BHSF Form 1-G
Rev. 06/11
Prior Issue Obsolete

LOUISIANA MEDICAID
General Application

Use this application to apply for all Medicaid programs, except Long Term Care Medicaid (Nursing Facility and Home and Community Based (HCBS) Waiver services). Long Term Care Medicaid has a specialized application. To apply for Long Term Care Medicaid, fill out a 1-L or call 1-888-342-6207. If you are deaf or hard of hearing and have a TTY text telephone, call 1-800-220-5404.

How to Apply:

1. **Fill out and sign this application. Use black ink.** If you need extra space to answer any questions use a separate sheet of paper.
2. **Get the documents of proof we need.** Look for a list on page 8.
3. **Send the application and proofs to us.** Mail it to P.O. Box 91278, Baton Rouge, LA 70821-9278 or fax it to our toll-free fax number 1-877-523-2987. You may also take **OR** fax it to a local Medicaid office or Application Center. For the office closest to you call 1-888-342-6207. If you are deaf or hard of hearing and have a TTY text telephone, call 1-800-220-5404. **Send the application right away. We will give you more time to get the proofs to us.**

What language do you speak best? ❑ *English* ❑ *Spanish* ❑ *Vietnamese* ❑ *Other* ____________________
What language do you write best? ❑ *English* ❑ *Spanish* ❑ *Vietnamese* ❑ *Other* ____________________

1. Where did you get this Medicaid application?

❑ Medicaid office ❑ Hospital ❑ Pharmacy ❑ Doctor's Office ❑ Friend/Relative ❑ Internet ❑ School ❑ Office of Family Support (Food Stamp Office) ❑ Office of Public Health (Health Unit) ❑ Social Security Office ❑ Business (Store, Work) ❑ Festival/Health Fair ❑ Other: ____________________

2. Tell us about yourself.

Name (first, middle initial, last) ____________________ ❑ Male ❑ Female
Your Maiden Name ____________________
Social Security Number ____________________ Date of Birth (month, day, year) ____________________
Marital Status: ❑Single ❑Married ❑Widowed ❑Divorced/Separated

Race/Ethnic Background (You do not have to answer. You may mark one or more.): ❑ White ❑ Black ❑ Asian ❑ American Indian or Alaska Native ❑ Native Hawaiian or Pacific Islander ❑ Hispanic or Latino

3. Tell us how to reach you.

Mailing Address ____________________ Apartment/Lot # __________
City ____________________ State ________ Zip __________
Home Address (if different) ____________________ Apartment/Lot # __________
City ____________________ State ________ Zip __________
Parish Where You Live ____________________ Home Phone (________) ____________________
Cell Phone (________) ____________________ Daytime Phone (________) ____________________
E-mail Address ____________________
Best Day/Time to Call Monday through Friday Between 8 a.m. and 4:30 p.m. ____________________

4. Are you applying for Medicaid? ❑ Yes – Fill Out Below ❑ No – Go to Question 5

Where were you born? City ____________________ State ________ Country ____________________
Mother's Name (first, middle initial, last) ____________________
Mother's Maiden Name ____________________
Are you a U.S. citizen? ❑ Yes – Go to Question 5 ❑ No – Fill Out Below
Are you a lawful permanent resident? ❑ Yes ❑ No Date You Came to U.S. ____________________
Permanent Resident Card Number (green card#): **A**____________________

5. Tell us about the people living with you (include children under age 19, parents of the children, and your spouse). ❑ No One Lives with Me – Go to Question 6

A. Name (first, middle initial, last) ____________________ ❑ Male ❑ Female
Social Security Number ____________________ Date of Birth (month, day, year) ____________________
This person is my: ❑ Spouse ❑ Child ❑ Stepchild ❑ Grandchild ❑ Other: ____________________

If you have questions or need help with this application, call Medicaid at 1-888-342-6207. If you are deaf or hard of hearing and have a TTY text telephone, call 1-800-220-5404. THESE CALLS ARE FREE.

