CommCare Corporation

the caring company

2025 Medicare

Medicare: A, B & D

Medicare: A federal health insurance program for people:

- 65 or older, who have paid into the Medicare system,
- People under 65 with certain disabilities,
- People of any age with end-stage Renal Disease

Medicare Part A: Benefits for Skilled Nursing & Rehabilitation

Medicare helps cover care in a skilled nursing and rehabilitation center for a maximum of 100 days. This includes room, meals, rehabilitation services and medication among other medical services.

Medicare covers skilled nursing & rehabilitation care:

- After a 3-day minimum inpatient stay at a hospital for a related illness or injury; (Medicare doesn't cover long term or custodial care.)
- SNF benefits available up to 30 days after discharge.
- At 100% for the first 20 days,
- Pays all but $209.50 for days 21-100

Medicare Part B: Physician & Outpatient Services

Medicare Part B helps cover doctors' services, hospital outpatient care, home health and some preventative services. In a skilled nursing & rehabilitation center, Part B covers evaluation and treatment to help individuals return to their usual activities after an illness or accident. There are limits and certain criteria that must be met. The beneficiary pays 20% of the Medicare amount and the Part B deductible applies

- Part B's deductible must be met ($257.00 in 2025)
- Beneficiary pays 20% of the Medicare-approved amount after the deductible has been met

Medicare Part D: Prescription Drug Coverage

Medicare Part D is a prescription drug option in which beneficiaries may choose to join a plan run by a Medicare-approved private insurance company. The Part D prescription drug plan can help individuals cover prescription drug costs.

Source: www.medicare.gov

950 W. Causeway Approach, Mandeville, LA 70471-3082 • P 504-324-8950
Email: info@commcare.com • www.commcare.com

CommCare Corporation

the caring company

Medicaid Overview

2025 Medicaid

Medicaid: A federal & state program for individuals requiring both medical and financial assistance

Long term care is a program covered by Louisiana Medicaid to assist individuals requiring financial assistance with long term health care needs.

Medicaid criteria include:

- Monthly gross income of $2,901 for an individual or $5,802 for married couples. (People with income above the threshold may qualify for long term care through medically needy spend-down.)
- Maximum assets of $2,000 for an individual; or if both spouses reside in the nursing home, $3,000 for married couples.

Protected Resources for a Spouse in the Community:

- A couple can maintain up to $157,920 in countable resources
- Excludes the value of home, household goods, personal goods, one car and burial funds.

What Counts as Income?

- Social Security Benefits
- Private Pensions
- Railroad Benefits
- State or Local Retirement Benefits
- Federal Employee Annuities
- Certain Veteran Benefits
- Royalty or Rental Income
- Gifts or Contributions
- Earnings or Wages

What Counts as a Resource?

- Bank Accounts & CDs
- Life Insurance Policies
- Oil, Gas or Mineral Rights
- Burial Policies
- IRAs
- Stocks & Bonds
- Vehicles, Boats & RVs
- Property or Rental Income
- Jewelry & Antiques

What Can Be Excluded?

- Homestead in Louisiana in which the individual intends to return,
- Life insurance with combined face value of $10,000
- Separate, irrevocable burial funds of $10,000 for the beneficiary
- One vehicle is excluded

Other Criteria

- **Individual must be contracted for a nursing facility stay of at least 30 days.**
- **Individual must meet medical necessity**
- **Individual must be a resident of Louisiana and a U.S. citizen or alien with approved status (i.e. legalized or permanent resident alien)**
- **Includes a look-back period of 60 months.**

Patient Liability

- **Individual – Total gross income, less health insurance premiums and $38 a month for personal needs.**
- **Individual with a Community Spouse – Total gross couple income, less $38 a month for personal needs; less $3,948 for community spouse; less $2,555 for dependents living with a community spouse.**

950 W. Causeway Approach, Mandeville, LA 70471-3082 • P 504-324-8950
Email: info@commcare.com • www.commcare.com

CommCare Corporation
the caring company

Medicaid

Things to know when seeking Medicaid Long Term Care admission into a Long Term care facility.

What is Medicaid? It is often confused with Medicare, which provides federal government insurance for retirees. Contrary to Medicare, Medicaid is a jointly funded, Federal-State health care program for persons who are financially eligible. Medicaid provides care for acute medical needs, rehabilitation, and long-term care at home and in nursing homes.

Who qualifies? In addition to medically qualifying, a patient must meet certain income and asset criteria to qualify for Medicaid long-term care benefits. Before Medicaid will authorize payment for nursing home services, a patient must prove he or she is 65 or over and or disabled. Individual must be contracted for a nursing facility stay of at least 30 days.

Does Income matter? To qualify for Medicaid long-term care, the applicant's monthly income must not be greater than $2,829 for a non-married applicant. This amount is also known as the long-term care special income limit (SIL), and it includes the income of Medicaid applicant from all sources. An individual is allowed the maximum assets of $2000.

Does Medicaid look at the spouses income? Yes, the monthly gross income for married couples is $5,658. People with income above the threshold may qualify for long term care through medically needy spend-down. Spousal poverty protection laws have been passed to assist the spouse of a senior who needs long-term care by using the Minimum Monthly Maintenance Needs Allowance. A couple with a spouse living in the community can maintain up to $154,140 in countable resources.

950 West Causeway Approach
Mandeville, LA 70471
www.commcare.com

Considerable Assets or Resources:

- Bank Accounts & CDs
- Life Insurance Policies
- Oil, Gas or Mineral Rights
- Burial Policies
- IRAs
- Stocks & Bonds
- Vehicles, Boats & RVs
- Property or Rental Income
- Jewelry & Antiques

Excluded Countable Resources:

- Homestead
- Household goods
- Personal goods
- One car
- Life insurance with combined face value of $10,000
- Separate, irrevocable burial funds of $10,000 for the beneficiary

Income Limit:

Single $2,829
Couple $5,658

- It is important to know that the income of a couple is only subject to the above limit ***ONLY*** when both spouses are institutionalized.

Countable Resource Limit:

Single $2,000
Couple $3,000

- It is important to know that the resources of a couple are subject to the lower limit above, ***ONLY*** when both spouses are institutionalized.

CommCare Corporation
the caring company

Medicaid

Does the state make adjustments for income Caps? Yes, Louisiana makes adjustment for some incomes exceeding the cap subject to the Medically Needy Program but does not allow Qualified Income Trusts, also known as Miller Trusts. Miller Trusts provide a way for Nursing Home Medicaid and Medicaid Waiver applicants who have income over Medicaid's limit to become income-eligible for Medicaid long-term care. In short, income over Medicaid's limit is put into a trust and is no longer as counted as income, thus allowing the applicant to become eligible.

Can I sell or gift my house and assets? Only within a certain time frame. There is a 60 month (5 year) look-back period. With limits some assets can be gifted to a beneficiary.

What Information do I need to provide to apply for Medicaid Long Term Care?

- Checking & Savings statements from the last 3 months
- Marriage License
- Death Certificate (if widowed within the last 5 years)
- Burial Polices
- Life Insurance Polices
- Prepaid burial plots
- Verification of Gross Income: Social Security. Pension and retirement, V.A. Benefits

How long do I have to gather information for the Long Term Care Financials? Long Term Care information must be provided within 5 business days of admission.

