BHSF Form 1-G
Rev. 07/07
Prior Issue Obsolete

LOUISIANA MEDICAID
General Application

Use this application to apply for all Medicaid programs, except Long Term Care Medicaid (Nursing Facility and Home and Community Based (HCBS) Waiver services). Long Term Care Medicaid has a specialized application. To apply for Long Term Care Medicaid, fill out a 1-L or call 1-888-342-6207. If you are deaf or hard of hearing and have a TTY text telephone, call 1-800-220-5404.

How to Apply:

1. **Fill out and sign this application. Use black ink.** If you need extra space to answer any questions use a separate sheet of paper.
2. **Get the documents of proof we need.** Look for a list on page 8.
3. **Send the application and proofs to us.** Mail it to P.O. Box 91278, Baton Rouge, LA 70821-9278 or fax it to our toll-free fax number 1-877-523-2987. You may also take **OR** fax it to a local Medicaid office or Application Center. For the office closest to you call 1-888-342-6207. If you are deaf or hard of hearing and have a TTY text telephone, call 1-800-220-5404. **Send the application right away. We will give you more time to get the proofs to us.**

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

1. Where did you get this Medicaid application?
❑ Medicaid office ❑ Hospital ❑ Pharmacy ❑ Doctor's Office ❑ Friend/Relative ❑ Internet ❑ School ❑ Office of Family Support (Food Stamp Office) ❑ Office of Public Health (Health Unit) ❑ Social Security Office ❑ Business (Store, Work) ❑ Festival/Health Fair ❑ Other: _____

2. Tell us about yourself.

Name (first, middle initial, last) _____ ❑ Male ❑ Female
Your Maiden Name _____
Social Security Number _____ Date of Birth (month, day, year) _____
Marital Status: ❑Single ❑Married ❑Widowed ❑Divorced/Separated

Race/Ethnic Background (You do not have to answer. You may mark one or more.): ❑ White ❑ Black ❑ Asian ❑ American Indian or Alaska Native ❑ Native Hawaiian or Pacific Islander ❑ Hispanic or Latino

3. Tell us how to reach you.

Mailing Address _____ Apartment/Lot # _____
City _____ State _____ Zip _____
Home Address (if different) _____ Apartment/Lot # _____
City _____ State _____ Zip _____
Parish Where You Live _____ Home Phone (_____) _____
Cell Phone (_____) _____ Daytime Phone (_____) _____
E-mail Address _____
Best Day/Time to Call Monday through Friday Between 8 a.m. and 4:30 p.m. _____

4. Are you applying for Medicaid? ❑ Yes – Fill Out Below ❑ No – Go to Question 5

Where were you born? City _____ State _____ Country _____
Mother's Name (first, middle initial, last) _____
Mother's Maiden Name _____
Are you a U.S. citizen? ❑ Yes – Go to Question 5 ❑ No – Fill Out Below
Are you a lawful permanent resident? ❑ Yes ❑ No Date You Came to U.S. _____
Permanent Resident Card Number (green card#): A_____

5. Tell us about the people living with you (include children under age 19, parents of the children, and your spouse). ❑ No One Lives with Me – Go to Question 6

A. Name (first, middle initial, last) _____ ❑ Male ❑ Female
Social Security Number _____ Date of Birth (month, day, year) _____
This person is my: ❑ Spouse ❑ Child ❑ Stepchild ❑ Grandchild ❑ Other: _____

If you have questions or need help with this application, call Medicaid at 1-888-342-6207.
If you are deaf or hard of hearing and have a TTY text telephone, call 1-800-220-5404.
THESE CALLS ARE FREE.

