

Medicaid Renewal Form for HCBS Waivers and PACE

Renewal Month: _____

CSLD/WKR: _____

Return this form or call us by:

Use this form to renew Medicaid coverage for the person in the Waiver or PACE program. If you **do not** renew, medical coverage **will end**. You may renew by mail, phone, fax, or in person. 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. Return the form and needed documents (see page 6) in the envelope provided. If you need extra space on any question, use a separate sheet of paper.

By phone: Call the worker who sent you this form. You may also call (toll-free) 1-888-342-6207 Monday through Friday 8:00 A.M. to 4:00 P.M. Press 1 for English and then 0 for an operator who will transfer you to your worker. You must speak to your worker to renew by phone. If you are deaf or hard of hearing and have a TTY text telephone, call 1-800-220-5404.

By fax: Fill out and sign this form. Fax it and needed documents (see page 6) to the fax number on the letter that came with this form. If you need extra space on any question, use a separate sheet of paper.

In person: Visit your closest Medicaid office. The address to your local Medicaid office is on the letter that came with this form.

START HERE – Please use a black ink pen.

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

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

1. Person Getting Medicaid

Name _____ Date of Birth _____
First Middle Initial Last

Social Security Number _____ Medicare Claim Number _____

Home Address _____ Apt/Lot _____

City _____ State _____ Zip _____ Parish _____

Mailing Address (if different) _____ Apt/Lot _____

City _____ State _____ Zip _____

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

E-mail Address _____

Best Day and/or Time for Us to Call You During Our Office Hours (8:00am-4:30pm, Monday - Friday) _____

2. Who takes care of this person's business affairs? They Do – Go to Question 3 I Do – Fill Out Below

Your Name _____

Mailing Address _____ Apt/Lot _____

City _____ State _____ Zip _____

**Questions - Call 1-888-342-6207
(TTY text telephone for deaf and hard of hearing: 1-800-220-5404)**

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

E-mail Address _____

Best Day and/or Time for Us to Call You During Our Office Hours (8:00am-4:30pm, Monday - Friday) _____

Do you have Power of Attorney? Yes No Are you the Curator or Under Curator? Yes No

3. Give us information about this person’s health insurance, Long Term Care Insurance, Medicare supplement, or Medicare prescription plan. No Insurance – Go to Question 4 If more than 2, use another sheet of paper.

Policy #1

Insurance Company Name _____ Monthly Premium Cost _____

Policy Number _____ Group Number _____

Policy #2

Insurance Company Name _____ Monthly Premium Cost _____

Policy Number _____ Group Number _____

4. Do they have a spouse living with them? Yes – Fill Out Below No – Go to Question 5

Spouse’s Name _____
First Middle Initial Last

5. INCOME: Give us information about the income of the person getting Medicaid.

What is it?	How often is it received?	Gross Amount Received \$
What is it?	How often is it received?	Gross Amount Received \$
What is it?	How often is it received?	Gross Amount Received \$

6. Has the person who gets Medicaid applied for income like Social Security or Veteran’s Benefits, but did not get it, yet? Yes – Fill Out Below No – Go to Question 7

What is it? Social Security Veteran’s Benefits Other _____

7. Has the person who gets Medicaid or their spouse received a lump sum of money such as from an insurance, lawsuit, or worker’s comp settlement, inheritance, or a Social Security payment or are they expecting to receive a lump sum? Yes – Fill Out Below No – Go to Question 8

Who? Person Getting Medicaid Spouse

Amount \$ _____ When? _____ From what? _____

For what reason? _____

Attorney's Name, Address, and Phone Number _____

8. ASSETS / RESOURCES: Fill out the spaces below about the assets of the person who gets Medicaid and their spouse. (Let us know if they still have these and about new things).

