Louisiana Medicaid/LaCHIP
P.O. Box 91283
Baton Rouge, LA 70821-9278

LOUISIANA DEPARTMENT OF HEALTH
Renewal Letter

[redacted]

Case ID #: [redacted]
Date: 07/03/2023

Dear [redacted]

It is time to renew Medicaid eligibility for your household.

There are four (4) ways to renew coverage. Choose the one that is best for you. You must do one of these by **08/02/2023** or coverage will end. If you need more time, let us know. If you no longer want Medicaid coverage, let us know.

1. Renew online at **www.healthy.la.gov**
    - Log into your account and choose “Renew my Coverage.”
    - Haven’t created an online account yet? Use the same link to create an account. You’ll need your Medicaid card number to create an account.
2. Renew over the telephone by calling toll free at 1 888-342-6207.
3. Fill out and return the attached renewal packet
    - **U.S Mail:**
      Louisiana Medicaid/LaCHIP, P.O. Box 91283, Baton Rouge, LA 70821-9278
    - **Email:** MyMedicaid@la.gov
    - **Fax:** 1-877-523-2987
4. Renew in person at the Medicaid office of your choice.

If you choose to fill out and return this renewal packet (option 3 above), here's what we need from you:

1. Check the information we have to make sure it is correct.
2. Tell us about any changes and send us proof of these changes.
3. Answer all of the questions.
4. You must include this page along with the signed Standard Renewal Packet.

Be sure to write your name and this number [redacted] on any proof you send us.

Things you may need to complete this renewal packet

- Social Security Numbers.
- Employer and income information (for example, paystubs, W-2 forms or tax returns). Having this proof may help us decide faster if you can keep coverage.
- Policy numbers for other health insurance or information about any job related health insurance available to your family.

You may receive multiple envelopes. All pages must be returned with your signature on Part 11 when you send us your completed renewal packet.

Sincerely,
Medicaid Analyst

Email: MyMedicaid@la.gov Phone Number: 1-888-342-6207

Fax Number: 1-877-523-2987

To Keep Your Information Up to Date: 

Part 1 Your Contact Information

Review your contact information here.	Correct any wrong or missing information here.		
[redacted] **This person will be referenced throughout as "you".**	**Name**		
Residence address [redacted]	**Residence** address		Apartment #
	City	State	Zip Code
Mailing address [redacted]	**Mailing** address		Apartment #
	City	State	Zip Code
Phone number Cell: [redacted] Landline: No reported phone number Work: No reported phone number Other: No reported phone number	Best phone number to reach you: ☐ Cell ☐ Landline ☐ Work ☐ Other Number:		
Personal email: [redacted] Work email: No reported email address	Email address, if you have one:		

Part 2 People in your household

This part shows the information that we have on file for people in your household

Review the information below. Cross out anything that is wrong. Write correct information in the space right next to it. Fill in any missing information.

Who should be listed in Part 2? Use the list below to be sure everyone in your household is included, even if they aren't enrolled in Medicaid.

- Any spouse
- Any son or daughter under age 21 they live with, including stepchildren
- Any other person on the same federal income tax return (including claimed children over age 21). You don't need to file taxes to get health coverage.
- Any parent (or stepparent) they live with
- Any sibling they live with

Name:
[redacted]
This person is up for renewal

☐ Check here if this person is no longer living in the household.

☑ LDH **has** this person's Social Security number

☐ LDH does **not** have this person's Social Security number. Write it in the spaces below.

___ ___ ___ - ___ ___ - ___ ___ ___ ___

Is this person enrolled in Medicaid? ☑ Yes ☐ No	***If no*** and this person wants to **apply**, go to healthy.la.gov.
Name: [redacted] **This person is up for renewal**	☐ Check here if this person is no longer living in the household.
☐ LDH **has** this person's Social Security number ☑ LDH does **not** have this person's Social Security number. Write it in the spaces below. ___ ___ ___ - ___ ___ - ___ ___ ___ ___	
Is this person enrolled in Medicaid? ☑ Yes ☐ No	***If no*** and this person wants to **apply**, go to healthy.la.gov.

If there is anyone in your household not listed above, fill in their information here. Make a copy first if you need space for more people.	
Name *(first, middle, last & suffix)*:	If this person wants to **apply** for Medicaid, go to healthy.la.gov.
This person is: ☐ Male ☐ Female	Even if this person doesn't want coverage, providing the Social Security number speeds up application and renewal for other household members. ___ ___ ___ - ___ ___ - ___ ___ ___ ___
Date of birth *(month/day/year)*:	
How is this person related to you?	

