Traumatic Brain and Spinal Cord Injury (TBSCI)
Trust Fund Program

Thank you for your interest in the Traumatic Brain and Spinal Cord Injury (TBSCI) Trust Fund Program.

The attached TBSCI Trust Fund Application packet includes the TBSCI Fact Sheet, TBSCI Application for Services form, and the Medical Eligibility form. Please make sure that when you return this packet, the **Medical Eligibility form is included**. This form **MUST be completed and signed by a MEDICAL DOCTOR** before mailing this packet back to us.

To comply with the National Voter Registration Act (NVRA), we have also attached a Voter Registration Declaration (VRD) form and a Louisiana Voter Registration Application (LA-VRA) to offer you the opportunity to register to vote. If you would like to register to vote, fill out the attached VRD and LA-VRA forms and mail them to us along with the other completed forms in this packet.

You must mail us the **ORIGINAL LA-VRA** form OR you can mail it directly to the Registrar of Voters (ROV) office in the parish in which you live. Please note that we are only allowed to forward the LA-VRA form to the ROV office if the form contains your name, address, and signature. Also, the ROV office will **NOT** accept copies of the LA-VRA form.

PLEASE DO NOT FAX THE DOCUMENTS IN THIS PACKET BACK TO US

Please mail the completed forms with the original signatures to:

TBSCI Trust Fund Program
P.O. Box 2031 – Bin #14
Baton Rouge, LA 70821-2031

If you have any questions or need any additional information, please contact our office at **1-888-891-9441 or (225) 219-2410**.

For additional information regarding other available resources related to traumatic brain and/or spinal cord injuries, please contact:

The Brain Injury Association of Louisiana (BIALA) Resource Center
3433 Highway 190, Suite 270
Mandeville, LA 70471
(504) 982-0685
info@biala.org

Attachments:

LOUISIANA DEPARTMENT OF HEALTH
Aging and Adult Services

Traumatic Brain and Spinal Cord Injury (TBSCI) Trust Fund Program

What is the TBSCI Trust Fund program?

The TBSCI Trust Fund Program was created to provide services in a flexible, individualized manner to Louisiana citizens who have survived a traumatic brain and spinal cord injury. The TBSCI program assists participants with returning to a reasonable level of functioning and independent living.

What services does the TBSCI Trust Fund program pay for?

- Support Coordination
- Personal Assistance Services
- Medication and Medical Supplies
- Assistive Technology
- Environmental Accessibility Adaptations
- Evaluations and Therapy Services
- Transportation for Non-Emergency Medical Appointments
- Durable Medical Equipment (prosthetic devices, walkers, bath chairs, etc.)
- Rehabilitation
- Other Goods and Services (must be deemed appropriate and necessary)

What limitations apply to the TBSCI Trust Fund program?

- The TBSCI Trust Fund program **must** pre-approve **all** service providers. (In-state facilities/programs are given priority for approval as service providers)
- Services are provided on a first come, first served basis.
- All goods and services **must** be pre-approved before they are delivered and/or rendered.
- Expenditures shall not exceed $15,000 for any 12-month period or a $50,000 in a lifetime.

Who qualifies for the TBSCI Trust Fund program?

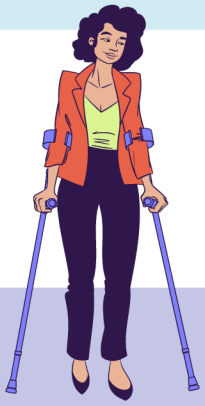
Individuals who meet the definition for Traumatic Brain Injury or Spinal Cord Injury defined as:

- **Traumatic Brain Injury -** An injury to the head, affecting the brain, not of a degenerative or congenital nature, but caused by an external physical force that may produce diminished or altered state of consciousness which results in an impairment of cognitive abilities or physical functioning.
- **Spinal Cord Injury** - An injury, not degenerative or congenital, involving damage to any part of the spinal cord caused by an external physical force resulting in paraplegia or quadriplegia.