Race/Ethnic Background (You do not have to answer. You may mark one or more.): ❑ White ❑ Black ❑ Asian ❑ American Indian or Alaska Native ❑ Native Hawaiian or Pacific Islander ❑ Hispanic or Latino

Is this person applying for Medicaid? ❑ Yes – Answer the Next Questions ❑ No – Go to **B**

Place of Birth: City _____ State _____ Country _____

Mother's Name (first, middle initial, last) _____

Mother's Maiden Name _____

Is this person a U.S. citizen? ❑ Yes – Go to **B** ❑ No – Answer the Next Questions

Are they a lawful permanent resident? ❑ Yes ❑ No Date They Came to U.S._____

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

B. Name (first, middle initial, last) _____ ❑ Male ❑ Female

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

This person is my: ❑ Spouse ❑ Child ❑ Stepchild ❑ Grandchild ❑ Other: _____

Race/Ethnic Background (You do not have to answer. You may mark one or more): ❑ White ❑ Black ❑ Asian ❑ American Indian or Alaska Native ❑ Native Hawaiian or Pacific Islander ❑ Hispanic or Latino

Is this person applying for Medicaid? ❑ Yes – Answer the Next Questions ❑ No – Go to **C**

Place of Birth: City _____ State _____ Country _____

Mother's Name (first, middle initial, last) _____

Mother's Maiden Name _____

Is this person a U.S. citizen? ❑ Yes – Go to **C** ❑ No – Answer the Next Questions

Are they a lawful permanent resident? ❑ Yes ❑ No Date They Came to U.S._____

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

C. Name (first, middle initial, last) _____ ❑ Male ❑ Female

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

This person is my: ❑ Spouse ❑ Child ❑ Stepchild ❑ Grandchild ❑ Other: _____

Race/Ethnic Background (You do not have to answer. You may mark one or more.): ❑ White ❑ Black ❑ Asian ❑ American Indian or Alaska Native ❑ Native Hawaiian or Pacific Islander ❑ Hispanic or Latino

Is this person applying for Medicaid? ❑ Yes – Answer the Next Questions ❑ No – Go to **D**

Place of Birth: City _____ State _____ Country _____

Mother's Name (first, middle initial, last) _____

Mother's Maiden Name _____

Is this person a U.S. citizen? ❑ Yes – Go to **D** ❑ No – Answer the Next Questions

Are they a lawful permanent resident? ❑ Yes ❑ No Date They Came to U.S._____

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

D. Name (first, middle initial, last) _____ ❑ Male ❑ Female

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

This person is my: ❑ Spouse ❑ Child ❑ Stepchild ❑ Grandchild ❑ Other: _____

Race/Ethnic Background (You do not have to answer. You may mark one or more.): ❑ White ❑ Black ❑ Asian ❑ American Indian or Alaska Native ❑ Native Hawaiian or Pacific Islander ❑ Hispanic or Latino

Is this person applying for Medicaid? ❑ Yes – Answer the Next Questions ❑ No – Go to **Question 6**

Place of Birth: City _____ State _____ Country _____

Mother's Name (first, middle initial, last) _____

Mother's Maiden Name _____

Is this person a U.S. citizen? ❑ Yes – Go to **Question 6** ❑ No – Answer the Next Questions

Are they a lawful permanent resident? ❑ Yes ❑ No Date They Came to U.S._____

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

6. Does anyone applying have a deceased spouse? ❑ Yes – Fill Out Below ❑ No – Go to Question 7

Who has a deceased spouse? _____

Tell us about the deceased spouse. *If more than one, use a separate sheet of paper.*

Name (first, middle initial, last) _____ Maiden _____

Social Security Number _____ Date of Birth (month/day/year) _____

Date of Death (month/day/year) _____ Has a succession been opened? ❑ Yes ❑ No

Veteran? ❑ Yes ❑ No Railroad Retiree? ❑ Yes ❑ No Divorced from applicant? ❑ Yes ❑ No

Date and Parish/County of Divorce _____

7. Is anyone applying pregnant? ❑ Yes – Fill Out Below ❑ No – Go to Question 8

Who is pregnant? _____ Best Guess of the Due Date _____

Is more than one baby expected? ❑ Yes ❑ No

Answer Question 8 for applicants who are under age 65.

