



Interviewer: _____

Date of Interview: _____

Application

Use this application to apply for LaCHIP, LaCHIP Affordable Plan, or Medicaid for children under age 19. You may also apply online at www.LaCHIP.org.

To apply using this application:

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

LaCHIP
P.O. Box 91278
Baton Rouge, LA 70821-9278
FAX: 1-877-523-2987

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

Si usted quiere una solicitud en español o quiere hablar con alguien que habla español, llame al 1-877-252-2447.
 Nếu quý vị cần đơn tiếng Việt hoặc tham khảo với nhân viên người Việt, Xin gọi số điện thoại miễn phí 1-877-252-2447.

1. Does anyone get Medicaid in another state? Yes – Who? _____ No
You cannot get Medicaid benefits in more than one state at the same time. We can help to get your Medicaid closed in another state. You must be a Louisiana resident to get Louisiana LaCHIP or Medicaid.

2. Where did you get this LaCHIP application form?

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

3. Parent or Caregiver Information (List a second parent or caregiver in Question 4)

Name _____ Male Female
First Middle Initial Last

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

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

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

City State Zip Code

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

City State Zip Code

Parish _____ E-mail Address _____

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

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

4. Does another parent or caregiver live in the home? Yes – Answer Questions Below No - Go to Question 5

Name _____ Male Female
First Middle Initial Last

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

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

Relationship to the person listed in Question #3: Husband Wife Friend Other: _____

Questions? Call 1-877-252-2447

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

5. List ALL children under age 19 who live in the home. Use a separate sheet of paper if more than 4.

A. Name _____ Male Female

First

Middle Initial

Last

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

Relationship to Person in Question 3: Child Stepchild Grandchild Other: _____

Relationship to Person in Question 4: Child Stepchild Grandchild Other: _____

Race/Ethnic Background (Optional- you may mark one or more):

White Black Hispanic or Latino Asian Native Hawaiian or Pacific Islander

American Indian or Alaska Native – Tribe: _____

Is this child applying? Yes – Answer the next questions No – Go to B

Does this child have a disability? Yes No If yes, explain: _____

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

Mother's Name _____

First

(Maiden Name)

Last

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

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

Permanent Resident Card (green card) Number A# _____

B. Name _____ Male Female

First

Middle Initial

Last

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

Relationship to Person in Question 3: Child Stepchild Grandchild Other: _____

Relationship to Person in Question 4: Child Stepchild Grandchild Other: _____

Race/Ethnic Background (Optional- you may mark one or more):

White Black Hispanic or Latino Asian Native Hawaiian or Pacific Islander

American Indian or Alaska Native – Tribe: _____

Is this child applying? Yes – Answer the next questions No – Go to C

Does this child have a disability? Yes No If yes, explain: _____

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

Mother's Name _____

First

(Maiden Name)

Last

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

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

Permanent Resident Card (green card) Number A# _____

C. Name _____ Male Female

First

Middle Initial

Last

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

Relationship to Person in Question 3: Child Stepchild Grandchild Other: _____

Relationship to Person in Question 4: Child Stepchild Grandchild Other: _____

Race/Ethnic Background (Optional- you may mark one or more):

White Black Hispanic or Latino Asian Native Hawaiian or Pacific Islander

American Indian or Alaska Native – Tribe: _____

Is this child applying? Yes – Answer the next questions No – Go to D

Does this child have a disability? Yes No If yes, explain: _____

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

Mother's Name _____

First

(Maiden Name)

Last

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

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

Permanent Resident Card (green card) Number A# _____

D. Name _____ Male Female

First

Middle Initial

Last

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

Relationship to Person in Question 3: Child Stepchild Grandchild Other: _____

Relationship to Person in Question 4: Child Stepchild Grandchild Other: _____

Race/Ethnic Background (Optional- you may mark one or more):

White Black Hispanic or Latino Asian Native Hawaiian or Pacific Islander

American Indian or Alaska Native – Tribe: _____

Is this child applying? Yes – Answer the next questions No – Go to Question 6

Does this child have a disability? Yes No If yes, explain: _____

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

Mother's Name _____
First (Maiden Name) Last

Is this child a U.S. citizen? Yes – Go to Question 6 No – Answer the next questions

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

Permanent Resident Card (green card) Number A# _____

6. Is anyone pregnant? Yes – Answer the Next Questions No – Go to Question 7

Who is pregnant? _____ Due Date _____

7. Do any children have health insurance? Yes – Fill Out Below No – Go to Question 8

Which children are covered? _____

Policyholder's Name _____ Coverage Start Date _____

Insurance Company Name and Phone Number _____

Policy Number _____ Group Number _____

Is this policy through a job? Yes No If yes, name of employer: _____

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

8. Has health insurance ended for any child in the past 12 months? Yes – Answer the Next Questions No – Go to Question 9

Who was covered? _____ Coverage End Date: _____

Insurance Company Name and Phone Number _____

Why did coverage end? Employment ended Reduced number of work hours Death of parent Divorce

Exceeded lifetime maximum COBRA expired New employer does not offer dependent coverage

Too expensive – If too expensive, what was the family premium each pay period? \$ _____

Other reason for insurance ending _____

9. Does anyone work? Yes – Fill Out Below No – Go to Question 10

Include all wages or cash received from working, self-employment, and tips.

We do not count the income of grandparents and other non-parent caregivers.