950 West Causeway Approach
Mandeville, LA 70471
www.commcare.com

Things to know:

- Individuals must be contracted for a nursing facility stay of at least ***30 days***. The individual must meet medical necessity criteria.
- Individual must be a resident of Louisiana and a U.S. citizen or alien with approved status (i.e. legalized or permanent resident alien).
- If an individual is over resourced they can consult with Certified Medicaid and Estate Planners to assist in preparing for Medicaid long term care. These professionals can provide alternatives that meet Medicaid rules and preserve assets for the benefit of the applicant.

Ridgecrest
Community Care Center

Common Myths regarding Medicaid

1. **True or False: Medicare & Medicaid are the same.**
   False. While they may sound the same, they are not. Medicare is a national insurance program for people over the age of 65 and certain people with disabilities.

   There are 50 Medicaid programs administered by each state. To become eligible for Medicaid individuals must meet both medical and financial criteria.

2. **True or False: Medicare & Medicaid pay for long term care**
   False. Medicare pays for short-term care for up to 100 days. Medicaid pays for long term care and is the only widely available government program to do so.

3. **True or False: I can transfer money or property to another individual to become eligible for Medicaid.**
   Depends. Medicaid has a look-back period of 60 months (5 years). If an individual transfers assets within that time period, Medicaid will consider that as an asset.

4. **True or False: If my spouse requires the services of a nursing facility and qualifies for Medicaid, I will be left with no income or assets.**
   False. For individuals with a Community Spouse, Medicaid takes the total gross couple income, less $38 a month for personal needs; less $3,435 for community spouse; less $2,177.50 for any dependents living with a community spouse.

   Medicaid allows a monthly gross income of $2,523 for an individual or $5,046 for married couples. (People with income above the threshold may qualify for long term care through medically needy spend-down.)

   Protected assets for a community spouse allows the couple to maintain up to $137,400 in countable resources. This excludes the value of home, household goods, personal goods, one car and burial funds

There are some things few people plan for until it happens. Nursing Home Care is one of them.

Generally, the first time people consider the services of a nursing home is when they find themselves in a predicament.

Maybe a family member finds themselves in the hospital after a heart attack, stroke, a broken hip or pneumonia. Perhaps a widow has dementia and this time she forgot to turn the stove off or has wandered out of the house into the night.

At this point families find themselves having to make a decision that the service that best meets the needs of the loved one may be the services of a skilled nursing facility. And often that decision must be made quickly.

Because most have never considered having to make the decision of choosing a nursing facility, they find themselves distraught over making such a momentous decision in a short timeframe.

950 West Causeway Approach • Mandeville, LA 70471-3082 • www.commcare.com

Ridgecrest
Community Care Center

Common Myths regarding Medicaid

5. True or False: Medicaid will take my home if I use the program for long term care.

Depends. There are certain conditions under which the state may pursue what is called Estate Recovery.

- Estate recovery can only be pursued for expenses paid by Medicaid for an individual who was 55 or older when he received long term care and related hospital and prescription drug services.
- No lien may be imposed by the state on an individual's home as long as the spouse, a child under age 21, or a child who is blind or permanently disabled is lawfully residing in the home.
- The state may not pursue estate recovery in cases of undue hardship, which is deemed to exist if an heir's family income is 300% or less than the federal poverty level.
- The state may not pursue estate recovery where the amount to be recovered is economically inappropriate in relation to the expense of the recovery. The state is prohibited from pursuing estate recovery on the first $15,000 or one half the median value of homesteads in each parish, whichever is higher.

6. True or False: If a Medicaid recipient's name is on a joint bank account, the funds in the bank account can be withdrawn by the non-Medicaid recipient in order to get the funds out of the name of the Medicaid recipient and maintain eligibility.

False. .

7. True or False: Funds received in a personal injury settlement can put Medicaid eligibility at risk.

True

8. True or False: Not providing all of the Medicaid applicant's fund and resource information can result in either an initial denial of benefits, or retroactive ineligibility leaving the individual personally responsible for charges.

True.

Most questions cover two areas: Quality and Financial

Questions we most often hear:

"What services can I expect from a nursing facility?"

"What will my day be like?"

"When can I visit?"

"How can I find out if a nursing facility has a good reputation?"

Will my health insurance pay for my care?

"Will Medicare pay for my care?

Is Medicaid different from Medicare?

Will Medicaid take my house?

If my dad qualifies for Medicaid, will my mom be left without any money?

1616 Wellerman Road • West Monroe, LA 71291 • 318-387-2577 • www.ridgecrestccc.com

Medicaid CHECKLIST

To apply for Medicaid assistance for long term coverage, the application will require these following documents. (if applicable)

No.	DOCUMENTATION NEEDED	✓
01	State issued ID	☐
02	Social Security Card	☐
03	All Health Insurance Cards (Medicare, Managed Care, Supplemental, long -term care insurance, prescription drug plans, etc.)	☐
04	Bank statements for any/all accounts (Last 3 months of statements)	☐
05	Stocks/ Bonds/ Investments / CD's / Mutual Funds (Statements showing current values)	☐
06	Verification of medical insurance premiums (only if you have a secondary you pay premiums on)	☐
07	Verification of all income (Social Security, Pensions, IRA's, Annuities, etc.)	☐
08	Documentation of any property or assets transfers/sales in the last 5 years. (this is only if you have transferred ownership)	☐
09	Life Insurance or Burial policies (documents showing face value)	☐
10	Power of Attorney, Guardianship or Interdiction	☐
11	Marriage License and Death Certificates	☐
12	Succession documents filed in courthouse.	☐
13	Trust - Trust documents filed at a courthouse	☐
14	Vehicle - Title or Registration for each vehicle registered in applicants name.	☐
15	Properties (will need proof of fair market value for all properties that are not the primary residence)	☐

	QUESTIONS WE WILL ASK	
01	How much money is in your account now?	
02	Do you own a home?	
03	How many vehicles do you own?	
04	Monthly income? (Stocks, Bonds, IRA, Trust, CD's)	
05	Have you given or transferred anything in the past 5 years? (house, cars, etc.)	

Medicaid Questions

Date: _____

№	Questions we will ask:	✓
1	How much money is in your account now?	
2	Do you own a home?	
3	How many vehicles do you own?	
4	Monthly income? (Stocks, Bonds, IRA, Trust, CD's)	
5	Have you given or transferred anything in the past 5 years? (house, land, cars)	

Individual: you can have $2,000 or less in resources.

Married: you can have $150,000 in resources.

THIS DOES NOT INCLUDE YOUR HOME OR VEHICLES

CommCare Corporation
the caring company

APPLICATION FOR LONG-TERM CARE SERVICES

Medicaid Benefits for People Needing Long-Term Care

- Fill out this application to see if you qualify for long-term care services coverage through Medicaid. This program is only for those who are planning to live or now live in a nursing facility, group home, or developmental center in Louisiana, or who have been offered an opportunity through Home and Community-Based Services (HCBS) or the Program of All-Inclusive Care for the Elderly (PACE).
- If you need extra space, use a separate sheet of paper or the space provided for you on page 13.
- If you have any questions, call 1-800-230-0690 from Monday–Friday to speak with a Medicaid representative. TTY Text Telephone users call 1-800-220-5404.
- Complete and mail this application to the **Medicaid Application Office, 6069 I-49 Service Rd, Suite B, Opelousas, LA 70570** or fax it to 225-389-8019.

