

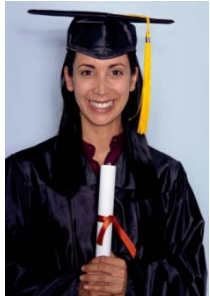
TAKE CHARGE

Louisiana Family Planning Waiver Services

Family Planning services are available to many women ages 19-44 through **TAKE CHARGE**, a Louisiana waiver program.



What is family planning?



Family Planning helps a woman avoid an unintended pregnancy. The spacing of childbirths increases a child's chances of survival and allows a mother to better plan for her children and herself. Family planning is

one important way women can **TAKE CHARGE** of their lives.

Who can qualify?

Women ages 19-44 who:

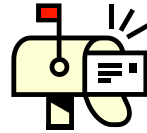
- ★ do not have Medicaid or other insurance that covers family planning;
- ★ are not pregnant; and
- ★ have not had a procedure to prevent pregnancy like a hysterectomy.

If you already get Medicaid, you are eligible for family planning services.

How to Apply

① **Online** –
www.Medicaid.DHH.Louisiana.gov.

② **Mail** –



TAKE CHARGE
P.O. Box 91278
Baton Rouge, LA
70821-9278

③ **Fax** – 1-877-523-2987 (toll-free)

④ **Drop Off** – Go to your local Medicaid Office. Call 1-888-342-6207 for the closest office or visit our web site at www.TAKECHARGE.DHH.Louisiana.gov.

Is income counted?

Yes. Your family's gross income for the month has to be less than the amounts in the chart. We give deductions for things like child support, child care payments, and \$90 for each employed person.

We **do not** count things like bank accounts, cash on hand, vehicles or property.

Number in Family	Income Amounts April 1, 2012 through March 31, 2013	
	Weekly Income	Monthly Income
1	\$466	\$1,862
2	\$631	\$2,522
3	\$796	\$3,182
4	\$961	\$3,842
5	\$1,126	\$4,502
6	\$1,291	\$5,162
More than 6	For each extra person, add \$660 to the monthly amount	

What services are covered?

- ★ Four yearly physical examinations and laboratory tests
- ★ Contraceptive counseling
- ★ Birth control products that require a prescription, such as birth control pills, patches, injections, IUDs, and diaphragms
- ★ Sterilization procedures

Questions

If you need help filling out the application or getting any of the needed proofs, call **1-888-342-6207**. If you are deaf or hard of hearing and use a TTY text telephone, call **1-800-220-5404**.

**NO enrollment fees,
NO premiums, NO co-payments
NO deductibles**

(TEAR OFF THE APPLICATION HERE BEFORE MAILING. KEEP THIS PAGE FOR YOURSELF.)

Your Rights

If you think the decision we make is unfair, not correct, or made too late, you may ask for a fair hearing by:

- ✓ Calling the Family Planning Waiver/**TAKE CHARGE** Program office at 1-888-342-6207, and/or
- ✓ Writing to
LA DHH Bureau of Appeals
P.O. Box 4183
Baton Rouge, LA 70821-4183

TAKE CHARGE is an Equal Opportunity Program.

We can't treat you differently because of your race, color, sex, age, disability, religion, nationality or political belief. If you think we have:

- ✓ Call the U.S. DHHS Regional Office for Civil Rights in Dallas, TX at 1-800-368-1019, and/or
- ✓ Call the Family Planning/**TAKE CHARGE** Program office at 1-888-342-6207, TTY users call 1-800-220-5404, and/or
- ✓ Write to
LA Department of Health & Hospitals
P.O. Box 4818
Baton Rouge, LA 70821-4818

Si ud quiere un solicitud in espanol o quiere a hablar con alguien que habla espaniol, llama
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.

This public document was printed at a total cost of \$1,408.30. Three thousand (3,000) copies were produced. The total cost of all printing of this document including reprints is \$1408.30. This document was published by the Department of Health and Hospitals, Bureau of Health Services Financing, 628 North 4th Street, Baton Rouge, LA to advise applicants, recipients, and other individuals of family planning waiver services from the **TAKE CHARGE** Program through LA DHH under authority of 42 CFR 435.905. This material was printed according to standards for printing by State agencies established pursuant to R.S. 43.31.

BHSF Form 1-FP Cover
Rev. 04/12
Prior Issue Obsolete



Application For



Helping Women Ages 19-44 TAKE CHARGE of their Lives

1-888-342-6207

Apply Online at
www.TAKECHARGE.DHH.Louisiana.gov

Louisiana Department of Health & Hospitals

TAKE CHARGE

Family Planning Waiver Application



Use this form to apply for family planning services for Women age 19-44.