AND

Individuals who:

- Are residents of Louisiana, officially living in the state at the time of injury and during the provision of services;
- Have a reasonable expectation to achieve improvement in functional outcomes with assistance (per the treating doctor);
- Have exhausted all other Medicare and Medicaid sources (as attested to by the applicant);
- Provide proof of denial from other sources (if requested);
- Are willing to accept services from an approve facility/program;
- Complete and submit an application for services; and
- Are willing to participate in the development of an Individualized Service Plan that outlines the services that will be provided by the trust fund.



For more information
OR
to apply for the TBSCI Trust Fund Program, please call:

1-888-891-9441

Monday through Friday, 8:00 a.m. to 5:00 p.m.
The call is FREE!

LOUISIANA DEPARTMENT OF HEALTH
Aging and Adult Services

APPLICATION FOR SERVICES

Traumatic Brain and Spinal Cord Injury (TBSCI) Trust Fund Program

P.O. Box 2031-Bin #14, Baton Rouge, LA 70821-2031 – Phone #: 1-888-891-9441

Applicant's Name (Last, First, MI):	**Social Security #:** - -	**Date of Birth** (mm/dd/yyy)**:**
Home Address:		**Apt. or Suite #:**

City:	**State:**	**Zip Code:**	**Parish:**

Phone #:	**Alternate Contact Name:**	**Alternate Contact Phone #:**
Email Address:	**Sex:** ☐ Male ☐ Female	**Highest Grade Completed:**

Other Health Insurance (if known)**:**

☐ Medicaid ☐ Medicare ☐ Other Insurance
☐ N/A ☐ Other:

If Other, list here:_____

Medicaid HCBS Programs (if known)**:**

☐ ROW ☐ NOW ☐ LT-PCS
☐ Supports Waiver ☐ ADHC ☐ SPAS
☐ CCW ☐ N/A ☐ Other

If Other, list here: _____

Have you ever been enrolled in the TBSCI Trust Fund Program? ☐ Yes ☐ No

INJURY INFORMATION SECTION

(A Medical Eligibility Form, completed by the physician, MUST be attached.)

Primary Diagnosis: ☐ Traumatic Brain Injury (TBI) ☐ Spinal Cord Injury (SCI) ☐ Both

Primary Treating Physician's Name:	**Phone #:**	
Physician's Mailing Address:	**State:**	**Zip Code:**

How were you injured? (Describe the incident that caused your TBI or SCI Injury.)	**Date of Injury:**
	Age at time of Injury:

Where were you living at the time of the injury?	**City:**	**State:**
Is this where the ACCIDENT TOOK PLACE?	**If not, list the city where the accident took place?**	**State:**

Where did you obtain this application? ☐ TBSCI Office Mailed ☐ LDH Website ☐ Other
☐ BIALA (Directly or Website) ☐ BIALA Outreach or Medical Facility Name: _____

Please Read Carefully & Sign the Bottom of this Application

By signing and submitting this application, I hereby apply for services through the Louisiana Traumatic Brain and Spinal Cord Injury (TBSCI) Trust Fund Program. **I will voluntarily provide any and all information/documentation relative to my disability/injury/accident and resources upon request.**

I understand that the Louisiana Department of Health (LDH), TBSCI Trust Fund Program 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.

I understand that providing the requested information (including social security numbers) is voluntary. However, failing to provide it may delay or prevent me from receiving services through the TBSCI Trust Fund Program. I understand that all information will be held confidential and will only be used to determine my eligibility for the program and/or the delivery of services. Information will only be released with my written consent or as otherwise authorized by the policy of the Louisiana Traumatic Brain and Spinal Cord Injury Trust Fund Program.

