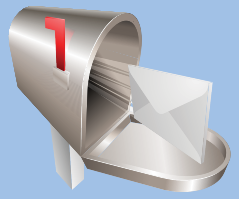
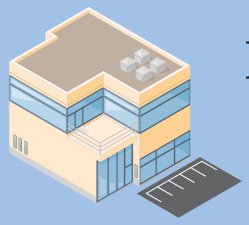
4 EASY WAYS TO APPLY

ONLINE
www.dhh.louisiana.gov



MAIL
Medicaid
Application Office
P.O. Box 91278
Baton Rouge, LA
70821-9278

FAX
1-877-523-2987
(toll-free)



IN PERSON
Call 1-877-252-2447
for the office closest
to you.

Questions?
1-877-252-2447

• • •

¿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

• • •

TTY Text Telephone
1-800-220-5404

BHSF Form 1-G
Rev. 10/12
Prior Issue Obsolete

DEPARTMENT OF HEALTH AND HOSPITALS
Medicaid

APPLICATION

Louisiana Medicaid

Real Solutions For Your Health Care Needs

1-877-252-2447
www.dhh.louisiana.gov

If you qualify for Medicaid health coverage, you may be able to enroll in **Bayou Health**. Enrolling in **Bayou Health** will allow you to choose a Health Plan that can help you get access to the health care that you need. If you qualify for Medicaid, we will help you enroll in a **Bayou Health** Plan. Some of the benefits of enrolling in **Bayou Health** are:

- More doctors and specialists to choose from.
- More contact between your doctors so you can get better treatments.
- No limit to the number of doctor visits.

If you pay for health insurance through your employer, you may qualify for **LaHIPP (The Louisiana Health Insurance Premium Payment Program)**. This program pays you back for money you spend on your health insurance premiums. If you have questions about how to qualify, call 1-888-695-2447 or visit online at www.lahipp.dhh.louisiana.gov.

YOUR RIGHTS AND RESPONSIBILITIES

When you apply for assistance with the Louisiana Department of Health and Hospitals (DHH), you agree to the following:

- You agree to tell DHH within 10 days of these changes:
  - Mailing or home address.
  - Health insurance coverage or premiums.
  - Income.
  - Things owned by anyone who gets health care coverage who has a disability or is age 65 or older.
  - If anyone getting health care coverage moves out of state.
  - If anyone moves in or out of the home.
- You state that answers you gave on this application are true and correct. If you purposely gave information that is not true or if you withheld information, you have committed fraud. If you commit fraud, you may have to pay back money that DHH pays for care that you receive.
- You understand Social Security numbers will only be used to get information from other government agencies to see if you qualify for benefits.
- By accepting medical care, you understand that DHH has the right to get money received by you from other sources like insurance payments or lawsuit settlements for care that DHH has paid for you.
- You understand that if you qualify for the Louisiana Health Insurance Premium Payment Program (LaHIPP), we will reimburse you for Employer Sponsored Health Insurance (ESI). You must be enrolled in ESI while you are receiving payments from LaHIPP. If your insurance coverage ends, you must tell LaHIPP. You will be responsible for paying back any money we pay while you are not covered by ESI.
- You understand that DHH will only send case information to Child Support Enforcement for medical support if you ask them to. DHH will make a referral only if parents of children under age 19 get Medicaid. You can request that DHH not refer you to Child Support Enforcement if you feel you have good cause not to cooperate with Support Enforcement.
- You understand that information about the Women, Infants, and Children Program (WIC), Early Periodic Screening, Diagnosis, and Treatment (EPSDT), and other programs may be sent to anyone who qualifies.
- You understand that Estate Recovery rules require DHH to recover the cost of certain Medicaid payments from the applicant's estate. These costs include the total amount of payments for facility services, hospital care, payments to Home and Community Based Services (HCBS) or Program for All-Inclusive Care for the Elderly (PACE) providers, and prescription drugs received at age 55 or older. The estate is the property owned at the time of death. DHH will not make a claim against the estate while the applicant or his or her legal spouse is still living. DHH also will not make a claim if the applicant has a dependent child who is under age 21, blind, or disabled. Collection may not be made if it is not cost effective for DHH to do so, or if the heirs apply for a hardship waiver after the applicant's death. A hardship may exist if the estate property is the only source of income for the heirs, if that income is limited, or if there are other convincing situations.