How to apply

1. **Fill out and sign this application. Use black ink.** If you need extra space to answer any questions use a separate sheet of paper.
2. **Get the documents of proof.** Look for a list of things we need beginning on page 6.
3. **Send the application and proofs to us right away. We will give you more time to get the proofs to us if you need it.**

Where to send the application and proofs

Mail to: P.O. Box 91278, Baton Rouge, LA 70821-9278

Fax to: 1-877-523-2987 (toll-free)

Drop off at: Your local Medicaid office or Application Center. For the office closest to you, call 1-888-342-6207. If you are deaf or hard of hearing and have a TTY text telephone, call 1-800-220-5404.

What language do you speak best? English Spanish Vietnamese Other (specify) _____

What language do you write best? English Spanish Vietnamese Other (specify) _____

1. Tell Us About You – The woman wanting family planning waiver services.

Name _____
First Middle Initial Maiden Last

Mailing Address _____
Street Address Apartment/Lot Number

City State Zip Code

Home Address (if different) _____
P.O. Box or Street Address Apartment/Lot Number

City State Zip Code

Social Security Number _____ - _____ - _____ Date of Birth _____
Month Day Year

Parish Where You Live _____ E-mail Address _____

Home Phone (____) _____ Cell Phone (____) _____ Daytime Phone (____) _____

Best Day/Time to Call Monday through Friday between 8 a.m. and 4:30 p.m. _____

Marital Status: Married Single Separated Divorced Widowed

Race and Ethnic Background (You do not have to answer. You may mark more than one box.) White Black Asian
 American Indian or Alaska Native Hispanic or Latino Native Hawaiian or Pacific Islander

If you have questions or need help with this application, call Medicaid at 1-888-342-6207. If you are deaf or hard of hearing and have a TTY text telephone, call 1-800-220-5404. THESE CALLS ARE FREE.

2. Pregnancy

A. Are you pregnant? Yes No

B. Were you pregnant in any of the last three months? Yes No

3. Citizenship/Immigration Status

A. Are you a U.S. citizen? Yes – Go to B No – Answer next questions

Are you a lawful permanent resident? Yes No Date you came to the U.S. _____

Permanent Resident Card Number (green card #): A _____

B. Tell us where you were born.

City _____ State _____ Country _____

Mother's Full Name (first, middle initial, last) _____

Mother's Maiden Name _____

4. Tell Us About the Other People Living With You – List your husband first (if married) and then all children under age 18. If no one lives with you, go to Question 5.

*If there are more than 4 people, use a separate sheet of paper. Social Security numbers **must** be given for spouse, children, and anyone who gets Medicaid.*

Name (first, middle initial, last) _____

Date of Birth (month, day, year) _____ Social Security Number _____ - _____ - _____

Relationship to You: Husband Child Step-Child Grandchild Other _____

Name (first, middle initial, last) _____

Date of Birth (month, day, year) _____ Social Security Number _____ - _____ - _____

Relationship to You: Child Step-Child Grandchild Other _____

Name (first, middle initial, last) _____

Date of Birth (month, day, year) _____ Social Security Number _____ - _____ - _____

Relationship to You: Child Step-Child Grandchild Other _____

Name (first, middle initial, last) _____

Date of Birth (month, day, year) _____ Social Security Number _____ - _____ - _____

Relationship to You: Child Step-Child Grandchild Other _____

5. Health Insurance

Do you have health insurance? Yes – Fill Out Below No – Go to Question 6

Policyholder's Name _____ Coverage Start Date _____

Insurance Company Name and Phone Number _____

Policy Number _____ Group Number _____

It covers: Hospital Doctor Medicine Dental Ambulance Pregnancy Family Planning

6. Medical Procedures

Have you had any medical procedures which would keep you from getting pregnant like having your tubes tied or a hysterectomy? Yes No

If yes, you cannot get family planning waiver services through the TAKE CHARGE program.

7. Income from Working


Does anyone work (you, your husband, or children under age 18)? Yes – Fill out below No – Go to Question 8

Tell us about **each** full-time job, part-time job, or business.

Who works?	Employer/Business Name and Phone Number	Self Employed	How much? (show gross, not take home pay)	How often paid?
		<input type="checkbox"/> Yes <input type="checkbox"/> No		
		<input type="checkbox"/> Yes <input type="checkbox"/> No		
		<input type="checkbox"/> Yes <input type="checkbox"/> No		

8. Other Income

Tell us about any income that you, your husband, and children under age 18 get, like the kinds listed below.