What long-term care benefits are you applying for? *(you may mark one or more)*
☐ Nursing facility services **(Applicant Only)** ☐ Nursing facility services **(Applicant and Spouse)**
☐ HCBS Waiver ☐ PACE ☐ Intermediate Care Facility for the Intellectually Disabled (ICF/ID) or other group home

What is your preferred language? ☐ English ☐ Spanish ☐ Vietnamese ☐ Other: _____

► *Please **PRINT** clearly in black ink.*

1 — Applicant's Personal Information

First name	Middle initial	Last name	Suffix *(Sr., Jr., etc.)*

Social Security number	Date of birth	Sex ☐ Male ☐ Female	Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

If Hispanic/Latino, ethnicity *(optional – you may mark one or more)*
☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other: _____

Race *(optional – you may mark one or more)*
☐ White ☐ Asian Indian ☐ Japanese ☐ Other Asian ☐ Samoan
☐ Black or African American ☐ Chinese ☐ Korean ☐ Native Hawaiian ☐ Other Pacific Islander
☐ Filipino ☐ Vietnamese ☐ Guamanian or Chamorro
☐ American Indian or Alaska Native – Tribe: _____ ☐ Other: _____

Mailing Address			Home Address *(if different)*		
P.O. box or street address		Apt/Lot #	Street address		Apt/Lot #
City	State	Zip	City	State	Zip
E-mail address *(if you have one)*			Home parish *(where you live)*		
Cell phone ( )	Home phone ( )		Other phone ( )		
Are you a Louisiana resident? ☐ Yes ☐ No			Do you plan to stay in Louisiana? ☐ Yes ☐ No		

2 — Application Assistance

Do you have someone helping you with this application? ☐ Yes ☐ No *(If **NO**, skip to section 3)*

Name of Assistant	Relationship to Applicant
Mailing address	

Do you want your mail to be sent to the address listed above? ☐ Yes ☐ No

Daytime phone ( )	Other phone ( )	E-mail address *(if they have one)*

3 — Legal Assistance

Do you have someone legally appointed to act on your behalf? ☐ Yes ☐ No *(If **NO**, skip to section 4)*

What kind of appointment does this person have? ☐ Power of Attorney ☐ Curator ☐ Other

Name of Appointee	Relationship to Applicant
Mailing address	

Do you want your mail to be sent to the address listed above? ☐ Yes ☐ No

Daytime phone ( )	Other phone ( )	E-mail address *(if they have one)*

4 — Citizenship

Are you a veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

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)*

Alien number	Certificate type	Certificate number

If **NO**, do you have eligible immigration status? ☐ Yes ☐ No *(If **YES**, fill in your information below if it applies to you)*

Document type	Document expiration date

Alien, I-94, or SEVIS ID number	Card or Passport number	Have you lived in the U.S. since 1996? ☐ Yes ☐ No

5 — Long-Term Care

Do you currently live at or are planning to enter a long-term care facility? ☐ Yes ☐ No *(If **NO**, skip to section 6)*

Facility name

Date you entered or plan to enter this facility	Are you planning to stay at this facility for at least 30 days? ☐ Yes ☐ No

Were you living with a legal spouse prior to entering this facility? ☐ Yes ☐ No

If **NO**, were you living apart from a legal spouse for medical reasons? ☐ Yes ☐ No

6 — Home and Community Based Services

Have you been offered a HCBS waiver slot? ☐ Yes ☐ No *(If **NO**, skip to section 7)*

What type of HCBS waiver are you applying for?
☐ Adult Day Health Care ☐ Children's Choice ☐ New Opportunities ☐ Community Choices ☐ Other

Name of Support Coordination Agency

Are you expected to get waiver services for at least 30 days? ☐ Yes ☐ No

7 — Disability

Do you have a disability? ☐ Yes ☐ No *(If **NO**, skip to section 8)*
(NOTE: A disability is a physical, mental, or emotional health condition that causes limitations in daily activities like bathing, dressing, chores, etc.)

Describe your disability

When did this disability start?	Was the disability caused by an accident? ☐ Yes ☐ No
Have you ever applied for disability benefits? ☐ Yes ☐ No	If **YES**, has a decision been made regarding your application for disability benefits? ☐ Yes ☐ No

Name of doctor, hospital, or other medical provider with records that can support your disability claim

Medical provider's address	Medical provider's phone number ( )

8 — Health Insurance *(other than Medicaid)*

Do you want help paying for medical bills (paid or unpaid) for medical care received in the past 3 months? ☐ Yes ☐ No

Do you have health insurance? ☐ Yes ☐ No *(If **NO**, skip to section 9)*

What type of insurance coverage do you have?
☐ Private Health Insurance ☐ Medicare Supplement ☐ Medicare Drug Plan ☐ Medicare Advantage

Name of policyholder

Insurance company name

Group/Policy number	Medicare Claim Number *(if you have one)*
How much is the premium for this insurance?	Do you have a Long-Term Care or Partnership Insurance policy? ☐ Yes ☐ No

9 — Members of your Household

Provide information about your spouse, parents, children, and anyone else living with you or who lived with you before you entered a long-term care facility. If no one lives with you or had lived with you, leave blanks empty.

	Person 1	Person 2	Person 3
Name			
Relationship to you			
Social Security number			
Date of birth			
Sex	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female
Does this person want to apply for Medicaid?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is this person a veteran?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Do you want to give a portion of your income to a spouse or dependent listed above? ☐ Yes ☐ No

If **YES**, who do you want to give it to?

Provide information about your former or deceased spouse(s).
If you do not have a former or deceased spouse, leave blanks empty and skip to section 10.

	Former Spouse 1	Former Spouse 2
Name		
Social Security number		
Date of birth		
Sex	☐ Male ☐ Female	☐ Male ☐ Female
Did you divorce this person?	☐ Yes ☐ No	☐ Yes ☐ No
If **YES**, date of divorce		
Has community property been settled?	☐ Yes ☐ No	☐ Yes ☐ No
Is this person deceased?	☐ Yes ☐ No	☐ Yes ☐ No
If **YES**, date of death		
Has succession been opened?	☐ Yes ☐ No	☐ Yes ☐ No
Is this person a veteran?	☐ Yes ☐ No	☐ Yes ☐ No

10 — Lump Sum Payments

Have you or anyone in your household received or are expecting to receive a lump sum of money, such as from an insurance/lawsuit/worker's comp settlement, an inheritance, or Social Security backpay? ☐ Yes ☐ No *(If **NO**, skip to section 11)*

Who received or is receiving the lump sum? ☐ You ☐ Spouse ☐ You and spouse ☐ Parent(s) ☐ Other: _____

When was or will it be received?	Who was it received from?	How much is it worth?