Race/Ethnic Background (You do not have to answer. You may mark one or more.): ❑ White ❑ Black ❑ Asian
❑ American Indian or Alaska Native ❑ Native Hawaiian or Pacific Islander ❑ Hispanic or Latino

Is this person applying for Medicaid? ❑ Yes – Answer the Next Questions ❑ No – Go to **B**

Place of Birth: City ____________________ State ________ Country ____________________

Mother's Name (first, middle initial, last) ____________________

Mother's Maiden Name ____________________

Is this person a U.S. citizen? ❑ Yes – Go to **B** ❑ No – Answer the Next Questions

Are they a lawful permanent resident? ❑ Yes ❑ No Date They Came to U.S. ____________________

Permanent Resident Card Number (green card#): **A** ____________________

B. Name (first, middle initial, last) ____________________ ❑ Male ❑ Female

Social Security Number ____________________ Date of Birth (month, day, year) ____________________

This person is my: ❑ Spouse ❑ Child ❑ Stepchild ❑ Grandchild ❑ Other: ____________________

Race/Ethnic Background (You do not have to answer. You may mark one or more): ❑ White ❑ Black ❑ Asian
❑ American Indian or Alaska Native ❑ Native Hawaiian or Pacific Islander ❑ Hispanic or Latino

Is this person applying for Medicaid? ❑ Yes – Answer the Next Questions ❑ No – Go to **C**

Place of Birth: City ____________________ State ________ Country ____________________

Mother's Name (first, middle initial, last) ____________________

Mother's Maiden Name ____________________

Is this person a U.S. citizen? ❑ Yes – Go to **C** ❑ No – Answer the Next Questions

Are they a lawful permanent resident? ❑ Yes ❑ No Date They Came to U.S. ____________________

Permanent Resident Card Number (green card#): **A** ____________________

C. Name (first, middle initial, last) ____________________ ❑ Male ❑ Female

Social Security Number ____________________ Date of Birth (month, day, year) ____________________

This person is my: ❑ Spouse ❑ Child ❑ Stepchild ❑ Grandchild ❑ Other: ____________________

Race/Ethnic Background (You do not have to answer. You may mark one or more.): ❑ White ❑ Black ❑ Asian
❑ American Indian or Alaska Native ❑ Native Hawaiian or Pacific Islander ❑ Hispanic or Latino

Is this person applying for Medicaid? ❑ Yes – Answer the Next Questions ❑ No – Go to **D**

Place of Birth: City ____________________ State ________ Country ____________________

Mother's Name (first, middle initial, last) ____________________

Mother's Maiden Name ____________________

Is this person a U.S. citizen? ❑ Yes – Go to **D** ❑ No – Answer the Next Questions

Are they a lawful permanent resident? ❑ Yes ❑ No Date They Came to U.S. ____________________

Permanent Resident Card Number (green card#): **A** ____________________

D. Name (first, middle initial, last) ____________________ ❑ Male ❑ Female

Social Security Number ____________________ Date of Birth (month, day, year) ____________________

This person is my: ❑ Spouse ❑ Child ❑ Stepchild ❑ Grandchild ❑ Other: ____________________

Race/Ethnic Background (You do not have to answer. You may mark one or more.): ❑ White ❑ Black ❑ Asian
❑ American Indian or Alaska Native ❑ Native Hawaiian or Pacific Islander ❑ Hispanic or Latino

Is this person applying for Medicaid? ❑ Yes – Answer the Next Questions ❑ No – Go to **Question 6**

Place of Birth: City ____________________ State ________ Country ____________________

Mother's Name (first, middle initial, last) ____________________

Mother's Maiden Name ____________________

Is this person a U.S. citizen? ❑ Yes – Go to **Question 6** ❑ No – Answer the Next Questions

Are they a lawful permanent resident? ❑ Yes ❑ No Date They Came to U.S. ____________________

Permanent Resident Card Number (green card#): **A** ____________________

6. Does anyone applying have a deceased spouse? ❑ Yes – Fill Out Below ❑ No – Go to Question 7

Who has a deceased spouse? ____________________

Tell us about the deceased spouse. *If more than one, use a separate sheet of paper.*

Name (first, middle initial, last) ________________________________ Maiden ____________

Social Security Number ____________________ Date of Birth (month/day/year) ____________

Date of Death (month/day/year) ____________________ Has a succession been opened? ❑ Yes ❑ No

Veteran? ❑ Yes ❑ No Railroad Retiree? ❑ Yes ❑ No Divorced from applicant? ❑ Yes ❑ No

Date and Parish/County of Divorce ____

7. Is anyone applying pregnant? ❑ Yes – Fill Out Below ❑ No – Go to Question 8

Who is pregnant? ______________________________ Best Guess of the Due Date ____________

Is more than one baby expected? ❑ Yes ❑ No

Answer Question 8 for applicants who are under age 65.

