



# **Louisiana Medicaid Online Application Training**



The screenshot shows the Louisiana Department of Health website. At the top, there is a navigation bar with the Louisiana Department of Health logo, language options for Spanish and Vietnamese, a Help icon, and a 'LOGIN & CREATE ACCOUNT' button. Below this is a secondary navigation bar with three tabs: 'Public', 'Partner' (highlighted with a red box), and 'Provider'. The main content area features an 'ANNOUNCEMENT' section with a photo of a smiling woman at a computer. Below the photo are two columns: 'Are you a Partner?' and 'Helpful Links'. The 'Are you a Partner?' section contains a definition of a partner and a 'LOGIN & ENROLLMENT' button, which is also highlighted with a red box.

# Log in to the Self-Service Portal (SSP)

- First click on Partner
- Next, click on Login & Enrollment

## ANNOUNCEMENTS

If you need to submit a renewal and have questions, [Click here](#) for help. Are you having difficulty linking a case to your account? [Click here](#) for help. Are you having difficulty with the system logging you out? [Click here](#) for help.

## Application Center Login & Enrollment

### LOGIN

\* User ID:  [I forgot my User ID](#)

\* Password:  [I forgot my Password](#)

[Resend Confirmation Email](#)

LOGIN

### ENROLL AN APPLICATION CENTER

[Click here](#) to enroll an Application Center and its satellite locations.

### ENROLL AS A TRUSTED USER

To enroll as an Application Center Representative, Manager, or CEO/CFO you must first create a Trusted User account.

[Click here](#) to create your Trusted User Account.

If you would like to apply by mail to be an Application Center or an Application Center Representative, the required forms can be found [here](#).

BACK TO HOME PAGE

# Application Center Login & Enrollment

- Enter your User ID
- Enter your Password
- Click Login

## My Application Center



### APPLICATIONS

Start new applications, finish incomplete applications, or review your submitted applications.



### REPORT A CHANGE

Provide user details and submit a change report.



### UPDATE PROFILE

Update information for your profile such as your phone number and email address.



### MANAGE MY ACCOUNT

Link to your Application Center(s), change or reset your password, PIN, and other account information.

# My Application Center: Trusted User

- Submit Applications
- Report Changes
- Update Profile
- Manage My Account

# My Application Center: Managers CEO/CFO

## My Application Center



### APPLICATIONS

Start new applications, finish incomplete applications, or review your submitted applications.



### REPORT A CHANGE

Provide case credentials and submit a change report.



### UPDATE APPLICATION CENTER, LOCATION AND REPRESENTATIVE PROFILES

Update information for the Application Center, its location(s), and its representative(s) such as their phone number.



### PAYMENT HISTORY

Review your Application Center Location's payments by Application Center Representative.



### MANAGE MY ACCOUNT

Link to your Application Center(s), change or reset your password, PIN, and other account information.

- Submit Applications
- Report Changes
- Update Profile
- Manage My Account
- Payment History
- Update Application Center Location and Representative Profiles

## Applications

### START AN APPLICATION

Click here or on the "Apply Now" button to start a new application for health coverage. If you have already started an application but have not yet submitted it, you may continue that application by clicking the "Continue" link in the section below.

APPLY NOW

### INCOMPLETE APPLICATIONS

If you have started an application but have not yet submitted it, a "Continue" link will be displayed below. You can click on that link to return to your application.

#### WARNING

Please keep in mind, you have 24 hours to complete and submit any incomplete applications. If an application is not submitted within 24 hours, it will be deleted and you will need to start a new application.

LOCATION NAME/ID	APPLICATION CENTER REPRESENTATIVE NAME/ID	START DATE	PRIMARY CONTACT/APPLICATION NUMBER	SUBMIT BY	CONTINUE
You do not have any incomplete applications.					

### SUBMITTED APPLICATIONS

The table below displays applications you have submitted within the past 5 years. You can check the status of an application if it was submitted in the past 60 days.

\* Month:  \* Year:

LOCATION NAME/ID	APPLICATION CENTER REPRESENTATIVE NAME/ID	APPLICATION NUMBER	SUBMIT DATE	PRIMARY CONTACT	APPLICATION AND PAYMENT STATUS
You do not have any applications submitted in the past 5 years.					

BACK TO MY ACCOUNT

# Applications

- Start an Application
- Incomplete Applications
- Submitted Applications

## Applications

### START AN APPLICATION

Click here or on the "Apply Now" button to start a new application for health coverage. If you have already started an application but have not yet submitted it, you may continue that application by clicking the "Continue" link in the section below.



# Start an Application

- Individual is up for renewal or not currently receiving Medicaid.
- Click the Apply Now button to start a new application

# Incomplete Applications

- Click on the Continue hyperlink to navigate to the last screen saved on the selected application

## INCOMPLETE APPLICATIONS

If you have started an application but have not yet submitted it, a "Continue" link will be displayed below. You can click on that link to return to your application.

**WARNING**

Please keep in mind, you have 24 hours to complete and submit any incomplete applications. If an application is not submitted within 24 hours, it will be deleted and you will need to start a new application.

LOCATION NAME/ID	APPLICATION CENTER REPRESENTATIVE NAME/ID	START DATE	PRIMARY CONTACT/APPLICATION NUMBER	SUBMIT BY	CONTINUE
You do not have any incomplete applications.					

# Submitted Applications

- Click on the Application and Payment Status hyperlink for information about the selected application.

## SUBMITTED APPLICATIONS

The table below displays applications you have submitted within the past 5 years. You can check the status of an application if it was submitted in the past 60 days.

Month:  Year:

LOCATION NAME/ID	APPLICATION CENTER REPRESENTATIVE NAME/ID	APPLICATION NUMBER	SUBMIT DATE	PRIMARY CONTACT	APPLICATION AND PAYMENT STATUS
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You do not have any applications submitted in the past 5 years.

## Applications

### START AN APPLICATION

Click here or on the "Apply Now" button to start a new application for health coverage. If you have already started an application but have not yet submitted it, you may continue that application by clicking the "Continue" link in the section below.



# Start an Application

- Individual is not currently receiving Medicaid.
- Click the Apply Now button to start a new application

## Apply For Assistance

You are ready to start your application. Here are some helpful hints.

### WHO CAN USE THIS APPLICATION

- Use this application for anyone needing health care assistance.
- Apply even if you or your child already has health coverage. You could be eligible for lower-cost or free coverage.
- Families that include immigrants can apply. You can apply for your child even if you aren't eligible for coverage. Applying won't affect your immigration status or chances of becoming a permanent resident or citizen.

### WHAT YOU WILL NEED

When you apply for coverage you'll need to provide some information about you and your household, including income, any insurance you currently have, and some additional items. Information you give us will be used to help determine benefit levels.

