

Medicaid Application Center Handbook

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OVERVIEW OF THE MEDICAID PROGRAM

INTRODUCTION

This handbook is for the use of Medicaid Application Centers, referred to as “AC’s” that are participating in the Application Process for Louisiana’s Medicaid Program. It is not a legal description of all aspects of Medicaid regulations or Title XIX, and Title XXI (LaCHIP) of the Social Security Act. Should there be any discrepancies between material in this handbook and the pertinent laws or regulations governing these programs, then the latter takes precedence.

General information and the procedures set forth in this handbook will enable Application Centers to comply with the laws and regulations governing the Medicaid Program administered by the Louisiana Department of Health and Hospitals (DHH) Bureau of Health Services Financing (BHSF). This information is required to safeguard assistance benefits, to protect the integrity of the program, and to ensure equity among those served.

This handbook consists of five sections:

- I. Administrative Procedures
- II. Administrative Forms and Instructions
- III. Interview Procedures and Requirements
- IV. Verification and Documentation Requirements
- V. Situational Application Forms and Instructions

We suggest that you study this material and maintain it in a file for future reference. Application centers will be notified via FAX when revisions are made to this handbook as changes occur.

Questions concerning agency procedures, agency requirements, or the Application Center Agreement should be directed to:

Mailing Address: DHH, Medicaid Application Center Unit,
P. O. Box 91283, Baton Rouge, LA 70821-9278
FAX: (225) 376-4736
Email address: Applicationcenter.service@la.gov

Note: All inquiries and correspondence from Application Centers should include the Application Center name and AC-ID number.

GENERAL INFORMATION

The Louisiana Medical Assistance Program became effective on July 1, 1966, under provisions of Title XIX Amendments to the Federal Social Security Act, and Article 18, Section 7, Subsection 1, Louisiana Constitution, as amended. The United States Department of Health and Human Services (DHHS) issues guidelines for states' participation in Medicaid. These guidelines provide for the states' individual Medicaid programs with structure and direction, and allow for a degree of consistency in the scope of Medicaid coverage from one state to another. Additionally, DHHS allows the states to have flexibility in the administration of their individual Medicaid programs.

DHH is the designated State Medicaid agency that administers this program in Louisiana. The Medicaid Program is designated to provide certain health care benefits for those individuals who are in need of medical services and who meet the eligibility requirements. Individuals who are entitled to Medicaid benefits as a result of their eligibility for cash assistance are determined eligible by either the Social Security Administration or by the Department of Children and Family Services.

DHH is responsible for the overall management of the Medicaid Program, including these specific functions:

1. Promulgates all necessary regulations and guidelines for Medicaid program policy;
2. Administers the program;
3. Determines the services covered by the program and sets the reimbursement rates within federal guidelines;
4. Determines applicants' eligibility, maintains a recipient eligibility file, and issues Medicaid Eligibility Cards to eligible recipients;
5. Enrolls providers who wish to participate in the program;
6. Enlists Application Centers to provide outreach to individuals by interviewing such persons and completing the eligibility application;
7. Provides training for State and Application Center staff; and
8. Monitors providers and Application Centers for compliance with established procedures.

UNDERSTANDING THE MEDICAID PROGRAM

MEDICAID ASSISTANCE

Medicaid is a means of paying for the delivery of medical care to eligible individuals. The term “Medicaid” is comprised of parts of the words “medical” and “aid”.

Because the legal basis for the State’s Medicaid plan is contained in the Title XIX of the Social Security Act, the term “Title XIX” is also used to refer to this program. Louisiana’s “Medicaid Program” and “Title XIX” both generally mean “Medicaid”.

APPLICANTS/ENROLLEES, APPLICATION CENTERS, AND PROVIDERS

1. MEDICAID APPLICANTS/ENROLLEES: the purpose of Medicaid is to make health care services available to those who are in need of health insurance or health care. Determining eligibility for Medicaid is the responsibility of DHH, the Department of Children and Family Services, Office of Community Services, and the Social Security Administration.

2. APPLICATION CENTERS: the purpose of Application Centers is to provide outreach and assistance to individuals and families by interviewing and completing the initial application for Medicaid.

3. THE MEDICAID PROVIDER’S ROLE: the provider’s role is to render health care services within a specialized field to eligible Medicaid enrollees. In order to receive reimbursement for those services, the provider must agree to comply with the rules and regulations set forth by the Medicaid Program.

ABBREVIATIONS AND ACRONYMS

AC	Application Center
ACA	Affordable Care Act
ACR	Application Center Representative
ADHC	Adult Day Health Care
BCC	Breast and Cervical Cancer
BHSF	Bureau of Health Services Financing
CHAMP	Child Health and Maternity Program
CMS	Center for Medicare-Medicaid Services
DAC	Disabled Adult Child
DDS	Disability Determination Services
DHH	Department of Health and Hospitals
DHHS	Department of Health and Human Services
EDAW	Elderly and Disabled Adult Waivers
EW/W	Early Widows/Widowers
FFC	Former Foster Care
FFM	Federally Facilitated Marketplace
FITAP	Family Independence Temporary Assistance Program (Administered by the Department of Children and Family Services)
FOA	Family Opportunity Act
GNOCHC	Greater New Orleans Community Health Care
FQHC	Federally Qualified Health Center
HCBS	Home and Community Based Services
LaCHIP/LAP	Louisiana Children's Health Insurance Program/ LaCHIP Affordable Plan
LBHP	Louisiana Behavioral Health Partnership
LCC	Louisiana Children's Choice
LTC	Long Term Care
MEC	Medical Eligibility Card
MEDT	Medical Eligibility Determination Team
MPP	Medicaid Purchase Plan (for workers with disabilities)
MSP	Medicare Savings Program
MUM	Minor Unmarried Mother
NOW	New Opportunities Waiver
NVRA	National Voter Registration Act

PCR	Parents/Caretaker Relatives (Formerly LIF-C)
PUM	Pregnant Unmarried Minor
PW	Pregnant Woman
QI	Qualified Individuals
QMB	Qualified Medicare Beneficiary
RSDI	Retired, Survivor, Disability Insurance (Administered by the Social Security Administration)
SD/MNP	Spend-Down Medically Needy Program
SLMB	Specified Low Income Medicare Beneficiary
SSA	Social Security Administration
SSI	Supplemental Security Income (Administered by the Social Security Administration)
TANF	Temporary Aid to Needy Families (Administered by Department Children and Family Services)
TITLE XIX	Title XIX of the Social Security Act (Medicaid)
TCP	Take Charge Plus (Formerly Family Planning Waiver)
TITLE XXI	Title XXI of the Social Security Act
UCB	Unemployment Compensation Benefits
UNO	University of New Orleans
USCIS	United States Citizenship and Immigration Services
WIC	Provides nutritional foods, education and referrals for eligible women and children up to five years old.

MEDICAID PROGRAMS

BREAST & CERVICAL CANCER: Provides full Medicaid benefits to uninsured women under age 65 who are identified through the Centers for Disease Control and Prevention (CDC) who require treatment for breast and/or cervical cancer, including pre-cancerous conditions and early stage cancer. Provide the referral number 1-888-599-1073.

CHAMP CHILD: Children under the age of 19 are eligible for Medicaid if they meet all requirements of the program, and family income is below the limits.

DEEMED NEWBORN: A child born to a woman determined eligible for Medicaid benefits on the date the child is born shall be deemed Medicaid eligible until the child's first birthday. No application is required for these newborns.

EMERGENCY MEDICAL SERVICES FOR ILLEGAL & LEGAL ALIENS: Legal and illegal aliens who do not meet Medicaid alien status requirements may be eligible for coverage of treatment for life threatening emergency services only. Emergency Services include labor and delivery of a newborn.

EXTENDED MEDICAID: Medicaid coverage is provided for the following applicants/enrollees who lose SSI/MSS eligibility and who meet all eligibility requirements:

1. **Disabled Adult Child (DAC)** - Covers individuals over age 18 that became blind or disabled before age 22 and lost SSI eligibility on or after July 1, 1987, as the result of entitlement to or increase in RSDI.
2. **Early Widows/Widowers (EW/W)** - Covers individuals who received SSI prior to age 60 and lost SSI eligibility because of the receipt of RSDI early widow/widower's benefits.
3. **Disabled Widows/Widowers and Divorced Spouses Unable to Perform Any Substantial Gainful Activity (SGA Disabled W/W/DS)** - Individuals who lost SSI because of receipt of RSDI as a result of the change in the disability definition, and are not entitled to Part A Medicare, and who meet all requirements may be eligible.
4. **Pickle** - Protects Medicaid coverage for two different groups of the aged, blind, or disabled persons who became ineligible for SSI or MSS as the result of a cost of living increase in RSDI benefits or any other income reason.

FAMILY OPPORTUNITY ACT (FOA) Buy-In Provides coverage for children with disabilities up to age 19 with family gross income at or below the program limits. Monthly premiums are based on family income, and they range from zero to thirty-five dollars a month.

FORMER FOSTER CARE (FCC): Provides coverage for children who aged out of the foster care program at age 18. They may continue to be covered up to the age of 26.

GREATER NEW ORLEANS COMMUNITY HEALTH CARE (GNOCHC) Provides coverage for care received in Community Health Centers in four parishes: Orleans, Jefferson, St. Bernard, and Plaquemines.

HOME & COMMUNITY BASED SERVICES WAIVER (ADHC, CSoC-SED, ChildCW, CommCW, NOW, ROW, PCA, SW): Provides community/home-based coverage for individuals who would otherwise require services in an institution.

LONG TERM CARE NURSING FACILITY (LTC): Provides Medicaid coverage to residents of Title XIX certified nursing facilities, certified Medicare Skilled Nursing Facilities/ Medicaid Nursing Facilities, including a swing-bed facility or Title XIX certified Intermediate Care Facilities/Intellectual Disability Facilities and meet all eligibility requirements.

LOUISIANA CHILDREN'S HEALTH INSURANCE PROGRAM (LaCHIP): A Medicaid program with higher income limits and fewer verification requirements than other Medicaid programs for uninsured children from birth to age 19.

LaCHIP PHASE IV (Unborn Option): Provides coverage for uninsured pregnant women who have higher income than LaMOM's enrollees. U. S. Citizens, qualified aliens and non-qualified aliens may be eligible. No post-partum coverage is provided in this program.

LaCHIP PHASE V (AFFORDABLE PLAN): This program provides coverage to children up to age 19 who are uninsured with family income that is too high to qualify for zero premium LaCHIP.

PARENTS/CARETAKER RELATIVES: Medicaid coverage for adult caregivers in families with children who meet certain income and eligibility requirements.

PREGNANT WOMAN (LaMOM's): Medicaid eligibility may begin at any time during pregnancy and as early as three months prior to the month of application if all requirements of the program are met. 60 days of post-partum coverage is included.

PROVISIONAL MEDICAID: Provides Medicaid coverage to individuals who are disabled, or over age sixty-five, and have low income and few resources.

MEDICALLY NEEDY SPEND-DOWN PROGRAM (MNP-S/D): Provides Medicaid coverage when income and resources of the individual or family are sufficient to meet basic needs in a categorical assistance program, but they are not sufficient to meet medical needs according to MNP standards.

MEDICAID PURCHASE PLAN: A Medicaid program which allows a person with a disability, between the ages of 16-65, to obtain Medicaid Coverage necessary to allow them to work.

MEDICARE SAVINGS PROGRAMS (MSP): Provides assistance with Medicare costs for certain individuals who are age 65 or older or who have a disability.

1. **QUALIFIED MEDICARE BENEFICIARY (QMB):** Provides limited Medicaid coverage for certain Medicare individuals and expansion of Medicaid coverage for certain other Medicare beneficiaries. QMB-Only enrollees are eligible for coverage of Medicare premiums, co-payments, and deductibles only. QMB Plus enrollees are eligible for full Medicaid benefits in addition to the QMB benefit.
2. **SPECIFIED LOW-INCOME MEDICARE BENEFICIARY (SLMB):** An SLMB enrollee meets the same eligibility requirements as a Qualified Medicare Beneficiary (QMB) except that his or her income exceeds the QMB income limit. SLMB-only enrollees are eligible for payment of Medicare Part B Premium only. SLMB plus enrollees are eligible for full Medicaid coverage in addition to SLMB coverage.
3. **QUALIFIED INDIVIDUAL-** Qualified Individuals entitled to full payment of Medicare Part-B premiums.

TAKE CHARGE PLUS: Provides coverage for family planning and related services such as birth control, counseling, exams, and tests (including testing and treatment for STD/I's and genital infections), HPV vaccinations, and transportation to/from treatment, for females (non-pregnant) and males.

SECTION I: ADMINISTRATIVE PROCEDURES

Application Center Certification and Training Flow Chart

ENTITY	DESCRIPTION
FACILITY	Makes request to DHH/State Office to become a Medicaid Application Center.
DHH/SO	Mails Standards for Participation, Prospective Application Center Questionnaire to facility.
FACILITY	Returns completed Prospective Application Center Questionnaire to DHH / State Office.
DHH/SO	Mails Medicaid Application Center Request Form and Proposed Plan (application)
DHH/SO/RO	If application is returned, conducts physical inspection of facility.
DHH/SO	Approves, denies, or recommends changes/corrections to AC Proposed Plan. Notifies facility of decision. (Necessary recommendations for corrections and/or changes [i.e., ADA requirements] are issued in writing to the facility.)
	If approved: DHH/SO sends Contractual Agreement, Standards for Participation, Board Resolution Form, W-9 form, etc. to facility.
	If not approved: DHH/SO sends denial letter or contacts facility for additional documentation or other information.
FACILITY	Completes and returns Contractual Agreement, Standards for Participation, Board Resolution Form, etc. to DHH/SO.
DHH/SO	DHH provides website link and login information to AC Management Orientation Video and acknowledgment form.
CEO/ADMIN.	Views AC Management Orientation Video and confirms the date on which the video was viewed.
DHH/SO	Executes the Contractual Agreement, assigns an AC Identification Number, and makes the required data entries into the AC Master File.
	Sends the Application Center a copy of the executed Contractual Agreement, Board Resolution, and Facility Certification Letter. AC maintains copies of these documents on file.
	Updates internal listing of Certified Application Centers.
AC	Mails or faxes to DHH/State Office a completed and signed Request for AC Representative Training form (BHSF Form AC-4).
DHH/SO	Approves or denies Request for AC Representative Training.
	If approved: DHH/State Office processes the Request for AC Representative Training.
	If denied: DHH/State Office notifies the Application Center of the denial.
UNO	Invites and informs facility's AC Trainee of date, time and location of AC Representative training class.

AC TRAINEE	Attends a scheduled Representative training class and takes a written examination given by UNO.
UNO	Monitors participant's attendance and scores written examination.
	If trainee passes exam: UNO issues Certification Letter and a Training Certificate to the individual. AC maintains copies of these documents on file. Notifies DHH/State Office that certification requirements have been met. UNO grants access to the AC application site and informs AC Representative.
	If trainee does not pass exam: UNO issues a Letter of Regret to the Application Center. Individual must wait a minimum of six months before repeating the training. Notifies DHH/State Office that certification requirements have not been met.
DHH/SO	Compiles information into the AC Master File. Maintains and updates the system as required.
DHH/SO	Files, maintains, and updates all related documents and information in Application Center case files.

DHH/SO DHH State Office
DHH/RO DHH Regional Office
UNO University of New Orleans
AC Medicaid Application Center

STANDARDS FOR PARTICIPATION

Standards for participation are the guidelines, agreements, and required training and certification procedures established by DHH to ensure compliance with Federal and State regulations governing outreach and intake efforts to facilities, agencies, and organizations interested in serving as Medicaid Application Centers.

In order to participate as a Medicaid Application Center, the provider entity:

- Must not have been suspended or excluded from participating in the Medicaid Program, and
- Must meet one of the following criteria:
 1. An institutional provider of Medicaid services (e.g., private hospital).
 2. A state program which is staffed by state employees that provides health or social services to the local population (e.g., parish health units, mental health units).
 3. A federal program that provides health or social services to the local population. Authorized under Sections 329, 330, and 340 of the Public Health Services Act (e.g., Federally Qualified Health Center [FQHC] which includes designated city, local, and rural health clinics).
 4. A parish, state, or federally sponsored program providing services to the community that has designated business offices with established hours of operation, a full-time staff who works with the general public performing the normal duties of the program, and the endorsement and recommendation of local government for certification training (e.g., Head Start).
 5. An established private program providing health or social services to an identifiable segment of the local community that has designated business offices with established hours of operation, a full-time staff who works with the general public in performing the duties of the program, and the endorsement and recommendation of local government for certification training (e.g., Volunteers of America, Catholic Community Services, etc.).
 6. Home Health agencies or other providers specifically approved by DHH.

AGREEMENTS/RESPONSIBILITIES OF APPLICATION CENTER

FACILITY REQUIREMENTS:

- ☐ Location of AC accessible by applicants
- ☐ Facility in compliance with minimum ADA requirements
- ☐ Posting of days and times Medicaid application interviews are available
- ☐ Designated area allowing for privacy during interviews
- ☐ Sufficient seating to accommodate waiting area, and
- ☐ Internet access

REQUIRED DOCUMENTATION Set up and maintain a facility file for the following types of Application Center materials and certification documents:

- ☐ AC Handbook (facility copy) available onsite or Internet access to the most current edition
- ☐ Copy of AC Handbook (or access to the Internet) for each certified AC Representative and CEO/Administrator
- ☐ The [Application Center Contractual Agreement \(AC-2\)](#) must be signed by the duly authorized representative (Chief Executive Officer or Administrator) of the Application Center.

The signature of the duly authorized representative of the Application Center on the "Contractual Agreement" form serves as the facility's agreement to abide by all policies and that to the best of his or her knowledge, information contained on the "Contractual Agreement" is true, accurate, and complete.

