None | | | | |
| <input type="checkbox"/> Unemployment | \$ _____ | How often? _____ | <input type="checkbox"/> Child support | \$ _____ How often? _____ |
| <input type="checkbox"/> Pensions | \$ _____ | How often? _____ | <input type="checkbox"/> Veteran's payments | \$ _____ How often? _____ |
| <input type="checkbox"/> Social Security | \$ _____ | How often? _____ | <input type="checkbox"/> Scholarships/Grants | \$ _____ How often? _____ |
| <input type="checkbox"/> Retirement accounts | \$ _____ | How often? _____ | <input type="checkbox"/> Capital Gains | \$ _____ How often? _____ |
| <input type="checkbox"/> Investments | \$ _____ | How often? _____ | <input type="checkbox"/> Net farming/fishing | \$ _____ How often? _____ |
| <input type="checkbox"/> Alimony received | \$ _____ | How often? _____ | <input type="checkbox"/> Net rental/royalty | \$ _____ How often? _____ |
| <input type="checkbox"/> Supplemental Security Income (SSI) | \$ _____ | How often? _____ | <input type="checkbox"/> 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).

- | | | | | |
|--|----------|------------------|---|------------------|
| <input type="checkbox"/> Alimony paid | \$ _____ | How often? _____ | <input type="checkbox"/> Other deductions | Type: _____ |
| <input type="checkbox"/> 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 _____		5. Relationships (examples: mother, father, daughter, son, etc.) This person's relationship to: PERSON 1: _____
2. Date of birth (mm/dd/yyyy) _____	3. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	
4. Social Security number (SSN) _____ - _____ - _____ We need this if PERSON 2 wants health coverage and has an SSN.		

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.)

<input type="checkbox"/> White	<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Filipino	<input type="checkbox"/> Vietnamese	<input type="checkbox"/> Guamanian or Chamorro
<input type="checkbox"/> Black or African American	<input type="checkbox"/> Asian Indian	<input type="checkbox"/> Japanese	<input type="checkbox"/> Other Asian	<input type="checkbox"/> Samoan
<input type="checkbox"/> Chinese	<input type="checkbox"/> Korean	<input type="checkbox"/> Native Hawaiian	<input type="checkbox"/> Other Pacific Islander	<input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No
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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.

- | | | | | |
|---|----------|------------------|--|--|
| <input type="checkbox"/> None | | | | |
| <input type="checkbox"/> Unemployment | \$ _____ | How often? _____ | <input type="checkbox"/> Child support | \$ _____ How often? _____ |
| <input type="checkbox"/> Pensions | \$ _____ | How often? _____ | <input type="checkbox"/> Veteran's payments | \$ _____ How often? _____ |
| <input type="checkbox"/> Social Security | \$ _____ | How often? _____ | <input type="checkbox"/> Scholarships/Grants | \$ _____ How often? _____ |
| <input type="checkbox"/> Retirement accounts | \$ _____ | How often? _____ | <input type="checkbox"/> Capital Gains | \$ _____ How often? _____ |
| <input type="checkbox"/> Investments | \$ _____ | How often? _____ | <input type="checkbox"/> Net farming/fishing | \$ _____ How often? _____ |
| <input type="checkbox"/> Alimony received | \$ _____ | How often? _____ | <input type="checkbox"/> Net rental/royalty | \$ _____ How often? _____ |
| <input type="checkbox"/> Supplemental Security Income (SSI) | \$ _____ | How often? _____ | <input type="checkbox"/> 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).

- | | | | | |
|--|----------|------------------|---|------------------|
| <input type="checkbox"/> Alimony paid | \$ _____ | How often? _____ | <input type="checkbox"/> Other deductions | Type: _____ |
| <input type="checkbox"/> Student loan interest | \$ _____ | How often? _____ | \$ _____ | 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 _____		5. Relationships (examples: mother, father, daughter, son, etc.) This person's relationship to: PERSON 1: _____ PERSON 2: _____
2. Date of birth (mm/dd/yyyy) _____	3. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	
4. Social Security number (SSN) _____ - _____ - _____ We need this if PERSON 3 wants health coverage and has an SSN.		

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.)**

<input type="checkbox"/> White	<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Filipino	<input type="checkbox"/> Vietnamese	<input type="checkbox"/> Guamanian or Chamorro
<input type="checkbox"/> Black or African American	<input type="checkbox"/> Asian Indian	<input type="checkbox"/> Japanese	<input type="checkbox"/> Other Asian	<input type="checkbox"/> Samoan
<input type="checkbox"/> Chinese	<input type="checkbox"/> Korean	<input type="checkbox"/> Native Hawaiian	<input type="checkbox"/> Other Pacific Islander	<input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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.