Explain the reason the lump sum was paid out

Give the name, address, and phone number of any attorney involved in this payment

11 — Income from Jobs *(examples: cash, checks, tips, etc.)*

Do you or anyone in your household work? ☐ Yes ☐ No *(If **NO**, skip to section 12)*

	Job 1	Job 2	Job 3
Worker's name			
Is this person self-employed?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Employer name			
Employer address			
Employer phone number	( )	( )	( )
How often paid? *(weekly, biweekly, monthly, etc.)*			
How much are they paid? *(gross income before taxes)*	$	$	$

12 — Other Income

Do you or anyone in your household receive:	Who receives this money? *(you, spouse, parent, etc.)*	Where does it come from or who pays it?	How often are they paid? *(weekly, monthly, etc.)*	How much are they paid? *(before taxes)*
Social Security ☐ Yes ☐ No				$
SSI ☐ Yes ☐ No				$
Veteran's Benefits ☐ Yes ☐ No		VA file #:		$
Railroad Retirement ☐ Yes ☐ No		Claim #:		$
Retirement/Pension ☐ Yes ☐ No				$
Annuities ☐ Yes ☐ No				$
Royalties ☐ Yes ☐ No				$
Rental Income ☐ Yes ☐ No				$
Worker's Comp ☐ Yes ☐ No				$
Unemployment ☐ Yes ☐ No				$
Alimony/Child Support ☐ Yes ☐ No				$
Other: _____ ☐ Yes ☐ No				$

13 — Bank Accounts

Do you or anyone in your household have any bank accounts or Certificates of Deposit (CDs)?
☐ Yes ☐ No *(If **NO**, skip to section 14)*

Type of Account: *(check only one per row)*	Who does it belong to?	Name of Bank/ Credit Union	Account Number	How much is it worth?
☐ Checking ☐ Savings ☐ Christmas Club ☐ Direct Express Card Acct ☐ Certificate of Deposit				$
☐ Checking ☐ Savings ☐ Christmas Club ☐ Direct Express Card Acct ☐ Certificate of Deposit				$
☐ Checking ☐ Savings ☐ Christmas Club ☐ Direct Express Card Acct ☐ Certificate of Deposit				$

14 — Retirement Accounts

Do you or anyone in your household have a pension or retirement account (IRA, Keogh, 401-K, etc.)?
☐ Yes ☐ No *(If **NO**, skip to section 15)*

Who does this account belong to? ☐ You ☐ Spouse ☐ You and spouse ☐ Parent(s) ☐ Other: _____

Name of bank/company

Account number	How much is it worth?

Do you currently receive regular payments from this account? ☐ Yes ☐ No

If **YES**, how much are they and how often do you receive them?	If **NO**, are regular payments available? ☐ Yes ☐ No ☐ I'm Not Sure

Can a lump sum withdrawal of funds be made from this account? ☐ Yes ☐ No ☐ I'm Not Sure

15 — Annuities

Do you or anyone in your household own annuities? ☐ Yes ☐ No *(If **NO**, skip to section 16)*

Who owns the annuities? ☐ You ☐ Spouse ☐ You and spouse ☐ Parent(s) ☐ Other: _____

Name of annuity beneficiary	Name of annuity remainder beneficiary

Name of insurance company

Account number	Date of purchase	How much is it worth?

Do you currently receive regular payments from this account? ☐ Yes ☐ No

If **YES**, how much are they and how often do you receive them?	If **NO**, are regular payments available? ☐ Yes ☐ No ☐ I'm Not Sure

Can a lump sum withdrawal of funds be made from this account? ☐ Yes ☐ No ☐ I'm Not Sure

16 — Patient Trust Fund

Do you have a patient trust fund account at a nursing facility? ☐ Yes ☐ No *(If **NO**, skip to section 17)*

Facility name	How much is it worth?

17 — Safe Deposit Box

Do you or anyone in your household own a safe deposit box? ☐ Yes ☐ No *(If **NO**, skip to section 18)*

Who owns the safe deposit box? ☐ You ☐ Spouse ☐ You and spouse ☐ Parent(s) ☐ Other: _____

Name of bank where box is located

List items that are kept in the box *(any items that can be converted to cash)*

How much are the items kept in the box worth?

18 — Stocks

Do you or anyone in your household own stocks? ☐ Yes ☐ No *(If **NO**, skip to section 19)*

Who owns the stocks? ☐ You ☐ Spouse ☐ You and spouse ☐ Parent(s) ☐ Other: _____

Name of company stock is held in

How many shares?	How much are they worth?

19 — Bonds

Do you or anyone in your household own bonds? ☐ Yes ☐ No *(If **NO**, skip to section 20)*

Who owns the bonds? ☐ You ☐ Spouse ☐ You and spouse ☐ Parent(s) ☐ Other: _____

How many bonds?	How much are they worth?

What type of bonds?

Bond number(s)

20 — Mortgages, Loans, and Promissory Notes

Do you or anyone in your household own a mortgage, loan, or other promissory note? ☐ Yes ☐ No *(If **NO**, skip to section 21)*

Who does the loan belong to? ☐ You ☐ Spouse ☐ You and spouse ☐ Parent(s) ☐ Other: _____

Date of agreement	Can this agreement be sold? ☐ Yes ☐ No	How much is it worth?

21 — Vehicles *(examples: cars, trucks, boats, trailers, campers, motorcycles, ATVs, etc.)*

Do you or anyone in your household own any vehicles? ☐ Yes ☐ No *(If **NO**, skip to section 22)*

Type of Vehicle: *(include make/model/year)*	Who does it belong to?	How much is it worth?	How much is owed on it?
		$	$
		$	$
		$	$
		$	$

22 — Primary Residential Real Estate

Do you or anyone in your household own property where they live, are in the process of buying property where they intend to live, or have usufruct of a property in which they live? ☐ Yes ☐ No *(If **NO**, skip to section 23)*

If **YES**, which is it? ☐ Own/buying property ☐ Usufruct of property

Who does the property belong to? ☐ You ☐ Spouse ☐ You and spouse ☐ Parent(s) ☐ Other: _____

Address of the property

Parish/county property is located	Property lot size	Number of buildings on property
How much is the property worth?	How much is owed on it?	
Who lives on the property?		
Is the property for sale? ☐ Yes ☐ No	Is the property rented/leased? ☐ Yes ☐ No	If you are currently in a facility, do you intend to return to this property? ☐ Yes ☐ No

23 — Secondary Real Estate

Do you or anyone in your household own or have usufruct of any additional property, including (but not limited to) a second home, out-of-state property, or a share of other inherited property? ☐ Yes ☐ No *(If **NO**, skip to section 24)*

Who does the property belong to? ☐ You ☐ Spouse ☐ You and spouse ☐ Parent(s) ☐ Other: _____

Address of the property

Parish/county property is located	Property lot size	Number of buildings on property
How much is the property worth?	How much is owed on it?	
Who receives the tax notice for this property?	What percentage of this property is owned/inherited?	
Is the property for sale? ☐ Yes ☐ No	Is the property rented/leased? ☐ Yes ☐ No	

24 — Burial Funds

Do you or anyone in your household have any funds set aside for burial? ☐ Yes ☐ No *(If **NO**, skip to section 25)*