- ☐ If the Application Center is a corporation, the authorization must be evidenced and accompanied by a [Standard Board Resolution Form \(AC-2a\)](#) which authorizes a particular person to sign on behalf of the corporation.
- ☐ If the Application Center is a partnership, the authorization should be evidenced and accompanied by the *Articles of Partnership*.
- ☐ [HIPAA Business Associate Addendum \(AC-2 addendum\)](#)
- ☐ AC Facility Certification Letter
- ☐ AC Representative Certification Letter
- ☐ Letters of Regret for unsuccessful participants
- ☐ [Confidentiality Responsibilities/Agreement \(AC-3\)](#) reviewed and signed by facility

administrator on a continuing basis, no less than once per year. Administrators should maintain records of all previously signed Confidentiality agreements.

- ☐ [Monitoring/Inspection Forms \(AC-8\)](#) - as completed by DHH staff or their designee, and
- ☐ [Monitoring Corrective Action Results \(AC-8a\)](#), if any.

The Application Center must be able to provide these records upon request by the State Medicaid Agency, the Secretary of the Department of Health and Hospitals, the Medicaid Fraud Control Unit, or the U.S. Department of Health and Human Services.

These records must be maintained for a minimum of five (5) years from the date of service. Any records necessary to support an active audit review or lawsuit must be maintained until these legal actions are disposed. **Never keep copies of completed and/or signed Medicaid applications.**

REQUIRED TRAINING

CEOs/Administrator

Application Center CEOs/Administrators are required to view the Application Center Management Orientation training video at initial certification of the facility and at any time the facility experiences a change in administration.

Application Center Representatives

Qualified personnel must be at least eighteen years old and must successfully complete the Medicaid Application Center Representative training. The AC Representative training includes an overview of the Medicaid programs available, the verification and/or documentation factors to be considered in the application process, pre-certification responsibilities, and a detailed review of the comprehensive application process. The attendee must successfully pass a written exam prior to being certified to complete Medicaid applications.

ON-SITE INSPECTIONS

A representative from the DHH Regional Office will inspect the physical plant of each new Application Center. The inspection will include such factors as the location of the AC in relation to the accessibility by applicants, location of interview space, Internet access, as well as accommodations for privacy, and physical accommodations for compliance with the Americans with Disabilities Act.

RULES GOVERNING PARTICIPATION

The Application Center must adhere to the published regulations of DHH.
The Application Center must follow all rules governing its participation as an Application Center.

TERMINATING THE AGREEMENT

The Application Center has the right to terminate its agreement for any reason, in writing, with thirty (30) days' prior written notice to DHH.

DHH has the right to terminate the agreement with ten (10) days' notice for violation of any of the stated agreements and responsibilities as set forth in the "Application Center Contractual Agreement."

CONFIDENTIALITY AGREEMENT

The Application Center understands that, as a condition of participation, it is responsible for assuring and monitoring confidentiality, privacy, security, non-discrimination, quality standards, and adhering to Federal and State requirements.

The intake or application unit of the provider entity is prohibited under the rules of [Confidentiality Responsibilities/Agreement \(AC-3\)](#), from sharing any information about the applicant received during the application process with any other unit of the provider entity. The [Confidentiality Responsibilities/Agreement \(AC-3\)](#) requirements should be reviewed with staff, and the form should be signed by staff, on a continuing basis, no less than once per year. Staff should also maintain records of all previously signed "Confidentiality Agreements."

MONITORING

The Application Center agrees to periodic monitoring by state officials or their designees without prior notice and agrees that state officials or their designees will have access to the premises to inspect records and evaluate work being performed.

CORRECTIVE ACTION

DHH reserves the right to institute a thirty (30) day period of corrective action in coordination with the Application Center.

DECERTIFICATION

The Application Center understands that decertification may result if, according to the determination of the State or Federal Agency, non-conformance with policies is found.

TRAINING REQUESTS AND CERTIFICATION PROCEDURES

As soon as the Application Center becomes aware of the need to have someone trained as an AC Representative, requests for training must be submitted to DHH for review and approval in advance of a scheduled training class. See [Application Center Request for Representative Training \(AC-4\)](#) for procedures.

The Application Center agrees that only persons who have successfully completed certification training with a passing grade will be allowed to complete Medicaid applications. Any staff member who does not successfully pass the certification test must obtain permission from the training staff to attend future training sessions.

The Application Center agrees to keep on file a copy of each employee's Certification Letter or Letter of Regret.

Replacement staff must be trained and certified prior to assisting applicants with completing Medicaid applications.

The AC also agrees to participation in required follow-up training provided by DHH or their designee.

REPORTING APPLICATION CENTER CHANGES

The AC agrees that any change in certified staff or with the facility must be reported to DHH within ten (10) days to be recorded in the Application Center profile.

Such changes include but are not limited to: staff changes such as CEO/Administrator or certified representatives, telephone or fax number changes, physical or mailing address changes, email address changes, or changes or modifications in the legal name of the Application Center.

Note: All inquiries and correspondence from Application Centers should include the Application Center name and identification number.

REQUIREMENTS FOR APPLICATION PROCESSING

- ☐ Professionalism in addressing applicants while obtaining information
- ☐ Timely processing of applications and daily submittal to Medicaid.
- ☐ Explanation of benefits to applicants
- ☐ Explanation of rights and responsibilities to applicants
- ☐ Designation of a secured storage area for records required by DHH to be maintained on file by the AC for a minimum of five (5) years. Any records necessary to support an active audit review or lawsuit must be maintained until these legal actions are disposed.

COMPLETING MEDICAID APPLICATION INTERVIEWS

The Application Center understands that an application interview must be completed within five (5) working days from the initial date the applicant requests a Medicaid application.

If the Application Center cannot accommodate the applicant within this established time frame, direct the applicant to the Medicaid Customer Service Unit at 1-877-252-2447 to complete the application.

RIGHTFAX COVER AND TRANSMITTAL LOG FOR APPLICATIONS AND DOCUMENTS

Each paper application and all related documents must be accompanied by a completed [RightFAX Cover and Transmittal Log \(AC-7\)](#). Only one application should be transmitted per RightFAX. Paper applications and all necessary documentation associated with each paper application must be transmitted daily to the Medicaid Customer Service Unit. RightFAX number (877) 523-2987.

COMPLETING ONLINE MEDICAID APPLICATIONS

The Application Center understands that it will transmit applications, whether in paper or online format, daily. All verifications and forms must be faxed, delivered or mailed to the Medicaid Customer Service Unit on a daily basis. The Application Center must provide a copy of the completed [BHSF Verification Form](#) an appropriately addressed envelope to each applicant, and advise the applicant to provide the information to the Medicaid Customer Service Unit within ten (10) calendar days from date of the interview, if the documentation was not provided during the interview.

INVOICING

The Center must submit all completed applications daily to DHH using either the online or paper format. DHH will review all submitted applications for completeness. Each month DHH will automatically process the invoices for accepted and approved applications.

Note: DHH will submit invoices for payment on the twentieth (20th) of each month for approved applications.

COST REIMBURSEMENT

Certified Medicaid Application Centers will be eligible for cost reimbursement to offset administrative expenses incurred during the process of completing Medicaid applications. Reimbursement will only be approved and paid on those applications that meet standards set forth in the *Application Center Handbook*.

Reimbursements will be issued in the form of a uniform, flat-fee amount on a per application basis.

Note: DHH will automatically generate reimbursement for each Application Center based on Medicaid applications the AC submits. Reimbursement will be generated whether or not the AC requests reimbursement for applications.

FRAUD

Federal regulations require that each state's Medicaid program establish criteria for identifying situations in which there may be fraud or situations of expected fraud and arrange for prompt referral of such situations to authorities. Federal regulations require a state to develop methods of investigation or review that ascertain the facts without infringing on the legal rights of the Application Center or individuals involved and that are consistent with principles recognized as affording due process of law.

Fraud is determined in accordance with State and Federal law. It is, in all of its aspects, a matter of law. The definition of fraud that governs citizens and government agencies is found in Louisiana R.S. 14:67 and Louisiana R.S. 14:70.1. Legal action may also be mandated under Section 1909 of the Social Security Act as amended by Public Law 95-142 (HR-3).

Prosecution for fraud and the imposition of a penalty, if the individual, liable representative, or Application Center is found guilty, are prescribed by law and are the responsibility of the law enforcement officials and the courts. All such legal action is subject to due process of law and to protection of the rights of an individual afforded by this process.

Penalties assessed as a result of fraud shall be a felony punishable by a fine in any amount not exceeding \$5,000.00 or imprisonment of not more than five (5) years, or both, together with the costs of prosecution.

Cases involving the following situations shall constitute sufficient grounds for a fraud referral of an individual, authorized representative, or an Application Center facility:

1. Misrepresentation of facts in order to assist an applicant to become or to remain eligible to receive benefits under or to obtain payment for services from the Medicaid program.
2. Misrepresentation of facts in order to obtain greater benefits once determined eligible.
3. Misrepresentation by Application Center personnel who may prompt responses of applicants to aid in eligibility of receiving benefits or payment of services from the Medicaid Program.

Situations involving potential fraud which are to be reviewed by the Medicaid Program may include any or all of the following:

1. Complaints reported by mail, phone, or online.
2. Cases referred by the U.S. Department of Health and Human Services. It is equally important that the Title XIX agency, in turn, refer suspected cases of fraud in the Medicare Program to the Center for Medicare & Medicaid Services (CMS) and work very closely with that agency in such matters.
3. Situations brought to light by special reviews, internal controls, provider audits, inspections, or monitoring of Application Center facilities.
4. Referrals from other agencies or sources of information.

WHERE TO REPORT FRAUD COMPLAINTS:

Report suspected Medicaid fraud and abuse by providers to:

Mail

Department of Health and Hospitals
Bureau of Health Services Financing
Program Integrity
P.O. Box 91030
Baton Rouge, Louisiana 70821-9278

Phone

Provider Fraud/Abuse Hotline 1-800-488-2917

Online

<http://new.dhh.louisiana.gov/index.cfm/form/22>

Report suspected Medicaid fraud and abuse by recipients to:

Mail

Department of Health and Hospitals
Bureau of Health Services Financing
Customer Service Unit
P. O. Box 91283
Baton Rouge, LA 70821-9278

Phone

Recipient Fraud/Abuse Hotline 1-888-342-6207

Online

<http://new.dhh.louisiana.gov/index.cfm/form/23>

DHH RESPONSIBILITIES TO APPLICATION CENTERS

DHH is responsible for the administration and oversight of Application Centers' participation in the Medicaid Program.

PROCESSING REQUESTS FOR ESTABLISHING APPLICATION CENTERS

Upon receipt of a request from a facility to participate in the Medicaid Application Center Program, DHH Medicaid Application Center Unit will provide the requesting facility with an Application Center Proposed Plan Questionnaire.

Upon receipt of the complete proposed plan, DHH will determine whether the facility qualifies as an Application Center. If a facility qualifies, a site inspection is completed by the local Medicaid office. Once the completed site inspection is forwarded to State Office, the following forms are sent to the facility for completion:

- [Application Center Contractual Agreement \(AC-2\)](#),
- [HIPAA Business Associate Addendum \(AC-2 Addendum\)](#),
- [Standard Board Resolution Form \(AC-2a\)](#), and
- IRS W9.

CERTIFICATION OF APPLICATION CENTERS

After receipt and approval of all required forms, DHH will certify the facility as an application center and issue a Facility Certification Letter.

REQUIREMENT FOR MANAGEMENT ORIENTATION

DHH will provide Application Center Management Orientation for the duly authorized representative (CEO/Administrator) upon receipt of the signed contract and "HIPAA addendum." DHH will also provide a facility copy of the *Application Center Handbook* listing all procedures and requirements of the program.

TRAINING FOR APPLICATION CENTER REPRESENTATIVES

Certified Application Centers will submit the [Request for Representative Training Form \(AC-4\)](#) to DHH. DHH will review the request forms and consider staff qualifications and the need for additional representatives. If approved, DHH will schedule the individuals for the Application Center Representative Training. DHH will conduct Application Center Representative training for AC staff.

Note: Any participant who has not received prior approval and subsequent confirmation for attendance will not be admitted to a scheduled class.

CERTIFICATION OF APPLICATION CENTER REPRESENTATIVES

Participants who successfully complete the Application Center Representative Training and pass the written exam are presented a Letter of Certification. Participants who fail the written test are presented a Letter of Regret and must reapply to be scheduled for a later class.

MONITORING

Periodically, DHH will monitor Application Center operations to ensure quality and adherence to required standards.

If inadequacies are found, DHH will review and determine appropriate corrective action. DHH will serve in a supportive role to both its applicants and Application Centers.

PROCESSING INVOICES FOR REIMBURSEMENT

DHH will process invoices monthly for reimbursement on all applications approved for payment. Invoices will be generated for every Application Center whether or not payment is requested.

Note: DHH will submit invoices for payment on the 20th of each month for “approved” application reimbursements.

The following reasons are valid to deny payments for applications submitted by Application Centers:

- Exceeds timeframe for request to interview
- Not completing required forms
- Not requesting the required forms
- Not mailing/sending verifications/summary on daily basis.
- Not completing all required fields (this applies to paper apps)
- Inappropriate application (app taken w/in last 90 days)
- Inappropriate application (currently certified eligible)
- Entered into Online Application more than once
- Other

TRANSMITTAL LOGS

Application Centers may obtain copies of transmittal logs via email requests to:
Applicationcenter.service@la.gov

SECTION II: ADMINISTRATIVE FORMS AND INSTRUCTIONS

See all forms and instructions online at the Application Center Forms Site:

<http://new.dhh.louisiana.gov/index.cfm/page/1274>

All forms in this section are immediately followed by instruction/explanation pages. The instruction/explanation pages describe when or why to use a particular form, how to complete required fields, and provide instruction on disposition of completed originals and copies of these forms. The forms are listed here in numeric order.

LOUISIANA'S MEDICAID PROGRAM / APPLICATION CENTER CONTRACTUAL AGREEMENT

Section One: Identifying Information					
Assigned AC-ID No.		Application Center Name			
Street Address			Post Office Box/Mailing Address		
City	State	Zip Code	City	State	Zip Code
Parish	E-mail Address		Federal Tax ID#		
Contact Person			Telephone Number ()	FAX Number ()	
Section Two: Type of Facility <div style="display: flex; flex-wrap: wrap;"> <div style="width: 33%;"> <input type="checkbox"/> 01 Council on Aging <input type="checkbox"/> 02 Pharmacy <input type="checkbox"/> 03 Adult Day Health Care <input type="checkbox"/> 05 Community Action Center or Community Services Provider <input type="checkbox"/> 06 Hospital - Private <input type="checkbox"/> 07 Medical or Physician's Clinic/Office </div> <div style="width: 33%;"> <input type="checkbox"/> 08 Mental Health Facility (Not group home) <input type="checkbox"/> 09 Head Start <input type="checkbox"/> 10 Group Home/Residential Care Facility <input type="checkbox"/> 11 Dental Clinic/Office <input type="checkbox"/> 12 Home Health Care Agency <input type="checkbox"/> 13 All OTHER Approved <input type="checkbox"/> 14 Religious Organization/Church <input type="checkbox"/> 15 Other State Government Agency </div> <div style="width: 33%;"> <input type="checkbox"/> 16 FQHC (Federally Qualified Health Center) <input type="checkbox"/> 17 KidMed Clinic <input type="checkbox"/> 18 Native American Health Center/Tribe <input type="checkbox"/> 19 City/Parish Government Agency <input type="checkbox"/> 20 Office of Mental Health <input type="checkbox"/> 21 Case Management or Waiver Service Provider <input type="checkbox"/> 22 School Based Health Clinic </div> </div>					
Section Three: Control of Facility <div style="display: flex; flex-wrap: wrap;"> <div style="width: 25%;"> <input type="checkbox"/> Public-Federal Agency <input type="checkbox"/> Public-State Agency </div> <div style="width: 25%;"> <input type="checkbox"/> Public-Parish Agency <input type="checkbox"/> Public-City Agency </div> <div style="width: 25%;"> <input type="checkbox"/> Non-Profit Corporation <input type="checkbox"/> Charitable or Religious Org. </div> <div style="width: 25%;"> <input type="checkbox"/> Privately Owned <input type="checkbox"/> Other (Specify) </div> <div style="width: 25%;"> <input type="checkbox"/> Partnership (Board Resolution Required) <input type="checkbox"/> Corporation (Board Resolution Required) </div> </div>					
Section Four: Types of Clients to Be Served for Medicaid Applications (Check all applicable boxes) <div style="display: flex; flex-wrap: wrap;"> <div style="width: 33%;"> <input type="checkbox"/> Walk-Ins by General Public <input type="checkbox"/> Referrals from the Parish Medicaid office </div> <div style="width: 33%;"> <input type="checkbox"/> Referrals from Hospitals <input type="checkbox"/> Referrals from Doctors' Offices </div> <div style="width: 33%;"> <input type="checkbox"/> Referrals from Community Centers or other Application Centers <input type="checkbox"/> NONE-Will Interview only Own Patients/Clients </div> </div>					
Section Five: Notice <p>The Department of Health & Hospitals has assured compliance with the Department of Health & Human Services regulations promulgated under Title VI of the Civil rights Act of 1964 and section 504 of the Rehabilitation Act of 1973, as amended, which require that: No person in the U.S. shall, on the grounds of race, color, religion, sex, national origin, or handicap be excluded from participation in, be denied the benefits of, or be subject to discrimination under any program or activity receiving Federal financial assistance.</p> <p>Under these requirements, payment cannot be made for care and services under federally assisted programs conducted by the Medical Vendor Administration unless such care and services are provided without discrimination on the grounds of race, color, religion, sex, national origin, or handicap. Written complaints of non-compliance should be made to the Secretary of the Department of Health and Hospitals, P.O. Box 91030, Baton Rouge, Louisiana 70821-9030, or the Secretary of DHHS, Washington, D.C., or both.</p>					
Section Six: Printed Name and Signature <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <div style="width: 40%;"> _____ Printed or Typed Name of Administrator/CEO </div> <div style="width: 30%;"> _____ Signature of Administrator/CEO </div> <div style="width: 30%;"> _____ Date </div> </div>					
Section Seven: DHH State Office / Designee Use Only <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <div style="width: 70%;"> _____ Signature of Medicaid of Louisiana Representative </div> <div style="width: 30%;"> _____ Date </div> </div>					

Section Eight: Administrator/CEO Confidentiality Statement

MVA Form AC-2 (06)

- I, _____, understand my organization as a designated state approved Application Center must adhere to the following regulations regarding confidentiality responsibilities.
- Federal Regulations 42 CFR 431.300 restricts the use or disclosure of information concerning applicants/recipients to purposes directly connected with the administration of Medicaid. Federal Regulations 45 CFR Part 160 and 164 governs the privacy of individually identifiable health information. (HIPAA Privacy Rule)
 - Purposes directly related to Medicaid include:
Establishing Medicaid eligibility and determining the type and amount of medical assistance.
 - Confidential information includes, at a minimum, the following:
Name and address of applicant/recipient, medical services provided, social and economic conditions or circumstances, evaluation of personal information and medical data, including diagnosis and past history of disease or disability.
 - It shall be unlawful for any person to solicit, disclose, receive, make use of, or to authorize, knowingly permit, participate in, or acquiesce in the use of applications or client information or the information contained therein for any purpose not directly connected with the administration of the Medicaid Program.
 - Publications of lists of names of applicants/recipients is prohibited.
 - Any person who violates any provisions of confidentiality is subject to a fine not more than two thousand five hundred dollars (\$2,500) or imprisonment for not more than **two (2) years** in the parish jail or both, not less than five hundred dollars (\$500) or **ninety (90) days** on each count. In addition to these criminal penalties, violation of confidentiality requirements shall result in the termination of certification to complete Medicaid applications.
 - I acknowledge that staff will adhere to all confidentiality provisions set forth in this agreement.

