Family Opportunity Act Medicaid Buy-In Program

Medicaid health care coverage is available to children under age 19 who meet the federal childhood disability definition. Income limits for children with disabilities are higher than for other Medicaid Programs.

NO enrollment fees, co-payments, or deductibles

To Qualify

- ★ Your child must meet the SSI childhood disability definition;
- ★ Family gross income must be below the amounts shown in the chart;
- ★ Parents must sign up for or keep health insurance through their job if the employer pays at least 50% of the premiums;
- ★ Some families will not pay a premium: most will pay $12 to $35 per month for the Medicaid coverage; and
- ★ You must meet other program requirements.

We Review Your Family's Income

We count your family's gross income, not take-home (net) pay, and compare it to the family size. A *family* includes the child who is applying, parents (legal and natural), and sisters and brothers under the age of 19 who live in the home. We **do not** count things like bank accounts, your home, vehicles, or land.

Income Limits Effective April 1, 2012 through March 31, 2013	
Family Size	**Monthly**
1	$2,793
2	$3,783
3	$4,773
4	$5,763
5	$6,753
6	$7,743
Each extra person	Add $990

How to Apply

- ★ **Online – www.Medicaid.DHH.Louisiana.gov**
- ★ **Mail -**
  Family Opportunity Act
  P.O. Box 91278
  Baton Rouge, LA 70821-9278
- ★ **FAX - 1-877-523-2987** (toll free)
- ★ **Drop Off –** Go to your local Medicaid office. To find the closest office call us at **1-888-342-6207**, or visit **www.Medicaid.DHH.Louisiana.gov**

After You Apply

We will let you know if your child qualifies. If they do, you will get a plastic Medicaid card about two weeks following the approval letter. If they already have a Medicaid card, we will reactivate it, and you can start using it as soon as you hear from us.

Covered Services

Doctor visits	Hospital care
Prescriptions	Shots
Lab work and tests	X-rays
Mental health	Psychological tests
Psychological therapy	Physical therapy
Speech therapy	Occupational therapy
Dental, vision, hearing	Medical transportation

Medical supplies and equipment
And all other Medicaid services for children.

Your child may use any doctor or clinic who accepts Medicaid. If you have other insurance Medicaid pays after your other health insurance has paid.

Questions

Call **1-888-342-6207**

TTY text telephone users:
1-800-220-5404

These calls are free.

← (TEAR OFF THE APPLICATION HERE BEFORE MAILING. KEEP THIS PAGE FOR YOURSELF.)

Your Rights

If you think the decision we make is unfair, not correct or made too late, you may ask for a fair hearing.

- ✓ Call the Family Opportunity Act Medicaid Buy-In Program office at 1-888-342-6207; and/or
- ✓ Write to:
  LA DHH Bureau of Appeals
  P.O. Box 4183
  Baton Rouge, LA 70821-4183

The Family Opportunity Act Medicaid Buy-In Program is an Equal Opportunity Program

We cannot treat you differently because of your race, color, sex, age, disability, religion, nationality or political beliefs. If you think we have:

- ✓ Call the U.S. DHHS Regional Office for Civil Rights in Dallas, TX at 1-800-368-1019;
- ✓ Call the Family Opportunity Act Medicaid Buy-In Program office at 1-888-342-6207, TTY text telephone users call 1-800-220-5404; and/or

- ✓ Write to:
  LA Department of Health & Hospitals
  P.O. Box 4818
  Baton Rouge, LA 70821-4818

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¿Necesita traductor de español? Llame al 1-877-252-2447.

Quí vị có cần thông dịch viên người Việt không? Nếu cần xin gọi số 1-877-252-2447.

LOUISIANA
Department of HEALTH and HOSPITALS

BHSF Form 1-FOA Cover
Revised 04/12

Family Opportunity Act Medicaid Buy-In Program

for Children with Disabilities

Let Us Be Your Partner in Health

1-888-342-6207

Apply Online
www.Medicaid.DHH.Louisiana.gov

Louisiana Department of Health & Hospitals

BHSF Form 1-FOA
Rev. 04/12
Prior Issue Obsolete

FAMILY OPPORTUNITY ACT MEDICAID BUY-IN PROGRAM APPLICATION

Interviewer: _____

Date of Interview: _____

Louisiana's Family Opportunity Act Medicaid Buy-In Program provides complete health care for **children under age 19 who have a physical, mental, or developmental disability**. If required, families will pay $12 to $35 per month for this coverage. Parents who have health insurance available through their employer are required to enroll the child as a condition of eligibility.