Part 3 Information about tax returns

You can still renew if you do not file tax returns.

Review the information below for people in your household who will file a **tax return** *next* year to report income earned *this* year. Cross out anything that is wrong.
Write correct information in the space right next to it. Fill in any missing information.

Tax filer: [redacted] ☐ Check here if this person does not plan to file a tax return.	
Spouse on tax return: No tax information reported	**Dependent** on tax return: No tax information reported

If there is another tax filer in your household, fill in the information below.

Tax filer name *(first, middle, last & suffix)*:
If this person is filing a joint return, write the name of the **spouse**:
If this person will claim dependents, write the name of the **dependents**:

Part 4 Other health insurance coverage

If anyone has **other** health insurance or has job related health insurance available to them, fill in the information below.

Name of **insurance company**:	Policy number:
Insurance type:	
Is this a state employee benefit plan? ☐ Yes ☐ No	
List everyone who is on this policy:	

Part 5 More information about household members

Make a copy first if you need space for more people.

If anyone is **pregnant**, fill in the information below.
Name *(first, middle, last & suffix)*:
How many babies are expected?
When is the due date?
If anyone is an **American Indian or Alaska Native**, fill in the information below and **go to** healthy.la.gov.
Name *(first, middle, last & suffix)*:
If anyone is blind, disabled, has Tuberculosis or a physical, mental or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.), fill in the information below.
Name *(first, middle, last & suffix)*:
Disability type:

Part 6 Income from jobs

Review the information below for everyone in your household. Cross out anything that is wrong. Write correct information in the space right next to it. Fill in any missing information.

- Be sure to include any changes in wages paid.
- If someone has more than one job, tell us about **all** jobs.
- Tell us about self-employment in the ***Self-employment income*** section below.

Job	**Name of person who is working:** [redacted]	☐ Check here if this person stopped working here.
Amount this person makes in wages and tips (before taxes) [redacted] a month		**Employer** name: [redacted]
Job	**Name of person who is working:** [redacted]	☐ Check here if this person stopped working here.
Amount this person makes in wages and tips (before taxes) [redacted] a month		**Employer** name: [redacted]

If anyone has any **other** job not listed, fill in the information below.

New job	**Name of person who is working** *(first, middle, last & suffix)*:	**Start** date:
Employer name:		**Employer** phone number:
Employer address:	City:	State: Zip code:
Amount this person makes in wages and tips (before taxes): $	How often: ☐ Hourly ☐ Daily ☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly ☐ Annually ☐ One time only	If hourly, average number of hours per week:
Is this job seasonal? ☐ Yes ☐ No		

Part 7 Income from self-employment

If anyone is **self-employed**, fill in the information below and send us poof of their income.

Name of the person who is self-employed *(first, middle, last & suffix)*:	
Type of work:	How much net income will this person get from self-employment this month? **$**

Part 8 Other income

Review the information below for everyone in your household. Cross out anything that is wrong. Write correct information in the space right next to it. Fill in any missing information. You don't need to tell us about child-support or Supplemental Security Income (SSI).

If anyone in your household gets any **other** income not listed, fill in the information below for each type of income.

Examples of other income: Unemployment, Social Security (RSDI), pensions, retirement accounts, alimony received, scholarships/grants, earned income tax credit/child tax credit, capital gains, inheritance/estate, net farming/fishing, lump sum lottery or gambling winnings, death benefits, disaster or relocation assistance, rental income, royalty, workman's compensation, Veterans Administration (VA) Aid and Attendance, VA Pension or Compensation, dividends, military allotments, railroad retirement benefits, interest, trust income and tutorship funds, business income or loss, disability payments, or state retiree benefits.

Other income type:	Name of owner *(first, middle, last & suffix):*	Amount:
		$
How often:	☐ Daily ☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly ☐ Annually ☐ One time only, date received: _____	

Part 9	**Deductions** *Deductions* are expenses that are subtracted from your income on your tax return. You do not need to tell us about child support or self-employment expenses.
If anyone in your household expects to claim any deductions on their next tax return, fill in the information below for each type of deduction.	
Name *(first, middle, last & suffix)*:	
Deduction type:	
How often:	☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly ☐ Yearly ☐ Other _____

Part 10 Read and sign this application

Your rights and responsibilities

By signing and submitting this application, I state that I have permission from all of the people listed on the application to both submit their information to the Louisiana Department of Health (LDH), and receive any information about their eligibility and healthcare coverage. I understand that if anyone on this application enrolls in Medicaid, I am giving LDH our rights to any money owed to us by any other health insurance, legal settlement, a spouse or parent, or other third party.