Your Rights

- You can ask for a Fair Hearing if you think any decision made on the case is unfair, incorrect, or made too late.
- DHH 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.

APPLICATION FOR LOUISIANA MEDICAID

Real Solutions For Your Health Care Needs

- Fill out this application to see if you and your family qualify for Medicaid health care coverage.
- If you need extra space, use a separate sheet of paper or the space provided for you on page 8.
- If you have any questions, call 1-877-252-2447 between 7:30 AM and 4:30 PM on Monday–Friday to speak with a Medicaid representative.
- Complete and mail this application to the **Medicaid Application Office, P.O. Box 91278 Baton Rouge, LA 70821-9893** or fax it to 1-877-523-2987.

What is your preferred language? ☐ English ☐ Spanish ☐ Vietnamese ☐ Other: _____

► *Please **PRINT** clearly in black ink.*

1 — Personal Information

First name	Middle initial	Last name	Suffix *(Sr., Jr., etc.)*

Social Security number	Date of birth	Sex ☐ Male ☐ Female

Marital status
☐ Single ☐ Married ☐ Widowed ☐ Divorced/separated

Are you Hispanic or Latino? *(optional)* ☐ Yes ☐ No	Race *(optional – you may mark one or more)* ☐ White ☐ Black ☐ Asian ☐ Native Hawaiian or Pacific Islander ☐ American Indian or Alaska Native — Tribe: _____ ☐ Other

2 — Contact Information

Mailing Address			Home Address *(if different)*		
P.O. box or street address		Apt/Lot #	Street address		Apt/Lot #
City	State	Zip	City	State	Zip
E-mail address *(if you have one)*			Home parish *(where you live)*		
Home phone ( )	Cell phone ( )		Other phone ( )		

3 — Members of your Household

*List **ALL** people living in your home. If no one lives with you, leave additional blanks empty.*

	You	Person 1	Person 2
Name	**You should have already provided the information in these boxes on the previous page.** **Please answer the questions below about yourself.**		
Relationship to you			
Social Security number			
Date of birth			
Sex		☐ Male ☐ Female	☐ Male ☐ Female
Hispanic/Latino? *(optional)*		☐ Yes ☐ No	☐ Yes ☐ No
Race *(optional – you may mark one or more)*		☐ White ☐ Black ☐ Asian ☐ Native Hawaiian or Pacific Islander ☐ American Indian or Alaska Native — Tribe: _____ ☐ Other	☐ White ☐ Black ☐ Asian ☐ Native Hawaiian or Pacific Islander ☐ American Indian or Alaska Native — Tribe: _____ ☐ Other
Does this person want to apply for Medicaid?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Does this person have an old Medicaid card?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Does this person have health insurance?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If **YES**, is this insurance through someone's job?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If **NO**, is *any* insurance available through a job?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Has insurance coverage ended in the past 12 months?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If **YES**, when did it end?			
Does this person have Medicare?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Medicare Claim number			
A disability is a physical or mental impairment that lasts for at least one year or is expected to result in death.			
Does this person have a disability?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
The answers you give about citizenship are kept private and only used to see if you qualify for health coverage.			
Is this person a U.S. citizen?	☐ Yes ☐ No *(If **YES**, skip to section 4)*	☐ Yes ☐ No *(If **YES**, skip to section 4)*	☐ Yes ☐ No *(If **YES**, skip to section 4)*
If **NO**, is this person a lawful permanent resident?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
When was this person granted residency?			
Alien Registration number			

3 — Members of your Household *(continued)*

*List **ALL** people living in your home. If no one lives with you, leave additional blanks empty.*