Who owns the funds?	For whose burial are they for?	Name of Bank or Funeral Home	How much are they worth?
			$
			$
			$

25 — Burial Contracts

Do you or anyone in your household have a pre-paid/pre-need burial contract? ☐ Yes ☐ No *(If **NO**, skip to section 26)*

Who owns the contract?	For whose burial is it for?	Name of Funeral Home	How much is it worth?
			$
			$
			$

26 — Life Insurance

Do you or anyone in your household have life or burial insurance? ☐ Yes ☐ No *(If **NO**, skip to section 27)*

Who is insured?	Who owns the policy?	Name of Insurance Co.	Policy Number	Policy Type	What is the face value?	Does this policy have accumulated dividends?
					$	☐ Yes ☐ No
					$	☐ Yes ☐ No
					$	☐ Yes ☐ No

27 — Burial Space

Do you or anyone in your household own a cemetery plot, grave site, mausoleum, vault, casket, urn, headstone, or other burial space/item? ☐ Yes ☐ No *(If **NO**, skip to section 28)*

Who does it belong to? ☐ You ☐ Spouse ☐ You and spouse ☐ Parent(s) ☐ Other: _____

Describe the site/item

Whose burial is it for?	How much is it worth?	Is it paid for in full? ☐ Yes ☐ No

28 — Other Ownership and Cash on Hand

Do you or anyone in your household own anything else of value, including (but not limited to) a business or mineral rights, or have access to any other cash on hand? ☐ Yes ☐ No *(If **NO**, skip to section 29)*

Who does it belong to? ☐ You ☐ Spouse ☐ You and spouse ☐ Parent(s) ☐ Other: _____

Describe what is owned and give as much information about it as you can, including how much it is worth

29 — Other Bank Accounts

Do you or anyone in your household have their name on **SOMEONE ELSE'S** bank/credit union account? ☐ Yes ☐ No

Does **SOMEONE ELSE** have a bank/credit union account with money in it that belongs to you or someone in your household? ☐ Yes ☐ No *(If **NO** for both questions, skip to section 30)*

Whose name is on the account?	Whose money is in the account?	Name of Bank/ Credit Union	Account Number	How much belongs to you or your household?
				$
				$

30 — Trusts

Have you or anyone in your household ever created a trust, placed items in a trust, or had a trust set up for them? ☐ Yes ☐ No *(If **NO**, skip to section 31)*

Who does the trust belong to? ☐ You ☐ Spouse ☐ You and spouse ☐ Parent(s) ☐ Other: _____

What kind of a trust is it?	Whose money/items/property were added to the trust?

Describe the money/items/property that are a part of the trust, including how much they are worth

31 — Transfer of Resources

Have you, anyone in your household, or anyone acting for them given away, sold, or transferred ownership of any item of value, including (but not limited to) land, houses, life insurance, vehicles, or bank accounts, in the past 60 months? ☐ Yes ☐ No

What was transferred/ sold?	When was it transferred/ sold?	Who was it transferred/ sold to?	How much was it worth?	Was anything received in return?	What happened to what was received?
			$		
			$		
			$		

APPENDIX A

Choosing a Dental Plan

Most people on Medicaid or LaCHIP need to choose a Dental Plan. These plans are groups of dentists and other staff who work together to provide dental care. You can look at information about the different Dental Plans at **www.healthy.la.gov**. If you know which Dental Plan you want, please choose now. If you do not choose, and you need to be in a Dental Plan, we will choose for you.

Which Plan is Right for You?

All Dental Plans must offer the same dental coverage. Certain plans may offer extra benefits. You can choose a different Dental 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 dentists to find out what plans they accept.
2. For more information about the plans you can choose, visit **www.healthy.la.gov** or call **1-855-229-6848**.

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

I choose the following plans for each person applying:

NAME OF PERSON APPLYING	SELECT A DENTAL PLAN FOR THE PERSON APPLYING *(Please select only ONE Dental Plan per person)*
	DENTAL PLANS
	☐ DentaQuest ☐ MCNA Dental
	DENTAL PLANS
	☐ DentaQuest ☐ MCNA Dental
	DENTAL PLANS
	☐ DentaQuest ☐ MCNA Dental
	DENTAL PLANS
	☐ DentaQuest ☐ MCNA Dental
	DENTAL PLANS
	☐ DentaQuest ☐ MCNA Dental
	DENTAL PLANS
	☐ DentaQuest ☐ MCNA Dental

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.

YOUR RIGHTS AND RESPONSIBILITIES

- By signing and submitting this application, you state that you have permission from all of the people listed on the application to both submit their information to the Louisiana Department of Health (LDH), and receive any information about their eligibility and health coverage.
- You understand that LDH is authorized to gather the information requested in this application and any supporting documentation, including social security numbers, under the Patient Protection and Affordable Care Act (Public Law No. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law No. 111-152), and the Social Security Act.
- You understand that providing the requested information (including social security numbers) is voluntary. However, failing to provide it may delay or prevent you from getting health coverage through Medicaid or any other insurance affordability program.
- You understand that LDH will check the information you give us to make sure it is correct. You give LDH permission to contact any outside source(s) necessary to check this information, process your application, determine eligibility, and otherwise operate the Medicaid program. These outside sources may include:
  - Federal agencies (such as the Internal Revenue Service, Social Security Administration, and Department of Homeland Security), other state agencies, and/or local government agencies.
  - Banks, financial institutions, and consumer reporting agencies.
  - Employers identified on applications for eligibility determinations.
  - Doctors or other medical providers.
  - Applicants/enrollees, and authorized representatives of applicants/enrollees.
  - LDH contractors engaged to perform a function for the Medicaid program.
  - Anyone else as required or allowed by law.
- You give these outside sources permission to give LDH any information about you, or any person necessary for this application, that it may request. You understand that this permission will end when this application is denied, when your Medicaid eligibility ends, or when you submit a written statement to LDH canceling this permission, whichever comes first. A cancellation may prevent you from being found to be eligible for Medicaid.
- You understand the social security numbers will only be used to get information from these outside sources to verify income, make eligibility determinations, or for other purposes directly connected to the administration of the Medicaid program.
- You must tell Medicaid if anything changes or is different than what you've written on this application. Call 1-888-342-6207 to report any changes. You also understand that a change in your information could affect the eligibility for member(s) of your household. You agree to tell Medicaid within 10 days if any of the following change: mailing or home addresses, things you own, health insurance coverage or premiums, income, if anyone moves in or out of your home, or if anyone moves out of state.
- You state that answers you gave on this application are true and correct. If you purposely gave information that is not true or if you withheld information, you have committed fraud. If you commit fraud, you may have to pay back money that Medicaid pays for care that you receive.
- You state that the information given in this application about your citizenship and immigration status is true and correct.
- By signing and submitting this application, you understand that if anyone on this application enrolls in Medicaid, you are giving LDH your rights to any money owed to you by any other health insurance, legal settlement, a spouse or parent, or other third party.
- You understand that Medicaid will only send case information to Child Support Enforcement for medical support if you ask them to. LDH will only make a referral if parents of children under age 19 receive Medicaid. You can request that Medicaid not refer you if you feel you have good cause not to cooperate with Child Support Enforcement.
- You understand that Estate Recovery rules require LDH to recover the cost of certain Medicaid payments from your estate in the event of your death. These costs include the total amount of payments for facility services, hospital care, waiver services, payments to Home and Community Based Services (HCBS) or Program for All-Inclusive Care for the Elderly (PACE) providers, and prescription drugs received at age 55 or older. LDH will not make a claim against the estate while you or your legal spouse is still living. LDH will also not make a claim 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 LDH 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 if there are other extenuating circumstances.
- You agree that by accepting Medicaid, the State of Louisiana or its assignee will be named as the remainder beneficiary of all annuities purchased on or after Feb. 8, 2006 for the total amount of medical assistance paid on your behalf, unless you have a spouse, minor child, or a child with a disability. In these cases, the State of Louisiana must be named as beneficiary after these individuals. You agree to tell Medicaid about any annuity you and your spouse own or co-own regardless if the annuity is irrevocable (cannot be changed) or Medicaid counts it. You understand that you must tell Medicaid about changes made to any annuity which may affect when payments begin, the amount paid, frequency of payments, and additions to the principal.
- You can ask for a Fair Hearing if you think any decision made on the case is unfair, incorrect, or made too late.
- LDH 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 the Louisiana Department of Health, Human Resources at P. O. Box 4818, Baton Rouge, LA 70821-4818.

