BHSF Form DRA-1
Rev. 2/07
Prior Issue Obsolete

Louisiana Medicaid – U.S. Citizen Information Form

1. **Please read the flyer "Important News from Louisiana Medicaid" that came with this form.**
2. **Fill out and sign this form.** If more space is needed, use another sheet of paper.
3. **Get this form to us right away. Mail, fax, or take this form** to your local Medicaid office. If you need the address or fax number, call 1-888-342-6207. If you are deaf or hard of hearing, call 1-800-220-5404.

If you choose to mail original proof of citizenship and/or identity, you do so at your own risk. Originals will be mailed back to you. We also accept photocopies.

Please give us the following information about each person who gets or is applying for Medicaid.

Person #1: Name: (first, middle initial, last) _____

Social Security Number: _____ Mother's Name: _____

Mother's Maiden Name: _____

Place of Birth: City_____Parish/County_____State_____Country_____

Do they now have or did they ever get Medicare or Supplemental Security Income (SSI)? ☐ Yes ☐ No

If **yes**, which one? ☐ Medicare ☐ SSI

Person #2: Name: (first, middle initial, last) _____

Social Security Number: _____ Mother's Name: _____

Mother's Maiden Name: _____

Place of Birth: City_____Parish/County_____State_____Country_____

Do they now have or did they ever get Medicare or Supplemental Security Income (SSI)? ☐ Yes ☐ No

If **yes**, which one? ☐ Medicare ☐ SSI

Person #3: Name: (first, middle initial, last) _____

Social Security Number: _____ Mother's Name: _____

Mother's Maiden Name: _____

Place of Birth: City_____Parish/County_____State_____Country_____

Do they now have or did they ever get Medicare or Supplemental Security Income (SSI)? ☐ Yes ☐ No

If **yes**, which one? ☐ Medicare ☐ SSI

Person #4: Name: (first, middle initial, last) _____

Social Security Number: _____ Mother's Name: _____

Mother's Maiden Name: _____

Place of Birth: City_____Parish/County_____State_____Country_____

Do they now have or did they ever get Medicare or Supplemental Security Income (SSI)? ☐ Yes ☐ No

If **yes**, which one? ☐ Medicare ☐ SSI

Sign your name here _____ **Date** _____

Spouse signs here (if applying) _____ **Date** _____