Please have the following items while completing your application:

- Social Security Numbers
- Citizenship or immigration information
- Income information for every member of your household
- Policy numbers for any current health insurance plans covering members of your household
- Medical bills from the past 3 months

If anyone in your household is claiming a disability or over age 65, you may also be asked for the following information:

- Power of attorney, Curator or Interdiction Documents
- Succession documents
- Account information for all Bank Accounts, Annuities, Certificates of deposit (CDs), IRAs, 401-Ks, Keoghs and Retirement accounts
- List of Safe-deposit box items
- Stock and Bonds information
- Vehicle Registration or Titles
- Property Owned or Inherited property
- Life and Burial Insurance Policies
- Burial or Funeral Accounts including Pre-arranged Burial Contracts with Funeral Homes
- Burial Space Items
- Trust Documents
- Act of Donation and Bill of Sale Items

### HOW TO COMPLETE THE APPLICATION

- It may take between 30-60 minutes to complete the application.
- You may use the "Previous" and "Next" buttons at the bottom of each page to go through the application.
- Your information is automatically saved every time you click "Next".
- You can start and then save your application. You can log back in to continue and complete your application(s).
- Once you have answered all the questions, click the "Submit" button at the end of the application.
- We will contact you if more information is needed regarding your application.
- Fields noted with an asterisk (\*) are required.

Click the "Next" button to save your information and continue.

### WHO TO INCLUDE ON THE APPLICATION

#### Who do you need to include on this application?

Tell us about all the family members who live with you. If you file taxes, we need to know about everyone on your tax return. (You don't need to file taxes to get health coverage.)

#### Do Include:

- Yourself
- Your spouse
- Your children under 21 who live with you
- Your unmarried partner who needs health coverage
- Anyone you include on your tax return, even if they don't live with you
- Anyone else under 21 who you take care of and lives with you

#### DO NOT include:

- Your unmarried partner who doesn't need health coverage
- Your unmarried partner's children
- Your parents who live with you, but file their own tax return (if you're over 21)
- Other adult relatives who file their own tax return
- Non-relatives that will not be included as a dependent when you file taxes

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# Apply for assistance

- Informational screen
- Click Next to continue

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# Who Can Use this Application

- Anyone
  - Parents
  - Families of Immigrants
- 

## WHO CAN USE THIS APPLICATION

- Use this application for anyone needing health care assistance.
  - Apply even if you or your child already has health coverage. You could be eligible for lower-cost or free coverage.
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- List of Safe-deposit box items
- Stock and Bonds information
- Vehicle Registration or Titles
- Property Owned or Inherited property
- Life and Burial Insurance Policies
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# How to Complete the Application

## HOW TO COMPLETE THE APPLICATION

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# Who To Include on the Application

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Tell us about all the family members who live with you. If you file taxes, we need to know about everyone on your tax return. (You don't need to file taxes to get health coverage).

### DO Include:

- Yourself
- Your spouse
- Your children under 21 who live with you
- Your unmarried partner who needs health coverage
- Anyone you include on your tax return, even if they don't live with you
- Anyone else under 21 who you take care of and lives with you

### You DON'T have to include:

- Your unmarried partner who doesn't need health coverage
- Your unmarried partner's children
- Your parents who live with you, but file their own tax return (if you're over 21)
- Other adult relatives who file their own tax return

# Privacy Policy

## Privacy Policy

We won't share your information, unless the law says we have to. We'll only use your answers to see if you are eligible for Medicaid or help paying for coverage. We'll check your answers using information we already have and information from other state and federal agencies. If it doesn't match, we may ask you to send us proof.

People who don't want coverage won't be asked about citizenship or immigration status.

**IMPORTANT:** To see if you are eligible, we may need to get information from the Internal Revenue Service (IRS), Social Security Administration (SSA), the Department of Homeland Security, and/or a consumer reporting agency. We need this information to give you the best service possible. We may also check your information later to make sure it is up to date. We'll let you know if we find something has changed.

[Learn more about your data and Privacy Act Statement](#)

\*I agree to have my information checked with the sources listed above and used for this application. Everyone I listed on the application also agrees.

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Start People Health Coverage Income Expenses Resources Submit Application Number: 2024002

## Primary Contact

**ABOUT YOU**

\* First Name:  Middle Name:  \* Last Name:  Suffix:

Maiden Name:

\* Sex:  Male  Female

\* Date of Birth:

Select your preferred spoken language:

Select your preferred written language:

NOTE: If you do not select a preferred spoken or written language, your default language for both will be English.

\* Is this person requesting health coverage?

**We need your Social Security Number if you want health coverage and have an SSN.** Providing your SSN can be helpful even if you don't want health coverage, and can speed up the application process. We need your Social Security Number to check income and other information to see who's eligible for help with health coverage costs. If someone does not have an SSN and wants help getting one, call 1-800-772-1213 or visit [www.socialsecurity.gov](http://www.socialsecurity.gov). TTY users should call 1-800-325-0778.

Social Security Number:  -  -

\* If you did not provide a Social Security Number (SSN), have you applied for one?:

**WHERE YOU LIVE**

Are you homeless?  If yes, you are only required to select the parish where you spend the most of your time.

\* Address:

Apt., Suite, etc.:

\* City:  \* State:  \* Zip Code:

\* Parish:

# Primary Contact

- Adult household member completing interview
- Language preference is important.
- SSN
  - May be requested but is not required
  - Don't make them up!

### MAILING ADDRESS

Is your mailing address the same as your home address above?

\* Address:

Apt., Suite, etc.:

\* City:  \* State:  \* Zip Code:

### CONTACT INFORMATION

NOTE: We encourage you to enter at least one phone number so that you can be contacted about this application if necessary.

Home Phone:  -  -

Work Phone:  -  -

Mobile Phone:  -  -

Other Phone:  -  -

Personal Email Address:

Work Email Address:

### AUTHORIZED REPRESENTATIVE

You can give someone you trust permission to help us with this application. They would be able to: talk with us, see your information and act for you (do things like provide information we ask for or sign the application for you). This person is called an "authorized representative". If you ever need to change your authorized representative, you may either report a change through your account or contact Medicaid.

\* Do you want to name someone as an authorized representative?

# Mailing Address

- Adult household member
- Address and contact info
- AR designation, if requested

Start | People | Health Coverage | Income | Expenses | Resources | Submit

**CONFIRM WHERE YOU LIVE**

The following address was suggested as a valid address:  
628 N 4th St Ste 674-3  
Baton Rouge, Louisiana 70802

• Would you like to use this address?

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**CONFIRM MAILING ADDRESS**

The following address was suggested as a valid address:  
628 N 4th St Ste 674-3  
Baton Rouge, Louisiana 70802

• Would you like to use this address?

# Confirm

- Physical Address – Correct?
- Mailing Address – Correct?

Start People Health Coverage Income Expenses Resources Submit Application Number # 20214058

### Primary Contact Summary

Here is a summary of what you've told us so far. You are not required to give all information before you submit the application.