- | | | | | |
|---|----------|------------------|--|--|
| <input type="checkbox"/> None | | | | |
| <input type="checkbox"/> Unemployment | \$ _____ | How often? _____ | <input type="checkbox"/> Child support | \$ _____ How often? _____ |
| <input type="checkbox"/> Pensions | \$ _____ | How often? _____ | <input type="checkbox"/> Veteran's payments | \$ _____ How often? _____ |
| <input type="checkbox"/> Social Security | \$ _____ | How often? _____ | <input type="checkbox"/> Scholarships/Grants | \$ _____ How often? _____ |
| <input type="checkbox"/> Retirement accounts | \$ _____ | How often? _____ | <input type="checkbox"/> Capital Gains | \$ _____ How often? _____ |
| <input type="checkbox"/> Investments | \$ _____ | How often? _____ | <input type="checkbox"/> Net farming/fishing | \$ _____ How often? _____ |
| <input type="checkbox"/> Alimony received | \$ _____ | How often? _____ | <input type="checkbox"/> Net rental/royalty | \$ _____ How often? _____ |
| <input type="checkbox"/> Supplemental Security Income (SSI) | \$ _____ | How often? _____ | <input type="checkbox"/> 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).

- | | | | | |
|--|----------|------------------|---|------------------|
| <input type="checkbox"/> Alimony paid | \$ _____ | How often? _____ | <input type="checkbox"/> Other deductions | Type: _____ |
| <input type="checkbox"/> Student loan interest | \$ _____ | How often? _____ | \$ _____ | 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.



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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 _____		5. Relationships (examples: mother, father, daughter, son, etc.) This person's relationship to: PERSON 1: _____ PERSON 2: _____ PERSON 3: _____
2. Date of birth (mm/dd/yyyy) _____	3. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	
4. Social Security number (SSN) _____ - _____ - _____ We need this if PERSON 4 wants health coverage and has an SSN.		

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.)**

<input type="checkbox"/> White	<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Filipino	<input type="checkbox"/> Vietnamese	<input type="checkbox"/> Guamanian or Chamorro
<input type="checkbox"/> Black or African American	<input type="checkbox"/> Asian Indian	<input type="checkbox"/> Japanese	<input type="checkbox"/> Other Asian	<input type="checkbox"/> Samoan
<input type="checkbox"/> Chinese	<input type="checkbox"/> Korean	<input type="checkbox"/> Native Hawaiian	<input type="checkbox"/> Other Pacific Islander	<input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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.

- | | | | |
|---|----------|------------------|--|
| <input type="checkbox"/> None | | | |
| <input type="checkbox"/> Unemployment | \$ _____ | How often? _____ | <input type="checkbox"/> Child support |
| <input type="checkbox"/> Pensions | \$ _____ | How often? _____ | \$ _____ How often? _____ |
| <input type="checkbox"/> Social Security | \$ _____ | How often? _____ | <input type="checkbox"/> Veteran's payments |
| <input type="checkbox"/> Retirement accounts | \$ _____ | How often? _____ | \$ _____ How often? _____ |
| <input type="checkbox"/> Investments | \$ _____ | How often? _____ | <input type="checkbox"/> Scholarships/Grants |
| <input type="checkbox"/> Alimony received | \$ _____ | How often? _____ | \$ _____ How often? _____ |
| <input type="checkbox"/> Supplemental Security Income (SSI) | \$ _____ | How often? _____ | <input type="checkbox"/> Capital Gains |
| | | | \$ _____ How often? _____ |
| | | | <input type="checkbox"/> Net farming/fishing |
| | | | \$ _____ How often? _____ |
| | | | <input type="checkbox"/> Net rental/royalty |
| | | | \$ _____ How often? _____ |
| | | | <input type="checkbox"/> 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).