Signature of Application Center Administrator/CEO

Date

Section Nine: Agreements and Responsibilities

- I do hereby agree to adhere to published regulations of the Secretary and *DHH/MVA*. I agree to any rules governing my participation as an Application Center.
- I understand that I have the right to terminate this agreement for any reason in writing with **thirty (30) days** advance notice to DHH. I understand that DHH has the right to terminate this agreement with **ten (10) days** notice for violation of any of the stated agreements and responsibilities as set forth in this agreement.
- I hereby agree to keep such records as are identified in the *Application Center Handbook* to disclose fully the extent of services provided to Medicaid individuals.
- I agree to maintain information regarding such records and regarding any payments claimed for providing such services that Louisiana's Medicaid Agency, the DHH Secretary, the Medicaid Fraud Control Unit, or the U.S. Department of Health and Human Services may request for **five (5) years** from the date of service. I further agree that any record being reviewed or under litigation must be maintained until completion and/or finalization of the audit or lawsuit.
- I understand that to qualify for certification training, employees must agree to be bound by Federal and State requirements on client confidentiality, non-discrimination, and quality standards.
- I agree to sign the above confidentiality statement on behalf of my facility.
- I agree to periodic monitoring by State officials without prior notice given. I further agree that state officials will have access to the premises to inspect and evaluate work being performed and to audit compliance with the Application Center Agreement requirements. I understand that decertification may result if non-compliance with policy is found.
- I agree that only persons who have successfully completed certification training with a passing grade will be allowed to take Medicaid Applications and agree to any additional follow-up training. I agree that any changes in certified staff will be reported to DHH within **ten (10) calendar days** and recorded in the facility's AC profile.
- I further agree to maintain training certification letters and letters of regret on file.
- I understand that the Medicaid *Application Center Handbook* will be furnished to my facility.
- I understand that application and/or packets to be used will be distributed by the DHH Office which will maintain a record of quantities issued to each Center.
- It is the responsibility of my facility to maintain copies of RightFAX Cover and Transmittal Log of applications for approval, monitoring, and review purposes.
- In the event this agreement is terminated by either party, I am responsible for returning all unused application within **ten (10) days** of the termination of the agreement.
- I understand that all Medicaid application interviews must be scheduled and completed within **five (5) working days** from the initial date of contact.
- Furthermore, I understand that all non-electronic Medicaid Applications must be signed and dated by the applicant, the AC Representative, and hand-delivered, sent by courier service, or **mailed daily**, to the designated Medicaid Office.

Signature of Application Center Administrator/CEO

Date

HIPAA BUSINESS ASSOCIATE ADDENDUM
DEPARTMENT OF HEALTH AND HOSPITALS
MEDICAL VENDOR ADMINISTRATION
ELIGIBILITY FIELD OPERATIONS

APPLICATION CENTER:	
ACID#	

This Business Associate Addendum is hereby made a part of the above referenced contract in its entirety as an attachment to the contract.

1. The U.S. Department of Health and Human Services has issued final regulations, pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), governing the privacy of individually identifiable health information. See 45 CFR Parts 160 and 164 (the "HIPAA Privacy Rule"). The Department of Health and Hospitals, ("DHH"), as a "Covered Entity" as defined by HIPAA, is a provider of health care, a health plan, or otherwise has possession, custody or control of health care information or records.
2. "Protected Health Information" ("PHI") means individually identifiable health information including all information, data, documentation and records, including but not limited to demographic, medical and financial information that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual or payment for health care provided to an individual; and that identifies the individual or which DHH believes could be used to identify the individual.

"Electronic protected health information" means PHI that is transmitted by electronic media or maintained in electronic media.
"Security incident" means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.
3. Contractor is considered a Business Associate of DHH, as contractor either: (A) performs certain functions on behalf of or for DHH involving the use or disclosure of protected individually identifiable health information by DHH to contractor, or the creation or receipt of PHI by contractor on behalf of DHH; or (B) provides legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, financial or social services for DHH involving the disclosure of PHI.
4. Contractor agrees that all PHI obtained as a result of this contractual agreement shall be kept confidential by contractor, its agents, employees, successors and assigns as required by HIPAA law and regulations and by this contract and addendum.
5. Contractor agrees to use or disclose PHI solely (A) for meeting its obligations under this contract, or (B) as required by law, rule or regulation or as otherwise permitted under this contract or the HIPAA Privacy Rule.
6. Contractor agrees that at termination of the contract, or upon request of DHH, whichever occurs first, contractor will return or destroy (at the option of DHH) all PHI received or created by contractor that contractor still maintains in any form and retain no copies of such information; or if such return or destruction is not feasible, contractor will extend the confidentiality protections of the contract to the information and limit further use and disclosure to those purposes that make the return or destruction of the information infeasible.

HIPAA BUSINESS ASSOCIATE ADDENDUM (cont'd)

7. Contractor will ensure that its agents, employees, subcontractors, or others to whom it provides PHI received by or created by contractor on behalf of DHH agree to the same restrictions and conditions that apply to contractor with respect to such information. Contractor also agrees to take all reasonable steps to ensure that its employees', agents', or subcontractors' actions or omissions do not cause contractor to breach the terms of this Addendum. Contractor will use all appropriate safeguards to prevent the use or disclosure of PHI other than pursuant to the terms and conditions of this contract and Addendum.
8. Contractor shall, within 3 days of becoming aware of any use or disclosure of PHI, other than as permitted by this contract and Addendum, report such disclosure in writing to the person(s) named in section 14 (Terms of Payment), page 1 of the CF-1.
9. Contractor shall make available such information in its possession which is required for DHH to provide an accounting of disclosures in accordance with 45 CFR 164.528. In the event that a request for accounting is made directly to contractor, contractor shall forward such request to DHH within two (2) days of such receipt. Contractor shall implement an appropriate record keeping process to enable it to comply with the requirements of this provision. Contractor shall maintain data on all disclosures of PHI for which accounting is required by 45 CFR 164.528 for at least six (6) years after the date of the last such disclosure.
10. Contractor shall make PHI available to DHH upon request in accordance with 45 CFR 164.524.
11. Contractor shall make PHI available to DHH upon request for amendment and shall incorporate any amendments to PHI in accordance with 45 CFR 164.526.
12. Contractor shall make its internal practices, books, and records relating to the use and disclosure of PHI received from or created or received by contractor on behalf of DHH available to the Secretary of the U.S. DHHS for purposes of determining DHH's compliance with the HIPAA Privacy Rule.
13. Compliance with Security Regulations:

In addition to the other provisions of this Addendum, if Contractor creates, receives, maintains, or transmits electronic PHI on DHH's behalf, Contractor shall, no later than April 20, 2005:
 - (a) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of DHH;
 - (b) Ensure that any agent, including a subcontractor, to whom it provides such information agrees to implement reasonable and appropriate safeguards to protect it; and
 - (c) Report to DHH any security incident of which it becomes aware.
14. Contractor agrees to indemnify and hold DHH harmless from and against all liability and costs, including attorney's fees, created by a breach of this Addendum by contractor, its agents, employees or subcontractors, without regard to any limitation or exclusion of damages provision otherwise set forth in the contract.
15. Notwithstanding any other provision of the contract, DHH shall have the right to terminate the contract immediately if DHH determines that contractor has violated any material term of this Addendum.

SIGNATURE OF APPLICATION CENTER ADMINISTRATOR/CEO

DATE

APPLICATION CENTER CONTRACTUAL AGREEMENT

BHSF FORM AC-2

(Page 1 of 3)

Completion of this form and HIPAA Business Associate Addendum is a condition of certification and participation as an Application Center in the Medicaid Program.

Answer all questions as of the date the form is completed. Ensure that all appropriate signatures are obtained in the designated areas and that the current date is used.

These instructions are designed to simplify the completion of this form. No instructions are given for sections considered to be self-explanatory.

Return the completed and signed original form to DHH. (A copy will be forwarded to you upon certification.) Mail to:

DHH/BHSF
Application Center Coordinator
P.O. Box 91283
Baton Rouge, LA 70821-9283

SECTION ONE: IDENTIFYING INFORMATION

Assigned Application Center Identification Number - If your facility is a new AC, leave this space blank. The AC-ID number will be assigned by staff of the Department of Health and Hospitals. If your facility is an existing AC and this contractual agreement is being submitted because of a change, such as a new administrator, please indicate your existing AC-ID number which was issued on the initial contract.

Application Center Name - Enter the legal name of your facility, organization, or agency.

Street Address - Enter the actual physical (geographical) location of your facility.

City, State, and Zip Code - Enter the city, state, and zip code for your facility's street address.

Post Office Box/Mailing Address - Enter the facility's mailing address if different from the street address. If the post office box/ mailing address is the same as the physical address, please enter "same" in the space provided.

Parish - Enter the name of the parish in which your facility is located.

City, State, and Zip Code - Enter the city, state, and zip code for your facility's Post Office Box/ mailing address.

APPLICATION CENTER CONTRACTUAL AGREEMENT

(Page 2 of 3)

Contact Person – Enter the name of a representative of your facility or organization who is responsible for Application Center operations and who will serve as liaison between DHH and your facility.

E-Mail – Enter the E-mail address of the contact person.

Federal Tax ID Number – Enter the federal tax ID number for the facility.

Telephone Number – Enter the area code and telephone number where your contact person may be reached.

Fax Number – Enter the area code and fax number where your contact person may be reached or notified.

SECTION TWO: TYPE OF FACILITY

Indicate the type of facility, organization, or agency. Check the most appropriate block that describes the type of services provided by your facility.

SECTION THREE: CONTROL OF FACILITY

Check the appropriate block that best describes the administration of your facility.

SECTION FOUR: TYPES OF CLIENTS TO BE SERVED FOR MEDICAID APPLICATIONS

Indicate the type(s) of clients or enrollees your facility will serve. Place a check in each box that applies.

SECTION FIVE: NOTICE

The notice section is self-explanatory. Please read carefully.

SECTION SIX: PRINTED OR TYPED NAME AND SIGNATURE

Printed or Typed Name and Signature of Administrator/CEO – Review Sections I-V then, print or type name, sign and indicate date in the appropriate spaces.

APPLICATION CENTER CONTRACTUAL AGREEMENT (Page 3 of 3)

SECTION SEVEN: DHH STATE OFFICE / DESIGNEE USE ONLY

This section is for official use by the DHH State Office only.

SECTION EIGHT: FACILITY CONFIDENTIALITY STATEMENT

Administrator/CEO - Review Confidentiality statement, then print name, sign and indicate date in the appropriate spaces.

SECTION NINE: AGREEMENTS AND RESPONSIBILITIES

Administrator/CEO - Review Agreements/Responsibilities Section then sign name and indicate date in the appropriate spaces.

BH&F Form AC-2a
Rev. January 2004

BOARD RESOLUTION

(This document is necessary for the Medicaid Application Center Program when it is required by your Board of Directors. If it is not required, please indicate so.)

STATE OF LOUISIANA, PARISH OF _____

on the _____ day of _____, _____ at a meeting of the Board of Directors of _____
Month Year

held in the City of _____,

a quorum of the Directors present, the following business was conducted:

It was duly moved and seconded that the following resolution be adopted:

BE IT RESOLVED that the Board of Directors of the above corporation do hereby authorize

_____ (Name and Title)
and his/her successors in the office to negotiate, on terms and conditions that he/she may deem advisable, a contract or contracts with the Louisiana Department of Health and Hospitals, and to execute said documents on behalf of the corporation, and further we do hereby give him/her the power and authority to do all the things necessary to implement, maintain, amend or renew said documents.

The above resolution was passed by a majority of those present and voting in accordance with the by-laws and articles of incorporation.

I certify that the above and foregoing constitutes a true and correct copy of a part of the minutes of a meeting of the Board of Directors of

Held on the _____ day of _____, _____
Month Year

Secretary _____

Subscribed and sworn before me, _____, a Notary Public

for the Parish of _____ on the _____ day of _____ Month _____ Year

BOARD RESOLUTION FORM

BHSF FORM AC-2a

The *Board Resolution Form* is a companion form to the *Application Center Contractual Agreement*. Whereas, an *Application Center Contractual Agreement* must be completed by each Application Center, a board resolution is **only** required by the Louisiana Medicaid Program when it is required by the AC's Board of Directors.

NOTE: *If a board resolution is not required, it is the Application Center's responsibility to notify DHH so that the processing of other matters pertaining to the AC will not be held up for this reason.*

The *Board Resolution Form* is a sample form. If a board resolution is required, this form may be used or your Application Center may use its own form or format, providing it contains at least the same basic provisions as the sample form appearing in the AC Handbook.

Completing the Form:

Parish: Enter the parish in which the Board of Directors met to vote on the board resolution.

Day, Month, & Year: Enter the day, month, and year the Board of Directors met to vote on the resolution.

City: Enter the name of the city in which the board meeting takes place.

Name and Title: Enter the name and title of the administrative person whom the Board of Directors authorizes to execute the Medicaid contractual agreement with the Louisiana Department of Health & Hospitals, on behalf of the corporation, and to whom power of authority is given to do all the things necessary to implement, maintain, amend, or renew said documents for the Medicaid Application Center.

Certification: The Secretary of the Board of Directors must complete this section with: the legal name of the entity which the Board of Directors represent; the address where the Board of Directors is domiciled; the day, month, and year the board resolution document is certified; and, the name of the Board Secretary.

Notary Section: This section is to be completed by a Notary Public.

Where to Send the Board Resolution: Return the completed (**original**) board resolution by mail to DHH:

DHH/BHSF
Eligibility Supports Section
Application Center Coordinator
P.O. Box 91283
Baton Rouge, LA 70821-9278

BHSF Form AC-3
Revised 2006



CONFIDENTIALITY RESPONSIBILITIES / AGREEMENT

Federal regulations 42 CFR 431.300 restricts the use or disclosure of information concerning applicants/enrollees to purposes directly connected with the administration of Medicaid. Federal regulations 45 CFR Part 160 and 164 governs the privacy of individually identifiable health information (HIPAA Privacy Rule.)

Purposes directly related to Medicaid include:

- Establishing Medicaid eligibility; and,
- Determining the type and amount of medical assistance.

Confidential information which shall be protected from disclosure includes, at a minimum, the following:

- Name, SSN, and address of applicant/enrollee
- Medical services provided
- Social and economic conditions or circumstances
- Evaluation of personal information, and
- Medical data, including diagnosis and past history of diseases or disability.

It shall be unlawful for any person to solicit, disclose, receive, make use of, or to authorize knowingly permit, participate in, or acquiesce in the use of applications or client case records or the information contained therein for any purposes not directly connected with the administration of the Medicaid Program.

Publication of lists of names of applicants/enrollees is prohibited.

Precautions in Safeguarding Information

• Informal Discussions:

All individuals, clerical as well as professional, shall refrain from discussing client situations informally in offices, restrooms, while in transit or at social gatherings, regardless of whether the client's name is used. The use of names or of descriptions of unusual circumstances in discussions may easily lead to identification of the client. Regardless of the possibility of identification, such discussions may create the impression that staff deals lightly with information received and does not have the proper respect for the affairs of others.

• Application Interviews:

The Application Center Representative shall rely on the applicant as the initial and primary source of information. If there is incomplete, unclear, inconsistent or otherwise questionable information, the AC Rep. shall be careful not to engage in any activity which will violate the client's rights. The AC Rep. shall be businesslike and give the client the opportunity to participate in the determination of his or her eligibility to the greatest extent possible.

• Record Material:

Material used at staff discussions or training classes shall be edited for all identifying names and circumstances. If the group discussion is about a case under a fictitious name, the danger of the client's identity being determined is lessened.

• Transporting Case Materials:

No case material shall be taken out of the office, except to transport it directly from one office to another. If the material is carried by automobile or public carrier, every precaution shall be taken to protect it from being observed or from falling into the hands of another person. DHH shall be notified immediately if case material taken out of the office is lost.

Any person who violates any of the provisions of confidentiality is subject to a fine of not more than two thousand, five hundred dollars (\$2500) or imprisonment for not more than two (2) years in the parish jail or both, nor less than five hundred dollars (\$500) or ninety (90) days on each count. In addition to these criminal penalties, violations of confidentiality requirements shall result in the termination of certification to complete Medicaid applications.

I have read, understand, and will abide by the confidentiality regulations in this agreement.

Printed or Typed Name

Signature

Date

CONFIDENTIALITY RESPONSIBILITIES / AGREEMENT

BHSF FORM AC-3

Confidentiality Agreement for Certified Staff/Administrator

This form explains the provisions and responsibilities of confidentiality requirements as set forth by DHH/BHSF. Each certified Application Center Representative and facility Administrator must read and sign this form prior to completing Medicaid applications on behalf of DHH/BHSF.