8. Does anyone applying have a disability? (They do not have to be getting payments from the Social Security Administration to answer yes.) ❑ Yes – Fill Out Below ❑ No – Go to Question 9

A. Who has a disability? ______________________________ When did it start? ____________

What is the disability? Tell us about it. ____

____

Was the disability caused by an accident? ❑ Yes ❑ No

Have they applied for Social Security Disability or SSI? ❑ Yes – Application Date ____________ ❑ No

Has a decision been made? ❑ Yes – Date of decision ________________ ❑ No

What was the decision? ❑ Approved ❑ Denied

Has the medical condition or disability changed since they applied with Social Security? ❑ Yes ❑ No

If **yes**, explain. ____

Tell us about the doctors, hospitals or other medical providers who care for the applicant.
If more space is needed, use a separate sheet of paper

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

B. Is the disability Breast or Cervical Cancer? ❑ Yes – Read & Fill Out Below ❑ No – Go to Question 9

Louisiana's Breast and Cervical Cancer Program is only for **women** who have been **screened** under the Center for Disease Control and Prevention's (CDC) National Breast and Cervical Cancer Early Detection Program and found to need treatment for breast and/or cervical cancer, including precancerous conditions.

Do you have proof of the Early Detection Program screening and diagnosis? ❑ Yes ❑ No

If **No**, please contact Louisiana's Early Detection Program at 1-888-599-1073 to get the proof.
You do not have to wait for the proof; apply now. A screening is required to be eligible for Medicaid coverage under this program.

9. Does anyone have Medicare? *The Medicare card looks like this.* →
❑ Yes – Fill Out Below ❑ No – Go to Question 10

Name ______________________ Claim Number ______________

Name ______________________ Claim Number ______________

10. Has anyone applying lost Medicare? ❑ Yes – Fill Out Below ❑ No – Go to Question 11

Name ______________________________ Claim Number (on Medicare card) ______________

11. Does anyone applying have health insurance, a Medicare supplement, or a Medicare prescription drug plan? ❑ Yes – Fill Out Below ❑ No – Go to Question 12
If there is more than one insurance, use another sheet of paper.

Who is insured? ____
Policyholder's Name ______________________________Coverage Start Date __________
Insurance Company Name and Phone Number ______________________________
Policy Number ______________________________Group Number __________________
It covers: ❑ Hospital ❑ Doctor ❑ Medicine ❑ Dental ❑ Ambulance ❑ Pregnancy ❑ Family Planning
How much does it cost every month? ____________Is this insurance through a job? ❑ Yes ❑ No

→ *If the insurance is through a job, Medicaid may be able to help pay the premiums through the LaHIPP program. Call 1-866-362-5253 or visit www.LaHIPP.DHH.Louisiana.gov for more information.*

12. If anyone applying <u>does not</u> have health insurance, could they get health insurance under someone else's policy? ❑ Yes – Fill Out Below ❑ No – Go to Question 13

Tell us under whose policy. ______________________Their Phone Number (______) __________

13. Is anyone working? ❑ Yes – Fill Out Below ❑ No – Go to Question 14

Who works?	Employer's Name and Phone Number	Self-employed?	How much? (show gross, not take home)	How often?	Is insurance offered?
		❑ Yes ❑ No			❑ Yes ❑ No
		❑ Yes ❑ No			❑ Yes ❑ No

14. Does anyone get income (money) from:
- Social Security • SSI • Alimony • Money from Friends/Relatives • Worker's Comp
- Unemployment • Retirement • Railroad Retirement • Rent from Property Owned • Annuities
- Veteran's Benefits • Child Support (give the name of child it is for) • Royalties • Something else (tell us)

❑ Yes – Fill Out Below ❑ No – Go to Question 15

Who gets it?	**What is it?**	**How much?** **$**__________	**How often?**	**VA File Number or Railroad Claim Number:**
Who gets it?	**What is it?**	**How much?** **$**__________	**How often?**	**VA File Number or Railroad Claim Number:**
Who gets it?	**What is it?**	**How much?** **$**__________	**How often?**	**VA File Number or Railroad Claim Number:**
Who gets it?	**What is it?**	**How much?** **$**__________	**How often?**	**VA File Number or Railroad Claim Number:**

15. Has anyone applied for income such as Social Security or Veteran's benefits, but they did not get it yet? ❑ Yes – Fill Out Below ❑ No – Go to Question 16