Who Works?	List Employer & Phone # or Write Self-Employed	How Much is Paid? <small>(show gross income, before deductions)</small>	How Often Paid? <small>(weekly, every 2 weeks, twice a month, monthly)</small>	Is Insurance Offered? <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

10. Does anyone get money that is not from a job like the kinds listed below?

• Social Security • SSI • Unemployment • Worker's Comp • Money from Friends/Relatives

• Child Support (list the child as the person who gets it) • Alimony • Something else (list below)

Yes – Fill Out Below No – Go to Question 11

We do not count the income of grandparents and other non-parent caregivers.

Who gets it?	What is it?	How much?	How often? <input type="checkbox"/> weekly <input type="checkbox"/> every 2 weeks <input type="checkbox"/> twice a month <input type="checkbox"/> monthly
			<input type="checkbox"/> weekly <input type="checkbox"/> every 2 weeks <input type="checkbox"/> twice a month <input type="checkbox"/> monthly
			<input type="checkbox"/> weekly <input type="checkbox"/> every 2 weeks <input type="checkbox"/> twice a month <input type="checkbox"/> monthly
			<input type="checkbox"/> weekly <input type="checkbox"/> every 2 weeks <input type="checkbox"/> twice a month <input type="checkbox"/> monthly

11. Does anyone pay for childcare or care for someone with a disability in order to work or get job training? Yes – Fill Out Below No – Go to Question 12

Whose care is paid for? _____ Who pays for the care? _____

How much is paid? _____ How often paid? _____

Is any help received paying it? Yes – How much? _____ No

Name of Daycare or Caregiver _____ Phone Number (____) _____

12. Does anyone in your home pay court-ordered child support or alimony? Yes – Fill Out Below No – Go to Question 13

Name of Person Who Pays It _____

How much is paid? _____ How often paid? _____

13. Does any child need LaCHIP or Medicaid for the last 3 months because there are medical bills (paid or unpaid) from this time? Yes – Fill Out Below No – Go to Question 14

LaCHIP/Medicaid may cover children up to 3 months before they apply if they had medical services during that time.

Who received medical services? _____ In what months? _____

14. Has any child ever received LaCHIP or Medicaid in Louisiana? Yes – Fill Out Below No – Go to Question 15

If anyone has received LaCHIP or Medicaid before and still has their plastic Medicaid card, we will re-activate the same card if they qualify again. We will not send a new card unless you tell us to.

Who needs a new Medicaid card? _____

15. If the children are approved for LaCHIP or Medicaid, we will review the case every year. If we need to contact you, how should we reach you? Telephone U.S. Mail E-mail

You should let us know if your contact information changes at any time, even if the change is temporary.

This is the end of the application. SIGN BELOW.

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



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

**Send Your Completed Application to:
LaCHIP
P.O. Box 91278
Baton Rouge, LA 70821-9278**

YOUR RIGHTS AND RESPONSIBILITIES KEEP THIS PAGE FOR YOUR RECORDS

WHAT MEDICAID HAS THE RIGHT TO EXPECT OF YOU

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 into or out of the home; 3) changes in mailing or home address; and 4) changes in health insurance and premiums.

CITIZENSHIP AND IMMIGRATION STATUS: You state that the information about citizen and immigration status given on this form is true and correct.

REPORTING THE TRUTH: You state that the information you give on the application form is true and correct. You understand if you purposely give information that is not true OR if you purposely do not tell information that you are supposed to, 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 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.

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 who are eligible for Medicaid.

Documents of Proof You May Need to Send Us

*If any of these things apply to you and your family, send copies of these documents.
Let us know if you cannot get them. We may be able to help.*

For all applicants, send copies of health insurance cards (front and back).

For applicants who are not U.S. citizens, send copies of Permanent Resident Cards (green cards) or other forms from U.S. Citizenship and Immigration Services.

For children born outside Louisiana, send proof of U.S. Citizenship such as a birth certificate, souvenir birth certificate, U.S. Passport, or adoption papers. Visit www.cdc.gov/nchs for a list of state vital records offices where you may request birth certificates.

For children and their parents, send 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. *Grandparents and other non-parent caregivers do not have to send this information.*

For applicant and their parents, send proof of gross income (before taxes) for all money that is not from a job like Veteran’s Benefits, worker’s comp, and alimony. Proof could be award letters or 1099 tax statements. *Grandparents and other non-parent caregivers do not have to send this information.*

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 you are requesting LaCHIP/Medicaid coverage for the three months before you apply, send proof of income for those months.

IMPORTANT PHONE NUMBERS

	PHONE NUMBER	TTY TEXT TELEPHONE
LaCHIP	1-877-252-2447 1-877-2LaCHIP	1-800-220-5404
KIDMED (EPSDT)	1-800-259-4444	1-877-544-9544
CommunityCARE (to request a change of Primary Care Doctor)	1-800-259-4444	1-877-544-9544
KIDMED and CommunityCARE Physician Referral Assistance	1-877-455-9955	
Medicaid Services	1-888-342-6207	
Office of Group Benefits (for LaCHIP Affordable enrollees)	1-800-272-8451	
Transportation (to request non-emergency transportation)	1-800-259-1944	

IMPORTANT WEB SITES

LaCHIP	www.LaCHIP.org
LaMOMS – Medicaid for Pregnant women	www.LaMOMS.DHH.Louisiana.gov
Other Medicaid Programs	www.Medicaid.DHH.Louisiana.gov
Find a Doctor Who Accepts Medicaid	www.La-CommunityCare.com
KIDMED & CommunityCARE	www.La-KidMed.com
Apply for or Renew Your Medicaid	www.Medicaid.DHH.Louisiana.gov
Office of Group Benefits (for LaCHIP Affordable enrollees)	www.GroupBenefits.org

KEEP THIS PAGE FOR YOUR RECORDS