WHAT LDH HAS THE RIGHT TO EXPECT OF YOU (the person renewing health care assistance)

REPORTING THE TRUTH: You state that the information on this application 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.

VERIFICATION OF INFORMATION: You understand that LDH is authorized to gather the information requested in this application and any supporting documentation, including social security numbers, under the Patient Protection and Affordable Care Act (Public Law No. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law No. 111-152), and the Social Security Act.

You understand that providing the requested information (including social security numbers) is voluntary. However, failing to provide it may delay or prevent you from getting health coverage through Medicaid or any other insurance affordability program.

You understand that LDH will check the information you give us to make sure it is correct. You give LDH permission to contact any outside source(s) necessary to check this information, process your application, determine eligibility, and otherwise operate the Medicaid program. These outside sources may include:

- Federal agencies (such as the Internal Revenue Service, Social Security Administration, and Department of Homeland Security), other state agencies, and/or local government agencies.
- Banks, financial institutions, and consumer reporting agencies.
- Employers identified on applications for eligibility determinations.
- Doctors or other medical providers.
- Applicants/enrollees, and authorized representatives of applicants/enrollees.
- LDH contractors engaged to perform a function for the Medicaid program.
- Anyone else as required or allowed by law.

You give these outside sources permission to give LDH any information about you, or any person necessary for this application, that it may request.

You understand that this permission will end when this application is denied, when your Medicaid eligibility ends, or when you submit a written statement to LDH cancelling this permission, whichever comes first. A cancellation may prevent you from being found to be eligible for Medicaid.

SOCIAL SECURITY NUMBERS: You understand the social security numbers will only be used to get information from these outside sources to verify income, make eligibility determinations, or for other purposes directly connected to the administration of the Medicaid program.

PAYMENT OF MEDICAL CARE BY A THIRD PARTY: You understand by accepting health care assistance, LDH has the right to get money received by you from other sources like insurance payments or lawsuit settlements for services that LDH has paid for you.

REPORTING CHANGES: You agree to tell LDH within 10 days of these changes: 1) if you move out of state; 2) changes in mailing or home address; 3) if anyone moves in or out of your home; 4) changes in health insurance and premiums; 5) changes in income; and 6) changes in things you own.

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

ANNUITIES: You agree that by accepting health care assistance, the State of Louisiana will be named as the remainder beneficiary of all annuities purchased on or after Feb. 8, 2006 for the total amount of medical assistance paid on your behalf, unless you have a spouse, minor child, or a child with a disability. In these cases, the State must be named as beneficiary after these individuals. You agree to tell LDH about any annuity you and your spouse own or co-own regardless if the annuity is irrevocable (cannot be changed) or LDH counts it. You understand that you must tell LDH about changes made to any annuity which may affect when payments begin, the amount paid, frequency of payments, and additions to the principal.

WHAT YOU (the person renewing health care assistance) HAVE THE RIGHT TO EXPECT FROM LDH

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 that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. You can file a complaint of discrimination by visiting www.hhs.gov/ocr/office/file, calling the US DHHS Regional Office for Civil Rights at 1-800-368-1019, or writing to LDH at PO Box 4818, Baton Rouge, Louisiana 70821.

ESTATE RECOVERY: You understand that Estate Recovery rules require LDH to recover the cost of certain health care assistance payments from your estate. These costs include the total amount of payments for facility services, waiver services, hospital care, and prescription drugs received at age 55 or older by Long Term Care and/or Home and Community Based Services recipients. LDH will not make a claim against the estate while you or your legal spouse is still living or if you have a dependent child who is under age 21, blind, or disabled. Collection may not be made if it is not cost effective for LDH to do so, or if your heirs apply for a hardship waiver after your death and the hardship waiver is granted by LDH. A hardship may exist if the estate property is the only source of income for the heirs, if that income is limited, or other extenuating circumstances.

Part 11 Signature

Sign this Renewal Packet in the space below. The person who filled out this renewal packet should **sign below**. If you are signing as the Authorized Representative, you must also provide proof that you are the Authorized Representative.

