BHSF Form AC-4
Revised 2007

Louisiana's Medicaid Program
Application Center Request for Representative Training

Mail To: DHH/MVA
Application Center Unit
AC ID#_____

OR P. O. Box 91278
Baton Rouge, LA 70821-9278
Parish_____

FAX To: (225) 376-4736

APPLICATION CENTER INFORMATION *(Please Print Clearly or Type)*:

Application Center Name_____

AC Street Address _____ P.O. Box _____

City _____State ___Zip _____ City _____State ____ Zip_____

AC Phone Number (____)_____ AC FAX Number (____)_____

Participant's (non-shared) eMail Address_____

AC's eMail: _____

PARTICIPANT INFORMATION *(Please Print Clearly or Type)*:

First Name _____ M. Initial _____ Last Name_____

Birth Date (MM/DD/YYYY)_____ Sex_____

Educational Level (H.S. = 12) ____ Job Title _____ Department_____

Job Description_____

Participant's Signature _____ **Date** _____

ADMINISTRATOR/CEO INFORMATION *(Please Print Clearly or Type)*:

The following questions <u>MUST</u> be answered by the Administrator/CEO or Contact Person:

1. Is the person for whom training is requested replacing a certified representative? ☐ YES ☐ NO
   If yes, what is the name of the representative being replaced? _____
2. Did the representative being replaced transfer to another Application Center? ☐ YES ☐ NO
   If yes, what is the name of the Application Center he/she transferred to? _____
3. Does the person for whom training is requested have a non-shared eMail address? ☐ YES ☐ NO

Admin/CEO's Name _____ **Admin/CEO's Signature**_____
(PRINT OR TYPE)

FOR DHH USE ONLY:

DHH Approval for Attendance ☐ Yes ☐ No Region _____

Approval Signature _____ Date_____