ASSET TYPE	Still Have It	No Longer Have It	New
<p>Tell us if the person getting Medicaid or their spouse has this item.</p>	<p>Answer each question below.</p>	<p>For each type, answer: What happened to it? When did you or they get rid of it?</p>	<p>For each type, answer: When did you or they get it? How much is it worth? Name of bank or company.</p>
<p>Life Insurance, Burial Insurance: <input type="checkbox"/> Never had it <input type="checkbox"/> No longer have it <input type="checkbox"/> Still have it <input type="checkbox"/> New: Got it in past year</p>	<p>How much?</p>		
<p>Bank Account for Burial, Pre-arranged Burial Contract with Funeral Home: <input type="checkbox"/> Never had it <input type="checkbox"/> No longer have it <input type="checkbox"/> Still have it <input type="checkbox"/> New: Got it in past year</p>	<p>How much is in the account/contract?</p>		
<p>Checking/Savings/Christmas Club Accounts: <input type="checkbox"/> Never had it <input type="checkbox"/> No longer have it <input type="checkbox"/> Still have it <input type="checkbox"/> New: Got it in past year</p>	<p>How much is in the account(s)?</p>		
<p>Certificates of Deposit (CDs): <input type="checkbox"/> Never had it <input type="checkbox"/> No longer have it <input type="checkbox"/> Still have it <input type="checkbox"/> New: Got it in past year</p>	<p>How much is it worth?</p>		
<p>Cash on Hand or Held by Someone Else: <input type="checkbox"/> Never had it <input type="checkbox"/> No longer have it <input type="checkbox"/> Still have it <input type="checkbox"/> New: Got it in past year</p>	<p>How much?</p>		<p>How much? Where did the cash come from?</p>
<p>Annuities, Trusts: <input type="checkbox"/> Never had it <input type="checkbox"/> No longer have it <input type="checkbox"/> Still have it <input type="checkbox"/> New: Got it in past year</p>	<p>How much is in the account(s)?</p>		
<p>Stocks, Bonds: <input type="checkbox"/> Never had it <input type="checkbox"/> No longer have it <input type="checkbox"/> Still have it <input type="checkbox"/> New: Got it in past year</p>	<p>How much is it worth?</p>		

ASSET TYPE	Still Have It	No Longer Have It	New
Tell us if the person getting Medicaid or their spouse has this item.	Answer each question below.	For each type, answer: What happened to it? When did you or they get rid of it?	For each type, answer: When did you or they get it? How much is it worth? Name of bank or company.
Retirement Accounts: <input type="checkbox"/> Never had it <input type="checkbox"/> No longer have it <input type="checkbox"/> Still have it <input type="checkbox"/> New: Got it in past year	How much is in the account(s)?		
Safe-Deposit Box: <input type="checkbox"/> Never had it <input type="checkbox"/> No longer have it <input type="checkbox"/> Still have it <input type="checkbox"/> New: Got it in past year	What is inside?		What is inside?
Land, Second Home (not home property): <input type="checkbox"/> Never had it <input type="checkbox"/> No longer have it <input type="checkbox"/> Still have it <input type="checkbox"/> New: Got it in past year	How much is it worth?		
Car, Truck, Camper, Boat, ATV, Motorcycle: <input type="checkbox"/> Never had it <input type="checkbox"/> No longer have it <input type="checkbox"/> Still have it <input type="checkbox"/> New: Got it in past year	How much is it worth?		
Other _____: <input type="checkbox"/> No longer have it <input type="checkbox"/> Still have it <input type="checkbox"/> New: Got it in past year	How much is it worth?		

9. Give us more information about annuities belonging to the person getting Medicaid and their spouse. No Annuities – Go to Question 10 *If more than 2, use another sheet of paper.*

Annuity #1

Date Purchased _____ Beneficiary _____ Remainder Beneficiary _____

Annuity #2

Date Purchased _____ Beneficiary _____ Remainder Beneficiary _____

10. Does the person who gets Medicaid own or co-own a home? Yes – Fill Out Below No – Sign Form on the Next Page

List all owners. _____

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

Give us information about it like the location, lot size or number of acres, and if there are buildings on it.

Does anyone live in the home? Yes – Fill Out Below No – Sign Form on the Next Page

What is their relationship to the person who gets Medicaid? 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? \$ _____

This is the end of the form. You must sign the form on the next page.

YOUR RIGHTS AND RESPONSIBILITIES

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

REPORTING THE TRUTH: You state that the information you give on this renewal 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, etc.

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 money you get 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 at your death for the total amount of medical assistance paid on your behalf for all annuities purchased on or after Feb. 8, 2006, 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 the amount paid, frequency of payments, when payments begin, and additions to the principal.

WHAT YOU (the person getting 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 your 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, 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. 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. A hardship may exist if the estate property is the only source of income for the heirs, if that income is limited, or other convincing situations.

↓ **SIGN BELOW** ↓

Sign Here: _____ **Date** _____

If signed with an “X”, two witnesses must sign.
_____ **Date** _____ **Date** _____

If Medicaid filled out this form, 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.

If you filled out the renewal form, 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.*

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 this form 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 health insurance premium amount.	3
	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, a job, Veteran's Benefits, annuities, mineral rights, worker's comp, child support, reverse annuity mortgages, and royalties.	5
	Proof of any lump sum payments received in the last year from an insurance or lawsuit settlement, inheritance, worker's comp settlement, or Social Security.	7
	Proof of ownership and value for any new assets/resources.	8
	If the person getting Medicaid has a home and they rent it to someone, send proof of the amount of rental income received (letter from renters or cancelled check) and proof of the expenses of the rental property.	10
	Other:	
	Other:	

**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 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

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

NATCHITOCHES

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 COUNTRY			
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							