Income Type	Tell us where this money is from or who pays this money. (name, address, and phone)	Who gets this income?	How much?	How often?
Social Security <input type="checkbox"/> Yes <input type="checkbox"/> No			\$	
SSI <input type="checkbox"/> Yes <input type="checkbox"/> No			\$	
Unemployment <input type="checkbox"/> Yes <input type="checkbox"/> No			\$	
Worker's Compensation <input type="checkbox"/> Yes <input type="checkbox"/> No			\$	
Child Support <input type="checkbox"/> Yes <input type="checkbox"/> No			\$	
Alimony <input type="checkbox"/> Yes <input type="checkbox"/> No			\$	
Money from Friends/Relatives <input type="checkbox"/> Yes <input type="checkbox"/> No			\$	
Other (tell us what it is) _____			\$	

9. Child Support and Alimony Paid to Someone Outside the Home

Do you or does your husband pay **court-ordered** child support or alimony to someone **outside your home**?

Yes No

If **yes**, to whom? _____ Monthly Amount \$ _____

10. Child Care/Adult Care

Do you or does your husband pay for child care or pay for care for an adult **with a disability** in order to work, go to school, or get training? Yes No If **yes**, tell us about it below.

Name of Child(ren) or Adult Who Gets Care _____

Who pays for the care? _____ How much is paid each month? _____

Is help received with paying it from anyone or another program? Yes No How much? _____

Name of Center or Caregiver _____ Phone Number (____) _____

11. Where did you get this TAKE CHARGE application form?

- Medicaid office hospital/clinic pharmacy doctor's office school Internet
- Office of Family Support friend/relative business church festival/health fair
- Toll Free hotline number Social Security Office other _____

12. Disability Benefits and Medicare

A. Are you unable to work because of a disability? Yes No

B. Did you ever get Medicare? Yes No

The Medicare Card looks like this.

C. Did you ever receive Social Security Disability payments or SSI? Yes No



THIS IS THE END OF THE APPLICATION. YOU MUST 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 also acknowledge that I have received and read the Rights and Responsibilities on the next page.

Sign Your Name Here: _____ **Date:** _____

If someone working for Medicaid helped you fill out this form, they will sign below.

_____ **Date:** _____

Please send the application to the TAKE CHARGE program office right away. The address is P.O. Box 91278, Baton Rouge, LA 70821-9278, and the fax number is 1-877-523-2987. We will give you more time to get the proofs to us if you need it.

YOUR RIGHTS AND RESPONSIBILITIES

WHAT MEDICAID/TAKE CHARGE PROGRAM HAS THE RIGHT TO EXPECT OF YOU

CITIZENSHIP AND IMMIGRATION STATUS: You state that the information about citizenship and immigration status given on 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 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/ **TAKE CHARGE** Program for the bills it paid by mistake.

VERIFICATION OF INFORMATION: 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/**TAKE CHARGE** Program 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 eligibility for you and/or the person(s) applying for Medicaid/family planning waiver services.

PAYMENT OF MEDICAL CARE BY A THIRD PARTY: You understand by accepting Medicaid/family planning waiver services, 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/**TAKE CHARGE** Program has paid for you and/or the person(s) applying.

REPORTING CHANGES: You agree to tell Medicaid/**TAKE CHARGE** Program within 10 days of these changes: 1) if anyone getting family planning waiver services moves out of state; 2) if there are any changes in your mailing or home address; 3) if anyone getting family planning gets health insurance or Medicare; and 4) if anyone getting family planning becomes pregnant.

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

WHAT YOU HAVE THE RIGHT TO EXPECT FROM MEDICAID/TAKE CHARGE PROGRAM

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 Medicaid/**TAKE CHARGE** Program 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

Send Us These Things

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

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

If you were **not** born in Louisiana **AND** you have never received benefits from Social Security Disability, Supplemental Security Income (SSI), or Medicare, send proof of U.S. Citizenship such as birth certificate or U.S. Passport. If you don't have these, ask us about other things you may use.

Pay stubs from last month showing gross pay (before taxes) or a letter from the employer. If self-employed, send copies of last year's tax return and all schedule attachments – for you, your husband, and children.

Proof of gross income (before taxes) from Veteran's Benefits, worker's comp, alimony, and any other income that is not from working. Proof could be award letters and 1099 tax statements from last year's tax return - for you, your husband, and children.

Statement from friends or relatives who give money to you, your husband, or children.