After reading, please continue to the next page to complete your application.

Use this space or an extra piece of paper for any comments or information that you could not fit on your application.

Read and sign below

By signing this application I am giving my permission to the State of Louisiana and its agents to verify the information given on this application. Under penalty of perjury, I certify that all information contained in this application, including U.S. citizenship or lawful immigrant status of all persons applying for benefits, is true and correct to the best of my knowledge. I have read or someone has read to me the "Rights and Responsibilities" section of the application (located on page 12), including fraud penalties.

Sign here:	Date:
Spouse sign here *(if applying)*:	Date:
Application assistant sign here *(if necessary)*:	Date:
Witness One sign here *(if any applicant signs with an X or other mark)*:	Date:
Witness Two sign here *(if any applicant signs with an X or other mark)*:	Date:

DOCUMENTS OF PROOF

We may ask you for documentation to prove what is reported on this application. Let us know if you do not have or cannot obtain any of these documents and we may be able to assist you. We are required by law to keep all information you provide to us private.

Use the checklist below to help keep track of what you may need to provide as proof.

- ❑ Proof of applicant's legal marriage such as a marriage certificate (not needed if applicant's spouse has Long-Term Care Medicaid or if spouse is deceased.)
- ❑ Copy of Permanent Resident Card (green card) or other cards/forms from U.S. Citizenship and Immigration Services. **Only for applicants who are not U.S. citizens.**
- ❑ Copy of legal documents to show power of attorney, curator, or interdiction.
- ❑ If applicant is widowed, copy of the succession. If the succession has not been completed, then a copy of the will.
- ❑ Proof of income, such as a check stub or award letter showing amount of gross income (before deductions), from retirement, pension, Veteran's benefits, annuities, mineral rights, worker's compensation, child support, reverse annuity mortgages, and royalties. **Provide for applicant, applicant's spouse, applicant's parents (if applicant is under 18), and applicant's dependents under age 18.**
- ❑ If the applicant, applicant's spouse, or applicant's parents (if applicant is under 18) own property that is rented out, send proof of the amount of rental income received (letter from renters or canceled check) and proof of expenses of rental property.
- ❑ Statement from friends and/or relatives who have given money to the applicant and/or their spouse.
- ❑ For anyone who works, send pay stubs or a letter from employer showing gross pay (before deductions) for the last month. If self-employed, send copies of their most recent tax return and all schedule attachments. **Provide for applicant, applicant's spouse, applicant's parents (if applicant is under 18), and applicant's dependents under age 18.**
- ❑ Proof of any lump sum payments received in the last five years from an insurance or lawsuit settlement, inheritance, worker's compensation settlement, or Social Security. **Provide for applicant, applicant's spouse, applicant's parents (if applicant is under 18), and applicant's dependents under age 18.**
- ❑ Copies of bank statements for the last three months. Send **ALL** pages showing the check images, account numbers, names and addresses of banks, all deposits and withdrawals, and all names on the accounts. **Provide for applicant, applicant's spouse, applicant's parents (if applicant is under 18), and applicant's dependents under age 18.**
- ❑ Copy of annuity and statements for the last three months. **Provide for applicant, applicant's spouse, applicant's parents (if applicant is under 18), and applicant's dependents under age 18.**
- ❑ Account statements for certificates of deposit (CDs), IRAs, 401-Ks, Keoghs, and retirement accounts for the last three months. **Provide for applicant, applicant's spouse, applicant's parents (if applicant is under 18), and applicant's dependents under age 18.**
- ❑ A list of what is inside any safe-deposit boxes and a sworn statement from the person who accessed them. **Provide for applicant, applicant's spouse, applicant's parents (if applicant is under 18), and applicant's dependents under age 18.**
- ❑ Copies of stocks and bonds, including any account statements. **Provide for applicant, applicant's spouse, applicant's parents (if applicant is under 18), and applicant's dependents under age 18.**

CONTINUED ON NEXT PAGE

DOCUMENTS OF PROOF *(continued)*

- ❑ If you own more than one vehicle, copies of vehicle registrations/titles and proof of what is owed on each vehicle, like a statement from creditor. **Provide for applicant, applicant's spouse, applicant's parents (if applicant is under 18), and applicant's dependents under age 18.**
- ❑ For property that is owned (not counting the applicant's home) or property that has been inherited (can be undivided), send proof to show what the property is worth and how much of a share the applicant and their family have. **Provide for applicant, applicant's spouse, applicant's parents (if applicant is under 18), and applicant's dependents under age 18.**
- ❑ Copy of the last bank statement for burial or funeral accounts. **Provide for applicant, applicant's spouse, applicant's parents (if applicant is under 18), and applicant's dependents under age 18.**
- ❑ Copies of pre-arranged burial contracts with funeral homes with included list of services. **Provide for applicant, applicant's spouse, applicant's parents (if applicant is under 18), and applicant's dependents under age 18.**
- ❑ Copies of life or burial insurance policies if the face value for all is more than $10,000 for each person. **Provide for applicant, applicant's spouse, applicant's parents (if applicant is under 18), and applicant's dependents under age 18.**
- ❑ For any burial space items, such as a mausoleum or cemetery plot that is not already paid in full, send proof of how much is owed and how much the items are worth. **Provide for applicant, applicant's spouse, applicant's parents (if applicant is under 18), and applicant's dependents under age 18.**
- ❑ Copies of trust documents, including schedule of assets and current values of the items in trust. **Provide for applicant, applicant's spouse, applicant's parents (if applicant is under 18), and applicant's dependents under age 18.**
- ❑ Copies of paid or unpaid medical bills for services received in the last 3 months (if applying for Medicaid for those months). **Provide for applicant, applicant's spouse, applicant's parents (if applicant is under 18), and applicant's dependents under age 18.**
- ❑ Copies of the Act of Donation, Bill of Sale, bank statements, or other documents showing items that were given away, sold, or a deed that was changed. Include fair market values of these items at the time the transaction occurred. **Provide for applicant, applicant's spouse, applicant's parents (if applicant is under 18), and applicant's dependents under age 18.**
- ❑ Copies of all health insurance cards (front **AND** back), including Medicare, long-term care insurance, Medicare prescription drug plans, and Medicare supplements. Include verification of premium amounts. **Provide for applicant, applicant's spouse, applicant's parents (if applicant is under 18), and applicant's dependents under age 18.**

LONG-TERM CARE SERVICES

THIS PAGE INTENTIONALLY LEFT BLANK.