- If you would like to change your answers, click on "Change".
- If you would like to remove information, click on "Erase".
- If you would like to add information, click on "Add".
- Once you've reviewed this summary and all the information is correct, click the "Next" button at the bottom of the page.

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**REVIEW YOUR ANSWERS: PRIMARY CONTACT INFORMATION**

PRIMARY CONTACT	RESIDENT ADDRESS	PARISH	MAILING ADDRESS	LANGUAGE	CHANGE
Cat Bailou [01/01/2000]	628 N 4th St Ste 674-3 Baton Rouge, LA 70802	East Baton Rouge	628 N 4th St Ste 674-3 Baton Rouge, LA 70802	Spoken: English Written: English	CHANGE

---

**REVIEW YOUR ANSWERS: AUTHORIZED REPRESENTATIVE**

NAME	ORGANIZATION	ADDRESS	ACCESS LEVEL/RECEIVES MAILINGS?	CHANGE	ERASE
You did not appoint an Authorized Representative.					

To add an Authorized Representative, click the "Add" button. [+ ADD](#)

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[< PREVIOUS](#)
[SAVE & EXIT](#)
[NEXT >](#)

# Primary Contact Summary

- Allow applicant to review
- Options
  - Previous
  - Save and Exit
  - Next

Start People Health Coverage Income Expenses Resources Submit Application Number # 20246058

## People In Your Home

**PERSONAL INFORMATION**  
Please enter your name exactly as it appears on your Social Security card or birth certificate.

\* First Name:  Middle Name:  \* Last Name:  Suffix:

Maiden Name:

\* Sex:  Male  Female

\* Date of Birth:

Marital Status:

\* Is this person requesting health coverage?

We need your Social Security Number if you want health coverage and have an SSN. Providing your SSN can be helpful even if you don't want health coverage, and can speed up the application process. We need your Social Security Number to check income and other information to see who's eligible for help with health coverage costs. If someone does not have an SSN and wants help getting one, call 1-800-772-1213 or visit [www.socialsecurity.gov](http://www.socialsecurity.gov).TTY users should call 1-800-325-0778.

Social Security Number:  -  -

\* If you did not provide a Social Security Number (SSN), have you applied for one?

**LIVING ARRANGEMENT**

\* What is this person's living arrangement?

**CITIZENSHIP INFORMATION**

\* Is this person a U.S. citizen or U.S. national?

\* Do you have eligible immigration status?  If this person is an immigrant or lawfully present in the U.S., select "Yes" and choose the immigration status that applies to this person.

\* Immigration Status:  Click here to see what is considered Non-Immigrant status.

Are you, or your spouse or parent, a veteran or an active-duty member of the US military?

Document Type:

\* Date of Entry:

# People in Your Home: Primary Contact

- Taxable Household
- Important
  - Living arrangement
  - Date of Entry

# Ethnicity and Race

## ETHNICITY

If this person is of Hispanic, Latino, or Spanish origin, check all that apply. (optional)

- Puerto Rican
- Mexican
- Mexican American
- Chicano/a
- Cuban
- Other
- Unknown

## RACE

Select this person's race. Check all that apply. (optional)

- American Indian/Alaska Native
- Guamanian or Chamorro
- Other Pacific Islander
- Asian Indian
- Japanese
- Samoan
- Black or African American
- Korean
- Vietnamese
- Chinese
- Native Hawaiian
- White
- Filipino
- Other Asian
- Other

\* American Indians and Alaska Natives may not have to pay cost sharing and may get special enrollment periods. Are you an American Indian, Alaska Native, or someone who is eligible to receive or has ever received services at Indian Health Services, tribal health providers, or urban Indian health providers?

No

MEDICAL BILLING IN THE LAST 3 MONTHS

# Medical Bills and Family Members

**MEDICAL BILLS IN THE LAST 3 MONTHS**

\* Does this person have medical bills, paid or unpaid, with a date of service within the last three months?

\* Select the month in which this person started incurring medical bills:

February  March  April

Date of Service:

Provider of Service:

**FORMER FOSTER CARE**

Was this person in foster care in Louisiana at age 18 or older?

**HCBS WAIVER SLOT**

Have you been offered a Home and Community Based Services waiver slot?  
If you are unsure if you have been offered a Home and Community Based Services waiver slot, [click here](#) for more information.

**VETERAN INFORMATION**

Is this person a veteran or the spouse of a deceased veteran?

**PEOPLE IN YOUR HOME**  
Who do you need to include on this application?  
Tell us about all the family members who live with you. If you file taxes, we need to know about everyone on your tax return. (You don't need to file taxes to get health coverage.)

<b>Do Include:</b>	<b>DO NOT include:</b>
<ul style="list-style-type: none"><li>• Yourself</li><li>• Your spouse</li><li>• Your children under 21 who live with you</li><li>• Your unmarried partner who needs health coverage</li><li>• Anyone you include on your tax returns, even if they don't live with you</li><li>• Anyone else under 21 who you take care of and lives with you</li></ul>	<ul style="list-style-type: none"><li>• Your unmarried partner who doesn't need health coverage</li><li>• Your unmarried partner's children</li><li>• Your parents who live with you, but file their own tax return (if you're over 21)</li><li>• Other adult relatives who file their own tax return</li><li>• Non-relatives that will not be included as a dependent when you file taxes</li></ul>

\* Do you want to add another person to this application?

Start People Health Coverage Income Expenses Resources Submit

Application Number # 202145158

## People In Your Home

You have told us that there is another person in your home. Please provide more information about this person.

**PERSONAL INFORMATION**

Please enter your name exactly as it appears on your Social Security card or birth certificate.

\* First Name:  Middle Name:  \* Last Name:  Suffix:

Maiden Name:

\* Sex:  Male  Female

\* Date of Birth:

Marital Status:

\* Is this person requesting health coverage?

**We need your Social Security Number if you want health coverage and have an SSN.** Providing your SSN can be helpful even if you don't want health coverage, and can speed up the application process. We need your Social Security Number to check income and other information to see who's eligible for help with health coverage costs. If someone does not have an SSN and wants help getting one, call 1-800-772-1213 or visit [www.socialsecurity.gov](http://www.socialsecurity.gov). TTY users should call 1-800-325-0778.

Social Security Number:  -  -

\* If you did not provide a Social Security Number (SSN), have you applied for one?

**LIVING ARRANGEMENT**

\* What is this person's living arrangement?

# People in Your Home

- Personal information
- SSN request
- Living Arrangement

**DO NOT refuse assistance because SSN or verifications are unavailable**

# People in Your Home

## CITIZENSHIP INFORMATION

\* Is this person a U.S. citizen or U.S. national?

\* Is this person a naturalized or derived citizen?