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 that you or your husband **PAYS** to someone **outside your home**. If it is paid through Louisiana Support Enforcement Services (SES), you **do not** have to send proof – let us know.

Department of Health and Hospitals
Voter Registration Declaration (Optional)

If you fill it out, your answers will not affect the benefits you get from the
Louisiana Department of Health and Hospitals.

If you are not registered to vote where you live now, would you like to apply to register to vote here today? Yes No

- If you checked "Yes," please complete the attached form called the "Louisiana Mail Voter Registration Application." You may mail your completed Voter Registration Application to your local Registrar of Voters listed on the application or mail it to the Department of Health and Hospitals.
- **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.

If you would like help in filling out the voter registration application form, we will help you. **You may call us toll-free at 1-888-342-6207.** The decision whether to seek or accept help is yours. You may fill out the application form in private.

If you choose to register to vote at this time, the information about the location where you completed the application to register will remain confidential and will only be used for voter registration purposes. If you choose not to register to vote, that information will also be kept confidential.

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:

Louisiana Secretary of State
Commissioner of Elections
P.O. Box 94125
Baton Rouge, LA 70804-9125
Phone: (toll-free) 1-800-883-2805

Print Your Name

Social Security Number

Date of Birth

Sign Your Name

Today's Date

ACADIA

Courthouse #115
Crowley, LA 70526-4363
(337) 788-8841

ALLEN

P. O. Box 150
Oberlin, LA 70655-0150
(337) 639-4966

ASCENSION

828 S. Irma Blvd. #205
Gonzales, LA 70737-3631
(225) 621-5780

ASSUMPTION

P. O. Box 578
Napoleonville, LA 70390-0578
(985) 369-7347

AVOYELLES

312 N. Main St. #E
Marksville, LA 71351-2409
(318) 253-7129

BEAUREGARD

P. O. Box 952
DeRidder, LA 70634-0952
(337) 463-7955

BIENVILLE

P. O. Box 697
Arcadia, LA 71001-0697
(318) 263-7407

BOSSIER

P. O. Box 635
Benton, LA 71006-0635
(318) 965-2301

CADDO

P.O. Box 1253
Shreveport, LA 71153-1253
(318)226-6891

CALCASIEU

1000 Ryan St. #7
Lake Charles, LA 70601-5250
(337)437-3572

CALDWELL

P. O. Box 1107
Columbia, LA 71418-1107
(318) 649-7364

CAMERON

P. O. Box 1
Cameron, LA 70631-0001
(337) 775-5493

CATAHOULA

P. O. Box 215
Harrisonburg, LA 71340-0215
(318) 744-5745

CLAIBORNE

507 W. Main Suite 1
Homer, LA 71040-3914
(318) 927-3332

CONCORDIA

4001 Carter St. #4
Vidalia, LA 71373-3021
(318) 3367770

DESOTO

105 Franklin St.
Mansfield, LA 71052-2046
(318) 872-1149

E. BATON ROUGE

222 St. Louis #201
Baton Rouge, LA 70802-5860
(225) 389-3940

E. CARROLL

P. O. Box 708
Lake Providence, LA 71254-0708
(318) 559-2015

E. FELICIANA

P. O. Box 488
Clinton, LA 70722-0488
(225) 683-3105

EVANGELINE

200 Court St. Ste. 102
Ville Platte, LA 70586-4463
(337) 363-5538

FRANKLIN

Courthouse
6560 Main St.
Winnsboro, LA 71295-2750
(318) 4354489

GRANT

Courthouse
200 Main St.
Colfax, LA 71417-1828
(318) 627-9938

IBERIA

300 S. Iberia St. #110
New Iberia, LA 70560-4543
(337) 369-4407

IBERVILLE

P. O. Box 554
Plaquemine, LA 70765-0554
(225) 687-5201

JACKSON

500 E. Court St. #102
Jonesboro, LA 71251-3400
(318) 259-2486

JEFFERSON

P. O. Box 10494
Jefferson, LA 70181-0494
(504) 736-6191

JEFFERSON DAVIS

302 N. Cutting Ave.
Jennings, LA 7054-65361
(337) 824-0834

LAFAYETTE

1010 Lafayette #313
Lafayette, LA 70501-6885
(337) 291-7140

LAFOURCHE