Who? ______________________________What is it? ______________________

16. Has anyone applying ever received Supplemental Security Income (SSI) benefits?
❑ Yes – Who? ______________________________ ❑ No – Go to Question 17

17. Does anyone pay for child care or care for an adult with a disability in order to work, go to school, or get training? ❑ Yes – Fill Out Below ❑ No – Go to Question 18

Name of Child(ren) or Adult Who Gets Care ______________________________
Who pays for the care? ____________________How much is paid each month? __________
Name of Day Care Center or Caregiver ______________________________
Day Care Center or Caregiver's Address ______________________________
City ______________________________Phone Number (______) __________
Is help received with paying it from anyone or another program? ❑ Yes – How much? __________❑ No

18. Does anyone in your home pay court-ordered child support or alimony?
❑ Yes – Fill Out Below ❑ No – Go to Question 19

Name of Person Who Pays It ____________________

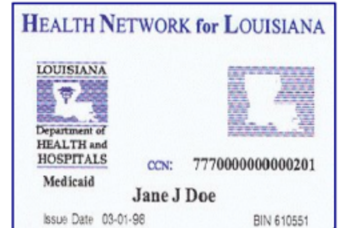
How much is paid? ____________________ How often? ____________________

19. Does anyone applying have medical bills (paid or unpaid) for services from the last three months? ❑ Yes – Fill Out Below ❑ No – Go to Question 20

If more than 4, use another sheet of paper.

Name, Address, and Phone Number of Medical Provider	Who received this care?	Date of Service	Total Cost of Service	Balance that is Unpaid

20. Has anyone applying ever received Medicaid in Louisiana?
❑ Yes – Fill Out Below ❑ No ***The Medicaid card looks like this*** →



If you or they still have the plastic Medicaid card, the same card can be used again. We will not send new cards unless you tell us to.

Who needs a new Medicaid card? ____________________

DO NOT answer Question 21 if you are applying for a pregnant woman or children under 19, ONLY. Sign the Application on Page 7, and look for a list of things we need on Page 8.

21. Tell us about things that are owned in A-J. Answer Yes or No for each.

A. Bank Accounts and Certificates of Deposit (CDs)? ❑ Yes – Fill Out Below ❑ No – Go to B

If more than 4, use another sheet of paper.

Type of Account	Who owns it?	Name of Bank or Credit Union	Account Number	How much is in it?
❑ checking ❑ savings ❑ Christmas club ❑ CD				
❑ checking ❑ savings ❑ Christmas club ❑ CD				
❑ checking ❑ savings ❑ Christmas club ❑ CD				
❑ checking ❑ savings ❑ Christmas club ❑ CD				

B. Annuities and/or retirement accounts (IRA, Keogh, 401-K)? ❑ Yes – Fill Out Below ❑ No – Go to C

Who does it belong to? ____________________

Account Number(s) ____________________ How much is it worth? ____________________

Are regular payments being received? ❑ Yes – How much? $________ How often? ____________ ❑ No

If **no**, are regular payments available? ❑ Yes ❑ No

Can a lump-sum withdrawal of these funds be made? ❑ Yes ❑ No ❑ Don't Know

C. Safe-Deposit Box(es)? ❑ Yes – Fill Out Below ❑ No – Go to D

Who does it belong to? ____________________

Name of the Bank or Credit Union ____________________

What is inside the box or boxes? ____________________

What are the items inside the box (boxes) worth? ____________________

D. Life or burial insurance? ❑ Yes – Fill Out Below ❑ No – Go to E
If more than 4, use another sheet of paper. **We do not need to know about term life insurance. If in doubt, fill it out.**

Who is insured?	Owner of Policy	Insurance Company	Face Value	Policy Number

E. Money set aside in a bank account for burial or a pre-arranged burial contract with a funeral home?
❑ Yes – Fill Out Below ❑ No – Go to F *If more than 2, use another sheet of paper.*

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

F. Cars, trucks, boats, campers, motorcycles, ATVs? ❑ Yes – Fill Out Below ❑ No – Go to G
If more than 3, use another sheet of paper.

