Application for Louisiana's Hurricane Katrina Medicaid Program

This program is for residents of Louisiana who have been affected by Hurricane Katrina.

It provides full Medicaid benefits until December 31, 2005, including prescriptions, hospital and doctor visits. People who need coverage after December must apply again.

It's easy to apply:

1. Fill out this form and sign it.
2. Give it to a Medicaid worker at the local Medicaid office or nearest FEMA Family Assistance Center

   or mail it to: P.O. Box 91278, Baton Rouge, LA 70821-9278

   or fax it to: (877) 523-2987

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

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

1. Your name _____ Today's date _____

2. What was the address where you lived on Sunday, August 28, 2005 (the day before Hurricane Katrina)?

Address _____

City _____ State _____ Zip Code _____

Parish _____

What is your address or location now? *(Tell us as much as you can, like the name of the shelter)*

Address _____

City _____ State _____ Zip Code _____

Parish _____

Phone number where we can reach you (_____) _____ Cell phone number (_____) _____

If you have e-mail, give us your e-mail address _____

For help with this application: go to a local Medicaid office or FEMA Family Assistance Center or call 1-888-342-6207. TTY 1-800-220-5404. *The call is free.*

PLEASE TURN THIS PAGE OVER ▸

Please tell us about yourself and your spouse.

NAME (FIRST, MIDDLE, LAST)	SOCIAL SECURITY NUMBER	DATE OF BIRTH (MONTH, DAY, YEAR)	SEX	U.S. CITIZEN	RACE MARK ONE OR MORE (YOU DO NOT HAVE TO ANSWER.)	RELATION TO YOU
Are you applying? ☐ Yes ☐ No			☐ Male ☐ Female	☐ Yes ☐ No	☐ White ☐ Black ☐ Asian ☐ American Indian or Alaska Native ☐ Native Hawaiian or Pacific Islander	**SELF**
Is this person applying? ☐ Yes ☐ No			☐ Male ☐ Female	☐ Yes ☐ No	☐ White ☐ Black ☐ Asian ☐ American Indian or Alaska Native ☐ Native Hawaiian or Pacific Islander	**SPOUSE**

3. Tell us who is living with you now and who needs health care coverage.

NAME (FIRST, MIDDLE, LAST)	SOCIAL SECURITY NUMBER	DATE OF BIRTH (MONTH, DAY, YEAR)	SEX	U.S. CITIZEN	RACE MARK ONE OR MORE (YOU DO NOT HAVE TO ANSWER.)	RELATION TO YOU
Is this person applying? ☐ Yes ☐ No			☐ Male ☐ Female	☐ Yes ☐ No	☐ White ☐ Black ☐ Asian ☐ American Indian or Alaska Native ☐ Native Hawaiian or Pacific Islander	
Is this person applying? ☐ Yes ☐ No			☐ Male ☐ Female	☐ Yes ☐ No	☐ White ☐ Black ☐ Asian ☐ American Indian or Alaska Native ☐ Native Hawaiian or Pacific Islander	
Is this person applying? ☐ Yes ☐ No			☐ Male ☐ Female	☐ Yes ☐ No	☐ White ☐ Black ☐ Asian ☐ American Indian or Alaska Native ☐ Native Hawaiian or Pacific Islander	
Is this person applying? ☐ Yes ☐ No			☐ Male ☐ Female	☐ Yes ☐ No	☐ White ☐ Black ☐ Asian ☐ American Indian or Alaska Native ☐ Native Hawaiian or Pacific Islander	
Is this person applying? ☐ Yes ☐ No			☐ Male ☐ Female	☐ Yes ☐ No	☐ White ☐ Black ☐ Asian ☐ American Indian or Alaska Native ☐ Native Hawaiian or Pacific Islander	
Is this person applying? ☐ Yes ☐ No			☐ Male ☐ Female	☐ Yes ☐ No	☐ White ☐ Black ☐ Asian ☐ American Indian or Alaska Native ☐ Native Hawaiian or Pacific Islander	
Is this person applying? ☐ Yes ☐ No			☐ Male ☐ Female	☐ Yes ☐ No	☐ White ☐ Black ☐ Asian ☐ American Indian or Alaska Native ☐ Native Hawaiian or Pacific Islander	
Is this person applying? ☐ Yes ☐ No			☐ Male ☐ Female	☐ Yes ☐ No	☐ White ☐ Black ☐ Asian ☐ American Indian or Alaska Native ☐ Native Hawaiian or Pacific Islander	

Is anyone Hispanic or Latino? *(you do not have to answer)* ☐ Yes ☐ No ☐ Don't know

If **yes**, please tell us who: _____

4. Is anyone pregnant? ☐ Yes ☐ No

If **yes**, who is this person? _____

Is she applying? ☐ Yes ☐ No What is the best guess of her due date? _____

5. Does anyone applying have other health insurance? ☐ Yes ☐ No If **yes**, tell us:

NAME OF INSURANCE COMPANY	GROUP/POLICY NUMBER	WHO IS COVERED?