It is important that each certified representative and administrator be aware of the penalties that can result from a violation of confidentiality requirements and of the possibility of decertification for completing Medicaid applications if any stated confidentiality responsibilities are violated.

It is the responsibility of the Application Center to have a signed and dated confidentiality agreement for each certified representative and the administrator on file and readily available to representatives of DHH or their designee, upon request.

Each year every certified Application Center Representative and the Application Center Manager must sign a new Confidentiality Responsibilities Agreement. All new agreements, and all previous years' agreements must be kept on file at the Application Center.

BHSF Form AC-4
Revised 2007

Louisiana's Medicaid Program Application Center Request for Representative Training

Mail To: DHH/MVA
Application Center Unit AC ID# _____

OR P. O. Box 91278
Baton Rouge, LA 70821-9278 Parish _____

FAX To: (225) 376-4736

APPLICATION CENTER INFORMATION *(Please Print Clearly or Type):*

Application Center Name _____

AC Street Address _____ P.O. Box _____

City _____ State _____ Zip _____ City _____ State _____ Zip _____

AC Phone Number (____) _____ AC FAX Number (____) _____

Participant's (non-shared) eMail Address _____

AC's eMail: _____

PARTICIPANT INFORMATION *(Please Print Clearly or Type):*

First Name _____ M. Initial _____ Last Name _____

Birth Date (MM/DD/YYYY) _____ Sex _____

Educational Level (H.S. = 12) _____ Job Title _____ Department _____

Job Description _____

Participant's Signature _____ Date _____

ADMINISTRATOR/CEO INFORMATION *(Please Print Clearly or Type):*

The following questions **MUST** be answered by the Administrator/CEO or Contact Person:

1. Is the person for whom training is requested replacing a certified representative? ☐ YES ☐ NO
If yes, what is the name of the representative being replaced? _____
2. Did the representative being replaced transfer to another Application Center? ☐ YES ☐ NO
If yes, what is the name of the Application Center he/she transferred to? _____
3. Does the person for whom training is requested have a non-shared eMail address? ☐ YES ☐ NO

Admin/CEO's Name _____ Admin/CEO's Signature _____
(PRINT OR TYPE)

FOR DHH USE ONLY:

DHH Approval for Attendance ☐ Yes ☐ No Region _____

Approval Signature _____ Date _____

REQUEST FOR REPRESENTATIVE TRAINING

BHSF FORM AC-4

(Page 1 of 2)

Purpose: The Request for Representative Training Form is used to request training for new employees or for employees requesting re-certification to assist applicants with their Medicaid applications. Only one individual should be listed per request form.

Prior Approval Required: All requests for Representative Training must be approved by DHH prior to the class. No individual will be allowed to participate in the class who has not received prior approval. Participants will be notified and invited via email prior to the class to attend training.

When Should A Request for Training Be Submitted? As soon as a need to have someone trained arises, a request should be submitted to DHH for review and approval.

Completing the Form

Each item must be completed as follows for DHH and the Medicaid Program to review and approve the individual's request for AC Representative Training. Failure to complete this information may result in the request for representative training being delayed or denied.

AC-ID#: Enter the Application Center ID#, if known.

Parish: Indicate the Parish in which the AC is located.

Application Center Information: Please print or type: the name of the AC, AC street (physical) address, and its city, state, and zip code, P.O. Box/mailling address, and its city, state, and zip code (if different from the street address), and, the AC area code, phone number, and FAX number where the individual for whom training is being requested can be reached. Please include the AC E-Mail address.

Participant Information: Please *print or type* the full name of the individual for whom approval is requested to attend a representative training class, including their first name, middle initial, and last name. Enter the participant's complete date of birth (*i.e.*, 02-13-1970) and, current education level by years (*i.e.*, High School = 12 and four years of college with a degree = 16). Enter the participant's job title; their email address, the department in which they work; and, a brief description of their current job duties and responsibilities.

REQUEST FOR REPRESENTATIVE TRAINING

(Page 2 of 2)

Participant's Signature: The form must be signed by the individual who requires training. Indicate the date on which the request is completed.

Questions that must be answered by the Administrator/CEO or Contact Person:

This section contains questions pertaining to the status of certified representatives in your Application Center. The answers to these questions will help DHH determine if additional representatives should be trained, and it will facilitate accurate information in DHH's database. Failure to complete this information may result in delays or denial of the training request.

NOTE: A non-public email address must be provided for each person attending training. Free email accounts may be obtained from a variety of Internet providers. All email addresses will be confirmed prior to approval to attend training.

Printed or Typed Name and Signature of Administrator/CEO: The completed form must include the Administrator/CEO's signature and printed or typed name.

For DHH Use Only: This section should be left blank by Application Center.

Where to Send the Form: After the form is completed, mail, email or fax it to DHH. The U. S. Postal Service address, email, and Fax number are listed at the top of the form.

MVA Form AC-7
Revised 2014

RightFAX Cover and Transmittal Log

(All non-electronic applications or documents must be accompanied by this completed log/cover sheet regardless of whether they are sent by FAX or mail.)

To: DHH Customer Service Unit

RightFAX Number: 877-523-2987

DATE:

INITIAL CONTACT DATE	INTERVIEW DATE	TRANSMITTAL DATE

APPLICANT INFORMATION:

NAME	SOCIAL SECURITY NUMBER	TELEPHONE NUMBER

Total number of pages including cover sheet: _____

Are you sending medical records for this application? **NO** ☐ **YES** ☐

APPLICATION CENTER NAME:

AC ID #: _____

AC Representative's Printed Name:

AC Representative's Phone Number:

Comments:

RIGHTFAX COVER AND TRANSMITTAL LOG

(Page 1 of 2)

Purpose: RightFAX Cover and Transmittal Log is used by Application Centers to send all documents to Medicaid Customer Service via RightFAX, US Mail, courier or hand delivery when any document, form, or paper application is transmitted.

Preparation: Use only ONE cover sheet for each application packet *unless medical records are faxed*. **If medical records are faxed, then fax them with a separate, appropriately completed, cover sheet.** If documents/applications are sent via a method other than fax, then submit only one cover sheet per application packet.

Before Faxing, sort the documents according the chart below.

Applications	Includes: Paper Application Forms, BHSF Clearance, BHSF Authorized Representative, BHSF NVRADF
Income Documents	Includes: Most recent Income Tax Return, with Schedule C attached, BHSF Form Wages, for self-employed household members only
Medical Documents	Includes: BHSF Form MS, BHSF Form MS/C, BHSF 202L/HIPAA, BHSF 402P/HIPAA, Medical Records, Medical Bills
Permanent Documents	Includes: Bank Account Verification, Home Property Verification, Medical Insurance Cards, Medicare Cards, Power of Attorney, Property Deeds, Appraisals, BHSF Form Resources, BSHF Form INS-LR

Each item on the cover sheet shall be completed as follows to document all non-electronic applications and forms completed by an AC Representative during the Medicaid Interview:

To: This item is pre-populated with the correct FAX number: **(877)-523-2987**

DATE:

Initial Contact Date: Enter the month, day, and year the applicant first contacted the AC to request Medicaid coverage.

Interview Date: Enter the actual date the application interview is completed.

Transmittal Date: Enter the date the application is transmitted – **All applications and associated documents must be sent to Medicaid daily!**

RIGHTFAX COVER AND TRANSMITTAL LOG

(Page 2 of 2)

Applicant Information:

Name: SSN: Telephone Number: Enter the appropriate identifying information for the person applying or the adult applying for the children.

Total number of pages including cover sheet: Indicate the number of pages being transmitted.

Are medical records sent for this application? Check Yes or No

AC ID#: Print the Application Center ID number for reimbursement

AC Representative's Name: Print the name of the AC Representative who assisted with the application

AC Representative's Phone Number: Print the phone number of the AC Representative who assisted with the application.

Comments: Use this section to add additional information

Disposition:

All verification and completed documents should be submitted daily to the Medicaid Office. Once a fax confirmation is received, then documents must be returned to the applicant or shredded. Application Centers may keep the completed cover/log or copies of completed cover/log **ONLY**.

All documents, other than the On-Line application, must be listed on a Transmittal Cover/Log including those sent via FAX, U. S. Mail, courier, and hand delivery.

BHSF Form AC-8
Revised 08/2012

Initial Visit ☐
Follow Up Visit ☐

LOUISIANA MEDICAID INSPECTION / MONITORING REPORT

Application Center Name: _____ AC ID#: _____

AC Satellite Office Name (If applicable): _____

Application Center Street Address: _____

Application Center P.O. Box: _____

AC Telephone Number: () _____ AC Fax Number: () _____

Name of Administrator/CEO: _____

AC E-mail Address: _____

SECTION ONE: INTERVIEW WITH ADMINISTRATOR/CEO

Name of Person Interviewed: _____

Title: _____

SECTION TWO: PHYSICAL PLANT

Does the reception area (if applicable) have adequate seating for Medicaid applicants? ☐ Yes ☐ No

Does the interview area have accommodations for privacy of conversation and intake? ☐ Yes ☐ No

Does the AC meet current ADA requirements? ☐ Yes ☐ No

SECTION THREE: CERTIFICATION

NOTE: *DHH monitor will view AC copies of *Certification Letters, Certificates, and Confidentiality Agreement (BHSF AC-3)*. DHH monitor will verify that all *Confidentiality Agreement Forms* were signed by Application Center staff within the most recent year.

Name of Contact Person: _____

AC Representative	Certification Date	Certification Letter or Certificate on file?	Confidentiality Agreement BHSF AC-3 on file?
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

(Use additional sheet to list AC Representatives, if necessary.)

Does the AC have use the on-line application? ☐ Yes ☐ No

If not, then does the AC have a current copy of the AC Handbook? ☐ Yes ☐ No

Is DHH Representative's Name / signature on most recent *Contractual Agreement*? ☐ Yes ☐ No

Is authorized signer on the *Contractual Agreement* still employed by the AC? ☐ Yes ☐ No

If no, give name of the new authorized individual:

SECTION FOUR: APPLICATIONS

Estimate the number of interviews conducted per month: _____. Can AC do more? ☐ Yes ☐ No
If yes, explain: _____

What is the source of AC's referrals? _____

Where does AC send verifications received from the applicant? _____

Who is AC's contact person at DHH? _____

Is a Medicaid Application Center sign posted? ☐ Yes ☐ No

Is the sign legible? ☐ Yes ☐ No

Is the information specific to clientele being served? ☐ Yes ☐ No

Is the sign visible to the public? ☐ Yes ☐ No

Are interviews scheduled within five (5) working days from initial contact with applicant? ☐ Yes ☐ No

Does the AC have pre-addressed envelopes to provide to the applicant? ☐ Yes ☐ No

If time frame cannot be met, are applicants referred to DHH Customer Service? ☐ Yes ☐ No

Are Rights, Responsibilities, and Benefits of programs explained to applicants? ☐ Yes ☐ No

How was this determined? ☐ Observed AC Representative assisting applicant;
☐ Statement from Certified AC Representative; or,
☐ Statement from Administrator or CEO.

Comments:

SECTION FIVE: CORRECTIVE ACTION

Is corrective action necessary at this time?

☐ Yes ☐ No

If yes, explain: _____

NOTE: If the Application Center feels it may have been treated unfairly during the monitoring process, the Louisiana Department of Health and Hospitals will provide an opportunity for an impartial review.

 Signature of DHH/BHSF Representative

 Date

 Signature of Application Center Official

 Date

<p style="text-align: center;">FOR DHH/BHSF USE, ONLY</p> <p>COMMENTS: _____</p>
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INSPECTION / MONITORING REPORT

BHSF FORM AC-8

(Page 1 of 2)

This form is used by the Department of Health and Hospitals in its monitoring and review of a certified Application Center and its certified representatives. Inspection and monitoring shall be completed at a minimum of once every other year for all certified Application Centers.

Each section of this form is completed by DHH/BHSF or their designee. Identifying information and the certification portion of Section Three will be partially completed prior to the on-site review to reflect information currently on the AC database.

The DHH Monitor will contact the Application Center to schedule an on-site visit. The visit shall include entrance and exit conferences with the Administrator as well as a review of the AC's procedures, files, and records.

Key factors to be noted in the review process are:

Physical Plant Inspection

- ☐ Location of the AC in relation to accessibility by the applicant
- ☐ Location of interview area and accommodations for privacy
- ☐ ADA accommodations, and
- ☐ Posted times/days for Medicaid application interviews.

Files and Record-Keeping and Correct Use of Appropriate Forms

- ☐ Current copy of AC Contractual Agreement
- ☐ AC Handbook (facility copy or Internet access)
- ☐ Certification letters
- ☐ Confidentiality Responsibility Statements
- ☐ Previously completed Monitoring/Inspection Reports, and
- ☐ Monitoring Corrective Action Reports, if any.

Application Processing

- ☐ Professionalism
- ☐ Processing time and timely submittal to DHH Parish Office
- ☐ Sufficient supply of Medicaid Flyers, Applications, and Voter Registration Forms
- ☐ Explanation of benefits
- ☐ Explanation of rights and responsibilities, and
 - ☐ Confidentiality and security of application information/forms.

INSPECTION / MONITORING REPORT

(Page 2 of 2)

The Monitor will inspect the AC Representative personnel files to verify that names of AC Representatives in the AC database are current, as well as to determine that certification letters, and current, signed *Statements of Confidentiality* are on file.

NOTE: *The AC is required to report **changes** on the AC database information in writing to DHH/BHSF Regional Medicaid Office within ten (10) calendar-days from the date each change occurs.*

The Monitor shall also make a random, visual inspection of previously completed monitoring/inspection reports.

Following the review, the Monitor shall discuss all findings, including any need for corrective action, with the Administrator and advise him or her of any required changes. If a need for corrective action is established, the AC has **thirty (30) days** to complete the required changes. The form shall be signed by both the Monitor and the Administrator (or his or her designee) during the exit conference.

The original *Inspection/Monitoring Report* is forwarded to DHH, State Office within **ten (10) days** of the inspection. After review, a copy of the inspection/monitoring report and the appropriate cover letter are sent to the Application Center, the Parish Medicaid Office and the Regional Medicaid Office.

SHSF Form AC-5a
Revised: 2014

MEDICAID PROGRAM MONITORING CORRECTIVE ACTION RESULTS

Initial Inspection/Monitoring Date _____

30-Day Corrective Action Date _____

60-Day Corrective Action Date _____

APPLICATION CENTER NAME _____ AC ID# _____

AC STREET ADDRESS _____ P.O. BOX _____

CITY _____ STATE _____ ZIP _____ CITY _____ STATE _____ ZIP _____

AC PHONE NUMBER (_____) _____ AC FAX NUMBER (_____) _____

AC E-mail Address _____

Corrective Action Measure(s) Completed? ☐ Yes ☐ No

Corrective Action Measure(s) Not Completed? ☐ Yes ☐ No

EXPLANATION/COMMENTS: *(Attach an additional sheet for comments if necessary.)*

RECOMMENDATIONS: *(Attach an additional sheet for recommendations if necessary.)*

Signature of Regional Administrator

Date

MONITORING CORRECTIVE ACTION RESULTS

BHSF FORM AC-8a

This *Monitoring Corrective Action Results Form* is used by the Department of Health and Hospitals, Bureau of Health Services Financing in its follow-up of corrective action requirements resulting from the monitoring and review of a certified Application Center.

- This form is completed by the DHH/BHSF Regional Administrator following the **thirty (30)- or sixty (60)-day** period granted the AC to make the required adjustments or corrections.
- The Regional Administrator shall indicate in the space provided the initial inspection/monitoring date of the Application Center. A date for the **thirty (30) or sixty (60)-day** corrective action time period must also be entered on the form.
- Identifying information completed on this form about the Application Center shall correspond to the identifying information on the *INSPECTION MONITORING FORM, BHSF Form AC-8*.
- The Regional Administrator shall check the appropriate block to indicate whether or not the required corrective action measures were completed; provide a narrative explanation in the EXPLANATION/COMMENTS section; and, make **specific** recommendations for further action, if necessary (i.e., decertification, etc.) in the RECOMMENDATIONS section.
- The completed form shall also contain the Regional Administrator's signature and a date.
- The original report is forwarded to DHH/BHSF State Office, copies are sent to the Application Center and Parish Office, and a file copy is maintained in the Regional Office.

SECTION III: COMPLETING THE INTERVIEW AND APPLICATION

GENERAL INFORMATION

This section of the *Application Center Handbook* contains instructions to guide the Application Center Representative in completing both the online and paper application forms. For all applications, the representative must:

- Conduct the interview face to face with the applicant or the applicant's appropriate family/household member, responsible party, or authorized representative. Application Center Representatives are not permitted to conduct Medicaid interviews via telephone or by mail correspondence, or by asking the applicant to complete applications or forms, or by completing applications or forms without the presence of the applicant or other appropriate persons.
- Always identify the applicant and all persons present prior to beginning the interview. The applicant may have anyone whom they choose (including non-related persons) with them during the interview. Document applicant's agreement to presence and purpose of non-applicants on the [BHSF-Clearance Form](#).
- Provide adequate physical facilities to receive persons who come to or contact the office, including orderly surroundings and privacy for interviews.
- Receive courteously and promptly all persons who come to or contact the office.
- Allow any individual the right to apply for any kind of Medicaid benefit, regardless of circumstances.
- Determine as soon as possible if the person asking for help is seeking a type of assistance that Medicaid Offers. If not, then refer them to another community agency or resource designed to meet their needs, if one is available.
- Communicate in a clear and courteous manner information regarding the services offered by the facility.

The plan outlined below shall be used for communicating with applicants who have special needs:

- **Applicant with visual impairment:**
Explain the various services offered through the agency and answer any questions the applicant asks. Read forms to the applicant in their entirety and assist the applicant as needed.
- **Applicant with hearing impairment:**
Communicate in writing or secure a person proficient in sign language to translate. If no translator is available, then contact Medicaid Customer Service at (1-877-252-2447) for assistance.
- **Applicant with limited literacy:**
Relate services offered by the agency in clear and simple terms, and assure that the applicant understands, and assist the applicant as needed.
- **Applicant with limited English Proficiency:**
Secure the assistance of an interpreter capable of communicating in the applicant's language to related the services offered and assist the applicant in the application process. If no translator is available, contact Medicaid Customer Service at (1-877-252-2447) and request translator services. Translator services are available at no charge to applicants and Application Centers.