I understand that LDH will review all of the information I provide to ensure it is correct. I give LDH permission to contact any outside source(s) necessary to confirm all provided information, process the completed and signed application, determine eligibility, and otherwise operate the TBSCI Trust Fund Program. These outside sources may include, but are not limited to:

- Federal Agencies (such as the IRS, Social Security Administration & Department of Homeland Security), other state agencies, and/or local government agencies.
- Banks, financial institutions, and consumer reporting agencies.
- Employers identified on the applications for eligibility determinations.
- Doctor's, Physicians, and/or other medical providers.
- Applicants/participants and authorized representatives of applicants/participants.
- LDH contractors are engaged to perform services for the TBSCI Trust Fund program.

I authorize the above outside sources to provide the LDH, TBSCI Trust Fund Program with my personal information as requested to determine eligibility for the program. I understand that this authorization will expire if this application is denied, my TBSCI eligibility ends, or if I submit a written statement to LDH, TBSCI Trust Fund Program to cancel this authorization, whichever may come first. This cancellation may prevent my eligibility for the TBSCI Trust Fund Program to be denied.

I understand that eligibility decisions will be made without regard to race, color, religion, sex, sexual orientation, age, national origin, disability, political affiliation, veteran status, or any other non-merit

factor. I further understand that eligibility decisions will be made without regard to disability unless, and only to the extent necessary, authorized by law to comply with Act 654 of the 1993 Louisiana Legislature created for the TBSCI Trust Fund Program.

I further understand that I must be willing to accept services from an approved facility or program and cooperate with my Support Coordinator and the TBSCI Trust Fund Program staff regarding services, plans, appointments, etc. I agree to notify my Support Coordinator and the TBSCI Trust Fund Program office within 30 days if I change my physical or mailing address and/or phone number. Please call 1-888-891-9441 to report any changes.

I understand that if I fail to notify the TBSCI Trust Fund Program office of any changes or do not provide all of the required documentation to the program office within the requested time frame, my name will I be removed from the waitlist. If I am still interested in the program, I must reapply for services to determine my eligibility.

I certify that I am a current resident of the state of Louisiana and was officially domiciled in the state of Louisiana at the time of the injury. In the event I move to another state, I understand that I will no longer be eligible for the TBSCI program.

I certify that the information provided is true and correct to the best of my knowledge and that knowingly providing false or incorrect information is cause for immediate termination of benefits and that I may be required to reimburse, in whole or in part, the Louisiana Traumatic Brain and Spinal Cord Injury Trust Fund Program for any and all services received that I was not eligible to receive.

DO NOT SIGN UNLESS YOU FULLY UNDERSTAND THE ABOVE STATEMENTS

Sign this Application

The person completing this form should sign this application. If you are an authorized representative of the applicant, **you should sign here AND complete Appendix C**.

Signature (All authorized representatives MUST complete Appendix C):	**Date:**

Please assure that the Medical Eligibility form is attached to this application or it will NOT be processed.

Please Mail the original application to:
TBSCI Trust Fund Program
P.O. Box 2031 Bin #14
Baton Rouge, LA 70821-2031

LOUISIANA DEPARTMENT OF HEALTH
Aging and Adult Services

APPENDIX C

You may choose a Trusted User/Authorized Representative.

I. Step 1: Applicant/Participant

You may authorize any Trusted User/Authorized Representative permission to discuss the information included in the application/eligibility, review your information provided and act on your behalf for matters related to this application/eligibility. This person is called an "authorized representative". If you ever need to change your authorized representative, contact the TBSCI Trust Fund Program Manager to request the change.

NOTE: If you are a legally appointed representative for the applicant/participant, please provide proof with the application.

Name of Applicant/Participant (First, Middle, Last & Suffix):		
Home Address:		**Apt. or Suite #:**
City:	**State:**	**Zip Code:**
Phone #:	**Email Address:**	
You may authorize any Trusted User/Authorized Representative permission to discuss the information included in the application/eligibility, review your information provided and act on your behalf for matters related to this application/eligibility. This person is called an "authorized representative". If you ever need to change your authorized representative, contact the TBSCI Trust Fund Program Manager to request the change.		
Applicant/Participant's Signature:		**Date** (mm/dd/yyyy)**:**

II. Step 2: Trusted User/Authorized Representative

By signing below, I, the Trusted User/Authorized Representative agree to abide by the conditions of this agreement and accept responsibility for fulfilling all responsibilities encompassed within the scope of the authorized representative to the same extent as the individual represented. I agree to maintain, or be legally bound to maintain, the confidentiality of any and all information regarding the applicant/participant provided by the Louisiana Department of Health, TBSCI Trust Fund Program. I will adhere to the regulations in relevant state and federal laws concerning conflicts of interest and confidentiality of information.