	Person 3	Person 4	Person 5
Name			
Relationship to you			
Social Security number			
Date of birth			
Sex	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female
Hispanic/Latino? *(optional)*	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Race *(optional – you may mark one or more)*	☐ White ☐ Black ☐ Asian ☐ Native Hawaiian or Pacific Islander ☐ American Indian or Alaska Native — Tribe: _____ ☐ Other	☐ White ☐ Black ☐ Asian ☐ Native Hawaiian or Pacific Islander ☐ American Indian or Alaska Native — Tribe: _____ ☐ Other	☐ White ☐ Black ☐ Asian ☐ Native Hawaiian or Pacific Islander ☐ American Indian or Alaska Native — Tribe: _____ ☐ Other
Does this person want to apply for Medicaid?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Does this person have an old Medicaid card?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Does this person have health insurance?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If **YES**, is this insurance through someone's job?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If **NO**, is *any* insurance available through a job?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Has insurance coverage ended in the past 12 months?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If **YES**, when did it end?			
Does this person have Medicare?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Medicare Claim number			
A disability is a physical or mental impairment that lasts for at least one year or is expected to result in death.			
Does this person have a disability?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
The answers you give about citizenship are kept private and only used to see if you qualify for health coverage.			
Is this person a U.S. citizen?	☐ Yes ☐ No *(If **YES**, skip to section 4)*	☐ Yes ☐ No *(If **YES**, skip to section 4)*	☐ Yes ☐ No *(If **YES**, skip to section 4)*
If **NO**, is this person a lawful permanent resident?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
When was this person granted residency?			
Alien Registration number			

4 — Pregnancy

Is anyone in the home pregnant? ☐ Yes ☐ No *(If **NO**, skip to section 5)*

	Person 1	Person 2	Person 3
Pregnant person's name			
When is the due date?			
How many babies expected?			

5 — Money from Jobs *(examples: cash, checks, tips, etc.)*

Does anyone in the home work? ☐ Yes ☐ No *(If **NO**, skip to section 6)*

	Job 1	Job 2	Job 3
Worker's name			
Employer name			
Employer phone number	( )	( )	( )
Is this person self-employed?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
How much are they paid? *(gross income before taxes)*	$	$	$
How often paid? *(weekly, biweekly, monthly, etc.)*			
Is health insurance offered?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

6 — Other Money *(examples: Social Security, unemployment, child support, worker's comp, etc.)*

Does anyone in the home get money from other sources? ☐ Yes ☐ No *(If **NO**, skip to section 7)*

	Source 1	Source 2	Source 3
Who receives the money? *(if child support, list the child's name)*			
Where does it come from?			
How much are they paid? *(gross income before taxes)*	$	$	$
How often paid? *(weekly, biweekly, monthly, etc.)*			

7 — Medical Expenses

Does anyone in the home have medical bills (paid or unpaid) for medical care received in the past 3 months?
☐ Yes ☐ No *(If **NO**, skip to section 8)*

	Expense 1	Expense 2	Expense 3
Who received care?			
Name of doctor, clinic, or other medical provider			
Phone number	( )	( )	( )
Dates of service			
Total cost	$	$	$

8 — Other Expenses

Does anyone pay...	Who pays this expense?	Monthly cost
Child support ☐ Yes ☐ No		$
Alimony ☐ Yes ☐ No		$
Child care or care for a person with a disability? ☐ Yes ☐ No Person cared for: _____		$

9 — Things You Own

ONLY complete this section if someone applying is 65 years of age or older, or if someone has a disability.
A disability is a physical or mental impairment that lasts for at least one year or is expected to cause death.

Does anyone own...	Who owns it?	Describe it *(include names of banks, insurance companies, etc.)*	How much is it worth?
Checking accounts ☐ Yes ☐ No			$
Saving accounts ☐ Yes ☐ No			$
Vehicle *(cars, trucks, boats, motorcycles, RVs, ATVs, etc.)* ☐ Yes ☐ No			$
Other Vehicles ☐ Yes ☐ No			$
Property other than where you live ☐ Yes ☐ No			$
Certificates of Deposit (CD) ☐ Yes ☐ No			$
Annuities, Trusts, Stocks, Bonds, Retirement Accounts ☐ Yes ☐ No			$
Life or burial insurance ☐ Yes ☐ No			$
Money set aside for burial or pre-need contract ☐ Yes ☐ No			$
Safe deposit box ☐ Yes ☐ No			$
Other ☐ Yes ☐ No			$

Read and 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 that all information contained in this application, including U.S. citizenship or lawful immigrant status of all persons applying for benefits, is true and correct to the best of my knowledge. I have read or someone has read to me the "Rights and Responsibilities" section of the application (located on page 2), including fraud penalties.