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**

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):

THIS PAGE INTENTIONALLY LEFT BLANK.

Louisiana Voter Registration Application
(LA-VRA - Rev. 6/19)

SEE THE OTHER SIDE OF THIS PAGE FOR INSTRUCTIONS ➔

QUESTIONS? - Call your parish Registrar of Voters Office or call the Secretary of State at 1-800-883-2805 or (225) 922-0900.

OFFICIAL USE ONLY: WD: _____ PCT: _____ REG. TYPE: _____ IN/OUT: _____ REG # _____

Please print clearly in ink, preferably black.

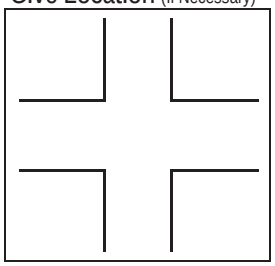
Reason for Application: ☐ New Voter Registration ☐ Updating Voter Registration

Eligibility 1. Are you a citizen of the United States of America? ☐ Yes ☐ No
Will you be 18 years of age on or before election day? ☐ Yes ☐ No
If you checked 'No' in response to either of these questions, do not complete this form. You are not eligible to vote at this time. (Please see application instructions for information regarding eligibility to register prior to age 18.)

Name 2. LAST NAME: _____ FIRST NAME: _____
FULL MIDDLE OR MAIDEN NAME: _____ SUFFIX (Sr., Jr., II): _____

Residence Address (Where you live and claim homestead exemption, if any)
HOUSE # & STREET (NO P.O. BOX): _____ UNIT/APT #: _____
CITY/TOWN: _____ STATE LA ZIP CODE: _____

Give Location (If Necessary)



Mailing Address (If different from Residence Address) 3. ☐ Check if no postal service at your residence address above and supply mailing address here.
HOUSE # & STREET/P.O. BOX: _____ UNIT/APT #: _____
CITY/TOWN: _____ STATE: _____ ZIP CODE: _____

Date of Birth 4. ____/____/____ (MM DD YYYY)

5. *SSN _____ - _____ - _____ (XXX XX XXXX)

6. Sex ☐ M ☐ F

7. Race (Optional) ☐ WHITE ☐ BLACK ☐ ASIAN ☐ HISPANIC ☐ AMERICAN INDIAN ☐ OTHER _____

Party Affiliation 8. ☐ DEMOCRAT ☐ GREEN ☐ INDEPENDENT ☐ LIBERTARIAN ☐ REPUBLICAN ☐ NO PARTY ☐ OTHER (Specify) _____

9. Place of Birth CITY/TOWN: _____ STATE: _____ PARISH/COUNTY: _____ COUNTRY: _____

Mother's Maiden Name 10. _____

11. Email _____

12. Phone Home: (____) _____ - _____ Other: (____) _____ - _____

LA DL/ID Card # 13. _____ ☐ I do not have a LA DL/ID card.

14. Do you need assistance in voting? ☐ No ☐ Yes, Reason: _____

Last Residence Address 15. HOUSE # & STREET: _____ CITY: _____ STATE: _____

16. Place of Last Registration STATE: _____ PARISH/ COUNTY: _____

17. Former Registered Name, if any _____

Affirmation and Signature (Read and sign or make your mark.)

18. 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 have not been incarcerated pursuant to an order of imprisonment for conviction of a felony within the past five years, nor am I under an order of imprisonment for a felony offense of election fraud or other election offense pursuant to R.S. 18:1461.2, 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.

Applicant Signature: ☒ _____ Date: _____

Witnesses (If your signature is a mark, you must have two witnesses sign.)

19. Witness #1 Signature: ☒ _____ Witness #1 Print Name: _____

Witness #2 Signature: ☒ _____ Witness #2 Print Name: _____

* If you do not have a LA driver's license or LA special ID, the last four digits of your social security number are required if you have one. Full SSN is preferred but optional.

Note: 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. You may request a copy of your voter registration form at any time from the registrar of voters.

OFFICIAL USE ONLY

☐ New Registration Updated Registration: ☐ Address Change ☐ Name Change ☐ Party Change ☐ Change to Assistance in Voting ☐ Other

REMARKS:

CIRCLE ONE:
PA MV RG SDA SS (Disability) Received by: _____ Date: _____

Louisiana Voter Registration Application
(LA-VRA - Rev. 6/19)

QUESTIONS? - Call your parish Registrar of Voters Office or call the Secretary of State at 1-800-883-2805 or (225) 922-0900.

APPLICATION INSTRUCTIONS

USE THIS LOUISIANA VOTER REGISTRATION APPLICATION TO: 1) register to vote; 2) change your address; 3) request a name change; 4) change party affiliation; or 5) request assistance in voting.

TO REGISTER AND BE ELIGIBLE TO VOTE, AN APPLICANT MUST: 1) be a U.S. citizen; 2) be at least 17 years old (16 years old if registering to vote in person at the Registrar's Office or with an application for a Louisiana driver's license) but must be 18 years old before actually voting; 3) not be under an order of imprisonment for conviction of a felony or, if under such an order, not have been incarcerated pursuant to the order within the last five years and not be under an order of imprisonment related to a felony conviction for election fraud or any other election offense pursuant to R.S. 18:1461.2; 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: the gray section numbers on this page correspond to the gray section numbers on the application.

Reason for Application: Check "New Voter Registration" if this is a first time registration or if a new registration in a new parish after moving. Check "Updating Voter Registration" if you are making any change to your present registration. If new registration, fill out the form completely.

1. *Eligibility* - Federal law requires you to affirm that you are a citizen of the United States of America and that you will be 18 years of age on or before the election day in which you are eligible to vote. If you checked 'No' in response to either of these questions, do not complete this form. You are not eligible to vote at this time. If you are registering as a 16 or 17 year old, you may check "Yes" because you will not be allowed to vote until you are 18.
2. *Name* - You must provide your full name. Do not use nicknames or initials for middle or maiden name. *If this application is for a change of name, please also complete section 17: "Former Registered Name."*
3. *Residence Address* - "Residence Address" means the address (number, street, city, state, and zip) where you live and are registering to vote. Residence address must be the address where you claim homestead exemption, if any, except for a resident in a nursing home or veterans' home who may choose to use the address of the nursing home or veterans' home or the home where they have a homestead exemption. A college student may elect to use their home address or their address at school while attending. Do not use a post office box for your "Residence Address." If you use a rural route and box number, you may draw a map in box labeled "Give Location" to provide the exact location. Write in the names of the crossroads (streets) nearest to residence. Draw an X to show residence. Use a dot to show any schools, churches, stores, or landmarks near residence and write the name of the landmark.