If you are applying for more than one child, please fill out separate applications for each child.

To apply using this application:

1. Fill it out and sign it. Use a black ink pen.
2. Get together the documents of proof we need.
3. Mail or fax the form and documents of proof to:

Family Opportunity Act Medicaid Buy-In Program
P.O. Box 91278
Baton Rouge, LA 70821-9278
FAX # (toll free): 1-877-523-2987

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

1. Where did you get this application form?

❑ Medicaid Office ❑ Hospital ❑ Pharmacy ❑ Doctor's Office ❑ Friend/Relative ❑ Internet
❑ School Clinic ❑ Food Stamp Office ❑ Health Unit ❑ Business (Store, Work) ❑ Festival/Health Fair
❑ Somewhere else: _____

2. Parent or Caregiver Information (List second parent or caregiver in Question 3)

Name _____ ❑ Male ❑ Female
First *Middle Initial* *Last*

Social Security Number_____ Date of Birth (month, day, year)_____

Relationship to Child Applying: ❑ Parent ❑ Stepparent ❑ Grandparent ❑ Other: _____

Race/Ethnic Background (Optional- you may mark one or more): ❑ White ❑ Black ❑ Asian ❑ Hispanic or Latino
❑ American Indian or Alaska Native ❑ Native Hawaiian or Pacific Islander ❑ Other: _____

Mailing Address_____
P.O. Box or Street Address *Apartment/Lot Number*

_____
City *State* *Zip Code*

Home Address (*if different*) _____
Street Address *Apartment/Lot Number*

_____
City *State* *Zip Code*

Parish _____ E-mail Address_____

Home Phone (_____)_____ Cell Phone (_____)_____ Daytime Phone (_____)_____

Best Day and Time to Call During our Office Hours (Mon-Fri, 8:00 am – 4:30 pm)_____

Questions? Call 1-877-252-2447

TTY Text Telephone For The Hearing Impaired, Call 1-800-220-5404

3. Does another parent or caregiver live in the home? ❑ Yes – Answer Questions Below ❑ No – Go to Question 4

Name _____ ❑ Male ❑ Female
First *Middle Initial* *Last*

Social Security Number_____ Date of Birth (month, day, year)_____

Relationship to Child Applying: ❑ Parent ❑ Stepparent ❑ Grandparent ❑ Other: _____

4. Child with Disability

If you are applying for more than one child, please fill out a separate application for each child.

Name _____ ❑ Male ❑ Female
First *Middle Initial* *Last*

Social Security Number_____ Date of Birth (month, day, year)_____

Race/Ethnic Background (Optional- you may mark one or more): ❑ White ❑ Black ❑ Asian ❑ Hispanic or Latino ❑ American Indian or Alaska Native ❑ Native Hawaiian or Pacific Islander ❑ Other: _____

Place of Birth: State (if born in the U.S.)_____ Country (if born outside the U.S.)_____

Mother's Name _____
First *(Maiden Name)* *Last*

Is this child a U.S. citizen? ❑ Yes – Go to Question 5 ❑ No – Answer the next questions

Is this child a lawful permanent resident? ❑ Yes ❑ No - What date did he come to the U.S.? _____

Permanent Resident Card (green card) Number **A#**_____

5. Has the child ever received Supplemental Security Income (SSI) benefits? ❑ Yes – Fill Out Below ❑ No – Go to Question 6

When did it end? _____

Why did it end? _____

6. List the child's brothers and sisters under age 19 who live in the home. ❑ None – Go to Question 7

Do not list step-brothers and step-sisters. If there are more than three children, use another sheet of paper.