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

G. Property you don't live on like inherited property (divided or undivided), out of state property, or a second house?
❑ Yes – Fill Out Below ❑ No – Go to H

Who does it belong to? ______________________________

What is their interest or share in the divided/undivided property? (such as ¼, ½) ______________

How much is it worth? ______________________________

Tell us about it (location, lot size, number of acres, buildings on it). ______________________________

____

H. Burial space items like a cemetery plot, grave site, crypt, mausoleum, vault, casket, urn, niche, burial markers, headstones, and costs for opening/closing grave that are not covered in a pre-arranged burial contract? ❑ Yes – Fill Out Below ❑ No – Go to I

Who owns it? ______________________________

For whose burial? ______________________________ Is it paid in full? ❑ Yes ❑ No

What is it? ______________________________

How much is it worth? ______________________________

I. Does anyone have a trust? ❑ Yes – Who? ______________ ❑ No – Go to J

(What is a trust? – A trust is a legal relationship in which a person called a "trustee" holds money or other assets for the benefit of another, the "Beneficiary." The Trust must be valid under State law. The Trust document will specify how the assets and money in Trust will be handled. It can be set up by a will.)

J. Is anything else owned (like cash on hand, stocks, bonds, savings bonds, mutual funds, or anything else of value)? ❑ Yes – Fill Out Below ❑ No – Sign on the Next Page

Who owns it? ______________________________

What is it? ______________________________

How much is it worth? ______________________________

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

YOUR RIGHTS AND RESPONSIBILITIES

WHAT MEDICAID HAS THE RIGHT TO EXPECT OF YOU

CITIZENSHIP AND IMMIGRATION STATUS: You state that the information about citizenship and immigration status given on this application form is true and correct.
REPORTING THE TRUTH: You state that the information you give on the application form is true and correct. You understand if you on purpose give information that is not true OR if you on purpose do not tell information that you are supposed to, you and/or the person(s) applying may get health benefits that you or they 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 about you and/or the person(s) applying will be checked. You agree to help do that and to let Medicaid get information it needs from government agencies, employers, medical providers, and others.
SOCIAL SECURITY NUMBERS: You understand Social Security numbers will only be used to get information from other government agencies to make a decision on eligibility for you and/or the person(s) applying for Medicaid.
PAYMENT OF MEDICAL CARE BY A THIRD PARTY: You understand by accepting Medicaid, the Department has the right to get money received by you and/or the person(s) applying from other sources like insurance payments or lawsuit settlements for services that Medicaid has paid for you and/or the person(s) applying.
REPORTING CHANGES: You agree to tell Medicaid within 10 days of these changes: 1) if anyone getting Medicaid moves out of state; 2) if anyone moves in or out of the home; 3) changes in mailing or home address; 4) changes in health insurance and premiums; 5) changes in income; 6) changes in things owned by anyone who gets Medicaid who is disabled or age 65 or older; and 7) if a pregnancy ends.
CHILD SUPPORT ENFORCEMENT: You understand that Medicaid will only send case information to Child Support Enforcement for medical support if you ask them to. We will make a referral if the parent(s) gets Medicaid unless Medicaid determines you have good cause not to cooperate with Support Enforcement.

WHAT YOU HAVE THE RIGHT TO EXPECT FROM MEDICAID

RIGHT TO A FAIR HEARING: You understand that you can ask for a Fair Hearing if you think any decision made on the case is unfair, incorrect, or made too late.
NO DISCRIMINATION: You understand Medicaid cannot treat you differently because of race, color, sex, age, disability, religion, nationality, or political belief. If you think it has, you can call the U.S. DHHS Regional Office for Civil Rights in Dallas, TX at 1-800-368-1019 or write to Louisiana's Department of Health & Hospitals, Human Resources at P. O. Box 4818 Baton Rouge, LA 70821-4818.
OTHER SERVICES: You understand that information about WIC, KIDMED, and other Medicaid services will be sent to the persons that are eligible for Medicaid.
ESTATE RECOVERY RULES FOR THOSE GETTING MEDICAID SERVICES SUCH AS NURSING HOME, GROUP HOME, AND HOME AND COMMUNITY BASED SERVICES: You understand that Estate Recovery rules require the Department to recover the cost of certain Medicaid payments from the applicant's estate. These costs include the total amount of payments for facility services, hospital care, payments to HCBS or PACE providers, and prescription drugs received at age 55 or older. The estate is the property owned at the time of death. The Department will not make a claim against the estate while the applicant or his or her legal spouse is still living. The Department also will not make a claim if the applicant has a dependent child who is under age 21, blind, or disabled. Collection may not be made if it is not cost effective for the Department to do so, or if the heirs apply for a hardship waiver after the applicant's 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 convincing situations.