- | | | | | |
|--|----------|------------------|---|------------------|
| <input type="checkbox"/> Alimony paid | \$ _____ | How often? _____ | <input type="checkbox"/> Other deductions | Type: _____ |
| <input type="checkbox"/> Student loan interest | \$ _____ | How often? _____ | \$ _____ | 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.**
- | | |
|--|---|
| <input type="checkbox"/> Medicaid _____ | <input type="checkbox"/> Employer insurance _____ |
| <input type="checkbox"/> CHIP _____ | Name of health insurance: _____ |
| <input type="checkbox"/> Medicare _____ | Policy number: _____ |
| <input type="checkbox"/> TRICARE (Don't check if you have direct care or Line of Duty) | Is this COBRA coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| _____ | Is this a retiree health plan? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> VA health care programs _____ | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Peace Corps _____ | Name of health insurance: _____ |
| | Policy number: _____ |
| | Is this a limited-benefit plan (like a school accident policy)? |
| | <input type="checkbox"/> Yes <input type="checkbox"/> 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'm 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 understand that the information I give will be checked. I agree to help Medicaid by letting them obtain the information they need from government agencies, employers, medical providers, and others.
- 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?: _____

We need the information you provide on this application to check your eligibility for help paying for health coverage if you choose to apply. We'll check your answers using information in our electronic databases and databases from the Internal Revenue Service (IRS), Social Security, the Department of Homeland Security, and/or a consumer reporting agency. If the information doesn't match, we may ask you to send us proof.



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STEP 5

Read & sign this application (continued)

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

- I am giving to the Medicaid agency our rights to pursue and get any money from other health insurance, legal settlements, or other third parties. I am also giving to the Medicaid agency rights to pursue and get medical support from a spouse or parent.

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)

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



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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	

<p>13. Are you currently eligible for coverage offered by this employer, or will you become eligible in the next 3 months?</p> <p><input type="checkbox"/> Yes (Continue)</p> <p>13a. If you're in a waiting or probationary period, when can you enroll in coverage? _____ (mm/dd/yyyy)</p> <p>List the names of anyone else who is eligible for coverage from this job.</p> <p>Name: _____ Name: _____ Name: _____</p> <p><input type="checkbox"/> No (Stop here and go to Step 5 in the application)</p>
--

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

14. Does the employer offer a health plan that meets the minimum value standard*? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Twice a month <input type="checkbox"/> Once a month <input type="checkbox"/> Quarterly <input type="checkbox"/> Yearly
16. What change will the employer make for the new plan year (if known)? <input type="checkbox"/> Employer won't offer health coverage. <input type="checkbox"/> 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? <input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Twice a month <input type="checkbox"/> Once a month <input type="checkbox"/> Quarterly <input type="checkbox"/> 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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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? <input type="checkbox"/> 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) _____ <input type="checkbox"/> 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*? <input type="checkbox"/> Yes (Go to question 15) <input type="checkbox"/> 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? <input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Twice a month <input type="checkbox"/> Once a month <input type="checkbox"/> Quarterly <input type="checkbox"/> 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? <input type="checkbox"/> Employer won't offer health coverage <input type="checkbox"/> 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? <input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Twice a month <input type="checkbox"/> Once a month <input type="checkbox"/> Quarterly <input type="checkbox"/> 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	
	First	Middle	First	Middle
1. Name	Last		Last	
2. Member of a federally recognized tribe?	<input type="checkbox"/> Yes If yes, what is the tribe's name? _____ <input type="checkbox"/> No		<input type="checkbox"/> Yes If yes, what is the tribe's name? _____ <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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.	<input type="checkbox"/> Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties \$ _____ How often? _____ <input type="checkbox"/> 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? _____ <input type="checkbox"/> Money from selling things that have cultural significance \$ _____ How often? _____		<input type="checkbox"/> Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties \$ _____ How often? _____ <input type="checkbox"/> 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? _____ <input type="checkbox"/> Money from selling things that have cultural significance \$ _____ How often? _____	



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APPENDIX C

Assistance with Completing this Application

You can choose an authorized representative.

You can give a trusted person permission to talk about this application with us, see your information, and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an “authorized representative”. If you ever need to change your authorized representative, contact Medicaid. If you’re a legally appointed representative for someone on this application, submit proof with the application.

1. Name of authorized representative (First name, Middle name, Last name)		
2. Address		3. Apartment or suite number
4. City	5. State	6. ZIP code
7. Phone number (___ ___) ___ ___ - ___ ___ ___		
8. Organization name		9. ID number (if applicable)
By signing, you allow this person to sign your application, get official information about this application, and act for you on all future matters with this agency.		
10. Your signature		11. Date (mm/dd/yyyy)

For certified Medicaid Application Centers only.