OBTAINING APPLICANT INFORMATION

Application information and discussions of the applicant's circumstances are considered official and confidential. The Application Center Representative must:

- Assist in obtaining the information from the:
 - Applicant,
 - Curator (if the applicant is interdicted),
 - Person living in the home of the applicant,
 - Person requesting assistance on behalf of a minor,
 - Individual designated as the applicant's authorized representative.
- Read the appropriate statements to the applicant from the paper/online application.
- Provide the applicant with information about the Medicaid Program.
- Ask all questions on the application, and record the applicant's answers to all questions.
- Explore and resolve with the applicant any information that is unclear or incomplete.
- Refer the applicant to other government assistance agencies based on the needs of the applicant.

WHO CAN COMPLETE AN APPLICATION FOR ASSISTANCE

The application may be completed by:

- The applicant,
- Any member of the household where the applicant lives
- A curator or other legal representative of an adult
- A spouse or other responsible person
- Any other person who is acting on behalf of the applicant
- Agencies to whom the court has awarded custody, or
- The Office of Community Services or Office of Youth Development for minors in state custody.

APPLICATION DATE AND INITIAL DATE OF CONTACT

The initial date of contact is the date that a certified Application Center is first contacted in person, by telephone, or by written request to initiate the application for assistance. The request may be made by:

- An applicant
- A family/household member of an applicant, or
- Any other representative of an applicant.

If the Application Center Representative is unable to complete the interview within five (5) working days from the date of initial contact, the Application Center must direct the applicant to the Medicaid Customer Service Unit at 1-877-252-2447 to complete the application.

If the applicant inquires about, or is interested in, services other than those provided by the application center, such as SNAP (formerly Food Stamps), or Social Security Benefits, then the Application Center Representative should appropriately direct the applicant to those agencies.

OFFICIAL APPLICATION FORMS

Applications may be completed in either paper or online formats. Application Centers should use the format that is most convenient while also assuring confidentiality of all applicant information.

- Applicants who do not have a credit history will not pass the ID Proofing requirements of the online application. Complete a paper application.
- If the applicant cannot provide a Social Security Number, or the applicant fails to correctly answer the Application ID Proofing questions for the online application, then a paper application must be completed.
 - If the applicant cannot provide a Social Security Number, then an explanation of why the applicant cannot provide a Social Security Number must be documented on the [BHSF Form Clearance](#).

THE APPLICATION FORM IS:

- the official Medicaid document used to collect information necessary to determine eligibility,
- the applicant's formal declaration of financial and other circumstances at the time of application,
- the applicant's certification that all information provided is true and correct,
- a document that may be used in formal court proceedings if necessary, and
- designed to be completed with information provided by the adult who is responsible for the children.
- All sections of the application must be completed.
- Select or list the applicant's preferred spoken and/or written language.
- Before the signature is received, read the required statements to each applicant.
- Offer the applicant a copy of their completed application.
- If verifications are requested of the applicant, then complete the [BHSF Form Verification](#). Make a copy of the completed [BHSF Form Verification](#) to send to Medicaid with the application and other documents after it is completed and signed by the applicant.
- The [Voter Registration Declaration Form \(NVRADF\)](#) must be completed each time the Application Center Representative offers the opportunity to register to vote.
- Appropriate flyers and brochures must be given to the applicant at the conclusion of the interview.
- All documentation received at the time of the interview must be sent daily to Medicaid.
- Application Centers and Application Center Representatives shall not keep copies of completed/signed applications (in any format).
- Application Centers and Application Center Representatives shall not keep copies of any forms completed by the applicant during the application process.

INTERVIEW SITES OR LOCATIONS

- Interviews with applicants must be conducted face-to-face.
- Assist the applicant at a site that is:
 - Adequate to preserve the confidentiality and privacy of information exchanged during the interview; no one else should be able to overhear, and
 - Convenient to both the applicant and the Application Center Representative.
- Interview sites may include:
 - Application Centers,
 - The applicant's home,
 - Hospitals,
 - Psychiatric facilities,
 - Additionally, certain institutions may apply for persons incarcerated/admitted to their facilities:
 - Correctional facilities for persons under their supervision (DOC),
 - Institutions for Mental Disease, for persons admitted to their facilities

APPLICANT EXPLANATIONS

During the interview with the applicant, certain explanations must be made using terms the applicant can understand:

Explain to each applicant:

- That there are penalties for giving false information, and that they must provide information that is true and correct, to the best of their knowledge
- That they must report all changes, (provide the Medicaid website: www.medicaid.dhh.la.gov and Medicaid phone number (1-888-342-6207) to report changes),
- That Medicaid does not discriminate, that Medicaid will keep all application and applicant information confidential, and that Medicaid delivers equal services to everyone
- That the applicant must report if or when they or a household member applying for or receiving Medicaid services is incarcerated in a detention center or jail,
- That applicants have the option of allowing Medicaid to independently obtain income data and tax return information for up to five years to determine ongoing Medicaid eligibility. Also inform the applicant that they may change this option at any time, and that Medicaid will notify enrollees of any proposed changes to eligibility,
- That their application information will be matched against information from: the Social Security Administration, Internal Revenue Service, Louisiana Department of Labor, Office of Employment and Security, Department of Homeland Security, and Consumer Reporting Agencies,
- That by accepting Medicaid, the enrolled individuals automatically give Medicaid rights to any third party money or payments from health insurance, legal settlements, or money from other third parties required to pay for the enrollee's health care costs,
- That by accepting Medicaid, the enrolled individuals give Medicaid the right to pursue medical support and payments from absent parents or spouses,
- That by accepting Medicaid, the enrolled individual understands that Medicaid may recover costs paid for certain Medicaid payments from the applicant's estate,
- That it is Medicaid's responsibility to determine eligibility for each individual, and that Medicaid will verify eligibility and document all decisions,
- That they have the right to appeal Medicaid's decision, and that Medicaid will conduct a fair hearing on all appeal requests,
- That they have the opportunity to register to vote or make changes to their voter registration as part of the Medicaid application process by completing the [Voter Registration Declaration Form \(NVRADF\)](#) and the [Louisiana Voter Registration Application \(LR-1 & 1M\)](#),
- That pregnant women, post-partum women (until six months after pregnancy ends), breast-feeding women (until the baby's first birthday), or families with infants children up to age five may be eligible for WIC benefits, and provide them with a [WIC brochure](#).
- That pregnant women may Sign up for Text4baby, a FREE mobile service that helps them prepare for motherhood. Text4baby sends tips and personalized information on prenatal care, baby's development, signs of labor, breastfeeding, nutrition and more. Text BABY (or BEBE) to 511411 to sign up.

INFORMATION SECURED DURING THE INTERVIEW

- Consider the applicant as the primary source of information. The applicant/responsible person must:
 - Appear for the Medicaid application interview,
 - Make an effort to obtain and provide documents and information necessary to determine eligibility,
 - Authorize Medicaid to obtain documents or information from third parties that they cannot provide by signing the appropriate situational form,
 - Answer all questions to the best of their knowledge, and
 - Report any changes to DHH that may affect eligibility.
- Inform the applicant, in writing using the [BHSF Form Verification](#), of the required verifications or documents that are necessary to determine their Medicaid eligibility.
- Provide the applicant with a properly addressed envelope to mail verifications or documents not available during the interview. Advise the applicant to send these items to Medicaid as soon as possible.

WITHDRAWALS

Applicants may voluntarily withdraw their application at any time during the interview or application process.

- Withdrawals should not be confused with a rejection by Medicaid. Medicaid rejects applications when no person on the application is eligible for any Medicaid program, or when eligibility cannot be established.
- Withdrawals are initiated by the applicant when the applicant decides not to continue the interview or eligibility process. A withdrawal must not be suggested or solicited by Application Center Representatives or staff.
- When an applicant chooses to withdraw their application, in any format, the [BHSF Form Clearance](#) must be completed to document the reason for withdrawal. The AC Representative must provide the applicant's name and identifying information on the [BHSF Form Clearance](#) form along with the applicant's statement regarding the reason for their withdrawal, in the applicant's own words, and request the applicant's signature. Forward all documents to Medicaid regardless of the applicant's withdrawal.
- If the applicant refuses to sign the statement of withdrawal, then document the refusal on the [BHSF Form Clearance](#) and submit all documents to Medicaid.

DEATH OF APPLICANT BEFORE APPLICATION

An application may be completed even if the applicant is deceased prior to requesting Medicaid assistance. If there is no one to act on behalf of a deceased applicant, complete the application with information received from any person who has information about the applicant's situation, **and** from documents on file at the Application Center. The Application Center Representative shall document on the application form that it is completed on behalf of a deceased individual, and **the Application Center Representative shall sign the application only as the person completing the form.**

APPLICATION FOR ASSISTANCE IN DISABILITY CATEGORIES

Questions on the application will provide information to determine if the applicant believes they are disabled. If the applicant, who is under age 65, replies "yes" to, "**Do you have a physical, emotional, or mental health condition that causes limitations in activities?**" on Step 2 of the paper application form, or replies "yes" on the first question on the "More About This Household" screen of the online application:

1.) Complete [Appendix D* \(Personal Assets\)](#) of the application,

AND for online/paper applications,

2.) Complete the appropriate Social Information Interview form:

[BHSF Form MS \(Social Information Interview for Adults\)](#), and [MS Supplement](#) if needed,
or

[BHSF Form MS/C \(Social Information Interview for Children\)](#), and

3.) Complete the appropriate number of [HIPAA Form 402P \(Authorization to Release or Obtain Health Information\)](#) to allow Medicaid to obtain medical files from the disabled individual's medical, and health care providers. Complete one HIPAA Form 402P for each medical provider that the applicant names.

4.) Complete a [HIPAA Form 202L \(Authorization to Release Health Information\)](#) to expedite the medical records collection process any time HIPAA Form 402P is submitted.

- **NOTE:** For online applications, copy Appendix D from a paper application and forward the completed Appendix D to Medicaid with all other documentation.

ACCEPTABLE APPLICATION FORMS

- Medicaid will accept the application form as official if it contains the applicant's name and address, and it is properly signed. The applicant, authorized representative, or responsible person must sign the application form unless they have a developmental disability. This signature requirement applies, even with authorized representation. Additionally, the applicant shall not have the right to remove themselves from the application and eligibility process by appointing an authorized representative.
- If the applicant is unable to provide information to complete and sign the application, then document the [BHSF Form Clearance](#) with the reason why, and allow any of the following to act on behalf of the applicant:
 - For an Adult:
 - Spouse,
 - Responsible person,
 - Curator or other legal representative,
 - Any other person who is acting on behalf of the applicant.

NOTE: If the applicant has a legal curator, then the curator shall complete and sign the application.
 - For a Child:
 - Parent,
 - Qualified relative,
 - Legal guardian,
 - Any responsible adult with whom the child lives may complete the application for the child.

This information will be completed in Step 1 of the paper application form.

Note: If the applicant is unable to complete the application form and there is no one to act on behalf of the applicant, the AC Representative shall sign the paper application as the person helping to complete the form. Document the reason on the [BHSF Clearance Form](#) the reason why the applicant could not complete/sign the application form.

AUTHORIZED REPRESENTATION

- An applicant may designate one or more individuals to act on their behalf with respect to a specific Medicaid application. This information should be listed on Appendix C of the BHSF Form 1-A application, and
- Complete the [BHSF Form AR](#) (Consent for Authorized Representation) to document the name(s) and contact information for the applicant's chosen representative(s). The consent for authorized representation automatically expires on the date that Medicaid completes a decision on the application submitted.
- The authorized representative shall be a person with knowledge of the applicant's situation. If the authorized representative does not know certain information or details, then that information may be solicited directly from the applicant. The authorized representative may be present for all contacts with the applicant if the applicant chooses.
- In no way shall the authorized representative act to either fail to obtain or to withhold pertinent information related to eligibility or payment information.
- If an applicant is currently in a coma or is deceased prior to beginning the application process, then the [BHSF Form AR](#) (Consent for Authorized Representation) is not required.
 - Document the reason that the applicant is unable to participate in the application process on the [BHSF Clearance Form](#).
 - Note: Entities, including Medicaid providers and Application Centers are prohibited from acting as an applicant's authorized representative. Individuals employed by such entities may act as an authorized representative with the applicant's signed consent.
- A properly signed paper application will contain one or more of the following signatures:
 - The signature of the applicant, responsible person, or authorized representative,
 - The signature of the MUM/PUM and the MUM/PUM's parent or legal guardian if they reside with the MUM/PUM, or
 - The signature of the parents of the child who resides in the home.
- The applicant will sign on page 11 (Step 5), of the BHSF Form 1-A application form, or page 5 of the BHSF Form 1-MB application form. The name of the Application Center, the name of the AC Representative who completes the paper application, and the Application Center ID number must be recorded on the form. For the General Application (BHSF Form 1-A), Application Center/Representative identification space is provided in Appendix C, in the section titled, "For certified Medicaid Application Centers only". For the Medicare Savings Program (BHSF Form 1-MB) Application Center/Representative identification space is provided on page 5.

PAPER APPLICATIONS

There are two paper application forms available:

BHSF Form 1-A (described and discussed in this section) is a general application form that can be used for any program except Long Term Care, and

BHSF Form 1-MB is a simplified application form that may be used when the applicant has Medicare Part A and wishes to apply for assistance with Medicare costs only.

- Paper applications and forms must be completed using permanent, black ink.
- Complete all fields of the paper application form with information provided by the applicant, or their representative.

Step 1 “Tell u about yourself” asks for information to identify the applicant in the household, and should list:

- An adult or adult caregiver for a child only application
- The Pregnant Woman

Step 2 “Tell us about your family” provides information to clarify who else may be included on the same application, if they live in the same home as the applicant. This section also lists who does not have to be included.

- Step 2: Person 1 “Start with yourself” asks for more information about the applicant from Step 1.
 - This step will ask for identifying information for each person, including the applicant, and:
 - Tax filing status, including students, and deductions
 - Pregnancy questions
 - Health Insurance coverage questions
 - Disability status
 - Other questions to determine if the person might meet special programs criteria
 - Citizenship and immigration status
 - Employment, Self-Employment and Income questions
 - Unearned Income questions
- There are additional pages and fields for up to four persons on the same paper application. These pages are all in the same format as listed above. Complete these pages as needed. They are all part of Step 2 on the paper application form.

Step 3 documents American Indian or Alaskan Native family members

Step 4 documents public/private health insurance coverage for family members

Step 5 is the signature portion of the application, and includes statements that must be read to the applicant before they sign the application. **Note: there are two pages of statements and these questions must be completed:**

- “Is anyone applying for coverage on this application incarcerated (detained or jailed)?”, and
- Complete the “Renewal of coverage in future years” section. This option allows Medicaid to automatically collect income information to determine ongoing Medicaid eligibility for up to five years without further applicant efforts, when possible.
- Complete “Does any child on this application have a parent living outside the home?”.

Paper Application Form Appendices

The BHSF Form 1-A has four optional appendices as listed below:

Appendix A asks for Health Coverage from Jobs. Complete this section if the applicant or someone in the same household has health insurance coverage available from a job. Complete one Appendix A for each job that offers coverage.

Appendix B asks for more information about American Indian or Alaskan native family members. There is space for up to two family members on this page. Make additional copies and complete as needed.

Appendix C asks for information about the household's Authorized Representative. If the applicant wishes to designate an Authorized Representative (as described previously), then complete items 1-9 of Appendix C, as appropriate. The applicant will sign on line 10, and complete the date on line 11 of Appendix C to document their designation of an Authorized Representative.

Appendix C also provides space for the Application Center Representative to document:

- *The application date*
- *AC Representative's Name*
- *Application Center Name*
- *Application Center ID Number*

Appendix D asks for information about the household's Personal Assets. Complete this section when the applicant is an adult who claims to be disabled, or is over sixty-five years of age, or is a resident of a medical/nursing facility.

Appendix E allows the applicant to select a Bayou Health Plan. If the applicant has questions about the plans, refer them to the website or phone number printed on Appendix E for more information.

ONLINE APPLICATIONS:

The website for the online application is: <https://ola.dhh.la.gov/Account/Login?type=trusted>

The name of the Application Center, the name of the AC Representative who completes the online application, and the Application Center ID number will be input by the system based on Certified Application Center Representative log-in.

Many screens of the application collect more than one piece of application information, and these screens may require that the information is saved on the screen in stages. Click the green “Save” button after typing or selecting appropriate information or responses in each field of the screen. When all information for a screen has been completed, then click the green “Next” button. Representatives will also have the option of clicking “Previous” to return to completed screens if they must change information.

To begin a new application, click the green “Start New Application” button on the home screen of the online application.

Always select “In Person” for Application Medium Type, and click “Save”.

A representation of the **Privacy & Use of Your Information** statement screen from the online application is shown below.

Each application will be designated with a unique “Application ID” number.

Application # 863352

START YOUR APPLICATION

1 Privacy Policy

2 Contact Information

3 Who Needs Coverage

APPLICANT DETAILS

HOUSEHOLD DETAILS

CURRENT/MONTHLY INCOME

ADDITIONAL QUESTIONS

MEDICAID & LACHIP QUESTIONS

REVIEW & SIGN

Privacy & Use of Your Information

We'll keep your information private as required by law. Your answers on this form will only be used to determine eligibility for health coverage or help paying for coverage. We'll check your answers using the information in our electronic databases and the databases of other state and federal agencies. If the information doesn't match, we may ask you to send us proof.

We won't ask any questions about your medical history. Household members who don't want coverage won't be asked questions about citizenship or immigration status.

IMPORTANT: As part of the application process, we may need to retrieve your 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 check your eligibility for coverage and help paying for coverage if you want it, and to give you the best service possible. We may also check your information at a later time to make sure it is up to date. We'll notify you if we find something has changed.

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

☐ I agree to have my information retrieved from data sources and used for this application. I have consent for all people I'll list on the application for their information to be retrieved and used from the data sources.