## ETHNICITY

If this person is of Hispanic, Latino, or Spanish origin, check all that apply. (optional)

- |                                       |                                  |   |                                    |
|---------------------------------------|----------------------------------|---|------------------------------------|
| <input type="checkbox"/> Puerto Rican | <input type="checkbox"/> Mexican | <input type="checkbox"/> Mexican American | <input type="checkbox"/> Chicano/a |
| <input type="checkbox"/> Cuban        | <input type="checkbox"/> Other   | <input type="checkbox"/> Unknown          |                                    |

## RACE

Select this person's race. Check all that apply. (optional)

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> American Indian/Alaska Native | <input type="checkbox"/> Guamanian or Chamorro | <input type="checkbox"/> Other Pacific Islander |
| <input type="checkbox"/> Asian Indian                  | <input type="checkbox"/> Japanese              | <input type="checkbox"/> Samoan                 |
| <input type="checkbox"/> Black or African American     | <input type="checkbox"/> Korean                | <input type="checkbox"/> Vietnamese             |
| <input type="checkbox"/> Chinese                       | <input type="checkbox"/> Native Hawaiian       | <input type="checkbox"/> White                  |
| <input type="checkbox"/> Filipino                      | <input type="checkbox"/> Other Asian           | <input checked="" type="checkbox"/> Other       |

\* American Indians and Alaska Natives may not have to pay cost sharing and may get special enrollment periods. Are you an American Indian, Alaska Native, or someone who is eligible to receive or has ever received services at Indian Health Services, tribal health providers, or urban Indian health providers?

# People in Your Home

## MEDICAL BILLS IN THE LAST 3 MONTHS

\* Does this person have medical bills, paid or unpaid, with a date of service within the last three months? Yes

\* Select the month in which this person started incurring medical bills:

February  March  April

Date of Service: 04/01/2021

Provider of Service: womans hospital

## FORMER FOSTER CARE

Was this person in foster care in Louisiana at age 18 or older? No

## HCBS WAIVER SLOT

Have you been offered a Home and Community Based Services waiver slot?

If you are unsure if you have been offered a Home and Community Based Services waiver slot, click here for more information. No

## VETERAN INFORMATION

Is this person a veteran or the spouse of a deceased veteran? No

## PEOPLE IN YOUR HOME

Who do you need to include on this application?

Tell us about all the family members who live with you. If you file taxes, we need to know about everyone on your tax returns. (You don't need to file taxes to get health coverage.)

### Do Include:

- Yourself
- Your spouse
- Your children under 21 who live with you
- Your unmarried partner who needs health coverage
- Anyone you include on your tax return, even if they don't live with you
- Anyone else under 21 who you take care of and lives with you

### DO NOT include:

- Your unmarried partner who doesn't need health coverage
- Your unmarried partner's children
- Your parents who live with you, but file their own tax return (if you're over 21)
- Other adult relatives who file their own tax return
- Non-relatives that will not be included as a dependent when you file taxes

\* Do you want to add another person to this application? No

« PREVIOUS

SAVE & EXIT

NEXT »

# Former Foster Care

Application Number # 202145158

## BEFORE YOU GO TO THE NEXT PAGE:

- **Error:** This individual is under the age of 18, so they do not need to provide answers to the Foster Care questions below. Please update the age or change your answer.

## People In Your Home

# How Are You Related

Start People Health Coverage Income Expenses Resources Submit



Application Number # 202145158

## How You Are Related

Please tell us how the people in your home are related.

---

**\* CAT'S RELATIONSHIP TO CATNESS**

 Cat Ballou [01/01/2000]   Catness Ballou [04/01/2021]

« PREVIOUS SAVE & EXIT NEXT »

Start People Health Coverage Income Expenses Resources Submit Application Number # 20240102

**BEFORE YOU GO TO THE NEXT PAGE:**

- Error: Please choose a value for "Are any individuals on the application deceased?".

### Additional Personal Details

**DISABILITY INFORMATION**  
 \* Mark all individuals who are blind, disabled, have tuberculosis or have a physical, mental or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.). If none of the individuals below are blind, disabled, have tuberculosis or have a physical, mental or emotional health condition that causes limitations in activities, please select "No one."

No one

Cat Balou [01/01/2000]  Catress Balou [04/01/2021]

**TAX FILERS**  
 \* Mark everyone who will file a federal income tax return NEXT year (only applies to ages 14 and up). If none of the individuals below are filing taxes next year, please select "No one"

No one

Cat Balou [01/01/2000]

**PREGNANCY**  
 Mark everyone who is currently pregnant or had a pregnancy that ended in the last 3 months.

Cat Balou [01/01/2000]  Catress Balou [04/01/2021]

**SCHOOL ENROLLMENT**  
 Mark everyone who is currently enrolled in school. This information is only needed for individuals who are 18-22 years old.

Cat Balou [01/01/2000]

**BREAST AND CERVICAL CANCER**  
 Mark everyone who has been diagnosed with breast or cervical cancer and has proof of the Early Detection Program screening and diagnosis.

Cat Balou [01/01/2000]  Catress Balou [04/01/2021]

**DECEASED**  
 \* Are any individuals on the application deceased?  Why are we asking this?

[PREVIOUS](#) [SAVE & EXIT](#) [NEXT](#)

# Additional Personal Details

- Disability
- Tax Filers
- Pregnancy
- School enrollment
- Breast and Cervical Cancer
- Deceased

# More About Pregnancy

Start People Health Coverage Income Expenses Resources Submit

Application Number # 202145153

## More About Pregnancy - Cat [01/01/2000]

You have told us that Cat is currently pregnant or had a pregnancy that ended in the last 3 months. Please provide more information about Cat's pregnancy.

---

### PREGNANCY DETAILS

If Cat is **currently pregnant**, please enter the following:

Number of babies expected during this pregnancy

What is the expected due date?

If Cat was **pregnant in the last 3 months and the pregnancy ended**, please enter the following:

Number of babies expected

What date did the pregnancy end?

« PREVIOUS SAVE & EXIT NEXT »

# Primary Caretaker

The screenshot shows a web application interface for the Louisiana Department of Health. At the top, there is a dark blue header with the state seal and the text "LOUISIANA DEPARTMENT OF HEALTH". On the right side of the header, it says "Logged in as Kathryn Loochelt" and "Help", with a "LOGOUT" button. Below the header is a navigation menu with tabs: "Start", "People", "Health Coverage", "Income", "Expenses", "Resources", and "Submit". The "Health Coverage" tab is currently selected. In the top right corner of the main content area, it says "Application Number # 202145251". The main content area has a title "PRIMARY CARETAKER — CATNESS [04/01/2021]". Below the title is a red asterisk and a note: "Mark the primary caretaker for Catness. If none of the individuals below are the caretaker, please select 'No one'". There are two radio button options: "No One/Someone outside of the home" (which is selected and highlighted with a red box) and "Cat Ballou [01/01/2000]". At the bottom of the form, there are three buttons: "PREVIOUS", "SAVE & EXIT", and "NEXT".

# More About Living Facility

## Provide Facility Information:

- Type
- Name
- Address
- Dates of residence
  - Date Entered
  - Date Discharged
- 30 Days?
- Patient Fund Account?