6. Does anyone applying have Medicare? ☐ Yes ☐ No If **yes**, please fill in below:

PERSON WHO IS COVERED	MEDICARE CLAIM NUMBER	PART A	PART B
SELF		☐ Yes ☐ No	☐ Yes ☐ No
SPOUSE		☐ Yes ☐ No	☐ Yes ☐ No
		☐ Yes ☐ No	☐ Yes ☐ No
		☐ Yes ☐ No	☐ Yes ☐ No

7. Since the hurricane, do you or your spouse and children have any income, such as from a job, unemployment or Social Security? ☐ Yes ☐ No

If **yes**, from where? _____

What is the amount of income each month before any deductions? _____

_____

_____

_____

_____

Do you or your spouse or children expect any income? ☐ Yes ☐ No

If **yes**, from where? _____

How much? _____

8. Does anyone applying have any medical bills for the last 3 months that are not paid? ☐ Yes ☐ No

Name of doctor or other medical provider _____

Date of service _____ Total cost _____ Amount not paid _____

9. Does anyone pay for child care, or for the care of an adult who is disabled, so you can work or get training? ☐ Yes ☐ No

If yes, tell us the name of the person who gets the care _____

How much do you pay? _____ How often? _____

Caregiver's name _____ Phone number _____

10. Does anyone pay child support or alimony to someone outside of your home? ☐ Yes ☐ No

If yes, how much? _____ How often? _____

Use the space below if you need to write more:

The next page is only for people who have a disability or are over age 65.

Remember to go to page 6 and sign the application.

This page is for people who have a disability or are over age 65.

Does anyone have a serious illness, injury or disability which you expect will last for 12 months or longer?

☐ **Yes** ☐ **No**

If yes, who is it? _____

What is the illness, injury or disability? _____

Do you or anyone applying have: *(If you need more space, use an extra sheet of paper)*

- Bank accounts? ☐ **Yes** ☐ **No** If yes, who? _____

Bank name _____

Bank account number _____ How much is in it? $ _____

Bank name _____

Bank account number _____ How much is in it? $ _____

- Annuities / Trusts / Stocks / Bonds? ☐ **Yes** ☐ **No** If yes, who? _____

Name of company or broker _____ How much is it? $ _____

Name of company or broker _____ How much is it? $ _____

- Do you own property other than your home? ☐ **Yes** ☐ **No**

What is it worth? $ _____ How much is owed? _____

Where is it? _____

- Life insurance or burial insurance? ☐ **Yes** ☐ **No** If yes, who? _____

Name of company _____

Policy number _____ How much is it? $ _____

Name of company _____

Policy number _____ How much is it? $ _____

- Funeral or burial plans (such as special bank accounts or a burial contract)? ☐ **Yes** ☐ **No**

If yes, who? _____ How much is owed? _____

Name of bank or funeral home _____ What is the value? $ _____

Name of bank or funeral home _____ What is the value? $ _____

- Do you have more than one vehicle? ☐ **Yes** ☐ **No** If yes, how many? _____

Who owns it? _____ What is it worth? $ _____ How much is owed? _____

Who owns it? _____ What is it worth? $ _____ How much is owed? _____

- Other, such as CDs, IRAs, mineral rights? ☐ **Yes** ☐ **No** If yes, who? _____

Name of bank _____ What is the value? $ _____

Name of bank _____ What is the value? $ _____

Has anyone applying given away or sold, or deeded any property or assets? (*assets* are things you own) ☐ **Yes** ☐ **No**

If yes, what? _____

What were the values? $ _____ How much was received? $_____

Who got the assets? _____ Phone numbers _____

- You state that everyone who is applying is a U.S. citizen or is in this country legally
- 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.
- 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.
- 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.
- 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. You must provide this information to the State Medicaid Agency.
- You agree to tell Medicaid within 10 days of these changes: 1) if anyone getting Medicaid moves out of state; 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 over age 64; and 6) if a pregnancy ends.
- 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.
- 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 1349 Baton Rouge, LA 70821-1349.
- You understand that Medicaid will only send case information to Child Support Enforcement for medical support if you ask them to.
- You understand that information about WIC, KIDMED, and other Medicaid services will be sent to the persons that are eligible for Medicaid.
- 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 compelling circumstances.

Please sign here: _____ Date _____

Signature of Agency Representative, if needed: _____

Date _____

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