   Mailing Address - If you check that you do not receive postal service at your residence address, you must provide your mailing address (number, street, city, state, and zip). Otherwise, a mailing address may be provided and you may use a post office box for a mailing address.
4. *Birthdate* - Print your date of birth. *The month and day of your birth remains confidential by law.*
5. *Social Security Number* - If you do not have a LA driver's license or LA special identification card, you must provide the last four digits of your social security number, if issued. The full social security number is preferred and may be provided on a voluntary basis and will be kept confidential. If you were not issued a social security number or a LA DL or ID 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 you must attach one or more documents to prove your identity, residence, and date of birth. Documents may be: a) a copy of current and valid photo identification and/or b) a copy of a current utility bill, bank statement, government check, paycheck, or other government document. *Your SSN remains confidential and is only used for registration purposes.*
6. *Sex* - Check male or female *(for statistical purposes only).*
7. *Race* - Race/Ethnic origin is optional *(for statistical purposes only).*
8. *Party Affiliation* - If you are registering for the first time, you may choose a party affiliation of Democrat, Green, Independent, Libertarian, or Republican parties. You may specify any other party affiliation by checking "other" and then listing the party with which you wish to affiliate. If you do not want to register with a political party affiliation check "No Party," or if you do not complete this section, your party affiliation will be listed as "No Party." If you are already registered with a party affiliation and no political party change is being made with this application, you may leave this section blank or re-enter your political party affiliation.
9. *Place of Birth* - Print the city/town, parish/county, state, and country of your birth place *(for statistical purposes only).*
10. *Mother's Maiden Name* - Print your mother's maiden name, which is her last name at her birth. If unknown, write "unknown."
11. *Email* - Give your email address for election officials to contact you if there is a problem with your registration. *Email addresses are protected from disclosure by law and are for official use only.*
12. *Phone* - Give your phone numbers for election officials to contact you if there is a problem with your registration. *Phone numbers are optional and a public record unless you make a request for your phone numbers to be kept confidential by election officials.*
13. *LA DL/ID Card #* - Print your LA driver's license or LA special identification card number, if issued. If you do not have one, check "I do not have a LA DL/ID card." *This ID number remains confidential and is for official use only.*
14. *Assistance in Voting Needed?* - Indicate if you will need assistance in voting by checking either the "No" or "Yes" box. If "Yes," write the reason for needing assistance. The registrar of voters in your parish may contact you for proof of disability.
15. *Place of Last Residence* - Print the address (number, street, city, and state) of your prior residence, if different from residence address in section 3 or write "Same."
16. *Place of Last Registration* - Print the state and parish (or county) of your last registration if you were registered in another parish or state prior to completing this application. *Important: Contact the local election office in your prior state and cancel your prior registration. Registering in Louisiana does not automatically cancel or transfer your voter registration from another state.*
17. *Former Registered Name* - If you are using this application to make a name change to your registration, print your former registered name (name you are changing) in this section. If name changed by court order, provide a copy of the order with this application.
18. *Affirmation and Signature* - Read the affirmation and sign your full name or make your mark and print the date this application was signed and completed. *If assistance in registering is being provided, make sure the applicant understands what they are affirming and that they meet the requirements to register to vote.*
19. *Witnesses* - If you are unable to sign your name, you may make your mark, but it must be witnessed by two people or it is not valid.

Mailing Instructions - If returned by mail, place in an envelope and mail to your Registrar of Voters Office. You can find your registrar of voters mailing address on the Registrar of Voters Address Page, by visiting our website at www.geauxvote.com or by calling toll free at 1-800-883-2805. Your application or envelope must be postmarked 30 days prior to the first election in which you seek to vote.

Online Voter Registration - Voter registration is also available at www.geauxvote.com and you may register online before the 20th day prior to the election. Please call your registrar of voters if you do not receive your voter information card two weeks after registering.

LOUISIANA
DEPARTMENT OF HEALTH
Medicaid

BHSF Form AVS
Rev. 05/19

Authorization for Verification of Resources

Applicant's name *(print)* | Applicant's Social Security Number

To determine whether an applicant or their legal spouse can receive or continue to receive Medicaid Healthcare Coverage, we must verify information about them and the amount of resources owned by them. This form authorizes Medicaid to request records from financial institutions for an individual and their spouse when one or both apply for Medicaid. **Please read and fill out this form.**

By signing this form you authorize verification of your resources (as well as those of your spouse, if applicable) with financial institutions for the purpose of determining eligibility for Medicaid. This authorization will end if your application for Medicaid is denied, you are no longer eligible for Medicaid, or if you revoke this authorization in a written statement to the Louisiana Department of Health (LDH).

You agree to allow organizations such as the following to give records about you or your spouse to LDH:

- Employers
- Insurance companies
- Real estate companies
- Government agencies
- Building associations
- Banks/Other financial institutions

This agreement does not include getting personal health information from doctors or healthcare providers.

Applicant's name *(print)* | Applicant's Social Security Number

Applicant's signature | Date

Applicant's spouse's name *(print)* | Spouse's Social Security Number

Spouse's signature | Date

Guardian/power of attorney/authorized representative's name *(print)* **– if applicable**

Representative's signature **– if applicable** | Date **– if applicable**

You can return this form by faxing it to **1-877-523-2987**.
You can also mail it to **Medicaid/LaCHIP Office, P.O. Box 91283, Baton Rouge, LA 70821-9278**.

MEDICAID CONSENT FOR AUTHORIZED REPRESENTATIVE

You Can Choose an Authorized Representative

You can give a trusted person permission to talk about your Medicaid application with us, see your information, and act for you on matters related to your application, including getting information about the 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 an application, submit proof with the application.

1. Name of authorized representative (First, Middle, Last, & Suffix) or name of organization		
2. Address		3. Apartment or suite number
4. City	5. State	6. ZIP code
7. Phone number (__ __ __) __ __ __ – __ __ __ __	8. ID number (if applicable)	

By signing, you allow this person to sign your application, get official information about the application, and act for you on all future matters with this agency.

9. Your signature	10. Date (mm/dd/yyyy)

For certified Medicaid Application Centers only.

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

For Trusted Users only.

By signing below, the Trusted User agrees to abide by the conditions of this agreement and accepts responsibility for fulfilling all responsibilities encompassed within the scope of the authorized representation to the same extent as the individual represented. And agrees to maintain, or be legally bound to maintain the confidentiality of any information regarding the applicant or beneficiary provided by the Louisiana Department of Health. And will adhere to the regulations in 42 CFR Part 431, Subpart F and at 45 CFR 155.260(f) (relating to the confidentiality of information), 42 CFR 447.10 (relating to the prohibition against reassignment of provider claims as appropriate for a facility or an organization acting on the facility's behalf), as well as other relevant state and federal laws concerning conflicts of interest and confidentiality of information.

1. Name (First, Middle, Last, & Suffix)	2. Application date (mm/dd/yyyy)
3. Name of organization	4. ID number (if applicable)
5. Trusted User's signature	6. Date (mm/dd/yyyy)

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**.