Next

Six major sections:

Applicant Details

Household Details

Current/Monthly Income

Additional Questions

Medicaid & LaCHIP Questions

Review & Sign

Read the Privacy statement to the applicant, advise the applicant that their information, and information for all persons listed on the application will be verified from data sources, and document that they agree to this process by checking the box on the Privacy Statement, then click the “Next” button.

The **Start Your Application** screen does not require any user input, simply read the information to the applicant, and click the “Next” button to move forward in the application.

The **Contact Information** screen is similar to Step 1 of the paper application form, and should be completed with information provided by the adult household member. Once the Name, Date of Birth, Optional Social Security Number (SSN), and Home Address fields are completed, click the button to indicate if the home and mailing address are the same. A Parish field will pop up, and this field must also be completed by selecting the appropriate parish from the drop-down list. If the applicant gives differing home and mailing addresses, then this can also be added to the application after clicking “No” to the home/ mailing address question. Click “Next”.

The **Contact Phone and Contact Preferences** should be completed with the applicant’s preferred and secondary phone numbers and phone type information. If the applicant prefers to communicate in a language other than English, then change the preferences in **Contact Preferences** by selecting the appropriate spoken and written languages in the drop-down boxes. Click “Next”.

The **Authorized Representative** option should be offered to the applicant. Document the applicant’s choice by marking yes or no in the radio buttons. **NOTE:** if the applicant chooses to have an Authorized Representative when completing an online application, then the Authorized Representative will be prompted to create a Medicaid/LaCHIP Online Services Account. If the Authorized Representative does not already have an online account with Medicaid at the time of application, then complete the Email Address and Confirmation fields with the AR’s email address, to proceed without creating an account for the Authorized Representative.

DO NOT MARK THE “Is this person part of an organization helping you apply for coverage?” field as “Yes”.

Click “Save and Continue”.

If the applicant has someone other than an Authorized Representative helping them, then mark the “Yes” radio button on the **Assistance with completing the application** screen. That person may be a: Navigator, Certified Application Counselor, In-Person Assistance Personnel, Agent or Broker, or (other) None of these. This screen is not required when Application Center Representatives complete applications.

For applicants who are known to Medicaid, the **Application ID Proofing Questions** screen will not appear. For applicants unknown to Medicaid, these optional questions may be completed to continue with the online application process. There are three questions that the applicant should be able to correctly answer. If the applicant does not correctly answer these questions the applicant may:

Contact the data providers (Experian) to verify their identity. The AC Representative should provide the reference number and the Experian Help Desk number to the applicant. If the applicant correctly verifies their identity, then they may resume the application by providing their Application ID number.

If the applicant cannot verify their identity, then the Application Center Representative may continue the online application process, and the Application Center Representative must advise the applicant that Medicaid may require additional information to confirm the applicant's identity. Click "**Continue**" to move to the next section.

The **Who needs health coverage** screen asks for information about the persons who will be listed on the application. There are three options to select from: Applicant only, Applicant and other family members, or Other family members, but NOT the applicant. Click "Next".

The **Tell us how many people are applying for health coverage** screen will ask for more information about the persons designated on the previous screen. The applicant's previously input information will appear at the top of the screen with "self" listed in the "Relationship" column. For each additional person, type the full name, select a suffix if appropriate, and type their date of birth. Click the "Add" button; a "Relationship" box will appear, select the appropriate relationship (of the newly added individual to the person listed as "Self" and other persons) description from the drop-down box. Note that persons may be deleted by clicking the "Delete" button on the appropriate line. Continue adding all household members. Click "Next". A "**Save Confirmation**" message will appear along with: "You cannot change coverage info for this application once you leave this section". Click "Save & Continue".

NOTE: users will have the opportunity to review and edit sections of the application before the signature is input.

The **Tell us about each Person** screen asks for confirmation of Sex, Social Security Numbers, Date of Birth, and name. Select the appropriate choices. Click "Next". The next part of this screen asks for citizenship status. Confirm whether the person is a: U.S. Citizen, U. S. National, Naturalized, or Derived Citizen by selecting the appropriate radio buttons, and then click "Save & Continue". This screen will appear for each person previously added to the application. Additional information may be required.

The **Family & Household** screen is used to collect information regarding the tax filing status, marital status, number of dependents claimed/if applicant is claimed by a tax filer for each member of the household already listed. Select the appropriate radio buttons. Click "Next". Each individual's information will be confirmed, click "Save & Continue". Non-filing questions may also appear; select the appropriate radio buttons. Click "Next".

The **Ethnicity & Race** questions are optional information. If applicants do not wish to provide this information, then click “Save & Continue”. This screen will appear for each previously listed person.

The **More about this household** screen collects information needed to determine which types of programs the applicant may be eligible for. Mark the appropriate boxes for each person shown. Click “Save & Continue”.

Complete the **Current/Monthly Income** screen based on the applicant’s statements. Ask about income for the thirty days prior to the application date. First, select the “Yes/No” button as appropriate, then select the type of income from the drop down box and click “Add income”.

Depending on the type of income selected from the drop-down list, additional information fields will appear. Complete all appropriate information for the income, including frequency of income. If an individual has multiple sources of income, then complete additional fields on the same screen as appropriate. Click “Next”. This section asks about deductions to income that the person claims on their taxes. If “Yes” is selected, then select the appropriate income deduction type box. Click “Next”. A “*Calculated Monthly Income*” summary will appear. Verify that the monthly amount is correct, and click “Next”. An Annual Summary of income will appear; verify that this is what the applicant expects to receive in the next twelve months, and click “Yes”. If the applicant expects their income to vary throughout the year, then select “No”. If “No” is selected, then ask the applicant what they expect to receive in the next twelve months and enter that information into the “Amount \$” field. If the applicant is not sure of their future income, then select the “I don’t know the total” box and click “Next”. *Calculated Yearly Income* will be shown; click “Save & Continue”. This process will repeat for each person who was previously listed as an applicant.

ADDITIONAL QUESTIONS

The **Employer Coverage Tool** screen collects information about Employer Sponsored Health Insurance (ESI) for each person previously listed as an applicant. Select the appropriate radio buttons; if “Yes” is selected, then additional information such as: date of coverage start, details of employer offering ESI, which person listed on the application works at that employer, and who is enrolled in the coverage must be input. Click “Next”.

The **Insurance Specific Question** screen gathers information for individuals who already have health insurance coverage. Select the appropriate radio button. If “Yes” is selected, then also select the correct program from the list provided and complete additional information as appropriate. Click “Save & Continue”.

The **Medicaid Questions** screen allows applicants to ask for retroactive Medicaid coverage for up to three months prior to the application date. Select the appropriate radio button and then click “Save & Continue”.

The **LaCHIP Questions** screen explores Louisiana state employee health insurance access. Select the appropriate radio button, then click “Save & Continue”.

The **Bayou Health** plan options are listed on this screen. The applicant may choose their Bayou Health provider by selecting the appropriate name on this screen. If a provider is not selected on the application, one will be assigned by Medicaid. For more information about Bayou Health providers, click the Bayou Health link on the screen.

The **Application Summary** screen provides a summary of all information that was previously input. Verify that this information is correct before proceeding. If any information should be corrected, then click the “Edit” button in the appropriate section. This will return the application to the appropriate screen for corrections. Once all information is corrected, then click “Next”, review all additional screens, and make corrections as needed until returned to the summary screen.

Important: offer the applicant a copy of their application. If the applicant wishes to have a copy of their application use the “Download” link at the top right of the Application Summary screen.

If all application information is correct, then click “Continue”.

The **Sign and Submit** screen contains statements that must be read to the applicant. Select the appropriate radio buttons as each statement is read to the applicant. Some selections will require additional input.

NOTE: the applicant may choose to have their income information sent to Medicaid for up to five years. Medicaid will only use this information to determine ongoing Medicaid eligibility. Medicaid will keep this and all information confidential.

Assure that the applicant understands that the online application will be signed when the Application Center Representative clicks the green “Sign & Submit” button.

The **Confirmation** screen will appear next with the Application ID number displayed; the message “Name, (DOB)’s application has been successfully submitted.” The link to “Go to Voter Registration Page” is also displayed.

NATIONAL VOTER REGISTRATION ACT

The National Voter Registration Act of 1993 (NVRA) is a federal statute that contains provisions that make it easier for individuals to register to vote in elections for federal office. To comply with the federal mandate, the Louisiana Legislature adopted Act 10 of the Third Extraordinary Session of 1994. Since states combine elections for federal and state offices, Louisiana opted to adopt a law that changed procedures for both federal and state offices maintaining a single voter registration.

- Under NVRA, States must designate as voter registration agencies, among others, all offices that provide “public assistance.” Effective July 1, 1997, Medicaid Application Centers have been included in the definition of “public assistance” agencies.
- The main intent of the NVRA is to encourage voter registration by providing new and innovative ways to register to vote. The NVRA mandates three intake programs:
 - Mail registration
 - Motor Voter registration, and
 - Agency based registration
- These programs will produce applications for new registrations and changes to existing registration records.

As required by the National Voter Registration Act (NVRA), the Application Center Representative must:

- Offer the opportunity to register to vote each time an applicant applies for services or assistance.
- Assist the applicant in completing the [Mail Voter Registration Application \(LR-1 & M\)](#), unless the applicant does not want to register.
- Ask the applicant if they want to make any changes to their previous registration.
- Provide the same degree of assistance to complete the Voter Registration Application as their agency provides in completing its own forms.

Note: an Authorized Representative or responsible party shall not be allowed to sign the voter registration application on behalf of another person. The Voter Registration Application form requires the original signature or mark of the person who wishes to register.

- **IMPORTANT:** After completion of the [Voter Registration Application \(LR-1 & M\)](#), the Application Center Representative shall complete the following information on the reverse side of the form in the box designated as “Official Use Only”:
 - The AC Representative must sign their name on the line marked “Received By”, and
 - Circle “PA” above the “Received By” line.

WHERE TO SEND THE FORMS

The AC Representative must send the completed **original** Voter Registration Application to the Office of the Registrar of Voters in the parish where the applicant resides. The addresses for each parish office are listed on the back of the Voter Registration Application. These forms should be mailed on a daily basis.

A **copy** of the completed Voter Registration Application must be forwarded to Medicaid along with other application materials.

Note: If an applicant requests a “Voter Registration Application” for someone else, the AC Representative shall provide the applicant with a registration form to take with them. The AC Representative will not be required to assist or mail the completed “Voter Registration Application” for anyone other than the Medicaid applicant.

If the applicant has questions about residence, election dates, or polling locations, then refer the applicant to the Registrar of Voters located in their home parish or provide them the toll free telephone number 1-800-883-2805, or provide them with the Registrar of Voters website: www.Geauxvote.com

Each and every time an AC Representative offers an applicant the opportunity to register to vote, the AC Representative must document that they offered the opportunity to register to vote by completing the [Voter Registration Declaration \(NVRADF\)](#). **The completed NVRADF shall be attached to the other documents received during the interview and forwarded daily to Medicaid along with a copy of the completed Voter Registration Application.**

Conversations with the applicant must be handled with sensitivity. When an AC Representative offers the opportunity to register to vote, the agency representative must not:

- Try to influence the applicant’s political preference or party affiliation,
- Display any political preference or party allegiance,
- Make any statement to an applicant or take any action that would discourage that person from registering to vote, or
- Make any statement or take any action that would lead the person to believe that a decision to register to vote or not to register to vote would have any bearing on the availability of services or benefits from the agency.

DECLINATIONS

When offered an opportunity to register to vote, an applicant may decline.

The [Voter Registration Declaration \(NVRADF\)](#) shall be completed every time an applicant is offered the opportunity to register to vote.

- The [Voter Registration Declaration \(NVRADF\)](#) is used to determine:
 - If the Medicaid applicant wants to register to vote, and
 - If the Medicaid applicant who wants to register requires any assistance with voter registration.
 - If the applicant does not want to register and refuses to sign the [Voter Registration Declaration \(NVRADF\)](#), they are considered to have declined to register to vote.
 - Forward the completed [Voter Registration Declaration \(NVRADF\)](#) and copies of any completed Voter Registration forms to the Medicaid office on a daily basis.
- Both the [Voter Registration Declaration \(NVRADF\)](#) and the Voter Registration Application are attached to the paper application forms 1-A and 1-MB.
- Both the [Voter Registration Declaration \(NVRADF\)](#) and the Voter Registration Application are linked to the online application.

DHH REVIEW OF APPLICATIONS

Medicaid will review all applications from Application Centers using the criteria shown below.

APPROVED FOR REIMBURSEMENT TO THE APPLICATION CENTER

Required Forms

- **Online Application or Paper Application form completed**
- **Voter Registration Declaration (NVRADF)**
- **Verification Form**
- **RightFAX Cover and Transmittal Log**

Application Form Completeness

- Signature by applicant, the applicant's responsible party, applicant's authorized representative in either application format
- Social Security Numbers must be provided, or provide an explanation of the reason that Social Security Numbers cannot be provided
- All items properly completed with the applicant's responses to each question
- Right and Responsibilities page given to the applicant
- Required verification needed for Medicaid to determine eligibility transmitted to Medicaid the same day that the application is completed and signed by the applicant
- Situational forms completed and signed by the applicant and forwarded to Medicaid the same day that the application is completed and signed by the applicant

NOT APPROVED FOR REIMBURSEMENT

- If the required interview attachments are not received timely, the Application Center will be notified by DHH with a warning statement of possible decertification and denial of reimbursement for application activity
- Applications received after the established time frame shall be processed and completed by Medicaid
- Application Centers will be denied reimbursement for the following reasons:
 - Exceeds timeframe for request to interview
 - Required Situational Forms not completed
 - Required Verification not provided by applicant and not requested on the BHSF Form Verification by the Application Center Representative
 - Required Verifications on hand at the time of the interview not forwarded to Medicaid the same day as the interview was completed
 - All fields on the paper application are not completed
 - Inappropriate application (Medicaid already has an application for this person/household that is less than 90 days old)
 - Duplicate applications completed online for same person/household
 - Inappropriate application (applicant already has Medicaid)

Note: DHH will monitor Application Centers for trends developing from an AC on submission of applications that are denied reimbursement. Continuous failure to submit complete and timely applications and forms may result in the decertification of Application Center Representatives and/or Application Centers.

SECTION IV: VERIFICATION/DOCUMENTATION FACTORS

ELIGIBILITY DECISION OVERVIEW

Each Medicaid Program is based on a combination of requirements that are used to determine eligibility for an individual. Factual information concerning the applicant's household and financial circumstances is collected through the completion of the Medicaid eligibility determination process.

- The Medicaid Analyst reviews the application to verify that the applicant meets a categorical requirement such as age, childhood, or pregnancy, etc.
- The analyst then compares the applicant's income (and sometimes resources) to eligibility standards.
- The applicant must meet all eligibility factors to be certified for any Medicaid program.

Eligibility is established by verification and documentation provided by the applicant, the applicant's representatives, or third parties. The Application Center Representative is responsible for requesting and/or securing certain essential information and/or documents during the interview. This will assist the Medicaid Analyst in determining the applicant's eligibility.

VERIFICATION

INCOME VERIFICATION

Income is money received as earnings, unearned money, and money received from self-employment. Explore and list on the application income for the last thirty days prior to the application date for each applicant and their household.

Medicaid only requires documentation of income if the income is from self-employment. Medicaid will accept these two types of self-employment documentation:

- Copy of the most recent tax return with schedule C attached, or
- Completed [BHSF Form Wages](#) if a tax return has not been filed for a self-employed person, or persons who work at incidental jobs.

PRIVATE (THIRD-PARTY) HEALTH INSURANCE

Always obtain copies of applicants' health insurance cards; copy both sides of health insurance cards, and forward these copies to Medicaid.

RESOURCES VERIFICATION

Resources are cash, assets, or possessions that can be converted to cash.

IMPORTANT: Resource information is only required when the applicant or household member is claiming a disability or is aged 65 or older.

Types of Resources are listed on the application forms:

- Vehicles (cars, boats, trucks, motorcycles, campers)
- Life or burial insurance policies
- Bank accounts (checking, saving, credit union)
- Stocks, bonds, Certificates of Deposit
- Trust funds
- IRA/Keogh accounts
- Safe deposit box contents, or
- Real estate

Documentation of resources must be provided or requested and may include:

- Statements from financial institutions
- Savings certificates
- [BHSF Form Resources](#) to verify bank accounts
- Stock certificates
- Legal documents including deeds, titles, and promissory notes
- Insurance policies
- BHSF Form INS-LR [Request for Life Insurance Policy Information](#) to verify the cash value of life insurance policies
- Tax records, or
- Property records

The applicant is the primary source of information and is responsible for accurate and complete reporting of their situation.

SECTION V: SITUATIONAL FORMS AND INSTRUCTIONS

All situational forms can be found online at: <http://new.dhh.louisiana.gov/index.cfm/page/1274>

All forms in this section are immediately followed by instruction pages. The instruction pages describe when or why to use a particular form, how to complete required fields, and provide instruction on disposition of completed originals and copies of these forms. The forms are listed here in alphabetical order.

NOTE: Completed applications and forms may be mailed to:

**Medicaid Application Office
P. O. Box 91283
Baton Rouge, LA 70821-9893**

OR

FAXED to: Medicaid Customer Service Unit: (877) 523-2987

BHSP Form AR
Rev. 11/03
II

MEDICAID PROGRAM Consent for Authorized Representation

Name of Applicant/Recipient

SSN

Case ID Number

I understand that all information gathered on my situation and those persons for whom I am legally responsible is personal and confidential. My decision to appoint an Authorized Representative is optional, made freely and does not relieve me of my responsibility to actively participate in the Medicaid eligibility process. I understand that the function of the Authorized Representative is to accompany, assist, and represent me in the eligibility determination process, and to aid in obtaining financial, medical and/or other documentation necessary for the agency's determination of my initial or continuing eligibility for Medicaid.

I understand that this authorization is limited to the individual(s) named below; is valid only for my Medicaid application or renewal form dated _____; and will automatically terminate on the date of the agency's decision regarding my initial or continuing eligibility. I also understand that I may cancel my appointment of the individual(s) named below as my Authorized Representative at any time prior to the automatic expiration.