Start | People | **Health Coverage** | Income | Expenses | Resources | Submit

Application Number # 202145

### More About Living Facility — Catness [04/01/2021]

You have told us that Catness either lives in or will be moved in the next 30 days to a:

- Nursing facility
- Developmental center
- Group home

Please provide more information about Catness's living facility.

---

#### FACILITY DETAILS

Facility Name:

Address:

Apt., Suite, etc.:

City:  State:  Zip Code:

When did Catness enter the Medical facility?  End/Discharge Date:

Is Catness expected to stay in the Medical facility for at least 30 days?

If Catness has a patient fund account at this facility, what is the amount in the account? \$

[◀ PREVIOUS](#) [SAVE & EXIT](#) [NEXT ▶](#)

Start People Health Coverage Income Expenses Resources Submit

Application Number # 20214058

### Household Member Summary

Here is a summary of what you've told us so far. You are not required to give all information before you submit the application.

- If you would like to change your answers, click on "Change".
- If you would like to remove information, click on "Erase".
- If you would like to add information, click on "Add".
- Once you've reviewed this summary and all the information is correct, click the "Next" button at the bottom of the page.

---

**REVIEW YOUR ANSWERS: PEOPLE IN YOUR HOME**

NAME/SEX/DATE OF BIRTH	SOCIAL SECURITY NUMBER PROVIDED?	REQUESTING COVERAGE?	LIVING ARRANGEMENT	CHANGE	ERASE
Cat Ballou Female [01/01/2000]	No	Yes	In home Offered waiver slot?: No	CHANGE	
Catness Ballou Female [04/01/2021]	No	Yes	Medical Facility Offered waiver slot?: No	CHANGE	ERASE

To add a person to your home, click the "Add" button.

---

**REVIEW YOUR ANSWERS: RELATIONSHIPS**

NAME	RELATIONSHIPS	CHANGE
Cat Ballou [01/01/2000]	Parent of Catness [04/01/2021]	CHANGE

---

**REVIEW YOUR ANSWERS: DISABILITY**

NAME	TYPE OF DISABILITY	CHANGE	ERASE
You have not provided any disability information.			

To add someone who has a disability, select that person's name from the drop down menu below. Then, click the "Add" button.

# Household Member Summary

Review to ensure accuracy of information entered up to this point!

- People in your home
- Relationships
- Disability

REVIEW YOUR ANSWERS: TAX INFORMATION

TAX FILER	FILING JOINTLY?	DEPENDENTS	CHANGE	ERASE
You have not provided any tax filing information.				

To add someone who files taxes, select that person's name from the drop down menu below. Then, click the "Add" button.

+ ADD

REVIEW YOUR ANSWERS: PREGNANCY

NAME	CURRENT PREGNANCY: NUMBER OF BABIES EXPECTED DUE DATE	RECENT PREGNANCY: NUMBER OF BABIES EXPECTED END DATE	CHANGE	ERASE
Cat Ballou [01/01/2000]	Number of Babies: Due Date:	Number of Babies Expected: 1 End Date: 04/01/2021	CHANGE	ERASE

To add someone who is pregnant, select that person's name from the drop down menu below. Then, click the "Add" button.

+ ADD

REVIEW YOUR ANSWERS: SCHOOL ENROLLMENT

NAME	FULL TIME/PART TIME	TYPE OF SCHOOL	GRADUATION DATE	CHANGE	ERASE
You have not provided any school enrollment information for individuals ages 18-22.					

To add someone who is enrolled in school, select that person's name from the drop down menu below. Then, click the "Add" button.

+ ADD

REVIEW YOUR ANSWERS: PRIMARY CARETAKER

CHILD	PRIMARY CARETAKER	CHANGE
Catness Ballou [04/01/2021]	No One/Someone outside of the home	CHANGE

# Household Member Summary

- Tax Information
- Pregnancy
- School Enrollment
- Primary Caretaker

# Household Member Summary

- Facility
- Deceased

**REVIEW YOUR ANSWERS: FACILITY**

NAME	NAME OF FACILITY	ADDRESS	END/DISCHARGE DATE	PATIENT FUND ACCOUNT AMOUNT	CHANGE
Catress Ballou [04/01/2021]	Womans hospital	628 N Fourth Street ste 674-3 baton rouge, LA 70902	End/Discharge Date:		CHANGE

To add or remove someone who lives in a facility, you must return to the person's People in Your Home screen and update where they live.

**REVIEW YOUR ANSWERS: DECEASED INFORMATION**

NAME	DATE OF DEATH	CHANGE	ERASE
You have not provided any deceased information.			

To add someone who is deceased, select that person's name from the drop down menu below. Then, click the "Add" button.

## Information About Health Coverage

Information about current health coverage for the following individuals, whether from a job or another source, may be needed in order to complete your application. You may still qualify for health benefits even if you already have health coverage.

### EMPLOYER SPONSORED HEALTH COVERAGE

Mark everyone who is offered health coverage through an employer, even if they are not enrolled.

<input type="checkbox"/>	<input type="checkbox"/>
 Cat Ballou [01/01/2000]	 Catness Ballou [04/01/2021]

### PRIVATE HEALTH INSURANCE

\*Mark everyone who has private health insurance. If no one has private health insurance, please mark "No one".

<input checked="" type="checkbox"/> No one	<input type="checkbox"/>	<input type="checkbox"/>
 Cat Ballou [01/01/2000]	 Catness Ballou [04/01/2021]	

### OTHER HEALTH COVERAGE

\*Mark everyone who has health coverage through Medicaid, CHIP, Tricare, Medicare, Veteran Affairs, the Peace Corps or other insurance. If no one has other health coverage, please mark "No one".

<input checked="" type="checkbox"/> No one	<input type="checkbox"/>	<input type="checkbox"/>
 Cat Ballou [01/01/2000]	 Catness Ballou [04/01/2021]	

◀ PREVIOUS

SAVE & EXIT

NEXT ▶

# Information about Health Coverage

- Employer Sponsored
- Private Health Insurance
- Other Health Coverage

## Health Coverage Summary

Here is a summary of what you've told us so far. You are not required to give all information before you submit the application.

- If you would like to change your answers, click on "Change".
- If you would like to remove information, click on "Erase".
- If you would like to add information, click on "Add".
- Once you've reviewed this summary and all the information is correct, click the "Next" button at the bottom of the page.

### REVIEW YOUR ANSWERS: EMPLOYER HEALTH COVERAGE

NAME	ENROLLED?	EMPLOYER NAME	WHO IS ELIGIBLE	CHANGE	ERASE
You did not provide any Employer Health Coverage information.					

To add employer health coverage, select that person's name from the drop down menu below. Then, click the "Add" button.

+ ADD

### REVIEW YOUR ANSWERS: PRIVATE HEALTH INSURANCE

NAME	INSURANCE NAME	POLICY NUMBER	START DATE/END DATE	CHANGE	ERASE
You did not provide Private Health Insurance information.					