8. Does anyone applying have a disability? (They do not have to be getting payments from the Social Security Administration to answer yes.) ❑ Yes – Fill Out Below ❑ No – Go to Question 9

A. Who has a disability? _____ When did it start? _____

What is the disability? Tell us about it. _____

_____

Was the disability caused by an accident? ❑ Yes ❑ No

Have they applied for Social Security Disability or SSI? ❑ Yes – Application Date _____ ❑ No

Has a decision been made? ❑ Yes – Date of decision _____ ❑ No

What was the decision? ❑ Approved ❑ Denied

Has the medical condition or disability changed since they applied with Social Security? ❑ Yes ❑ No

If yes, explain. _____

Tell us about the doctors, hospitals or other medical providers who care for the applicant.
If more space is needed, use a separate sheet of paper

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

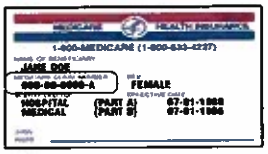
B. Is the disability Breast or Cervical Cancer? ❑ **Yes – Read & Fill Out Below** ❑ **No – Go to Question 9**

Louisiana's Breast and Cervical Cancer Program is only for **women** who have been **screened** under the Center for Disease Control and Prevention's (CDC) National Breast and Cervical Cancer Early Detection Program and found to need treatment for breast and/or cervical cancer, including precancerous conditions.

Do you have proof of the Early Detection Program screening and diagnosis? ❑ **Yes** ❑ **No**

If **No**, please contact Louisiana's Early Detection Program at 1-888-599-1073 to get the proof. **You do not have to wait for the proof; apply now. A screening is required to be eligible for Medicaid coverage under this program.**

9. Does anyone have Medicare? *The Medicare card looks like this.* →



❑ Yes – Fill Out Below ❑ No – Go to Question 10

Name _____ Claim Number _____

Name _____ Claim Number _____

10. Has anyone applying lost Medicare? ❑ Yes – Fill Out Below ❑ No – Go to Question 11

Name _____ Claim Number (on Medicare card) _____

11. Does anyone applying have health insurance, a Medicare supplement, or a Medicare prescription drug plan? ❑ Yes – Fill Out Below ❑ No – Go to Question 12
If there is more than one insurance, use another sheet of paper.

Who is insured? _____

Policyholder's Name _____ Coverage Start Date _____

Insurance Company Name and Phone Number _____

Policy Number _____ Group Number _____

It covers: ❑ Hospital ❑ Doctor ❑ Medicine ❑ Dental ❑ Ambulance ❑ Pregnancy ❑ Family Planning

How much does it cost every month? _____ Is this insurance through a job? ❑ Yes ❑ No

➜ *If the insurance is through a job, Medicaid may be able to help pay the premiums through the LaHIPP program. Call 1-866-362-5253 or visit www.LaHIPP.DHH.Louisiana.gov for more information.*

12. If anyone applying <u>does not</u> have health insurance, could they get health insurance under someone else's policy? ❑ Yes – Fill Out Below ❑ No – Go to Question 13

Tell us under whose policy. _____ Their Phone Number (_____) _____

13. Is anyone working? ❑ Yes – Fill Out Below ❑ No – Go to Question 14

Who works?	Employer's Name and Phone Number	Self-employed?	How much? (show gross, not take home)	How often?	Is insurance offered?
		❑ Yes ❑ No			❑ Yes ❑ No
		❑ Yes ❑ No			❑ Yes ❑ No

14. Does anyone get income (money) from:

- Social Security • SSI • Alimony • Money from Friends/Relatives • Worker's Comp
- Unemployment • Retirement • Railroad Retirement • Rent from Property Owned • Annuities
- Veteran's Benefits • Child Support (give the name of child it is for) • Royalties • Something else (tell us)

