

This form is only for use when persons are receiving SNAP benefits.

Screening Questions

Is anyone in your SNAP case eligible for Medicare?	Y <input type="checkbox"/> N <input type="checkbox"/>
If "Yes", stop. You must complete a full Application for Health Coverage .	
Is everyone in your household eligible for SNAP?	Y <input type="checkbox"/> N <input type="checkbox"/>
Is everyone you are requesting assistance for a U.S. Citizen or Lawful Permanent Resident?	Y <input type="checkbox"/> N <input type="checkbox"/>
Is everyone requesting assistance under age 65?	Y <input type="checkbox"/> N <input type="checkbox"/>
If the answer to any of these questions is "No", stop. You must complete a full Application for Health Coverage .	

Section A

Complete for the primary contact and everyone who lives with the primary contact.

First Name (Primary Contact)		Date	
Middle Name		SSN	
Last Name		Home Phone	
Mailing Address		Cell Phone	
		Work Phone	
Home Address (if different)		Email	
		Tax Filing Status	

Other Household Members You can be a tax filer, dependent, or a non-filer. See next page for details. *

Name	DoB	SSN	Relationship to Primary Contact	Tax Filing Status*

Section B Answer all four questions Space is provided to answer for up to 2 people.

Is anyone in your household claimed as a dependent on a tax return by someone who does not live with you?	Y <input type="checkbox"/> N <input type="checkbox"/>
If "Yes", who in your household is claimed?	
Who claims this person?	
How are they related?	
Does anyone in your household claim someone who does not live with you as a dependent on their taxes?	Y <input type="checkbox"/> N <input type="checkbox"/>
If "Yes", who claims this dependent?	
Who is the dependent that they claim?	
How are they related?	
Does anyone earn money from Delta Service Corps or AmeriCorps?	Y <input type="checkbox"/> N <input type="checkbox"/>
If "yes", who?	
How much do they make each month?	
Is anyone listed in your home under 18 years old and earns more than \$525 per month?	Y <input type="checkbox"/> N <input type="checkbox"/>
If "yes", who?	
How much do they make each month?	

Section C	Select a health plan.	
<p>When I have Medicaid I know I must let the Louisiana Department of Health (LDH) know about any changes in my mailing address, telephone number, kind of income, amount of income or the people living in my home. I will do this within 10 days of finding out about the change. I know that by signing and returning this letter I am asking to enroll everyone referred on my SNAP application in Medicaid.</p>		
<p>Signature _____ Date _____</p>		
<p><input type="checkbox"/> Review Voter Registration Declaration BHSF Form VRD and Voter Registration Form with applicant</p> <p><input type="checkbox"/> Review rights & responsibilities</p>		
<p>The form can be submitted to the Bureau of Health Services Financing via fax to 877-523-2987).</p>		

Tax filing status: Possible tax filing statuses are:

- Non-filer Does not file taxes and is not claimed as a dependent by any tax filer
- Filer Files taxes, whether or not any dependents are claimed, and
- Dependent Is claimed as a dependent by someone who does file taxes.

Relationship: Describe how the people are related: parent, stepparent, spouse, non-legal partner, child, stepchild, brother, sister, aunt, uncle, niece, nephew, grandparent, cousin, other relation, or no relation.

IMPORTANT INFORMATION

- Persons eligible for Medicaid will be enrolled in a Healthy Louisiana Plan. They will get a letter telling them how to change to another plan if they want to.
- Anyone who gets Medicaid and knowingly gave false information that was used to decide if they were eligible may be charged with a crime. He or she may lose Medicaid benefits, have to pay benefits back, pay fines, or even go to jail.
- Medicaid isn't allowed to treat you differently because of race, color, national origin, sex, age, sexual orientation, gender identity or disability. If you think Medicaid has treated you differently, you can file a complaint by visiting www.hhs.gov/ocr/office/file, calling the U.S. DHHS Regional Office for Civil Rights at 1-800-368-1019, or writing to Louisiana Department of Health (LDH) at PO Box 4818, Baton Rouge, Louisiana 70821.
- By enrolling in Medicaid you give LDH the right to use money you are owed from a health insurance company, a lawsuit, or any person or organization to pay for medical services, if that money is meant to pay for medical services covered by Medicaid. You will be expected to help LDH get in contact with anyone who should be paying for your medical care.
- Anyone who gets Medicaid will be asked to help the Department of Children and Family Services (DCFS) to get money or insurance from any parents not in the home to help pay for a child's medical care. If you think helping DCFS will harm you or your children, you can tell LDH and you may not have to help DCFS.
- If you are an American Indian and can show you are a member of a federally-recognized tribe, you do not have to pay any co-pays. Call us at: 1-888-342-6207 (Monday through Friday 8 a.m. – 5 p.m.) to learn more.
- If you get Medicaid you must let LDH know about any changes in my address, phone number, amount of income or the people living in my home. I will do this within 10 days of finding out about the change.

What You Need to do if You Have Health Insurance Through the Marketplace and Get Help Paying Your Insurance Premiums:

- **When you get Medicaid** you must **stop** your Marketplace plan.
- If you do not **stop** your Marketplace plan you may have to pay a penalty when you file your tax return next year.
- Call 1-800-318-2596 or (TTY: 1-855-889-4325) right away. Tell them you have Medicaid and you want to **stop** your Marketplace health insurance.