To add private health insurance, select that person's name from the drop down menu below. Then, click the "Add" button.

+ ADD

### REVIEW YOUR ANSWERS: OTHER HEALTH COVERAGE

NAME	TYPE	MEDICARE TYPE	START DATE/END DATE	CHANGE	ERASE
You did not provide Other Health Coverage information.					

To add other health coverage, select that person's name from the drop down menu below. Then, click the "Add" button.

+ ADD

< PREVIOUS

SAVE & EXIT

NEXT >

# Health Coverage Summary

Review to ensure accuracy of information entered up to this point!

## Health Coverage Summary

Here is a summary of what you've told us so far. You are not required to give all information before you submit the application.

- If you would like to change your answers, click on "Change".
- If you would like to remove information, click on "Erase".
- If you would like to add information, click on "Add".
- Once you've reviewed this summary and all the information is correct, click the "Next" button at the bottom of the page.

### REVIEW YOUR ANSWERS: EMPLOYER HEALTH COVERAGE

NAME	ENROLLED?	EMPLOYER NAME	WHO IS ELIGIBLE	CHANGE	ERASE
You did not provide any Employer Health Coverage information.					

To add employer health coverage, select that person's name from the drop down menu below. Then, click the "Add" button.

+ ADD

### REVIEW YOUR ANSWERS: PRIVATE HEALTH INSURANCE

NAME	INSURANCE NAME	POLICY NUMBER	START DATE/END DATE	CHANGE	ERASE
You did not provide Private Health Insurance information.					

To add private health insurance, select that person's name from the drop down menu below. Then, click the "Add" button.

+ ADD

### REVIEW YOUR ANSWERS: OTHER HEALTH COVERAGE

NAME	TYPE	MEDICARE TYPE	START DATE/END DATE	CHANGE	ERASE
You did not provide Other Health Coverage information.					

To add other health coverage, select that person's name from the drop down menu below. Then, click the "Add" button.

+ ADD

< PREVIOUS

SAVE & EXIT

NEXT >

# Income

- People who have a job
- People who have self-employment income
- People who have income from other sources

## Health Coverage Summary

Here is a summary of what you've told us so far. You are not required to give all information before you submit the application.

- If you would like to change your answers, click on "Change".
- If you would like to remove information, click on "Erase".
- If you would like to add information, click on "Add".
- Once you've reviewed this summary and all the information is correct, click the "Next" button at the bottom of the page.

### REVIEW YOUR ANSWERS: EMPLOYER HEALTH COVERAGE

NAME	ENROLLED?	EMPLOYER NAME	WHO IS ELIGIBLE	CHANGE	ERASE
You did not provide any Employer Health Coverage information.					

To add employer health coverage, select that person's name from the drop down menu below. Then, click the "Add" button.

+ ADD

### REVIEW YOUR ANSWERS: PRIVATE HEALTH INSURANCE

NAME	INSURANCE NAME	POLICY NUMBER	START DATE/END DATE	CHANGE	ERASE
You did not provide Private Health Insurance information.					

To add private health insurance, select that person's name from the drop down menu below. Then, click the "Add" button.

+ ADD

### REVIEW YOUR ANSWERS: OTHER HEALTH COVERAGE

NAME	TYPE	MEDICARE TYPE	START DATE/END DATE	CHANGE	ERASE
You did not provide Other Health Coverage information.					

To add other health coverage, select that person's name from the drop down menu below. Then, click the "Add" button.

+ ADD

< PREVIOUS

SAVE & EXIT

NEXT >

# Income Summary

Review to ensure accuracy of information entered up to this point!

# Expenses

Start People Health Coverage Income Expenses Resources Submit

Application Number # 202145153

## Expenses


Please tell us about money paid by the people listed below. If you pay for certain things that can be deducted from your federal income tax return, those expenses may help you become eligible for Medicaid. Please tell us as much as possible about these expenses.

---

### PEOPLE WHO HAVE EXPENSES

\* Mark the individuals who have expenses (Alimony/Child Support payments, Student Loan Interest paid, etc.). This only applies to individuals ages 14 and up. [Click here to view types of expenses we would like to know about.](#)

No one

 Cat Ballou [01/01/2000]

---

« PREVIOUS SAVE & EXIT NEXT »

Start People Health Coverage Income Expenses Resources Submit

Application Number # 202145158

## Expense Summary

Here is a summary of what you've told us so far. You are not required to give all information before you submit the application.

- If you would like to change your answers, click on "Change".
- If you would like to remove information, click on "Erase".
- If you would like to add information, click on "Add".
- Once you've reviewed this summary and all the information is correct, click the "Next" button at the bottom of the page.

---

**REVIEW YOUR ANSWERS: EXPENSES**

NAME	TYPE	AMOUNT	FREQUENCY	CHANGE	ERASE
You did not provide any expense information.					

To add expenses, select that person's name from the drop down menu below. Then, click the "Add" button.

---

# Expense Summary

Review to ensure accuracy of information entered up to this point!

Start People Health Coverage Income Expenses Resources Submit

Application Number # 202145153

## Resources

Please tell us more about the resources owned by the people listed below. Telling us about all resources helps us complete the application faster.

---

**PEOPLE WHO HAVE RESOURCES**

Mark all of the individuals who have resources. [Click here to see which resources we would like to know about.](#) If no one has resources, select "No one".

No one

Cat Ballou [01/01/2000]

Catness Ballou [04/01/2021]

---

**SOLD, TRANSFERRED OR GIVEN AWAY RESOURCES**

Mark the individuals that have ever sold, transferred, or given away a resource in the last 60 months. If no one has sold, transferred, or given away resources, select "No one".

No one

Cat Ballou [01/01/2000]

Catness Ballou [04/01/2021]

---

**MONEY HELD BY SOMEONE ELSE**

Mark the individuals that have money in an account owned by someone else. If no one has money held by someone else, select "No one".

No one

Cat Ballou [01/01/2000]

Catness Ballou [04/01/2021]

« PREVIOUS SAVE & EXIT NEXT »

# Resources

- People who have resources
- Sold, Transferred, or Given away resources
- Money held by someone else

# Resource Summary

Review to ensure accuracy of information entered up to this point!

Start People Health Coverage Income Expenses Resources Submit Application Number # 202145153

## Resources Summary

Here is a summary of what you've told us so far. You are not required to give all information before you submit the application.

- If you would like to change your answers, click on "Change".
- If you would like to remove information, click on "Erase".
- If you would like to add information, click on "Add".
- Once you've reviewed this summary and all the information is correct, click the "Next" button at the bottom of the page.

---

### REVIEW YOUR ANSWERS: RESOURCES

NAME	CATEGORY	TYPE	VALUE / AMOUNT / BALANCE	CHANGE	ERASE
You did not provide any resource information.					