A. Name _____ ❑ Male ❑ Female
First *Middle Initial* *Last*

Social Security Number_____ Date of Birth (month, day, year)_____

B. Name _____ ❑ Male ❑ Female
First *Middle Initial* *Last*

Social Security Number_____ Date of Birth (month, day, year)_____

C. Name _____ ❑ Male ❑ Female

First *Middle Initial* *Last*

Social Security Number_____Date of Birth (month, day, year)_____

7. Does the child who is applying have health insurance? ❑ Yes – Fill Out Below ❑ No – Go to Question 8

If more than one health insurance, use another sheet of paper.

Policyholder's Name _____Coverage Start Date_____

Insurance Name and Phone Number_____

Policy Number _____Group Number_____

What does the policy cover? ❑ Hospital ❑ Doctor ❑ Medicine ❑ Dental ❑ Ambulance

Who pays the premium? _____

If the insurance is through a job, name of employer: _____

When is open enrollment? _____

Does the employer pay more than 50% of the cost? ❑ Yes ❑ No

8. If child does not have other health insurance, could the child get health insurance from a parent's job? ❑ Yes ❑ No

9. Describe the child's disability.

What is the disability? Give us information about it. _____

_____

When did it start? _____

List the doctors, hospitals or other medical providers who have provided medical care and can provide medical records to support the child's medical condition. ***If more space is needed, use another sheet of paper.***

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

10. Do the child's parents, brothers, or sisters under age 19 receive earnings from employment?
❑ Yes – Fill Out Below ❑ No – Go to Question 11

Who Works?	List Employer & Phone # or Write Self Employed	Total Monthly Gross Earnings	How often paid? (weekly, every 2 weeks, twice a month, monthly)

11. Does the child or do their parents, brothers or sisters under age 19 get regular income such as those listed below? ❑ Yes – Fill Out Below ❑ No – Go to Question 12

• Social Security • SSI • Unemployment • Money from Friends/Relatives • Worker's Compensation
• Veteran's Benefits • Child Support (Give the name of child.) • Other (Specify)

Who gets it?	What is it?	How much?	How often?
		$_____	
		$_____	
		$_____	

12. Does the child need coverage for the last 3 months because there are medical bills (paid or unpaid) from this time? ❑ Yes ❑ No

13. Has the child ever received Medicaid in Louisiana? ❑ Yes – Fill Out Below ❑ No

Plastic Medicaid cards can be reactivated and reused. We will not send a new card unless you request one.

Does the child need a new Medicaid card? ❑ Yes ❑ No

This is the end of the application. SIGN BELOW

By signing this application I am giving my permission to the State of Louisiana and its agents to make contacts to verify the information given on this application. Under penalty of perjury I certify all information I have given is true. I also acknowledge that I have received and read the Rights and Responsibilities on the next page.

Sign Your Name Here:_____ **Date:** _____

Rights and Responsibilities

WHAT MEDICAID HAS THE RIGHT TO EXPECT OF YOU

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

WHAT YOU HAVE THE RIGHT TO EXPECT FROM MEDICAID

RIGHT TO A FAIR HEARING: You understand that you can ask for a Fair Hearing if you think any decision made on the case is unfair, incorrect, or made too late.

NO DISCRIMINATION: You understand Medicaid cannot treat you differently because of race, color, sex, age, disability, religion, nationality, or political belief. If you think it has, you can call the U.S. DHHS Regional Office for Civil Rights in Dallas, TX at 1-800-368-1019 or write to Louisiana's Department of Health & Hospitals, Human Resources at P. O. Box 4818 Baton Rouge, LA 70821-4818.
OTHER SERVICES: You understand that information about WIC, KIDMED, and other Medicaid services will be sent to the persons that are eligible for Medicaid.

Documents of Proof We May Need From You

Some of these documents of proof will not apply to your application. Let us know if you do not have or cannot get any of these things. We may be able to get them or help you get them.

