



# Application

Use this application to apply for LaMOMS or Medicaid for pregnant women. You may also apply online at [www.Medicaid.DHH.Louisiana.gov](http://www.Medicaid.DHH.Louisiana.gov).

## To apply:

1. Fill out this application with a black ink pen.
2. Get the documents of proof we need.
3. Send this application and documents of proof to us right away.  
We will give you extra time to send in the proofs if you need it.

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

What language do you speak best?  English  Spanish  Vietnamese  Other (tell us) \_\_\_\_\_  
 What language do you write best?  English  Spanish  Vietnamese  Other (tell us) \_\_\_\_\_

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. Where did you get this application?

- LaMOMS/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: \_\_\_\_\_

## 2. Information About You (the pregnant woman who is applying)

Name \_\_\_\_\_  
First Middle Initial Last

Maiden Name \_\_\_\_\_

Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Month Day Year

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

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

Mother's Maiden Name \_\_\_\_\_

Are you a U.S. citizen?  Yes – Go to Question 3  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 \_\_\_\_\_

## 3. How to Reach You

Mailing Address \_\_\_\_\_ Apartment/Lot # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home address (if different) \_\_\_\_\_ Apartment/Lot # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Parish \_\_\_\_\_ Home Phone ( ) \_\_\_\_\_

Cell Phone ( ) \_\_\_\_\_ Daytime Phone ( ) \_\_\_\_\_

E-mail Address \_\_\_\_\_

What is the best day and/or time to call you during our office hours, Monday – Friday, 8 a.m. – 4:30 p.m.?  
 \_\_\_\_\_

**Questions - Call 1-888-342-6207 (free call)**  
**(TTY text telephone for deaf and hard of hearing: 1-800-220-5404)**

4. What is your best guess of your due date? \_\_\_\_\_

Are you expecting more than one baby?  Yes  No

5. Give us information about your legal husband who lives with you. If you are under age 18, list your parents who live with you.  None – Go to Question 6 *Do not list step-parents.*

**Person #1**

Name \_\_\_\_\_  Male  Female  
*First Middle Initial Last*

Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_  
*Month Day Year*

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

Relationship to You:  Husband  Parent

**Person #2**

Name \_\_\_\_\_  Male  Female  
*First Middle Initial Last*

Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_  
*Month Day Year*

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

Relationship to You:  Husband  Parent

6. List ALL children under age 19 who live with you.  None – Go to Question 7

*If you are under age 18, list your brothers and sisters under age 19. If there are more than 4 children, use a separate sheet of paper.*

A. Name \_\_\_\_\_  Male  Female  
*First Middle Initial Last*

Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_  
*Month Day Year*

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

Relationship to You:  Child  Stepchild  Brother/Sister  Other: \_\_\_\_\_

B. Name \_\_\_\_\_  Male  Female  
*First Middle Initial Last*

Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_  
*Month Day Year*

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

Relationship to You:  Child  Stepchild  Brother/Sister  Other: \_\_\_\_\_

C. Name \_\_\_\_\_  Male  Female  
*First Middle Initial Last*

Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_  
*Month Day Year*

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

Relationship to You:  Child  Stepchild  Brother/Sister  Other: \_\_\_\_\_

D. Name \_\_\_\_\_  Male  Female  
*First Middle Initial Last*

Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_  
*Month Day Year*

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

Relationship to You:  Child  Stepchild  Brother/Sister  Other: \_\_\_\_\_

7. Is anyone working?  Yes – Fill Out Below  No – Go to Question 8

*Tell us about wages or cash received from working, self-employment, and tips for you and your husband. If you are under age 19, tell us your parents' information (not step-parents).*

Who works?	Employer's Name _____	How much is received (show gross, not take home pay)? \$ _____	Is insurance offered? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Employer's Phone Number _____		
	<input type="checkbox"/> Self-employed	How often? <input type="checkbox"/> weekly <input type="checkbox"/> every 2 weeks <input type="checkbox"/> twice a month <input type="checkbox"/> monthly	
Who works?	Employer's Name _____	How much is received (show gross, not take home pay)? \$ _____	Is insurance offered? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Employer's Phone Number _____		
	<input type="checkbox"/> Self-employed	How often? <input type="checkbox"/> weekly <input type="checkbox"/> every 2 weeks <input type="checkbox"/> twice a month <input type="checkbox"/> monthly	

8. Are you on maternity leave from your job?  Yes  No

9. 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 10

*Tell us about income for you and your husband. If you are under age 19, tell us about your parent's income (not step-parents).*

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
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
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
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

10. Do you have health insurance?  Yes – Fill Out Below  No – Go to Question 11

Policyholder's Name \_\_\_\_\_ Coverage Start Date \_\_\_\_\_

Insurance Name and Phone Number \_\_\_\_\_

Policy Number \_\_\_\_\_ Group Number \_\_\_\_\_

What does it cover? (check all that apply)  Hospital  Doctor  Medicine  Dental  Ambulance  
 Pregnancy  Family Planning

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

11. Will you have the option to get insurance for your newborn?  Yes  No

12. Do you need Medicaid for any of the last 3 months to cover medical bills (paid or unpaid) for these months?  Yes – Fill Out Below  No – Go to Question 13

Which months? \_\_\_\_\_

13. Does anyone pay for child care or care for an adult with a disability in order to work or get training?  Yes – Fill Out Below  No – Go to Question 14