_____	_____	_____
Signature	**Print Name**	**Date (mm/dd/yyyy)**

We won't share your information, unless the law says we have to. We'll only use your answers to see if you are eligible for Medicaid or help paying for coverage. We'll check your answers using information we already have and information from other state and federal agencies. If it doesn't match, we may ask you to send us proof.
People who don’t want coverage won’t be asked about citizenship or immigration status.
IMPORTANT: To see if you are eligible, we may need to get information from the Internal Revenue Service (IRS), Social Security Administration (SSA), the Department of Homeland Security, and/or a consumer reporting agency. We need this information to give you the best service possible. We may also check your information later to make sure it is up to date. We'll let you know if we find something has changed.

STATE OF LOUISIANA
VOTER REGISTRATION AGENCIES
DECLARATION FORM

If you are not registered to vote where you live now, would you like to apply to register to vote here today? (Check one)

☐ I want to register to vote. ☐ I do not want to register to vote.

IF YOU DO NOT CHECK EITHER BOX, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME.

Applying to register or declining to register to vote **will not** affect the amount of assistance that you will be provided by this agency. Voter eligibility requirements are found on the voter registration application form.

Note: If you do register to vote, the location where your application was submitted will remain confidential. If you decline to register to vote, this fact will remain confidential. Applying to register or declining to register to vote will be used **only** for voter registration purposes.

If you would like help in filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private. (Check one)

☐ **Yes, I would like help.** ☐ **No, I do not want help.**

For assistance in completing the voter registration application form outside our office, contact Louisiana Department of Health and Hospitals at 1-888-342-6207.

If completed outside our office, this declaration form and your completed voter registration application form (if you filled one out) should be returned to P.O. Box 91278 Baton Rouge, LA 70821-9278.

Signature or Mark **Name Typed or Printed** **Date**

Signatures of Two Witnesses If Signed With Mark:

1) _____ 2) _____

COMPLAINTS

If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with the Louisiana Secretary of State, Commissioner of Elections, P.O. Box 94125, Baton Rouge, LA 70804-9125 or by calling (225)922-0900 or 1-800-883-2805.

Comments/Remarks (for official use only):

Louisiana Voter Registration Application (LA-VRA - Rev. 6/19)

SEE THE OTHER SIDE OF THIS PAGE FOR INSTRUCTIONS->
QUESTIONS? - Call your parish Registrar of Voters Office or call the Secretary of State at 1-800-883-2805 or (225) 922-0900.

OFFICIAL USE ONLY: **WD:**_____ **PCT:**_____ **REG. TYPE:**_____ **IN/OUT:**_____ **REG #**_____

Please print clearly in ink, preferably black.

Reason for Application: ☐ New Voter Registration ☐ Updating Voter Registration

Eligibility 1. Are you a citizen of the United States of America? ☐ Yes ☐ No
Will you be 18 years of age on or before election day? ☐ Yes ☐ No
If you checked "**No**" in response to either of these questions, do not complete this form. You are not eligible to vote at this time. **(Please see application instructions for information regarding eligibility to register prior to age 18.)**

Name 2. LAST NAME: _____ FIRST NAME: _____
FULL MIDDLE OR MAIDEN NAME: _____ SUFFIX (Sr., Jr., II) _____

Residence Address (Where you live and claim homestead exemption, if any)
Mailing Address (If different from Residence Address) 3.
HOUSE # & STREET (NO P.O. BOX): _____ UNIT/APT #: _____ **Give Location** (If Necessary)
CITY/TOWN: _____ STATE: LA ZIP CODE: _____
☐ Check if no postal service at your residence address above and supply mailing address here.
HOUSE # & STREET/P.O. BOX: _____ UNIT/APT #: _____
CITY/TOWN: _____ STATE: _____ ZIP CODE: _____

Date of Birth 4. ___/___/_____ MM DD YYYY
5. ***SSN** _____ -- _____ -- _____ XXX XX XXXX
6. **SEX** ☐ M ☐ F
7. **Race** (Optional) ☐ WHITE ☐ BLACK ☐ ASIAN ☐ HISPANIC ☐ AMERICAN INDIAN ☐ OTHER _____

Party Affiliation 8. ☐ DEMOCRAT ☐ GREEN ☐ INDEPENDENT ☐ LIBERTARIAN ☐ REPUBLICAN ☐ NO PARTY ☐ OTHER (Specify):_____
9. **Place of Birth** CITY/TOWN: _____ STATE: _____ PARISH/COUNTY: _____ COUNTRY: _____