To add someone who has a resource, select that person's name from the drop down menu below. Then, click the "Add" button.

---

### REVIEW YOUR ANSWERS: SOLD, TRANSFERRED, OR GIVEN AWAY RESOURCES

NAME	TYPE OF RESOURCE/DATE OF TRANSFER	WORTH	AMOUNT RECEIVED	CHANGE	ERASE
You did not provide any Sold, Transferred, or Given Away Resource Information.					

To add someone who has sold, transferred, or given away a resource, select that person's name from the drop down menu below. Then, click the "Add" button.

---

### REVIEW YOUR ANSWERS: MONEY HELD BY SOMEONE ELSE

NAME	AMOUNT	CHANGE	ERASE
You did not provide information about Money Held by Someone Else.			

To add someone who has money held by someone else, select that person's name from the drop down menu below. Then, click the "Add" button.

Start People Health Coverage Income Expenses Resources Submit

Application Number # 202145158

### Health Plan Information

Most people with Medicaid need to choose a Health Plan. A Health Plan is a group of doctors, nurses, and other staff who work together to provide health care. You can look at information about the different Health Plans by clicking [here](#).

#### HEALTH PLAN SELECTION

The Health Plans listed below only apply to Louisiana Medicaid. If you are referred to Health Insurance Marketplace for health coverage, you will have to select another plan.

Health Plan for Cat [01/01/2000]:

Health Plan for Catness [04/01/2021]:

< PREVIOUS SAVE & EXIT NEXT >

# Health Plan Information

- Compare health plans
- Applicant may select a plan for each individual

Start People Health Coverage Income Expenses Resources Submit

Application Number # 202145258

**WARNING**

- You have selected different health plans for the people in your household. If you are sure about your selections, please click Next.

### Health Plan Information

Most people with Medicaid need to choose a Health Plan. A Health Plan is a group of doctors, nurses, and other staff who work together to provide health care. You can look at information about the different Health Plans by clicking [here](#).

---

#### HEALTH PLAN SELECTION

The Health Plans listed below only apply to Louisiana Medicaid. If you are referred to Health Insurance Marketplace for health coverage, you will have to select another plan.

Health Plan for Cat [01/01/2000]:

Health Plan for Catress [04/01/2021]:

[← PREVIOUS](#) [SAVE & EXIT](#) [NEXT →](#)

# Health Plan: Warning

Please review your selections.

Start People Health Coverage Income Expenses Resources Submit

Application Number # 202145351

### Dental Plan Information

Most people with Medicaid need to choose a Dental Plan. You can look at more information about the different Dental Plans by clicking [here](#).

---

#### DENTAL PLAN SELECTION

The Dental Plans listed below only apply to Louisiana Medicaid.

Dental Plan for Cat [01/01/2000]:

Dental Plan for Catness [04/01/2021]:

---

« PREVIOUS SAVE & EXIT NEXT »

# Dental Plan Information

1. Compare dental plans
2. Applicant may select a plan for each individual

Start People Health Coverage Income Expenses Resources Submit

Application Number # 20214515

## Sign and Submit

---

### CHILD SUPPORT ENFORCEMENT PROGRAM INFORMATION

The Child Support Enforcement program provides custodial parents with assistance in obtaining child and medical support for their children by locating parents, establishing paternity, establishing support orders, and collecting and distributing child support payments. To provide these services, the child support agency will require your cooperation.


---

### COOPERATION WITH CHILD SUPPORT ENFORCEMENT

\* Do you think cooperating to collect medical support will result in harm to you or your child(ren)? OR was the child(ren) born out of incest, born as the result of rape, was the child(ren) adopted, or are the child(ren)'s parent(s) deceased?

Yes - If you choose yes, Medicaid **will not** refer you to the Child Support Enforcement agency.  
 No - If you choose no, Medicaid **may refer** you to the Child Support Enforcement agency.

Please answer this question for the child(ren) listed below:

 Catness Ballou [04/01/2021]  Yes  No

---

### RENEWAL OF COVERAGE IN FUTURE YEARS

To make it easier to determine your eligibility for help paying for health coverage in future years, you may allow the Louisiana Department of Health (LDH) and the Federally Facilitated Marketplace (FFM) to use your income data, including information from tax returns. The LDH and FFM will send you a notice about this agreement, let you make any changes, and you can opt out at any time.

Renew my eligibility automatically for the next:

# Sign And Submit

1. Child Support Enforcement Program Information
2. Cooperation with Child Support Enforcement
3. Renewal of Coverage in Future Years

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# Privacy Option

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## PRIVACY OPTION

If you or anyone on this application is a victim of domestic violence or abuse, you have the opportunity to make your application and case information private so that it cannot be viewed online. If you are a victim of domestic violence or fear for your safety, you may also call the Louisiana Domestic Hotline at 1-888-411-1333 for free, confidential 24-hour assistance. Even if you are not a victim of domestic violence or abuse, you may still choose to make your case private and not viewable online.

**By selecting "Yes", you or others will not be able to view case information, renew your benefits, or report changes online. I would like my case to be marked as private, so that my information cannot be viewed online.**

Yes  No

---

## RIGHTS AND RESPONSIBILITIES

By signing and submitting this application, I state that I have permission from all of the people listed on the application to both submit their information to LDH, and receive any information about their eligibility and healthcare coverage. I understand that if anyone on this application enrolls in Medicaid, I am giving LDH our rights to any money owed to us by any other health insurance, legal settlement, a spouse or parent, or other third party.

### WHAT THE LOUISIANA DEPARTMENT OF HEALTH (LDH) HAS THE RIGHT TO EXPECT OF YOU (the person applying for health care assistance)

**CITIZENSHIP AND IMMIGRATION STATUS:** You state that the information about citizenship and immigration status given at the beginning of this application form is true and correct.

**REPORTING THE TRUTH:** You state that the information you give on this application form is true and correct. You understand if you purposely give information that is not true or if you purposely do not tell information that you are supposed to, you may get health benefits that you should not get. If that happens, you can by law be punished for fraud. Also, you may have to pay money back to LDH for the bills it paid by mistake.

**VERIFICATION OF INFORMATION:** 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 cancelling this permission, whichever comes first. A cancellation may prevent you from being found to be eligible for Medicaid.

**SOCIAL SECURITY NUMBERS:** 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.

**PAYMENT OF MEDICAL CARE BY A THIRD PARTY:** You understand by accepting health care assistance, the Department has the right to get money received by you from other sources like insurance payments or lawsuit settlements for services that LDH has paid for you.

**REPORTING CHANGE:** You agree to tell LDH within 10 days of these changes: 1) if you move out of state; 2) changes in mailing or home address; 3) if anyone moves in or out of your home; 4) changes in health insurance and premiums; and 5) changes in income.