YOU MUST SIGN BELOW

Sign Here:____ **Date** ____________

Spouse Signs Here (if applying)**:**______________________________ **Date** ____________

If Medicaid filled out this application, they will sign below.

____ **Date**____________________

Comments from Applicant or Medicaid Staff:

____

____

____

____

____

Person Making Comments Signs Here:______________________________ **Date**:____________

Send Us These Things
Copies of all health insurance cards (front and back)
If you are not a U.S. citizen send copies of Permanent Resident Cards (green cards) or other forms from U.S. Citizenship and Immigration Services.
If you were **not** born in Louisiana **AND** you have never received benefits from Social Security Disability, Supplemental Security Income (SSI), or Medicare, send proof of U.S. Citizenship such as birth certificate, souvenir birth certificate from hospital, U.S. Passport, or adoption papers. If you don't have any of these, ask us about other things you can use.
Pay stubs from last month showing gross pay (before taxes) or a letter from the employer. If self-employed, send copies of last year's tax return and all schedule attachments – for you, your spouse, and (if you are under age 19) your parents in the home with you.
Proof of gross income (before taxes) from Veteran's Benefits, worker's comp, alimony, and any other income that is not from working. Proof could be award letters and 1099 tax statements from last year's tax return – for you, your spouse, and (if you are under age 19) your parents in the home with you
Statement from friends or relatives who give money to you, your spouse, or children
Proof and the value of things owned like bank accounts, retirement accounts, life/burial insurance, pre-arranged burial contracts, or anything else. Examples: bank statements, insurance policies, burial contract, savings bonds, stock certificates, trust document, succession documents
Proof of child care payments from the day care center. Proof of payments for adult care from the caregiver.
Court order and proof of alimony or child support payments made to persons outside the home. If it is paid through Louisiana Support Enforcement Services (SES), you **do not** have to send proof – let us know.
If Medicaid coverage is needed for the three months before you apply, send proof of income for those months.
If you have been screened by the Early Detection Program & diagnosed with breast or cervical cancer, send proof of the results.

Please send the application and documents of proof to your local Medicaid office right away. If you do not have all the proofs we need now, send them later. If you need the address or fax number to your closest Medicaid office, call us free at 1-888-342-6207. If you are deaf or hard of hearing and have a TTY text telephone, call us free at 1-800-220-5404.

____
AC/Office Name

Department of Health and Hospitals
Voter Registration Declaration (Optional)

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

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

- If you checked "Yes," please complete the attached form called the "Louisiana Mail Voter Registration Application." You may mail your completed Voter Registration Application to your local Registrar of Voters listed on the application or mail it to the Department of Health and Hospitals.
- **IF YOU DO NOT CHECK EITHER BOX YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME.**

Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency.

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

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

If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with:

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

____________________	____________________	________________
Print Your Name	Social Security Number	Date of Birth
____________________	____________________	
Sign Your Name	Today's Date	

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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Name Change

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Party Change

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Remarks

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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 ☐ 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.

2 NAME OF APPLICANT (PLEASE PRINT NAME)
LAST First FULL MIDDLE OR MAIDEN

GIVE LOCATION

3 RESIDENCE ADDRESSS (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
MONTH DAY YEAR

6 * SOCIAL SECURITY #(CIRCLE ONE)
NO
YES #_______________________

7 SEX (CIRCLE ONE)
MALE FEMALE

8 ** RACE/ ETHNIC ORIGIN (CIRCLE ONE)
WHITE BLACK ASIAN HISPANIC
AMER. INDIAN
OTHER: ____________________

9 PARTY AFFILIATION (CIRCLE ONE)
DEM GRN LBT RFM REP NONE
OTHER (SPECIFY) ______________

10 APPLICANTS'S PLACE OF BIRTH
CITY OR TOWN PARISH OR COUNTY STATE COUTNRY

11 MOTHERS MAIDEN NAME

12 ** HOME PHONE
( )

13 ** DAYTIME PHONE
( )

14 LA DRIVERS LICENSE / I.D. #(CIRCLE ONE)
NO
YES #_________________

15 Will you require assistance at the polls?(CIRCLE ONE)
NO YES IF YES, GIVE REASON

16 LAST RESIDENCE ADRESS
ADDRESS

17 PLACE OF REGISTRATION
PARISH OR COUNTY STATE

18 FOMER REGISTERED NAME, IF APPLICABLE

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