1. Application start date (mm/dd/yyyy)	
2. First name, Middle name, Last name, & Suffix	
3. Organization name	4. ID number (if applicable)



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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 <input type="checkbox"/> Yes <input type="checkbox"/> No Who owns this? _____	\$ _____	
Savings accounts <input type="checkbox"/> Yes <input type="checkbox"/> No Who owns this? _____	\$ _____	
Vehicles <input type="checkbox"/> Yes <input type="checkbox"/> No Who owns this? _____	\$ _____	
Property other than your home <input type="checkbox"/> Yes <input type="checkbox"/> No Who owns this? _____	\$ _____	
Certificates of Deposit (CDs) <input type="checkbox"/> Yes <input type="checkbox"/> No Who owns this? _____	\$ _____	
Annuities, Trusts, Stocks, Bonds, or Retirement Accounts <input type="checkbox"/> Yes <input type="checkbox"/> No Who owns this? _____	\$ _____	
Life or burial insurance. <input type="checkbox"/> Yes <input type="checkbox"/> No Who owns this? _____	\$ _____	
Money set aside for burial or pre-need contract <input type="checkbox"/> Yes <input type="checkbox"/> No Who owns this? _____	\$ _____	
Safe deposit boxes <input type="checkbox"/> Yes <input type="checkbox"/> No Who owns this? _____	\$ _____	
Other (Please describe in detail) <input type="checkbox"/> Yes <input type="checkbox"/> No Who owns this? _____	\$ _____	

APPENDIX E

Choosing a Health Plan

Most people on Medicaid or LaCHIP need to choose a Health Plan. A Health Plan is a group of doctors, nurses, and other staff who work together to provide health care. You can look at information about the different Health Plans at www.healthy.la.gov. If you know which Health Plan you want, please choose now. If you do not choose, and you need to be in a Health Plan, we will choose for you.

Which Plan is Right for You?

All Health Plans must offer the same medical coverage. Some of the Health Plans offer extra benefits. You can choose a different Health 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 health plans you can choose, visit www.healthy.la.gov or call **1-855-229-6848**.

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

I choose the following plan for each person applying:

NAME OF PERSON APPLYING	SELECT A PLAN FOR THE PERSON APPLYING <i>(Please select only ONE plan per person)</i>
	<input type="checkbox"/> Aetna Better Health of Louisiana <input type="checkbox"/> Amerigroup <input type="checkbox"/> AmeriHealth Caritas Louisiana <input type="checkbox"/> Louisiana Healthcare Connections <input type="checkbox"/> UnitedHealthcare Community Plan
	<input type="checkbox"/> Aetna Better Health of Louisiana <input type="checkbox"/> Amerigroup <input type="checkbox"/> AmeriHealth Caritas Louisiana <input type="checkbox"/> Louisiana Healthcare Connections <input type="checkbox"/> UnitedHealthcare Community Plan
	<input type="checkbox"/> Aetna Better Health of Louisiana <input type="checkbox"/> Amerigroup <input type="checkbox"/> AmeriHealth Caritas Louisiana <input type="checkbox"/> Louisiana Healthcare Connections <input type="checkbox"/> UnitedHealthcare Community Plan
	<input type="checkbox"/> Aetna Better Health of Louisiana <input type="checkbox"/> Amerigroup <input type="checkbox"/> AmeriHealth Caritas Louisiana <input type="checkbox"/> Louisiana Healthcare Connections <input type="checkbox"/> UnitedHealthcare Community Plan
	<input type="checkbox"/> Aetna Better Health of Louisiana <input type="checkbox"/> Amerigroup <input type="checkbox"/> AmeriHealth Caritas Louisiana <input type="checkbox"/> Louisiana Healthcare Connections <input type="checkbox"/> UnitedHealthcare Community Plan
	<input type="checkbox"/> Aetna Better Health of Louisiana <input type="checkbox"/> Amerigroup <input type="checkbox"/> AmeriHealth Caritas Louisiana <input type="checkbox"/> Louisiana Healthcare Connections <input type="checkbox"/> UnitedHealthcare Community Plan

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.



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**.

**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
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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):

ACADIA
568 NW Court Circle
Crowley, LA 70526-4363
(337) 788-8841

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

ASCENSION
828 S. Irma Blvd., Rm. 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., Ste. 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 71163-1253
(318) 226-6891

CALCASIEU
1000 Ryan St., Rm. 7
Lake Charles, LA 70601-5250
(337) 721-4000

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 St., Ste. 1
Homer, LA 71040-3914
(318) 927-3332

CONCORDIA
4001 Carter St., Ste. K
Vidalia, LA 71373-3021
(318) 336-7770

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

E. BATON ROUGE
222 St. Louis St., Rm. 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) 435-4489

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

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

IBERVILLE
P. O. Box 554
Plaquemine, LA 70765-0554
(318) 687-5201

JACKSON
500 E. Court St., Rm. 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 70546-5361
(337) 824-0834

