For Agency Use Only
Request date______________ (Application date)
Date mailed______________
Agency Rep__________________

To protect your application date, we must receive this application by____________________.
(for agency use only)

What language do you **speak** best? ☐ English ☐ Spanish ☐ Vietnamese ☐ Other (specify) ___________
What language do you **write** best? ☐ English ☐ Spanish ☐ Vietnamese ☐ Other (specify) ___________

If you do not speak English we can get interpreter services to help at no cost to you. If you need help to fill out this form, call your local Medicaid office or call us toll free at 1+888+544-7996. If you are deaf or have hearing problems, call the TTY line toll free at 1+800+220-5404.

This application is to get healthcare coverage for persons with **disabilities** who **work** and who are at least age 16 but not yet age 65. If you want Medicaid for anyone else, check **(✓)** this ☐. We will send you information about applying for other Medicaid coverage. Please fill out every item on this form. If an answer to a question is none or 0, write "none". If you need more space for any item, use a separate sheet.

1. Tell us who YOU are, where YOU live, and where YOU get your mail:
Name ____Parish ________________
Home address __________________________City _____________State___ Zip code ______
Mailing address ________________________City _____________State___ Zip code ______
Home phone (____)______________ Daytime phone (____)______________

2. Tell us about **yourself** and your **spouse**. You do not have to give your spouse's Social Security number if he or she is not applying. If given, the number will only be used to verify assets.
You do not have to give race information. If you choose to do so, use the following codes:
1=White; 2=Black; 3=American Indian/Alaskan; 4=Asian; 5=Hispanic/Latino; 6=Hawaiian/Pacific Islander; 7=Hispanic/Latino & Other; 8=Multi-Race, Not Hispanic; 9=Unknown

Name - first, middle initial, last	Social Security number	Date of birth			Sex M/F	Race	US citizen/ Legal alien		Louisiana resident		Relation to you
		Month	Day	Year			Yes	No	Yes	No	
							☐	☐	☐	☐	self
							☐	☐	☐	☐	spouse

3. Tell us about EACH job or business that **you** have. Show the amount of total or gross income before any deductions, **not** your take-home pay. (Send copies of pay check stubs or other proof of your earnings for last month. If you are self-employed, send copies of your most recent federal tax form with all schedule attachments. Send other proof if you do not have tax forms.)

Employer name, address & phone OR Self-employment information	Amount paid	How often do you get paid?	# of hours worked per week
	$		
	$		

4. Do **you** get any money like the kinds listed below? ☐ Yes ☐ No
- Social Security
- Retirement/Pensions/Annuities
- Veteran's Benefits
- Unemployment
- Workman's Compensation
- Interest/Dividends/Royalties
- Money from friends or relatives
- **Any** other not listed

(Show **all** money that you get and send proof of the income. You **do not** have to send proof of Social Security or Unemployment income.)

Income type	Source name, address, & phone	How much do you get?	How often do you get it?
		$	
		$	

Have you ever applied for money from any of these sources? ☐ Yes ☐ No If **Yes**, when and from which ones? ____

5. Do **you** have Medicare or other health insurance? ☐ Yes ☐ No If **Yes**, answer the following.
(Send proof of coverage and premium payment.)

Insurance company name, address, & phone	Group/policy number	Monthly cost	Policy covers:		
			hospital	doctor	ambulance
			☐	☐	☐
			☐	☐	☐

Can you get health insurance from your employer? ☐ Yes ☐ No

6. Do **you**, or you **jointly** with your spouse, have any assets or resources like those listed below?
☐ Yes ☐ No If **Yes**, give us the following information. (Send proof of ownership and value.)

Asset/Resource	Company name, address, & phone; Account number and/or description	Value	Amount owed
Checking/Savings accounts (type)		$	
Certificates of Deposit		$	
Retirement accounts		$	
Annuities/Trusts		$	
Stocks/Bonds		$	
Vehicles (if more than one)		$	$
Property, other than your home		$	$
Other (please be specific)		$	$

7. Did you **ever** apply for or get Social Security Disability or Supplemental Security Income (SSI) benefits? ☐ Yes ☐ No If **Yes**, when? ____________________Was a decision made? ☐ Yes ☐ No
If **Yes**, what was the decision? ____

____

8. What is your disability? ____
____________________ Tell us about the doctors or other medical providers who care for you:

Provider's name(s)	Address & phone of this medical provider

9. Where did you find out about the Medicaid Purchase Plan? ______________________________

Rights and Responsibilities

❖ I declare that I am a U.S. citizen or in this country legally.
❖ The information I gave on this form is true and correct to the best of my knowledge. I realize if I knowingly give information that is not true OR if I knowingly hold back information, I may get health benefits for which I am not eligible. If that happens, I can be lawfully punished for fraud. I may also have to pay Medicaid back for any medical bills which are paid incorrectly.
❖ I understand that the information I give about my situation will be checked. I agree to help do that, and to let Medicaid get information it needs from government agencies, employers, medical providers, and other sources. If I refuse to help with this process or in later reviews caused by reported changes, or as part of a Recipient Eligibility review, it will mean that I can't get Medicaid until I do help.
❖ I know that Social Security numbers will only be used to get information from other government agencies to prove my eligibility.
❖ I agree to tell Medicaid within 10 days if 1) I move out of state; 2) there are changes in where I live or get my mail; 3) there are any changes in other health insurance coverage; 4) there is any change in my work status.
❖ By accepting Medicaid, I agree that any medical payments received from other sources will be sent to the Department of Health and Hospitals for any services that were covered by Medicaid.
❖ I can ask for a Fair Hearing if I think the decision made on my case is unfair, incorrect or being made too late.
❖ Medicaid can't treat me differently because of my race, color, sex, age, disability, religion, nationality or political belief. If I think they have, I 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 1349 Baton Rouge, LA 70821-1349.

______________________________________ ______________________
Signature of Applicant or Authorized Representative Date

______________________________________ ______________________
Signature of Agency Representative, if applicable Date