Copy of health insurance card (front and back) **for child**
If child is not a U.S. citizen, send copy of their Permanent Resident Card (green card) or other form from U.S. Citizenship and Immigration Services.
For children born outside Louisiana, send proof of U.S. Citizenship such as a birth certificate, souvenir birth certificate, U.S. Passport, or adoption papers. Visit www.cdc.gov/nchs for a list of state vital records offices where you may request birth certificates.
Pay stubs from last month showing gross pay (before taxes) or letter from employer. For self-employment, send copies of tax return and all schedule attachments - **for child's parents (legal and natural) and their brothers and sisters under age 19.**
Proof of gross income (before taxes) from child support, Veteran's Benefits, worker's comp, alimony, and any other income that is not from working. Proof could be award letters and 1099 tax statements from the last tax year - **for child, their parents (legal and natural), and brothers and sisters under age 19.**
If Medicaid coverage is needed for any of the three months before the month you apply for Medicaid, send proof of income for each month - **for child, their parents (legal and natural), and brothers and sisters under age 19.**
Copies of all medical reports and Individual Education Plans (IEP) to verify the child's disability.

Please mail or fax the application and documents of proof to us. You may also take it to your local Medicaid office.

Mailing Address:
Family Opportunity Act Medicaid Buy-In Program
P.O. Box 91278
Baton Rouge, LA 70821-9278

Fax:
1-877-523-2987 (toll free)

IMPORTANT PHONE NUMBERS

	PHONE NUMBER	TTY TEXT TELEPHONE
KIDMED (EPSDT)	1-800-259-4444	1-877-544-9544
CommunityCARE (to request a change of Primary Care Doctor)	1-800-259-4444	1-877-544-9544
KIDMED and CommunityCARE Physician Referral Assistance	1-877-455-9955	
Medicaid Services	1-888-342-6207	
Transportation (to request non-emergency transportation)	1-800-259-1944	

IMPORTANT WEB SITES

LaCHIP	www.LaCHIP.org
LaMOMS – Medicaid for Pregnant Women	www.LaMOMS.DHH.Louisiana.gov
Other Medicaid Programs	www.Medicaid.DHH.Louisiana.gov
Find a Doctor Who Accepts Medicaid	www.La-CommunityCare.com
KIDMED & CommunityCARE	www.La-KidMed.com
Apply for or Renew Your Medicaid	www.Medicaid.DHH.Louisiana.gov

BHSF Form VRD
Issued 07/21/11

_____
AC/Office Name

Department of Health and Hospitals
Voter Registration Declaration (Optional)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

NATCHITOCHES
P. O. Box 677
Natchitoches, LA 71458-0677
(318) 357-2211

ORLEANS
1300 Perdido #1W23
New Orleans, LA 70112-2127
(504) 658-8300

OUACHITA
122 St John St #114
Monroe, LA 71201-7342
(318) 3271436

PLAQUEMINES
P. O. Box 989
Port Sulphur, LA 70083-0989
(504) 564-6957

POINTE COUPEE
211 E. Main St.
New Roads, LA 70760-3661
(225) 638-5537

RAPIDES
701 Murray St.
Alexandria, LA 71301-8099
(318) 473-6770

RED RIVER
P. O. Box 432
Coushatta, LA 71019-0432
(318) 932-5027

RICHLAND
P. O. Box 368
Rayville, LA 71269-0368
(318) 728-3582

SABINE
400 Capitol St. #107
Many, LA 71449-3099
(318) 256-3697

ST. BERNARD
8201 W. Judge Perez Rm. 104
Chalmette, LA 70043-1696
(504) 278-4231

ST. CHARLES
P. O. Box 315
Hahnville, LA 70057-0315
(985) 783-2731

ST. HELENA
P. O. Box 543
Greensburg, LA 70441-0543
(225) 222-4440

ST. JAMES
P. O. Box 179
Convent, LA 70723-0179
(225) 562-2330

ST. JOHN
1801 W. Airline Hwy
LaPlace, LA 70068-3344
(985) 652-9797

ST. LANDRY
P. O. Box 818
Opelousas, LA 70571-0818
(337) 948-0572

ST. MARTIN
Courthouse
415 S. Martin St.
St. Martinville, LA 70582-4549
(337) 394-2204