Mother's Maiden Name 10. _____
11. **Email** _____
12. **Phone** Home: (_____) _____-_____ Other: (_____) _____-_____

LA DL/ID Card # 13. _____ ☐ I do not have a LA DL/ID card
14. **Do you need assistance in voting?** ☐ No ☐ Yes, Reason: _____

Last Residence Address 15. HOUSE # & STREET: _____ CITY: _____ STATE: _____
16. **Place of Last Registration** STATE: _____ PARISH/ COUNTY: _____
17. **Former Registered Name,** if any _____

Affirmation and Signature (Read and sign or make you mark.) 18. I do hereby solemnly swear or affirm that I am a United States citizen, that I am of eligible age to register to vote, that I have not been incarcerated pursuant to an order of imprisonment for conviction of a felony within the past five years, nor am I under an order of imprisonment for a felony offense of election fraud or other election offense pursuant to R.S. 18:1461.2, that I am not currently under a judgment of full interdiction or limited interdiction where my right to vote has been suspended, that I am a bona fide resident of this state and parish, and that the facts given by me on this application are true to the best of my knowledge and belief. If I have provided false information, I may be subject to a fine of not more than $2,000 ($5,000 for subsequent offense) or imprisonment for not more than 2 years (5 years for subsequent offense), or both.

Applicant Signature: ☒ _____ Date: _____

Witnesses (If your signature is a mark, you must have two witnesses sign.) 19.
Witness #1 Signature: ☒ _____ Witness #1 Print Name: _____
Witness #2 Signature: ☒ _____ Witness #2 Print Name: _____

***If you do not have a LA driver's license or LA special ID, the last four digits of your social security number are required if you have one. Full SSN is preferred but optional.**

Note: If you decline to register to vote, this fact will remain confidential and will be used only for voter registration purposes. If you register to vote, the office where your application was submitted will remain confidential and will be used only for voter registration purposes. You may request a copy of your voter registration form at any time from the registrar of voters.

OFFICIAL USE ONLY
☐ New Registration Updated Registration: ☐ Address Change ☐ Name Change ☐ Party Change ☐ Change to Assistance in Voting ☐ Other
REMARKS:

CIRCLE ONE:
PA MV RG SDA SS(Disability) Received by:_____ Date:_____

Louisiana Voter Registration Application (LA-VRA - Rev. 6/19)

QUESTIONS? - Call your parish Registrar of Voters Office or call the Secretary of State at 1-800-883-2805 or (225) 922-0900.

APPLICATION INSTRUCTIONS

USE THIS LOUISIANA VOTER REGISTRATION APPLICATION TO: 1) register to vote; 2) change your address; 3) request a name change; 4) change party affiliation; or 5) request assistance in voting.

TO REGISTER AND BE ELIGIBLE TO VOTE, AN APPLICANT MUST: 1) be a U.S. Citizen; 2) be at least 17 years old (16 years old if registering to vote in person at the Registrar's office or with an application for a Louisiana driver's license) but must be 18 years old before actually voting; 3) not be under an order of imprisonment for conviction of a felony or, if under such an order, not have been incarcerated pursuant to the order within the last five years and not be under an order of imprisonment related to a felony conviction for election fraud or any other election offense pursuant to R.S. 18:1461.2; 4) not be under a judgment of full interdiction or limited interdiction where your right to vote has been suspended; 5) reside in the state and parish in which you seek to register and vote.

Instructions: the gray section numbers on this page correspond to the gray section numbers on the application.

Reason for Application: Check "New Voter Registration" if this is a first time registration or if a new registration in a new parish after moving. Check "Updating Voter Registration" if you are making any change to your present registration. If new registration, fill out the form completely.

1. *Eligibility* - Federal law requires you to affirm that you are a citizen of the United States of America and that you will be 18 years of age on or before the election day in which you are eligible to vote. If you checked **"No"** in response to either of these questions, do not complete this form. You are not eligible to vote at this time. If you are registering as a 16 or 17 year old, you may check "Yes" because you will not be allowed to vote until you are 18.