Name (First, Middle, Last & Suffix)**:**	
Name of Organization (if applicable)**:**	
Trusted User/Authorized Representative Signature:	**Date:**

LOUISIANA DEPARTMENT OF HEALTH
Aging and Adult Services

☐ New Applicant ☐ Current Participant

Patient's Name: _____

Patient's DOB:

Traumatic Brain & Spinal Cord Injury (TBSCI) Trust Fund Program

Medical Eligibility Form Instructions

(MUST be completed by treating physician)

The Traumatic Head Brain and Spinal Cord Injury (TBSCI) Trust Fund program through the State of Louisiana has either received an application from one of your patients or the patient is currently eligible for the program and we need to determine if the patient shall continue to be eligible for the program. The program needs medical information/documentation from you that will be evaluated, along with other non-medical information, in connection with his or her application or existing eligibility. This documentation will be used in determining his or her eligibility for the TBSCI Trust Fund program.

Please complete the enclosed Medical Eligibility Form and return to the address below within 10 business days of receipt of this correspondence. If this Medical Eligibility Form request is in connection with a new application, please return this form to the participant so that he or she may attach this form to the application before submitting it to the program for review. If this form request is **NOT** in connection with a new application, you may fax the Medical Eligibility form to **(877) 747-0983.** You may also mail the form to the following address:

LDH/OAAS/TBSCI Trust Fund Program
Attention: Tonia Gedward, 2nd Floor
P. O. Box 2031, Bin #14
Baton Rouge, La 70821-2031

NOTE: The State of Louisiana's TBSCI Trust Fund program DOES NOT pay for the request of any medical documentation or information received from a physician.

If the individual is deemed eligible for the TBSCI Trust Fund program, the program will provide funding for flexible services and support for those with traumatic brain injuries (TBI) and/or spinal cord injuries (SCIs). The program enables individuals to return to a reasonable level of functioning and independent living in their communities. Services provided to eligible participants may include:

- Case management;
- Inpatient and outpatient rehabilitation;
- Home and vehicle modifications; and/or
- Assistive Technology.

If you need assistance or have any questions, please call 1-888-891-9441.

☐ New Applicant ☐ Current Participant

Patient's Name: _____

Patient's DOB:

Traumatic Brain & Spinal Cord Injury (TBSCI) Trust Fund Program

Medical Eligibility Form Instructions

(MUST be completed by treating physician)

I. STATE OF INJURY: Please indicate the patient's injury and current state as of today. Check all that apply. (Required)

☐ **SPINAL CORD INJURY (SCI) -** The patient currently meets the definition of SCI.

☐ The injury is a result of an insult to the spinal cord caused by an external force.

Cause of Injury: _____

Result of Injury: ☐ Paraplegia ☐ Quadriplegia ☐ N/A ☐ Other: _____

Current Level of Mobility:

- ☐ Independent: Able to move and transfer self and requires no hands on assistance
- ☐ Minimal Assistance: Able to bear weight and may require assistive devices
- ☐ Moderately Dependent: Able to come to a sitting position but is not able to stand or transfer
- ☐ Dependent: Confined to bed

☐ The injury is a result of a degenerative or congenital nature (**NOT** an external force).

☐ The injury is **NOT** a result of an insult to the spinal cord caused by an external force.

☐ **TRAUMATIC BRAIN INJURY -** The patient currently meets the definition of a TBI. (Required)

☐ The injury is a result of an insult to the brain, affecting the brain, caused by an external force.