I understand that while some of the information gathered may have no impact on my Medicaid eligibility, it may affect my liability to a third party should this information be disclosed to the third party by my Authorized Representative. I hereby hold the Department of Health and Hospitals harmless for any claim resulting from disclosure of information to a third party by my Authorized Representative.

I understand that if this authorization is not signed in the presence of agency staff or a program representative, a confirmation of authenticity may be conducted by agency staff.

Name of Authorized Representative

() _____
Phone

Name of Authorized Representative

() _____
Phone

Signature of Applicant/Recipient

Date

If Signed by an "X"

Signature of Witness

Date

<p align="center">For Agency Use ONLY</p>	
<p>On _____ (MM/DD/YY), the applicant or recipient was contacted to verify the authorization provided on the reverse side of this form.</p>	
<p>The authorization <input type="checkbox"/> is <input type="checkbox"/> is not valid.</p>	
<p>_____</p> <p>Date</p>	<p>_____</p> <p>Agency Representative</p>

CONSENT FOR AUTHORIZED REPRESENTATIVE BHSF Form AR

Purpose:

BHSF Form AR is used to obtain the applicant's signed consent for authorizations that involve the financial interests of third party representatives such as: individuals employed by Medicaid Providers, LTC facilities, Medicaid Application Centers, law firms, insurance companies, and estate planners, etc. to act on his or her behalf.

This form is not required if the authorized representative of the applicant is the applicant's parent, spouse, curator, legal guardian, or responsible person (a responsible person is a person trusted or depended upon to assist in the care and management of the person or property of a person who has not been declared incompetent to manage his or her own affairs).

Preparation:

Prepare this form as an original and photocopy it for the applicant upon completion, or use the fillable form available on the "BHSF Forms" This form is available online at <http://new.dhh.louisiana.gov/index.cfm/page/1274>.

Enter the applicant's name and Social Security number. Do not enter a case identification number.

Enter the specific date the application is signed in the blank of the second paragraph.

Complete the name(s) and phone number(s) of the person(s) authorized to act on the applicant's behalf, or have the applicant do so.

NOTE: *If the applicant chooses to name more than two individuals to provide authorized representation, complete multiple forms.*

Obtain the applicant's signature and date, and signature and date from a witness, if required.

NOTE: *ONLY the signature of the applicant or his or her parent, legally authorized guardian, or curator is acceptable. In NO case may an Application Center Representative complete the signature of the form. DO NOT complete the shaded section of the form titled: "For Agency Use Only;" (refer to Page 2 of BHSF Form AR).*

Disposition:

Forward the completed original BHSF Form AR (pages 1 and 2) to Medicaid daily. A copy of page 1 shall be given to the applicant.

Self Clearance
Rev 06/2015
Prior Issue Obsolete

Medicaid Program

Additional Statements and Notes

Applicant/ Enrollee Name

SSN

Statements and notes made below are for use by the Medicaid Program:

Medicaid/AC Representative

Date

APPLICATION CLEARANCE FORM

BHSF CLEARANCE

Purpose:

BHSF Clearance form is used by the Application Center Representative whenever it is determined that a documentary / explanatory statement is needed at initial application.

Preparation:

This form is completed as an original, or use the fillable form available at:
<http://new.dhh.louisiana.gov/index.cfm/page/1274>

Complete all identifying information except the Case ID number.

Photocopies are made as needed if the applicant requests a copy. The AC Representative shall complete, sign, and date the form.

Disposition:

Forward the completed original **BHSF Clearance** form to Medicaid **daily**.

BHSP Form DHS-LR
Rev. 07/03
IV
Prior Issue 1/04/04

MEDICAID PROGRAM
Request for Life Insurance Policy Information

Name of Insurance Co.	Name of Insured	
Address	Address	
City, State, Zip Code	City, State, Zip Code	
	Case I.D. #	SS #

In order to determine Medicaid eligibility for the person named above, the following information on his or her life insurance with your company is needed. The information shown has been provided by our client. Please provide the missing data; revise the information shown, if incorrect; and submit your reply to our address below. Our applicant/recipient's signed consent for disclosure of this information follows. We appreciate your assistance.

Agency Representative	Parish Bureau of Health Services Financing
Address	City, State, Zip Code

Applicant/Recipient and Spouse Authorization

I understand that any information obtained will be kept confidential and that: 1) this authorization is valid for only three months from the date of my signature; 2) I have the right to revoke this authorization at any time before the information is released; 3) the specific information requested is outlined below; 4) I have the right to obtain a copy of the record of information released; and 5) this authorization is not required as a condition of doing business with the _____ (Name of Insurance Company). You are hereby authorized to provide Louisiana's Medicaid Program with the information requested below.

Applicant's/Recipient's Signature	Spouse's Signature
Date	Date
Witness	Witness

Insurance Company Response

Name of Agent				District			
Policy #	Issue Date	Plan of Insurance	Face Value	CSV Minus Encumbrances	Dividends	Owner	Is policy Irrevocable?
							<input type="checkbox"/> Yes <input type="checkbox"/> No Effective:
							<input type="checkbox"/> Yes <input type="checkbox"/> No Effective:
							<input type="checkbox"/> Yes <input type="checkbox"/> No Effective:
Signature & Phone # of Insurance Co. Representative						Date	<input type="checkbox"/> Yes <input type="checkbox"/> No Effective:

REQUEST FOR LIFE INSURANCE POLICY INFORMATION BHSF FORM INS-LR

Purpose:

This form is used to request information from an insurance company regarding life insurance policy(ies) when such information may be needed to determine eligibility.

Preparation:

BHSF Form INS-LR is completed as an original, or use the fillable form available <http://new.dhh.louisiana.gov/index.cfm/page/1274>

Complete each field as follows:

- Enter the name and address of the insurance company and the applicant's or enrollee's name as it appears on the insurance policy. Enter his or her address, and Social Security Number in the spaces provided.
- **Do Not** sign the form as the **Agency Representative** and **Do Not** enter the name or the mailing address of the Parish Office.
- Enter the name of the insurance company in the space provided and obtain the signature(s) and signature date(s) of the applicant/enrollee and his or her spouse, if any. Obtain the signatures of two witnesses if required by policy.
- Complete all information available from the client's policy or other available records. At a minimum, enter the policy number and date of issue for each policy for which information is being requested.

Disposition:

Forward the completed original Form **INS-LR** to Medicaid **daily**.



Louisiana Department of Health and Hospitals
Authorization to Release Health Information
 (including paper, oral and electronic information)



Name:		Social Security #:	
Mailing Address:		Date of Birth:	
City/State/Zip code:		Telephone #:	
I authorize any provider that has treated me or is presently treating me to release requested Protected Health Information (PHI) to:			
Agency Name:		Louisiana Department of Health & Hospitals - Medicaid	
Mailing Address:		P O Box 91278	
City/ State/ Zip code :		Baton Rouge, LA 70821-9893	
<p>As the purpose of this authorization is to establish Medicaid eligibility, I authorize the release of all of the following protected health information: Medical History, Examination, Reports, Surgical Reports, Treatment or Tests, Prescriptions, Immunizations, Hospital Records including Reports, Laboratory Reports, X-ray Reports, DD Records, Discharge summaries</p> <p>In compliance with state and/or federal laws which require special permission to release otherwise privileged information, please release any of the following records that are applicable: Alcoholism, Drug Abuse, Mental Health, Vocational Rehabilitation, HIV (AIDS), Sexually Transmitted Diseases, Genetics, Psychotherapy Notes</p> <p>I do not authorize the release of the following types of my health information: (If none, leave blank)</p>			
Please provide medical records for the time period of _____ through _____.			
This authorization to release medical information shall expire on: _____ (date)			
I understand that if I do not specify an expiration date, this authorization will expire six (6) months from the date on which it was signed. I acknowledge that I have read both pages 1 and 2 of this form. I authorize a copy (including electronic or faxed copy) of this form for the disclosure of the information described above.			
Signature of individual or personal representative authorized by law		Date	
FOR OFFICE USE ONLY:			
Agency Representative:		Date:	
Telephone:	Fax:	Email:	

Important Information about Authorization

Medicaid may need your authorization to obtain your health information to determine your eligibility.

You do not have to sign this form. If you agree to sign this authorization to release information, you will be given a signed copy of the form.

A separate signed authorization form is required for the use and disclosure of Psychotherapy notes as defined by the HIPAA Privacy Rule.

When required by law or policy, Medicaid may only obtain your health information if the required written authorization includes all the required elements of a valid authorization.

An authorization is voluntary. You will not be required to sign an authorization as a condition of receiving treatment services or payment for health care services. If your authorization is required by law or policy, Medicaid will use and disclose your health information as you have authorized on the signed authorization form.

You may cancel an authorization in writing at any time but the cancellation will not affect any uses or disclosures already made before an authorization was cancelled.

Information disclosed by this authorization may be re-disclosed by Medicaid in accordance with applicable law.

Authorization to Release Health Information

HIPAA Form 202L

PURPOSE: This form is used to expedite the collection of medical records when they are needed by Medicaid to decide if the applicant/enrollee meets the factor of disability. The HIPAA Form 202L should always be completed when any HIPAA Form 402P is completed.

PREPARATION:

HIPAA Form 202L is completed as an original, or use the fillable form available in the AC Library at this link: <http://new.dhh.louisiana.gov/index.cfm/page/1274>

Complete the name, address, Social Security Number, Date of Birth, and Telephone number for the person whose records are needed.

Specific medical records may be withheld by. If the applicant/enrollee chooses to exclude records, then list the exclusions in the space titled: "I do not authorize the release of the following types of my health information." Leave this section blank if all records will be requested.

In the section marked "Please provide medical records for the time period of..." list the time frame. Do not routinely ask for records older than twenty-four months unless the applicant has a psychological illness. If the onset of disability is less than twenty-four months, then enter the onset date as the beginning date.

In the section marked, "This authorization to release medical information shall expire on:" enter, "Date of Medicaid Decision".

Obtain the date and signature of the person (or their legal representative) whose medical records are requested.

Do not complete any information in the section marked "For Official Use Only".

DISPOSITION:

Make a copy of both pages of the completed form, and give the copy of both pages to the applicant/enrollee. Forward both of the original pages to Medicaid daily.

Important Information about Authorization

We may need your authorization to use, disclose or obtain your health information for some of our services.

You do not have to sign this form. If you agree to sign this authorization to release or obtain information you will be given a copy of the signed form, upon request

A separate signed authorization form is required for the use and disclosure of health information for:

- ✓ Psychotherapy notes
- ✓ Employment-related determinations by an employer
- ✓ Research purposes unrelated to your treatment

When required by law or policy, DHH may only obtain, use and disclose your health information if the required written authorization includes all the required elements of a valid authorization.

- ✓ An authorization is voluntary. You will not be required to sign an authorization as a condition of receiving treatment services or payment for health care services. If your authorization is required by law or policy, DHH will use and disclose your health information as you have authorized on the signed authorization form.
- ✓ You may be required to sign an authorization before receiving research-related treatment.
- ✓ You may be required to sign an authorization form for the purpose of creating protected health information for disclosure to a third party. *Example:* In a juvenile court proceeding where a parent is required to obtain a psychological evaluation on their minor child by DHH, the parent may be required to sign an authorization to release the evaluation report (but not the psychotherapy notes) to DHH.
- ✓ You may cancel an authorization in writing at any time. DHH can not take back any uses or disclosures already made before an authorization was cancelled.
- ✓ Information used or disclosed by this authorization may be re-disclosed by the recipient and will no longer be protected by DHH privacy policies.

Your right to file a privacy complaint

You may contact the Privacy Office listed below if you want to file a complaint or to report a problem about how DHH has used or disclosed information about you. Your benefits will not be affected by any complaints you make. DHH cannot punish or retaliate against you for filing a complaint, cooperating in any investigation, or refusing to agree to something that you believe to be unlawful. Your Privacy office contact is: State of Louisiana, Department of Health and Hospitals, Office of Secretary, *Privacy Office*, P.O. Box 629, Baton Rouge, LA 70821-0629. Phone: 1-877-559-9664. E-mail: privacy-bhsf@la.gov

AUTHORIZATION TO RELEASE OR OBTAIN HEALTH INFORMATION HIPAA 402P FORM

Purpose:

The **HIPAA 402P Form** is used to obtain an applicant's consent to allow DHH-Medicaid authorization to obtain medical information.

Preparation:

Prepare this form as an original and photocopy it for the applicant (pages 1 & 2).

Complete one form per provider, or use the fillable form available at

<http://new.dhh.louisiana.gov/index.cfm/page/1274>

Enter the applicant's name and Social Security Number. If the applicant is a child, enter the child's information and document on the Clearance Form. The Request Date is today's date.

I authorize enter name of provider to release to Medicaid.

In the, "**Purpose of this authorization**" section, place an "x" in "Creating health information for disclosure to a third party."

In the, "**I authorize the release of the following protected health information,**" section, place an "x" in the box marked "Other". Use standard language: "All records from MO/DAY/YEAR to present." The date will be either 24 months retroactive from the date of the release, or the date of alleged onset of disability (if less than 24 months).

Do not complete the "**Compliance with state or federal laws which requires special permission to release otherwise privileged information, please release the following information**" section.

"This authorization shall expire on the date Medicaid determination is completed (date or event)."

Obtain the signature of the individual or their personal representative authorized by law. ***ONLY the signature of the applicant or his or her parent, legally authorized guardian, or curator is acceptable. In NO case may an Application Center complete the signature on the form.***

DO NOT complete any information in the "For DHH Use When Requesting Records" section.

Disposition:

Forward the completed original **HIPAA 402P Form** (pages 1 and 2) to the appropriate Medicaid Office **daily**. A copy of pages 1 and 2 shall be given to the applicant.

BHSF Form MS
Revised 6/27/14

Social Information Interview Form

A. Instructions

This form is used to help Medicaid determine if you have a disability. If you already have a disability decision from the Social Security Administration (SSA), you do not need to fill this out. Please print clearly and answer all questions.

B. Identifying Information

Name		Today's Date	
Social Security Number	Date of Birth	Age	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female

C. Education

Highest Grade Completed	Year you last attended school or a training program		
Were you in special education classes? <input type="checkbox"/> Yes <input type="checkbox"/> No	When?	Where?	
Did you go to a Vocational school? <input type="checkbox"/> Yes <input type="checkbox"/> No	What type?		
Have you had other training? <input type="checkbox"/> Yes <input type="checkbox"/> No	What type?		

D. Work History

Tell us about the jobs you've had over the past 15 years.

1	Where did you work?	When did you work there? From To	How many hours per week?
	Reason for Leaving	Do you believe you could perform this job now? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Describe your major duties at this job		
2	Where did you work?	When did you work there? From To	How many hours per week?
	Reason for Leaving	Do you believe you could perform this job now? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Describe your major duties at this job		
3	Where did you work?	When did you work there? From To	How many hours per week?
	Reason for Leaving	Do you believe you could perform this job now? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Describe your major duties at this job		
4	Where did you work?	When did you work there? From To	How many hours per week?
	Reason for Leaving	Do you believe you could perform this job now? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Describe your major duties at this job		

If you need more space, use a separate piece of paper and attach it.

E. Abilities

1. What is your disability? _____
2. When did your disability start? _____
3. Check each box if your illness, injury, or condition affects your ability to do the activity.

<input type="checkbox"/> Understand Directions	<input type="checkbox"/> Complete Tasks	<input type="checkbox"/> Stand for 30 Minutes
<input type="checkbox"/> Handle Change in Routine	<input type="checkbox"/> Get Along with Others	<input type="checkbox"/> Sit for an Hour
<input type="checkbox"/> Get Along with Authority	<input type="checkbox"/> Handle Stress	<input type="checkbox"/> Bend or Stoop Down
<input type="checkbox"/> Follow Spoken Instructions	<input type="checkbox"/> Concentrate	<input type="checkbox"/> Walk a Block
<input type="checkbox"/> Follow Written Directions	<input type="checkbox"/> See (w/glasses, if needed)	<input type="checkbox"/> Other, please explain: _____
<input type="checkbox"/> Remember Routine Things	<input type="checkbox"/> Hear (w/aid, if needed)	
4. List other ways your condition affects your ability to work or do activities. _____
5. Do you have problems getting along with family, friends, or neighbors? ☐ Yes ☐ No
If yes, explain. _____
6. Do you use any assistive devices (Examples: cane, wheelchair, or walker)?
☐ Yes – If yes, answer the next questions. ☐ No – If no, skip to Section F.
 - a. What kind of assistive device? ☐ Cane ☐ Wheelchair or scooter ☐ Walker ☐ Other: _____
 - b. How often do you use the assistive device? ☐ Seldom ☐ Frequently ☐ Always
 - c. Was the assistive device prescribed? ☐ Yes ☐ No — If Yes, who prescribed it? _____

F. Activities

1. Check each box for activities you can do by yourself.

<input type="checkbox"/> Yard Work	<input type="checkbox"/> Light Housekeeping	<input type="checkbox"/> Cook and Prepare Meal
<input type="checkbox"/> Drive	<input type="checkbox"/> Pay Bills	<input type="checkbox"/> Shop
<input type="checkbox"/> Child Care	<input type="checkbox"/> Care for Pets/Animals	<input type="checkbox"/> Daily Hygiene (bathe, etc.)
<input type="checkbox"/> Take Medication	<input type="checkbox"/> Attend Church	<input type="checkbox"/> Talk on Phone
<input type="checkbox"/> Use Computer	<input type="checkbox"/> Social Activities	<input type="checkbox"/> Care for Elderly/Others
<input type="checkbox"/> Keep a Checkbook	<input type="checkbox"/> Make Purchases	<input type="checkbox"/> Count Change
2. For activities you need help with, who helps you and how do they help you? _____
3. When going out, how do you travel?
☐ Walk ☐ Drive a Car ☐ Ride in a Car ☐ Ride a bicycle ☐ Take public transportation/bus ☐ Other
4. List places where you regularly go. _____
5. What are your hobbies and interests? (Examples: read, watch TV, play sports, exercise, volunteer, sew)

G. Healthcare Information

List all doctors, hospitals, and clinics where you have received treatment. Send all medical records from the last 24 months pertaining to your disability. If you have a mental disability, send all medical records. If we have to request your medical records from your providers, we will need you to sign a form for each provider.