Name of Person Who Gets Care \_\_\_\_\_

Who pays for the care? \_\_\_\_\_

How much is paid? \_\_\_\_\_ How often paid? \_\_\_\_\_

Is any help received with paying it?  Yes – How much? \_\_\_\_\_  No

Name of Day Care or Caregiver \_\_\_\_\_

Phone Number (\_\_\_\_\_) \_\_\_\_\_

14. Does anyone in your home pay court-ordered child support or alimony?  Yes – Fill Out Below  No – Go to Question 15

Name of Person Who Pays It \_\_\_\_\_

How much is paid? \_\_\_\_\_ How often paid? \_\_\_\_\_

15. Have you ever received LaMOMS or Medicaid in Louisiana?  Yes – Answer the Question Below  No – Go to Question 16

*If you still have your plastic Medicaid card, you can use the same card if you qualify again. We will not send a new card unless you tell us to.*



Will you need a new plastic Medicaid card?  Yes  No

16. Have you ever received Supplemental Security Income (SSI)?  Yes  No

17. Do you have or have you ever received Medicare?  Yes  No

*The Medicare card looks like this.* →



**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 state that I have received and read the Rights and Responsibilities on the next page.

 Sign Your Name Here: \_\_\_\_\_ Date: \_\_\_\_\_

**Send Your Completed Application to:  
LaMOMS  
P.O. Box 91278  
Baton Rouge, LA 70821-9278  
FAX: 1-877-523-2987**

## YOUR RIGHTS AND RESPONSIBILITIES

Keep this page for your records.

### WHAT MEDICAID HAS THE RIGHT TO EXPECT OF YOU

**CITIZENSHIP AND IMMIGRATION STATUS:** You state that the information about citizenship and immigration status given at the beginning of 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 purposely give information that is not true OR if you purposely do not tell information that you are supposed to, you may get health benefits that you 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 yourself 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 your eligibility for Medicaid.

**PAYMENT OF MEDICAL CARE BY A THIRD PARTY:** By accepting Medicaid, you understand that the Department has the right to get money received by you from other sources like insurance payments or lawsuit settlements for services that Medicaid has paid for you.

**REPORTING CHANGES:** You agree to tell Medicaid within 10 days: 1) if you move out of state; 2) there is a change in your mailing or home address; and 3) there is any change in your health insurance and premiums.

**CHILD SUPPORT ENFORCEMENT:** You understand that Medicaid will send case information to Child Support Enforcement for medical support only if you ask them to.

### WHAT YOU HAVE THE RIGHT TO EXPECT FROM MEDICAID

**RIGHT TO A FAIR HEARING:** You understand that you may ask for a Fair Hearing if you think any decision made on your 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 you if you 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.*

Copies of your health insurance cards (front and back).

**If you are not a U.S. citizen,** send a copy of your Permanent Resident Card (green card) or other form from U.S. Citizenship and Immigration Services.

**If you were not born in Louisiana,** send proof of U.S. Citizenship such as a birth certificate, souvenir birth certificate, U.S. Passport, or adoption papers. *If you don't have any of these things, ask us about other things you can use.*

Proof of income received by you, your husband, and if you are under age 19, your parents who live with you. Send pay stubs from last month showing gross pay (before taxes), a letter from the employer, if self-employed send copies of last year's tax return and all schedule attachments. Examples of proof for any income not received from working would be award letters, or letters from the friend or relative who is giving you or your family money.

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

## IMPORTANT PHONE NUMBERS

	PHONE NUMBER	TTY TEXT TELEPHONE
<b>LaMOMS</b>	1-888-342-6207	1-800-220-5404
<b>EPSDT</b> (prenatal clinics, family planning, helps with finding a Primary Care Doctor)	1-800-359-2122	1-877-544-9544
<b>CommunityCARE</b> (to request a change of Primary Care Doctor)	1-800-259-4444	1-877-544-9544
<b>Physician Referral Assistance</b>	1-877-455-9955	
<b>Medicaid Services</b>	1-888-342-6207	
<b>Dental Program</b>	1-800-251-2229	
<b>Transportation</b> (to request non-emergency transportation – call at least 48 hours in advance)	1-800-259-1944	
<b>24 Hour Nurses Hotline</b> (CommunityCARE)	1-866-529-1681	
<b>Replace Medicaid Card</b>	1-800-834-3333	

## IMPORTANT WEB SITES

<b>LaMOMS – Medicaid for Pregnant Women</b>	<a href="http://www.LaMOMS.DHH.Louisiana.gov">www.LaMOMS.DHH.Louisiana.gov</a>
<b>LaCHIP – Medicaid for Children</b>	<a href="http://www.LaCHIP.org">www.LaCHIP.org</a>
<b>Other Medicaid Programs</b>	<a href="http://www.Medicaid.DHH.Louisiana.gov">www.Medicaid.DHH.Louisiana.gov</a>
<b>Find a Doctor Who Accepts Medicaid</b>	<a href="http://www.La-CommunityCare.com">www.La-CommunityCare.com</a>
<b>KIDMED &amp; CommunityCARE</b>	<a href="http://www.La-KidMed.com">www.La-KidMed.com</a>
<b>Apply for or Renew Medicaid</b>	<a href="http://www.Medicaid.DHH.Louisiana.gov">www.Medicaid.DHH.Louisiana.gov</a>

**KEEP THIS PAGE FOR YOUR RECORDS**