Sign here:	Date:
Spouse sign here *(if applying)*:	Date:

Use this space for any comments or information that you could not fit on your application.

AC Center_____ **AC ID**_____ **AC Rep**_____

DEPARTMENT OF HEALTH
AND HOSPITALS
Medicaid

VOTER REGISTRATION DECLARATION
(Optional)

If you fill this 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?

☐ Yes ☐ No

- If you checked "Yes," please complete the attached form called the "Louisiana Mail Voter Registration Application" on page 9. Return all forms to the **Medicaid Application Office, P.O. Box 91278 Baton Rouge, LA 70821-9893**.
- 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 or call toll-free at 1-800-883-2805.

► *Please **PRINT** clearly in black ink.*

First name	Middle initial	Last name	Suffix *(Sr., Jr., etc.)*

Sign here:	Date:

ACADIA
568 NW Court Circle
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 71163-1253
(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 St. - Suite 1
Homer, LA 71040-3914
(318) 927-3332

CONCORDIA
4001 Carter St. - #4
Vidalia, LA 71373-3021
(318) 336-7770

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) 435-4489

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 70546-5361
(337) 824-0834

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

LAFOURCHE
307 W. 4th St.
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 70754-0968
(225) 686-3054

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

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

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

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

OUACHITA
122 St John St #114
Monroe, LA 71201-7342
(318) 327-1436

PLAQUEMINES
P. O. Box 989
Port Sulphur, LA 70083-0989
(504) 934-3620

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
415 Saint 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
119 W. Main St. - 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(Disability)

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.

Boxes 5 & 13: You must provide your LA driver's license number or LA special identification card 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 LA driver's license number or LA special identification card 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 7, 11 & 12: The items 'race/ethnic origin', 'email' and 'phone' are not required but are helpful. Email is protected from disclosure by law.

Box 8: 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 17: If you are using this form to request a change of name, you must print the name to be changed here.

Box 18: 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 CUT HERE BEFORE MAILING.

LOUISIANA VOTER REGISTRATION APPLICATION

LR-1 &1M, FORM # 100

OFFICIAL USE ONLY
Wd / Dist _____ Pct _____ Reg Type _____ In/Out _____ REG # _____

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 ADDRESS (MUST BE ADDRESS WHERE YOU CLAIM HOMESTEAD EXEMPTION, IF ANY)
HOUSE OR APT. NO. & STREET (IF RURAL, ROUTE & BOX NO.) CITY OR TOWN STATE ZIP

If NO mail delivery to residential address, check here: ( )

MAILING ADDRESS, IF DIFFERENT

4 DATE OF BIRTH
MONTH DAY YEAR

5 * SOCIAL SECURITY # (CIRCLE ONE)
NO
YES # _____

6 SEX (CIRCLE ONE)
MALE FEMALE

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

8 PARTY AFFILIATION (CIRCLE ONE)
DEM GRN LBT RFM REP NONE
OTHER (SPECIFY) _____

9 APPLICANT'S PLACE OF BIRTH
CITY OR TOWN PARISH OR COUNTY STATE COUNTRY

10 MOTHER'S MAIDEN NAME

11 **EMAIL

12 ** PHONE
HOME ( )
DAY ( )

13 LA DRIVER'S LICENSE / I.D. # (CIRCLE ONE)
NO
YES # _____

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

15 LAST RESIDENCE ADDRESS
ADDRESS

16 PLACE OF LAST REGISTRATION
PARISH OR COUNTY STATE

17 FORMER REGISTERED NAME, IF APPLICABLE

AFFIRMATION: I do hereby solemnly swear or affirm that I am a United States citizen, that I am at least 17 years old, that I am not currently under an order of imprisonment for conviction of a felony, that I am not currently under a judgment of full interdiction or limited interdiction where my right to vote has been suspended, that I am a bona fide resident of this state and parish, and that the facts given by me on this application are true to the best of my knowledge and belief. If I have provided false information, I may be subject to a fine of not more than $2,000 ($5,000 for subsequent offense) or imprisonment for not more than 2 year (5 years for subsequent offense), or both. Any false statement may constitute perjury.

18 SIGN YOUR NAME IN BOX AT RIGHT.

DATE: _____ / _____ / _____

19 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**