2. *Name* - You **must** provide your full name. Do not use nicknames or initials for middle or maiden name. *If this application is for a change of name, please also complete section 17: "Former Registered* Name.*"*

3. *Residence Address* - "Residence Address" means the address (number, street, city, state, and zip) where you live and are registering to vote. Residence address **must** be the address where you claim homestead exemption, if any, except for a resident in a nursing home or veterans' home who may choose to use the address of the nursing home or veterans' home or the home where they have a homestead exemption. A college student may elect to use their home address or their address at school while attending. Do not use a post office box for your "Residence Address." If you use a rural route and box number, you may draw a map in box labeled "Give Location" to provide the exact location. Write in the names of the crossroads (streets) nearest to residence. Draw an X to show residence. Use a dot to show any schools, churches, stores, or landmarks near residence and write the name of the landmark.
   Mailing Address - If you check that you do not receive postal service at your residence address, you **must** provide your mailing address (number, street, city, state, and zip). Otherwise, a mailing address may be provided and you may use a post office box for a mailing address.

4. *Birthdate* - Print your date of birth. *The month and day of your birth remains confidential by law.*

5. *Social Security Number* - If you do not have a LA driver's license or LA special identification card, you **must** provide the last four digits of your social security number, if issued. The full social security number is preferred and may be provided on a voluntary basis and will be kept confidential. If you were not issued a social security number or a LA DL or ID and this form is submitted by mail, and you are registering to vote for the first time, in order to avoid additional identification requirements for first time voters you **must** attach one or more documents to prove your identity, residence and date of birth. Documents may be: a) a copy of current and valid photo identification and/or b) a copy of a current utility bill, bank statement, government check, paycheck, or other government document. *Your SSN remains confidential and is only used for registration purposes.*

6. *Sex* - Check male or female *(for statistical purposes only).*

7. *Race* - Race/Ethnic origin is optional *(for statistical purposes only).*

8. *Party Affiliation* - If you are registering for the first time, you may choose a party affiliation of Democrat, Green, Independent, Libertarian, or Republican parties. You may specify any other party affiliation by checking "other" and then listing the party with which you wish to affiliate. If you do not want to register with a political party affiliation check "No Party," or if you do not complete this section, your party affiliation will be listed as "No Party." If you are already registered with a party affiliation and no political party change is being made with this application, you may leave this section blank or re-enter your political party affiliation.

9. *Place of Birth* - Print the city/town, parish/county, state, and country of your birth place (*for statistical purposes only*).

10. *Mother's Maiden Name* - Print your mother's maiden name, which is her last name at her birth. If unknown, write "unknown."

11. *Email* - Give your email address for election officials to contact you if there is a problem with your registration. *Email addresses are protected from disclosure by law and are for official use only*.

12. *Phone* - Give your phone numbers for election officials to contact you if there is a problem with your registration. *Phone numbers are optional and a public record unless you make a request for your phone numbers to be kept confidential by election officials.*

13. *LA DL/ID Card #* - Print your LA driver's license or LA special identification card number, if issued. If you do not have one, check "I do not have a LA DL/ID card." *This ID number remains confidential and is for official use only.*

14. *Assistance in Voting Needed?* - Indicate if you will need assistance in voting by checking either the "No" or "Yes" box. If "Yes," write the reason for needing assistance. The registrar of voters in your parish may contact you for proof of disability.

15. *Place of Last Residence* - Print the address (number, street, city, and state) of your prior residence, if different from residence address in section 3 or write "Same."

16. *Place of Last Registration* - Print the state and parish (or county) of your last registration if you were registered in another parish or state prior to completing this application. ***Important:*** *Contact the local election office in your prior state and cancel your prior registration. Registering in Louisiana does not automatically cancel or transfer your voter registration from another state*.

17. *Former Registered Name* - If you are using this application to make a name change to your registration, print your former registered name (name you are changing) in this section. If name changed by court order, provide a copy of the order with this application.

18. *Affirmation and Signature* - Read the affirmation and sign your full name or make your mark and print the date this application was signed and completed. *If assistance in registering is being provided, make sure the applicant understands what they are affirming and that they meet the requirements to register to vote.*

19. *Witnesses* - If you are unable to sign your name, you may make your mark, but it **must** be witnessed by two people or it is not valid.

Mailing Instructions - If returned by mail, place in an envelope and mail to your Registrar of Voters Office. You can find your registrar of voters mailing address on the Registrar of Voters Address Page, by visiting our website at www.geauxvote.com or by calling the toll free at 1-800-883-2805. Your application or envelope **must** be postmarked 30 days prior to the first election in which you seek to vote.

Online Voter Registration - Voter registration is also available at www.geauxvote.com and you may register online before the 20th day prior to the election. Please call your registrar of voters if you do not receive your voter information card two weeks after registering.