Provider (doctor, hospital, or clinic name)	Provider Address and Phone Number	Dates Treated		Reason for Treatment
		From	To	
		From	To	
		From	To	
		From	To	
		From	To	
		From	To	
		From	To	
		From	To	
		From	To	
		From	To	
		From	To	

If you need more space, use a separate piece of paper and attach it.

H. Medications

Tell us about all medications that you currently take.

Name of medication	Dosage	How often do you take it?	Who prescribed this medication?	Date of last visit with this provider

If you need more space, use a separate piece of paper and attach it.

I. Other Benefits

We need to know about benefits that you get or benefits for which you might qualify. Check all boxes that apply.

Benefit Type	Tell us if you get this benefit, if you've applied, or if you might qualify.
Social Security Disability (SSDI) You might qualify for this if you or a spouse has worked and paid into Social Security.	<input type="checkbox"/> I already get this benefit. <input type="checkbox"/> I might qualify, but I have not applied. <input type="checkbox"/> I applied. The status of my benefit is: <input type="checkbox"/> Pending <input type="checkbox"/> Denied or terminated
Supplemental Security Income (SSI) You might qualify for this if you have not paid into Social Security and you have very low income.	<input type="checkbox"/> I already get this benefit. <input type="checkbox"/> I might qualify, but I have not applied. <input type="checkbox"/> I applied. The status of my benefit is: <input type="checkbox"/> Pending <input type="checkbox"/> Denied or terminated
Retirement or Disability Retirement You might qualify for this if you've paid into a retirement plan through an employer.	<input type="checkbox"/> I already get this benefit. <input type="checkbox"/> I might qualify, but I have not applied. <input type="checkbox"/> I applied. The status of my benefit is: <input type="checkbox"/> Pending <input type="checkbox"/> Denied or terminated
Disability Insurance Plan You might qualify for this if you've paid for an insurance plan that offers disability coverage (like Aflac).	<input type="checkbox"/> I already get this benefit. <input type="checkbox"/> I might qualify, but I have not applied. <input type="checkbox"/> I applied. The status of my benefit is: <input type="checkbox"/> Pending <input type="checkbox"/> Denied or terminated
Veterans Benefits You might qualify for this if you or a spouse is a Veteran.	<input type="checkbox"/> I already get this benefit. <input type="checkbox"/> I might qualify, but I have not applied. <input type="checkbox"/> I applied. The status of my benefit is: <input type="checkbox"/> Pending <input type="checkbox"/> Denied or terminated
Vocational Rehabilitation (VR) This program helps people with disabilities get training so they can work.	<input type="checkbox"/> I already get this benefit. <input type="checkbox"/> I might qualify, but I have not applied. <input type="checkbox"/> I applied. The status of my benefit is: <input type="checkbox"/> Pending <input type="checkbox"/> Denied or terminated
Other (please explain):	<input type="checkbox"/> I already get this benefit. <input type="checkbox"/> I might qualify, but I have not applied. <input type="checkbox"/> I applied. The status of my benefit is: <input type="checkbox"/> Pending <input type="checkbox"/> Denied or terminated

J. Other Information

Tell us any other information you'd like us to know about your condition.

Who filled out this form? _____ Relation to applicant _____

K. Agency Use Only

Was a face to face interview conducted? ☐ Yes ☐ No

If yes, date of interview: _____ If no, why wasn't an interview conducted? _____

Provide additional information such as appearance and manifestations of the condition.

Agency Representative _____ Agency Name _____

MS Supplement A
Issued 6/27/14

Social Information Interview Form – Work History continued

5	Where did you work?	When did you work there? From To	How many hours per week?
Reason for Leaving		Do you believe you could perform this job now? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Describe your major duties at this job			
5	Where did you work?	When did you work there? From To	How many hours per week?
Reason for Leaving		Do you believe you could perform this job now? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Describe your major duties at this job			
7	Where did you work?	When did you work there? From To	How many hours per week?
Reason for Leaving		Do you believe you could perform this job now? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Describe your major duties at this job			
8	Where did you work?	When did you work there? From To	How many hours per week?
Reason for Leaving		Do you believe you could perform this job now? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Describe your major duties at this job			
9	Where did you work?	When did you work there? From To	How many hours per week?
Reason for Leaving		Do you believe you could perform this job now? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Describe your major duties at this job			
10	Where did you work?	When did you work there? From To	How many hours per week?
Reason for Leaving		Do you believe you could perform this job now? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Describe your major duties at this job			
11	Where did you work?	When did you work there? From To	How many hours per week?
Reason for Leaving		Do you believe you could perform this job now? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Describe your major duties at this job			
12	Where did you work?	When did you work there? From To	How many hours per week?
Reason for Leaving		Do you believe you could perform this job now? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Describe your major duties at this job			

SOCIAL INFORMATION INTERVIEW

BHSF FORM MS

Purpose:

BHSF Form MS is used to record specific social data needed by the Medical Eligibility Determination Team to determine whether the **adult** applicant meets the eligibility factor of disability or incapacity.

Preparation:

Complete as an original paper form, or use the fillable form available at: <http://new.dhh.louisiana.gov/index.cfm/page/1274>.

All items are completed by the AC Representative based on the statements of the applicant or other person during the scheduled interview.

Use the Social Information Interview Form –Work History Continued (BHSF Form MS Supplement A) if there are more than four jobs to report.

The item titled: “Agency Representative Conducting Interview” is completed by the AC Representative who conducts the interview based on observations he or she makes of the applicant.

NOTE: *BHSF Form MS/C shall be used to document social information for a minor child.*

BHSF Form MS is prepared as an original.

The AC Representative is responsible for completing and obtaining the required information to complete the form. Additional comments or information for which there is no space on this form may be attached.

Most items are self-explanatory, but specific instructions for the agency representative are included in italics on the form.

NOTE: *A response to all questions is required.*

The **BHSF Form MS** shall be signed and dated by the AC Representative completing the form.

Disposition:

Forward the completed original **BHSF Form MS** to Medicaid **daily**.

BHSF Form MS/C
Rev. 02-2011
Prior Issue Obsolete

CHILD'S MEDICAL & SOCIAL INFORMATION

(To be completed by parent/guardian/care-giver)

INSTRUCTIONS	<p>➤ Please fill out completely. <u>Please Print.</u></p> <p>➤ Failure to do so may delay the decision</p>
---------------------	--

IDENTIFYING INFORMATION

1. Child's Name _____ Today's Date _____
 Male ☐ Female ☐ Age ____ Height/Weight ____ / ____ Parish of Residence _____

Date of Birth	___ __	___ __	___ __	Social Security #	___ - ___ - ____	___ __	___ __
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2. Name of person providing information _____
 Relationship to child _____
3. Describe the child's condition and how it affects his or her daily activities.

4. At what age did the condition begin? _____
5. At what age was the condition first treated? _____

SCHOOL INFORMATION

6. What grade is the child currently attending? _____ Teacher's Name: _____
7. Please list school/ preschool information below for the last two years. If more space is required, add additional pages. Attach Individual Education Plan (IEP) or other Pupil Appraisal reports, if any.

Current School Name			Previous School Name	
Address			Address	
City, State			City, State	
Zip Code			Zip Code	
Phone #	()		Phone #	()
Dates Attended			Dates Attended	
Any Special Education Services Received? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Reason for Special Education:		Any Special Education Services Received? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Reason for Special Education:

8. Does child have any behavioral problems in school? ☐ Yes ☐ No If **Yes**, please describe.

 Have behavioral problems resulted in any in-school or out-of -school suspensions? ☐ Yes ☐ No
 If yes, Please explain _____

9. If child is school-age but is **not** in school, please explain why he or she is not in school.

10. Has child been tested for learning or behavioral problems at school? ☐ Yes ☐ No. If Yes, please list type of tests, and where and when testing was done.

ACTIVITIES

11. How does the child spend free time? List hobbies (reading, collecting, computer, etc.) and/or activities: (sports, dance, school activities, scouting, clubs, etc.) and how often he/she participates. _____

12. Have there been any changes in the child's activities or behavior since his or her condition began?
☐ Yes ☐ No
 If **Yes**, please explain. _____

13. Does the child help with household chores? ☐ Yes ☐ No If **Yes**, what are the chores (make bed, feed pets, clean room, yard work, etc.) and how often are they done? _____

 How much assistance does the child need to complete chores? _____
14. How does the child behave with adults (parents, teachers, neighbors)? Please give examples.

15. How does the child relate with peers (friends, other family members)? Please give examples.

16. Is the child able to care for himself/ herself in an age appropriate way? Please give examples.

MEDICAL AND HEALTHCARE INFORMATION

17. List all medications that the child currently takes for his/ her condition, and who prescribes it:

Name of Medication	Dosage & How often taken	Who Prescribed	Date of Last Visit with this Provider

18. How does the medication affect the child? _____

19. During the last 24 months, has the child received any testing or special examinations (for example: hearing or vision, IQ testing, blood tests, breathing tests, X-rays)? Please list these below, and include HeadStart, Early Intervention Services, Mental Health/ Mental Retardation Centers, etc.:

Name of Doctor/ Hospital/ Clinic/ Agency Include Specialists	Address, Zip Code & Phone #	Date of Test or Evaluation	Type of Test or Evaluation

20. Does the child's condition cause pain or discomfort? ☐ Yes ☐ No If **Yes**, how does this affect his/her daily activities? _____

21. During the last 12 months, where has the child received medical/ psychological treatment?
☐ Mental Health Clinic ☐ Private Physician/ Therapist ☐ Clinic ☐ Hospital ☐ Other Source
 Please List below:

Doctor/ Hospital/ Clinic Include Specialists Seen	Address, Zip Code & Phone #	Dates Treated	Reason for Treatment

OTHER INFORMATION

22. Has this child applied for Supplemental Security Income (SSI) benefits? ☐ Yes ☐ No
 If **Yes**, when? _____
 What is the status of the application? ☐ Approved ☐ Pending ☐ Appealed ☐ Denied ☐ Terminated
 If denied OR terminated, when? _____ Why? _____

23. Tell us any other information that you think we need to know about this child. _____

Name of Person Completing Form _____

Date _____

Phone _____

CHILD'S MEDICAL & SOCIAL INFORMATION

BHSF FORM MS/C

Purpose:

BHSF Form MS/C is used to record specific social data needed by the Medical Eligibility Determination Team to determine whether a **child** meets the eligibility factor of disability.

Preparation:

All questions are completed by the parent/guardian/care-giver, or by an Application Center Representative, based on the statements of the child's parent or other person during the scheduled interview. Complete the paper form, or use the fillable form available at:

<http://new.dhh.louisiana.gov/index.cfm/page/1274>

NOTE: *This form is used instead of BHSF Form MS when documenting disability of a minor child.*

BHSF Form MS/C is prepared as an original.

Items are self-explanatory.

Enter the name and phone number of person providing information.

Enter the date the form is completed.

Disposition:

Forward the completed original **BHSF Form MS/C** to the Medicaid Office **daily**.

**STATE OF LOUISIANA
VOTER REGISTRATION AGENCIES
DECLARATION FORM**

If you are not registered to vote where you live now, would you like to apply to register to vote here today? (Check one)

☐ I want to register to vote. ☐ I do not want to register to vote.

IF YOU DO NOT CHECK EITHER BOX, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME.

Applying to register or declining to register to vote **will not** affect the amount of assistance that you will be provided by this agency. Voter eligibility requirements are found on the voter registration application form.

Note: If you do register to vote, the location where your application was submitted will remain confidential. If you decline to register to vote, this fact will remain confidential. Applying to register or declining to register to vote will be used **only** for voter registration purposes.

If you would like help in filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application in private. (Check one)

☐ Yes, I would like help. ☐ No, I do not want help.

For assistance in completing the voter registration application form outside our office, contact Louisiana Department of Health and hospitals at 1-888-342-8207.

If completed outside our office, this declaration form and your completed voter registration application form (if you filled one out) should be returned to P.O. Box 91278 Baton Rouge, LA 70821-9278.

Signature or Mark	Name Typed or Printed	Date
Signatures of Two Witnesses If Signed With Mark:		
1) _____	2) _____	

COMPLAINTS

If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with the Louisiana Secretary of State, Commissioner of Elections, P.O. Box 94125, Baton Rouge, LA 70804-9125 or by calling 1-225-922-0900 or 1-800-883-2805.

Comments/Remarks (for official use only):

VOTER REGISTRATION DECLARATION

BHSF FORM NVRADF

Purpose:

BHSF Form NVRADF is used by Medicaid Eligibility Offices and Medicaid Application Centers to document that they have offered the applicant the opportunity to register to vote. It is also used to determine if an applicant/enrollee wishes to register to vote requires assistance to complete the Louisiana Mail Voter Registration Application.

Preparation:

The form is prepared as an original. Complete the paper form, or use the fillable form available at: <http://new.dhh.louisiana.gov/index.cfm/page/1274>

“BHSF Forms” link on the On-Line Application homepage.

Enter Application Center Name in the blank at the top of the form.

The remainder of the form is to be completed, signed and dated by the applicant/enrollee.

If the applicant checks “Yes”, then they should be provided with Louisiana’s Voter Registration Application Form.

If the individual does not wish to register and refuses to sign the NVRADF form, he is considered to have declined to register to vote. The agency representative should indicate on the form that the individual refused to sign.

Disposition:

Forward the original to the Medicaid office.

Note: When the applicant completes the LA mail voter registration application (LR-1m), make a copy of the completed LA Mail Voter Registration Application and forward the copy of the Registration form to the Medicaid Office with the application and other forms. The original LR-1m shall be forwarded to the Registrar of Voters for the parish where the applicant lives.

REQUEST FOR RESOURCES & INTEREST INCOME INFORMATION

BHSF RESOURCES

Purpose:

BHSF Resources is used to secure authorization of the applicant and his or her spouse for the release of and to obtain information regarding resources and interest income, from financial institutions, persons, or agencies.

Preparation:

BHSF Resources is completed as an original during the application interview. Complete the paper form, or use the fillable form available at:

<http://new.dhh.louisiana.gov/index.cfm/page/1274>

Address the form to the financial institution, person, or agency being requested to give information about current and past resources and income of the applicant and/or his or her spouse.

Complete the identifying information prior to obtaining signatures. Obtain signature of the applicant. Obtain signatures of witnesses, if required by policy.

Complete the "Return to" address section with the mailing address of the appropriate Medicaid office.

DO NOT sign as the Agency Representative.

Disposition:

Forward the completed original **BHSF Resources** to Medicaid Office **daily**.

BH&F Verification
Rev. 04/2014
Prior Issue: Obsolete

DEPARTMENT OF HEALTH AND HOSPITALS
Medicaid Program
Application Verification Request Form

Case Name: _____ SSN: _____

The items listed on this form are needed to help us decide if you are eligible for Medicaid. Please send copies of the items checked (☑) to: Medicaid Application Office, P. O. Box 91278, Baton Rouge, LA 70821-9893 by _____. If you need more time or help to get any of the needed information, call Medicaid at 1-877-252-2447 by this date.

- ☐ Copy of Tax Return, with Schedule C attached, from self employment _____
- ☐ Any medical insurance cards or other proof of medical insurance coverage (include proof of the cost/premiums amount(s) and a copy of both sides of the card(s))
- ☐ Last month's statements from all bank accounts and proof of any interest earned
- ☐ All life and burial insurance policies (current or lapsed) and funeral contracts
- ☐ Proof of the value of savings bonds, stocks, owned mortgages or notes, trust funds or other such items
- ☐ Proof of ownership, value, and amount owed on any vehicles (car, boat, truck, etc.)
- ☐ Proof of ownership, value, and amount owed on any land (including land in which you have joint ownership or ownership in an undivided estate)
- ☐ Medical bills and receipts for hospital, doctor visits, prescribed medicines, lab tests, X-rays, and any other medical services
- ☐ Social Security numbers for _____
- ☐ Other: _____

Signature of Applicant

Date

Signature of Agency Representative

() Phone Number

Date

APPLICATION VERIFICATION REQUEST FORM

BHSF VERIFICATION

Purpose:

This form is completed by the **Application Center Representative** to inform the Medicaid applicant of the information required to reach an eligibility/ineligibility decision on an application.

Preparation:

This form is completed as an original, and it is photocopied upon completion.

The online version of the form may be accessed at:

<http://new.dhh.louisiana.gov/index.cfm/page/1274>

Complete the form as follows:

Enter the applicant's name and Social Security Number. Do not enter the MEDS Case Identification Number. Enter the date agreed upon for providing the requested information. This date shall be **no less than 10 calendar-days** from the date of the interview to allow the applicant a reasonable amount of time to secure the needed information.

Check **only** the items necessary to make an eligibility decision.

The form must be signed and dated by applicant. The agency representative shall also sign and date the form and include their agency phone number.

Disposition:

The original is given to the applicant, and a copy is forwarded to Medicaid **daily**.

BHSF Wages
Rev. 01/01
Prior Issues Usable
IV

**MEDICAID PROGRAM
PERSONAL WAGE RECORD**

[illegible]

Signature of Applicant/Recipient

Date _____

PERSONAL WAGE RECORD

BHSF WAGES

Purpose:

BHSF Form Wages is used **at initial application only** for persons who are self-employed with no other verification of earnings, **OR** to identify incidental employment for persons working at odd jobs.

Preparation:

This form is prepared as an original and is photocopied upon completion. An online version of the form may be accessed at: <http://new.dhh.louisiana.gov/index.cfm/page/1274>

Enter the applicant's name and SSN.

Leave Case ID# blank.

The return date for the applicant is **two weeks** from the date of the interview.

The applicant shall sign the form to indicate that they agree to provide the necessary information.

Disposition:

BHSF Form Wages is given to each applicant who is self-employed, or working at odd jobs and has no other proof of earnings. This form may be given to an applicant who is incidentally employed for maintaining wage records on a continuing basis.

Give the original **BHSF Form Wages** to the applicant, and forward the signed copy to the Medicaid Office **daily**. Inform the applicant to return their original form with employment information completed, to the Medicaid Office within **two weeks** from the date of the scheduled interview.