Cause of Injury: _____

Result of Injury:

- ☐ Mild TBI - Glasgow Coma Scale score is 13-15
- ☐ Moderate TBI - Glasgow Coma Scale score is 9-12
- ☐ Severe TBI – Glasgow Coma Scale core is 8 or less.
- ☐ N/A

☐ Impairments: ☐ Cognitive Functioning ☐ Physical Functioning ☐ N/A

Current Level of Mobility:

- ☐ Independent: Able to move and transfer self and requires no hands on assistance
- ☐ Minimal Assistance: Able to bear weight and may require assistive devices
- ☐ Moderately Dependent: Able to come to a sitting position but is not able to stand or transfer
- ☐ Dependent: Confined to bed

☐ New Applicant ☐ Current Participant

Patient's Name: _____

Patient's DOB:

☐ The injury is a result of Anoxia

Cause of Injury: ☐ Stroke or Cardiac Arrest

☐ External Force (drowning, poisoning, electrocution, etc.)

☐ Other: _____

☐ The injury is a result of a degenerative or congenital nature (NOT an external force).

☐ The injury is **NOT** a result of an insult to the brain, affecting the brain, caused by an external force.

☐ **NO TRAUMATIC SPINAL CORD OR BRAIN INJURY**

II. FUNCTIONAL OUTCOMES (Required)

Does this patient have a reasonable expectation to achieve improvement in functional outcomes with assistance? (Specifically, can the patient benefit from the provision of appropriate services and support through the TBSCI Trust Fund program, which can assist the patient in returning to a reasonable level of functioning and independence in their community?)

☐ Yes ☐ No

III. MEDICAL HISTORY AND PROGNOSIS (Required)

Please list any other medical information related to the patient's injury that you feel is relevant to the medical determination and may assist the program in making and informed eligibility decision (if applicable).

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

☐ New Applicant ☐ Current Participant

Patient's Name: _____

Patient's DOB:

IV. GOODS AND SERVICE RECOMMENDATIONS (Required)

Please provide your professional insight regarding the types of services or support the patient might benefit from, based on their current medical condition. The recommended services and support must have a reasonable expectation to improve health outcomes and assist with returning the patient to a reasonable level of functioning and independent living. If possible, please provide a brief overview of recommended services (e.g., physical therapy, counseling, home modifications, durable medical equipment, etc.). This information is not a guarantee for service but will assist in determining eligibility.

_____

_____

_____

_____

_____

_____

_____

V. PHYSICIAN'S INFORMATION AND ATTESTATION (Required)

I attest that the patient's condition meets the entry-level definition of TBI/SCI: A non-degenerative, non-congenital insult to the brain and/or spinal cord, caused by an external physical force resulting in total or partial functional disability and/or psychosocial impairment.

_____ _____

Physician's Signature Date

_____ _____

Physician's Name (please print) Contact Number

Physician's Office Address: _____

_____

NOTE: This form is invalid if incomplete and/or without a signature and legible contact.

*****PLEASE SEE THE FIRST PAGE OF THIS DOCUMENT FOR RETURN INSTRUCTIONS*****

LOUISIANA DEPARTMENT OF HEALTH
Aging and Adult Services

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 the Office of Aging and Adult Services at 1-866-758-5035.

If completed outside our office, this declaration form and your completed voter registration application form (if you filled one out) should be returned to the Office of Aging and Adult Services, 628 North 4th Street, 2nd Floor, P.O. Box 2031 (Bin 14), Baton Rouge, Louisiana 70821.

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):

Louisiana Voter Registration Application
(LA-VRA - Rev. 08/25)

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. NO.

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)
3. 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)
☐ 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 ☐ 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 ____

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

18. I do hereby solemnly swear or attest 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. 08/25)

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* - You may choose to affiliate with the Democrat, Green, 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." If you do not complete this section or if you write "Independent," 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. *Attestation and Signature* - Read the attestation 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 attesting 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. Whenever a document required or provided for in the Louisiana Election Code is required to be witnessed, the witness shall be at least 18 years of age (R.S. 18:4(A)).

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.