LAFAYETTE
1010 Lafayette St., Ste. 313
Lafayette, LA 70501-6885
(337) 291-7140

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

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

LINCOLN
100 W. Texas Ave., Rm. 10
Ruston, LA 71270-4463
(318) 251-5110

LIVINGSTON
P. O. Box 968
Livingston, LA 70754-0968
(225) 686-3054

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

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

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

ORLEANS
1300 Perdido St., Rm. 1W23
New Orleans, LA 70112-2127
(504) 658-8300

OUACHITA
1650 Desiard St., Ste. 125
Monroe, LA 71201
(318) 327-1436

PLAQUEMINES
P. O. Box 989
Port Sulphur, LA 70083-0989
(504) 934-3620

POINTE COUPEE
211 E. Main St., Flr. 2
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., Rm. 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) 783-5120

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

ST. MARY
500 Main St., Ste. 301
Franklin, LA 70538-6144
(337) 828-4100, ext. 360

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
8026 Main St., Ste. 101
Houma, LA 70360
(985) 873-6533

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

VERMILION
100 N. State St., Ste. 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., #105
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
119 W. Main St., Rm. 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(Disability)

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 17 years old (16 years old if registering to vote in person at the Registrar of Voters' Office or the Office of Motor Vehicles) 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 the election day in which you are eligible to vote.

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' if it is different from the 'Residence Address' or if mail is not delivered to your residence address.

Boxes 5 & 13: You must provide your LA driver's license number or LA special identification card 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 LA driver's license number or LA special identification card 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 7, 11 & 12: The items 'race/ethnic origin', 'email' and 'phone' are not required but are helpful. Email is protected from disclosure by law.

Box 8: If you do not complete this item, your party affiliation will be listed as 'no party', 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 'no party'. The recognized political parties are Democrat, Green, Libertarian, Reform and Republican or you may specify any other party affiliation.

Box 17: If you are using this form to request a change of name, you must print the name to be changed here.

Box 18: 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 CUT HERE BEFORE MAILING.

LOUISIANA VOTER REGISTRATION APPLICATION			OFFICIAL USE ONLY				
LR-1 & 1M, FORM #100			Wd _____	Pct _____	Reg Type _____	In/Out _____	REG # _____
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) LAST _____ FIRST _____ FULL MIDDLE OR MAIDEN _____						GIVE LOCATION 	
3 RESIDENCE ADDRESS (MUST BE ADDRESS WHERE YOU CLAIM HOMESTEAD EXEMPTION, IF ANY) HOUSE OR APT. NO. & STREET (IF RURAL, ROUTE & BOX NO.) _____ CITY OR TOWN _____ STATE _____ ZIP _____							
If NO mail delivery to residential address, check here: () _____ MAILING ADDRESS, IF DIFFERENT _____							
4 DATE OF BIRTH MONTH _____ DAY _____ YEAR _____		5 * SOCIAL SECURITY # (CIRCLE ONE) NO _____ YES # _____		6 SEX (CIRCLE ONE) MALE _____ FEMALE _____		7 ** RACE / ETHNIC ORIGIN (CIRCLE ONE) WHITE _____ BLACK _____ ASIAN _____ HISPANIC _____ AMER. INDIAN _____ OTHER: _____	
8 PARTY AFFILIATION (CIRCLE ONE) DEM _____ GRN _____ LBT _____ RFM _____ REP _____ NO PARTY _____ OTHER (SPECIFY) _____			9 APPLICANT'S PLACE OF BIRTH CITY OR TOWN _____ PARISH OR COUNTY _____ STATE _____ COUNTRY _____			10 MOTHER'S MAIDEN NAME _____	
11 **EMAIL _____		12 ** PHONE HOME () _____ DAY () _____		13 LA DRIVER'S LICENSE / I.D. # (CIRCLE ONE) NO _____ YES # _____		14 Will you require assistance at the polls? (CIRCLE ONE) NO _____ YES _____ IF YES, GIVE REASON : _____	
15 LAST RESIDENCE ADDRESS ADDRESS _____			16 PLACE OF LAST REGISTRATION PARISH OR COUNTY _____ STATE _____		17 FORMER REGISTERED NAME, IF APPLICABLE _____		
AFFIRMATION: 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 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 \$2,000 (\$5,000 for subsequent offense) or imprisonment for not more than 2 years (5 years for subsequent offense), or both. Any false statement may constitute perjury.							
18 SIGN YOUR NAME IN BOX AT RIGHT. DATE: _____ / _____ / _____							
19 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-1 & 1M (REV. 2/16) R.S. 18:104; FORM #100							