❑ Yes – Fill Out Below ❑ No – Go to Question 15

Who gets it?	What is it?	How much?	How often?	VA File Number or Railroad Claim Number:
		$_____		
Who gets it?	What is it?	How much?	How often?	VA File Number or Railroad Claim Number:
		$_____		
Who gets it?	What is it?	How much?	How often?	VA File Number or Railroad Claim Number:
		$_____		
Who gets it?	What is it?	How much?	How often?	VA File Number or Railroad Claim Number:
		$_____		

15. Has anyone applied for income such as Social Security or Veteran's benefits, but they did not get it yet? ❑ Yes – Fill Out Below ❑ No – Go to Question 16

Who? _____ What is it? _____

16. Has anyone applying ever received Supplemental Security Income (SSI) benefits?

❑ Yes – Who? _____ ❑ No – Go to Question 17

17. Does anyone pay for child care or care for an adult with a disability in order to work, go to school, or get training? ❑ Yes – Fill Out Below ❑ No – Go to Question 18

Name of Child(ren) or Adult Who Gets Care _____

Who pays for the care? _____ How much is paid each month? _____

Name of Day Care Center or Caregiver _____

Day Care Center or Caregiver's Address _____

City _____ Phone Number (_____) _____

Is help received with paying it from anyone or another program? ❑ Yes – How much? _____ ❑ No

18. Does anyone in your home pay court-ordered child support or alimony?
❑ Yes – Fill Out Below ❑ No – Go to Question 19

Name of Person Who Pays It _____

How much is paid? _____ How often? _____

19. Does anyone applying have medical bills (paid or unpaid) for services from the last three months? ❑ Yes – Fill Out Below ❑ No – Go to Question 20

If more than 4, use another sheet of paper.

Name, Address, and Phone Number of Medical Provider	Who received this care?	Date of Service	Total Cost of Service	Balance that is Unpaid

20. Has anyone applying ever received Medicaid in Louisiana?
❑ Yes – Fill Out Below ❑ No ***The Medicaid card looks like this*** →

If you or they still have the plastic Medicaid card, the same card can be used again. We will not send new cards unless you tell us to.

Who needs a new Medicaid card? _____

DO NOT answer Question 21 if you are applying for a pregnant woman or children under 19, ONLY. Sign the Application on Page 7, and look for a list of things we need on Page 8.

21. Tell us about things that are owned in A-J. Answer Yes or No for each.

A. Bank Accounts and Certificates of Deposit (CDs)? ❑ Yes – Fill Out Below ❑ No – Go to B

If more than 4, use another sheet of paper.

Type of Account	Who owns it?	Name of Bank or Credit Union	Account Number	How much is in it?
❑ checking ❑ savings ❑ Christmas club ❑ CD				
❑ checking ❑ savings ❑ Christmas club ❑ CD				
❑ checking ❑ savings ❑ Christmas club ❑ CD				
❑ checking ❑ savings ❑ Christmas club ❑ CD				

B. Annuities and/or retirement accounts (IRA, Keogh, 401-K)? ❑ Yes – Fill Out Below ❑ No – Go to C

Who does it belong to? _____

Account Number(s) _____ How much is it worth? _____

Are regular payments being received? ❑ Yes – How much? $_____ How often? _____ ❑ No

If **no**, are regular payments available? ❑ Yes ❑ No

Can a lump-sum withdrawal of these funds be made? ❑ Yes ❑ No ❑ Don't Know

C. Safe-Deposit Box(es)? ❑ Yes – Fill Out Below ❑ No – Go to D

Who does it belong to? _____

Name of the Bank or Credit Union _____

What is inside the box or boxes? _____

What are the items inside the box (boxes) worth? _____

D. Life or burial insurance? ❑ Yes – Fill Out Below ❑ No – Go to E

If more than 4, use another sheet of paper. **We do not need to know about term life insurance. If in doubt, fill it out.**

Who is insured?	Owner of Policy	Insurance Company	Face Value	Policy Number

E. Money set aside in a bank account for burial or a pre-arranged burial contract with a funeral home?

❑ Yes – Fill Out Below ❑ No – Go to F *If more than 2, use another sheet of paper.*

Who owns it?	Whose burial?	Name of Bank/Credit Union/Funeral Home	How much is it worth?