ST. MARY
500 Main St. #301
Franklin, LA 70538-6144
(337) 828-4100

ST. TAMMANY
701 N. Columbia St.
Covington, LA 70433-2709
(985) 809-5500

TANGIPAHOA
P. O. Box 895
Amite, LA 70422-0895
(985) 748-3215

TENSAS
P. O. Box 183
St. Joseph, LA 71366-0183
(318) 766-3931

TERREBONNE
P. O. Box 9189
Houma, LA 70361-9189
(985) 873-6533

UNION
P. O. Box 235
Farmerville, LA 71241-0235
(318) 368-8660

VERMILION
100 N. State St. #120
Abbeville, LA 70510
(337) 898-4324

VERNON
P. O. Box 626
Leesville, LA 71496-0626
(337) 239-3690

WASHINGTON
Courthouse Bldg.
900 Washington St.
Franklinton, LA 70438
(985) 839-7850

WEBSTER
P. O. Box 674
Minden, LA 71058-0674
(318) 377-9272

W. BATON ROUGE
P. O. Box 31
Port Allen, LA 70767-0031
(225) 336-2421

W. CARROLL
P. O. Box 71
Oak Grove, LA 71263-0071
(318) 428-2381

W. FELICIANA
P. O. Box 2490
St. Francisville, LA 70775-2490
(225) 635-6161

WINN
Courthouse Room 105
Winnfield, LA 71483-3238
(318) 628-6133

OFFICIAL USE ONLY

Address Change

_____
_____
_____
_____
_____

Name Change

_____
_____
_____
_____

Party Change

_____
_____

Remarks

_____

Circle One: PA MV RG SDA SS

Received by: _____

PLACE IN AN ENVELOPE AND MAIL TO YOUR
REGISTRAR OF VOTERS

USE THIS FORM TO: 1) register to vote 2) change your address 3) request a name change 4) change party affiliation

TO REGISTER TO VOTE AND BE ELIGIBLE TO VOTE YOU MUST: 1) be a United States citizen 2) be at least 17 years old to register but must be 18 years old to vote 3) not be under an order of imprisonment for conviction of a felony 4) not be under a judgment of full interdiction or limited interdiction where your right to vote has been suspended 5) reside in the state and parish in which you seek to register and vote.

INSTRUCTIONS FOR COMPLETING THIS FORM: All information except your signature should be printed clearly in ink, preferably black, or typed. Fill in all boxes that apply to you.

Box 1: Indicate whether you are a citizen of the United States of America. Indicate whether you will be 18 years of age on or before election day.

Box 2: Provide full name. Do not use initials for middle or maiden name.

Box 3: 'Residence Address' means the address where you live and are registering to vote. If you claim a homestead exemption, you must list the address of that residence. Do not use a post office box for your 'Residence Address'. If you use a rural route and box number, draw a map in the space labeled 'Give Location.' Write in the names of the crossroads (streets) nearest to where you live. Draw an X to show where you live. Use a dot to show any schools, churches, stores or landmarks near where you live and write the name of the landmark. Check the box provided if mail is not delivered to your residence address by the post office. Complete 'Mailing Address' only if it is different from the 'Residence Address' or if mail is not delivered to your residence address.

Box 4: Provide your age.

Boxes 6 & 14: You must provide your Louisiana driver's license number, if issued. If not issued, you must provide at least the last four digits of your social security number, if issued. The full social security number may be provided on a voluntary basis. If neither a social security number nor a Louisiana driver's license number has been issued, and this form is submitted by mail, and you are registering to vote for the first time, in order to avoid additional identification requirements for first time voters, attach either a) a copy of a current and valid photo identification or b) a copy of a current utility bill, bank statement, government check, paycheck, or other government document that shows your name and address.

Boxes 8, 12 & 13: The items 'race/ethnic origin', 'home phone' and 'daytime phone' are not required but are helpful.

Box 9: If you do not complete this item, your party affiliation will be listed as 'none', unless you are presently registered with a party affiliation and no change is being made today. If you are not registering with a political party, circle 'none'. The recognized political parties are Democrat, Green, Libertarian, Reform and Republican or you may specify any other party affiliation.

Box 18: If you are using this form to request a change of name, you must print the name to be changed here.

Box 19: Date and sign the card with your signature or mark.
If returned by mail, place in an envelope and mail to the appropriate registrar of voters at the address found on the reverse side of this card. If you have not been issued a social security number or Louisiana driver's license number, you must mail the required documentation with your application. Your application or envelope must be postmarked 30 days prior to the first election in which you seek to vote based on the residence listed on this application.