### WHAT YOU (the person applying for health care assistance) HAVE THE RIGHT TO EXPECT FROM THE LOUISIANA DEPARTMENT OF HEALTH (LDH)

**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:** I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting [www.hhs.gov/ocr/office/file](http://www.hhs.gov/ocr/office/file), calling the US DHHS Regional Office for Civil Rights at 1-800-368-1019, or writing to the LDH at PO Box 4818, Baton Rouge, Louisiana 70821.

**ESTATE RECOVERY:** You understand that Estate Recovery rules require the Department to recover the cost of certain health care assistance payments from your estate. These costs include the total amount of payments for facility services, waiver services, hospital care, and prescription drugs received at age 55 or older by Long Term Care and/or Home and Community Based Services recipients. The Department will not make a claim against the estate while you or your legal spouse is still living or if you have a dependent child who is under age 21, blind, or disabled. Collection may not be made if it is not cost effective for the Department to do so, or if your heirs apply for a hardship waiver after your death and the hardship waiver is granted by the Department. A hardship may exist if the estate property is the only source of income for the heirs, if that income is limited, or other extenuating circumstances.

# Rights and Responsibilities

## READ THEM

## VOTER REGISTRATION OPTIONS

If you are not registered to vote where you live now, would you like to register to vote here today?

Yes  No

You may also apply to register to vote online at [www.geauxvote.com](http://www.geauxvote.com). A valid Louisiana driver's license or ID card is required.

You may click [here](#) to print and mail the Mail Voter Registration Application.

A Mail Voter Registration Application will be mailed to you.

**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

# Voter Registration Options

## Wish to register?

- [Geauxvote.com](http://Geauxvote.com)
- Apply by Mail

### ELECTRONIC SIGNATURE

I certify under penalty of perjury that the information I have given on this application is true, complete, and correct to the best of my knowledge, including the information I have given regarding the U.S. citizenship or immigration status of all household members. I understand that I and any adult household member will be subject to disqualification and prosecution and will be required to repay ineligible benefits or services if we knowingly give false, incorrect, or incomplete information in order to obtain or try to obtain health care assistance. By signing this application, I give permission for the release of information to the Louisiana Department of Health by any persons or agencies who have knowledge of my circumstances.

\* Are you a LDH employee, or are you related to a LDH employee?  Yes  No

\*Please check this box to let us know that you have read your rights and responsibilities

\*Please check this box to let us know that you have read the "Electronic Signature Agreement"

\* Please select the correct description of the person signing this application:

I am the applicant signing for myself

I am signing on the applicant's behalf

\* First Name:

\* Last Name:

\* User PIN:

← PREVIOUS

SAVE & EXIT

SUBMIT

# Electronic Signature

- Final step
- Read the statement as written
- Attestations

## Confirmation

You have completed this application and your information has been sent to the department mentioned below for review.

### APPLICATION INFORMATION

#### Application

If you would like to review the summary of the application you submitted and print or save a copy of your application for your files, please click the Print PDF button below. If you decide to print or save, please keep in mind that your application has your private, personal information on it.

PRINT PDF

Keep in mind that you'll need to have a program called Adobe Acrobat Reader to see and print the summary. If you don't have this program on your computer, you may install it for free by clicking on the button below:



### LOUISIANA DEPARTMENT OF HEALTH

Your information has been sent to the department mentioned below:

#### Louisiana Medicaid/LACHIP

P.O. Box 91283

Baton Rouge, LA 70821-9278

Customer Service Number: 1-888-342-6207

Fax Number: 1-877-523-2987

Email: [MyMedicaid@la.gov](mailto:MyMedicaid@la.gov)

# Confirmation

- Print a copy for the applicant

# AC Representatives vs Authorized Representatives (AR)

## Application Center (AC) Representatives

- Application Center Representative is an alternate term for Trusted User.
- It is often used by medical facilities in various capacities.
- In fact, Medicaid referred to our partners as Application Center Representatives (ACRs) prior to adopting the term Trusted User.

## Authorized Representatives (ARs)

- Authorized Representatives (ARs) are friends or family members selected to act on behalf of an applicant or client in their best interest. An Appendix C must be completed whenever an AR is named.
- If granted partial access, the AR can contact the Customer Service Unit (CSU) to inquire about any case on which they are the AR and receive the same case details that would be provided to the applicant or client.

# AC Representatives vs Authorized Representatives (AR) (cont.)

## Application Center (AC) Representatives

## Authorized Representatives (ARs)

- If an AR is granted full access, they receive the same information as someone with partial access, plus case notices sent via mail.
- Trusted Users are not allowed to act as ARs, as this would create a conflict of interest; Trusted Users act on behalf of Medicaid.

# Application Signatures

- When applications are completed, the Trusted User enters the data into the Partner Portal, but the applicant provides the information. Therefore, the applicant's name should be listed on the signature line. This name should match the Contact Person listed in Step 1, unless the applicant is deceased or otherwise incapacitated. If the applicant is unable to sign, submit a BHSF Clearance Form explaining why the applicant could not sign on their own.
- The Trusted User PIN is also listed on the signature line, but it is used only to link the application to the Trusted User who completed it, for reporting purposes.



# Helpful Links and Contact Information

## AC Resource Library

<https://ldh.la.gov/medicaid-application-centers>

# Contact Information

## Application Centers (AC)

- [ApplicationCenter.Service@la.gov](mailto:ApplicationCenter.Service@la.gov)
- (225) 342 – 6312
- Valerie McManus

## Medical Eligibility Determinations Team (MEDT)

- [MEDT@la.gov](mailto:MEDT@la.gov)
- Angel Wilson Jolivette

## Newborn Eligibility Unit (NEU)

- [NEU@la.gov](mailto:NEU@la.gov)
- Kiarah Dugas

## Outstation

- [Outstation@la.gov](mailto:Outstation@la.gov)
- K'Maya Franklin

## Optional State Supplement (OSS)

- [OSS@la.gov](mailto:OSS@la.gov)
- K'Maya Franklin

## Medicaid Outreach

- [MedicaidOutreach@la.gov](mailto:MedicaidOutreach@la.gov)

## Healthy Louisiana

- 1-855-229-6848

## Louisiana Medicaid Customer Service

- 1-888-342-6207

# Contact Information (cont.)

## Aetna Better Health

- 1-855-242-0802
- <http://www.aetnabetterhealth.com/louisiana>

## AmeriHealth Caritas Louisiana

- 1-888-756-0004
- <http://www.amerihealthcaritasla.com/>

## Healthy Blue

- 1-844-521-6941
- <https://www.myhealthybluela.com/la/louisiana-home.html>

## Humana Healthy Horizons in LA

- 1-800-448-3810
- <http://www.humana.com/healthylouisiana>

## Louisiana Healthcare Connections

- 1-866-595-8133
- <http://www.louisianahealthconnect.com/>

## DentalQuest

- 1-800-685-0143
- <https://dentaquest.com/stateplans/regions/louisiana/>

## MCNA Dental

- 1-855-702-6262
- <https://www.mcnala.net/members>



**Thank you for your  
Partnership!**