F. Cars, trucks, boats, campers, motorcycles, ATVs? ❑ Yes – Fill Out Below ❑ No – Go to G

If more than 3, use another sheet of paper.

Owner	What is it?	Make, Model, Year	What is it worth?	How much is owed on it?

G. Property you don't live on like inherited property (divided or undivided), out of state property, or a second house?

❑ Yes – Fill Out Below ❑ No – Go to H

Who does it belong to? _____

What is their interest or share in the divided/undivided property? (such as ¼, ½) _____

How much is it worth? _____

Tell us about it (location, lot size, number of acres, buildings on it). _____

_____

H. Burial space items like a cemetery plot, grave site, crypt, mausoleum, vault, casket, urn, niche, burial markers, headstones, and costs for opening/closing grave that are not covered in a pre-arranged burial contract? ❑ Yes – Fill Out Below ❑ No – Go to I

Who owns it? _____

For whose burial? _____ Is it paid in full? ❑ Yes ❑ No

What is it? _____

How much is it worth? _____

I. Does anyone have a trust? ❑ Yes – Who? _____ ❑ No – Go to J

(What is a trust? – A trust is a legal relationship in which a person called a "trustee" holds money or other assets for the benefit of another, the "Beneficiary." The Trust must be valid under State law. The Trust document will specify how the assets and money in Trust will be handled. It can be set up by a will.)

J. Is anything else owned (like cash on hand, stocks, bonds, savings bonds, mutual funds, or anything else of value)? ❑ Yes – Fill Out Below ❑ No – Sign on the Next Page

Who owns it? _____

What is it? _____

How much is it worth? _____

This is the end of the application. You must sign the application on the next page.

YOUR RIGHTS AND RESPONSIBILITIES

WHAT MEDICAID HAS THE RIGHT TO EXPECT OF YOU

CITIZENSHIP AND IMMIGRATION STATUS: You state that the information about citizenship and immigration status given on this application form is true and correct.
REPORTING THE TRUTH: You state that the information you give on the application form is true and correct. You understand if you on purpose give information that is not true OR if you on purpose do not tell information that you are supposed to, you and/or the person(s) applying may get health benefits that you or they should not get. If that happens, you can by law be punished for fraud. Also, you may have to pay money back to Medicaid for the bills it paid by mistake.
VERIFICATION OF INFORMATION: You understand that the information you give about you and/or the person(s) applying will be checked. You agree to help do that and to let Medicaid get information it needs from government agencies, employers, medical providers, and others.
SOCIAL SECURITY NUMBERS: You understand Social Security numbers will only be used to get information from other government agencies to make a decision on eligibility for you and/or the person(s) applying for Medicaid.
PAYMENT OF MEDICAL CARE BY A THIRD PARTY: You understand by accepting Medicaid, the Department has the right to get money received by you and/or the person(s) applying from other sources like insurance payments or lawsuit settlements for services that Medicaid has paid for you and/or the person(s) applying.
REPORTING CHANGES: You agree to tell Medicaid within 10 days of these changes: 1) if anyone getting Medicaid moves out of state; 2) if anyone moves in or out of the home; 2) changes in mailing or home address; 3) changes in health insurance and premiums; 4) changes in income; 5) changes in things owned by anyone who gets Medicaid who is disabled or age 65 or older; and 6) if a pregnancy ends.
CHILD SUPPORT ENFORCEMENT: You understand that Medicaid will only send case information to Child Support Enforcement for medical support if you ask them to. We will make a referral if the parent(s) gets Medicaid unless Medicaid determines you have good cause not to cooperate with Support Enforcement.