NOTE:1. If you decline to register to vote, this fact will remain confidential and will be used only for voter registration purposes. If you register to vote, the office where your application was submitted will remain confidential and will be used only for voter registration purposes. 2. Your social security number will also remain confidential and is intended to be used for voter registration purposes only.

QUESTIONS? Call your Parish Registrar of Voters OR call the Department of State at 1¬800¬883¬2805 or (225) 922¬0900.

COMPLETE AND CHECK ALL APPLICABLE BOXES AND TEAR ALONG PERFORATED LINE BEFORE MAILING.

LOUISIANA MAIL VOTER REGISTRATION APPLICATION FORM #04

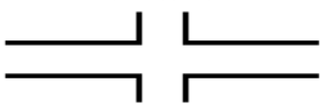
OFFICIAL USE ONLY
COMP REG # _____ Reg Type _____ Wd/ Dist_____ Pct_____ In_____ Out_____

1 Are you a citizen of the United States of America? YES ☐ NO ☐ Will you be 18 years of age on or before election day YES ☐ NO ☐
If you checked no in response to either of these questions, DO NOT COMPLETE THIS FORM.

2 NAME OF APPLICANT (PLEASE PRINT NAME)

LAST | First | FULL MIDDLE OR MAIDEN

GIVE LOCATION



3 RESIDENCE ADDRESSS (MUST BE ADDRESS WHERE YOU CLAIM HOMESTEAD EXEMPTION, IF ANY)

HOUSE OR APT. NO. & STREET | CITY OR TOWN | STATE | ZIP

IF NO mail delivery to residential address, check here:( ) | MAILING ADDRESS IF DIFFERENT

4 AGE	**5 DATE OF BIRTH**		**6 * SOCIAL SECURITY #**(CIRCLE ONE)	**7 SEX** (CIRCLE ONE)	**8 ** RACE/ ETHNIC ORIGIN** (CIRCLE ONE)
	MONTH DAY	YEAR	NO YES #_____	MALE FEMALE	WHITE BLACK ASIAN HISPANIC AMER. INDIAN OTHER: _____

9 PARTY AFFILIATION CIRCLE ONE)	**10 APPLICANTS'S PLACE OF BIRTH**				**11 MOTHERS MAIDEN NAME**
DEM GRN LBT RFM REP NONE OTHER (SPECIFY) _____	CITY OR TOWN	PARISH OR COUNTY	STATE	COUTNRY	

12 ** HOME PHONE	**13 ** DAYTIME PHONE**	**14 LA DRIVERS LICENSE / I.D. #**(CIRCLE ONE)	**15 Will you require assistance at the polls?**(CIRCLE ONE)
( )	( )	NO YES #_____	NO YES IF YES, GIVE REASON

16 LAST RESIDENCE ADRESS	**17 PLACE OF REGISTRATION**		**18 FOMER REGISTERED NAME, IF APPLICABLE**
ADDRESS	PARISH OR COUNTY	STATE	

AFFIRMATION : I do hereby solemnly swear or affirm that I am a United States citizen, that I am at least 17 years old, that I am not currently under an order of imprisonment for conviction of a felony, that I am not currently under a judgment of full interdiction or limited interdiction where my right to vote has been suspended, that I am a bona fide resident of this state and parish, and that the facts given by me on this application are true to the best of my knowledge and belief. If I have provided false information, I may be subject to a fine of not more than $1,000 ($2,500 for subsequent offense) or imprisonment for not more than 1 year.

19 SIGN YOUR NAME IN BOX AT RIGHT

DATE: _____/_____/_____

20 IF YOU ARE UNABLE TO SIGN YOUR NAME, TWO WITNESSES TO YOUR MARK MUST SIGN HERE

WITNESS SIGNATURE | WITNESS SIGNATURE

*** Last 4 digits of the social security number required if no LA driver's license issued; social security number is intended to be used for voter registration purposes only** **Full # Optional** **** OPTIONAL**

LR-1M (REV. 1/11, 7/11) R.S. 18:104 FORM #04