WHAT YOU HAVE THE RIGHT TO EXPECT FROM MEDICAID

RIGHT TO A FAIR HEARING: You understand that you can ask for a Fair Hearing if you think any decision made on the case is unfair, incorrect, or made too late.
NO DISCRIMINATION: You understand Medicaid cannot treat you differently because of race, color, sex, age, disability, religion, nationality, or political belief. If you think it has, you can call the U.S. DHHS Regional Office for Civil Rights in Dallas, TX at 1-800-368-1019 or write to Louisiana's Department of Health & Hospitals, Human Resources at P. O. Box 4818 Baton Rouge, LA 70821-4818.
OTHER SERVICES: You understand that information about WIC, KIDMED, and other Medicaid services will be sent to the persons that are eligible for Medicaid.
ESTATE RECOVERY RULES FOR THOSE GETTING MEDICAID SERVICES SUCH AS NURSING HOME, GROUP HOME, AND HOME AND COMMUNITY BASED SERVICES: You understand that Estate Recovery rules require the Department to recover the cost of certain Medicaid payments from the applicant's estate. These costs include the total amount of payments for facility services, hospital care, payments to HCBS or PACE providers, and prescription drugs received at age 55 or older. The estate is the property owned at the time of death. The Department will not make a claim against the estate while the applicant or his or her legal spouse is still living. The Department also will not make a claim if the applicant has a dependent child who is under age 21, blind, or disabled. Collection may not be made if it is not cost effective for the Department to do so, or if the heirs apply for a hardship waiver after the applicant's death. A hardship may exist if the estate property is the only source of income for the heirs, if that income is limited, or if there are other convincing situations.

↓ YOU MUST SIGN BELOW ↓

Sign Here:_____ **Date** _____

Spouse Signs Here (if applying):_____ **Date** _____

If Medicaid filled out this application, they will sign below.

_____ **Date**_____

Comments from Applicant or Medicaid Staff:

_____

_____

_____

_____

_____

Person Making Comments Signs Here:_____ **Date:**_____

Send Us These Things
Copies of all health insurance cards (front and back)
If you are not a U.S. citizen send copies of Permanent Resident Cards (green cards) or other forms from U.S. Citizenship and Immigration Services.
If you were **not** born in Louisiana **AND** you have never received benefits from Social Security Disability, Supplemental Security Income (SSI), or Medicare, send proof of U.S. Citizenship such as birth certificate, souvenir birth certificate from hospital, U.S. Passport, or adoption papers. If you don't have any of these, ask us about other things you can use.
Pay stubs from last month showing gross pay (before taxes) or a letter from the employer. If self-employed, send copies of last year's tax return and all schedule attachments – for you, your spouse, and (if you are under age 19) your parents in the home with you.
Proof of gross income (before taxes) from Veteran's Benefits, worker's comp, alimony, and any other income that is not from working. Proof could be award letters and 1099 tax statements from last year's tax return – for you, your spouse, and (if you are under age 19) your parents in the home with you
Statement from friends or relatives who give money to you, your spouse, or children
Proof and the value of things owned like bank accounts, retirement accounts, life/burial insurance, pre-arranged burial contracts, or anything else. Examples: bank statements, insurance policies, burial contract, savings bonds, stock certificates, trust document, succession documents
Proof of child care payments from the day care center. Proof of payments for adult care from the caregiver.
Court order and proof of alimony or child support payments made to persons outside the home. If it is paid through Louisiana Support Enforcement Services (SES), you **do not** have to send proof – let us know.
If Medicaid coverage is needed for the three months before you apply, send proof of income for those months.
If you have been screened by the Early Detection Program & diagnosed with breast or cervical cancer, send proof of the results.

Please send the application and documents of proof to your local Medicaid office right away. If you do not have all the proofs we need now, send them later. If you need the address or fax number to your closest Medicaid office, call us free at 1-888-342-6207. If you are deaf or hard of hearing and have a TTY text telephone, call us free at 1-800-220-5404.