307 W. 4th St. #101
Thibodaux, LA 70301-3105
(985) 447-3256

LASALLE

P. O. Box 2439
Jena, LA 71342-2439
(318) 992-2254

LINCOLN

100 W. Texas Ave.
Ruston, LA 71270-4463
(318) 251-5110

LIVINGSTON

P. O. Box 968
Livingston, LA 707540968
(225) 686-3054

MADISON

100 N. Cedar St.
Tallulah, LA 71282-3892
(318) 574-2193

MOREHOUSE

129 N. Franklin
Bastrop, LA 71220-3815
(318) 281-1434

NATCHITOCHES

P. O. Box 677
Natchitoches, LA 71458-0677
(318) 357-2211

ORLEANS

1300 Perdido #1W23
New Orleans, LA 70112-2127
(504) 658-8300

OUACHITA

122 St John St #114
Monroe, LA 71201-7342
(318) 3271436

PLAQUEMINES

P. O. Box 989
Port Sulphur, LA 70083-0989
(504) 564-6957

POINTE COUPEE

211 E. Main St.
New Roads, LA 70760-3661
(225) 638-5537

RAPIDES

701 Murray St.
Alexandria, LA 71301-8099
(318) 473-6770

RED RIVER

P. O. Box 432
Coushatta, LA 71019-0432
(318) 932-5027

RICHLAND

P. O. Box 368
Rayville, LA 71269-0368
(318) 728-3582

SABINE

400 Capitol St. #107
Many, LA 71449-3099
(318) 256-3697

ST. BERNARD

8201 W. Judge Perez Rm. 104
Chalmette, LA 70043-1696
(504) 278-4231

ST. CHARLES

P. O. Box 315
Hahnville, LA 70057-0315
(985) 783-2731

ST. HELENA

P. O. Box 543
Greensburg, LA 70441-0543
(225) 222-4440

ST. JAMES

P. O. Box 179
Convent, LA 70723-0179
(225) 562-2330

ST. JOHN

1801 W. Airline Hwy
LaPlace, LA 70068-3344
(985) 652-9797

ST. LANDRY

P. O. Box 818
Opelousas, LA 70571-0818
(337) 948-0572

ST. MARTIN

Courthouse
415 S. Martin St.
St. Martinville, LA 70582-4549
(337) 394-2204

ST. MARY

500 Main St. #301
Franklin, LA 70538-6144
(337) 828-4100

ST. TAMMANY

701 N. Columbia St.
Covington, LA 70433-2709
(985) 809-5500

TANGIPAHOA

P. O. Box 895
Amite, LA 70422-0895
(985) 748-3215

TENSAS

P. O. Box 183
St. Joseph, LA 71366-0183
(318) 766-3931

TERREBONNE

P. O. Box 9189
Houma, LA 70361-9189
(985) 873-6533

UNION

P. O. Box 235
Farmerville, LA 71241-0235
(318) 368-8660

VERMILION

100 N. State St. #120
Abbeville, LA 70510
(337) 898-4324

VERNON

P. O. Box 626
Leesville, LA 71496-0626
(337) 239-3690

WASHINGTON

Courthouse Bldg.
900 Washington St.
Franklinton, LA 70438
(985) 839-7850

WEBSTER

P. O. Box 674
Minden, LA 71058-0674
(318) 377-9272

W. BATON ROUGE

P. O. Box 31
Port Allen, LA 70767-0031
(225) 336-2421

W. CARROLL

P. O. Box 71
Oak Grove, LA 71263-0071
(318) 428-2381

W. FELICIANA

P. O. Box 2490
St. Francisville, LA 70775-2490
(225) 635-6161

WINN

Courthouse Room 105
Winnfield, LA 71483-3238
(318) 628-6133

OFFICIAL USE ONLY**Address Change**

Name Change

Party Change

Remarks

Circle One: PA MV RG SDA SS

Received by: _____

PLACE IN AN ENVELOPE AND MAIL TO YOUR
REGISTRAR OF VOTERS

USE THIS FORM TO: 1) register to vote 2) change your address 3) request a name change 4) change party affiliation

TO REGISTER TO VOTE AND BE ELIGIBLE TO VOTE YOU MUST: 1) be a United States citizen 2) be at least 17 years old to register but must be 18 years old to vote 3) not be under an order of imprisonment for conviction of a felony 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 FOR COMPLETING THIS FORM: All information except your signature should be printed clearly in ink, preferably black, or typed. Fill in all boxes that apply to you.

Box 1: Indicate whether you are a citizen of the United States of America. Indicate whether you will be 18 years of age on or before election day.

Box 2: Provide full name. Do not use initials for middle or maiden name.

Box 3: 'Residence Address' means the address where you live and are registering to vote. If you claim a homestead exemption, you must list the address of that residence. Do not use a post office box for your 'Residence Address'. If you use a rural route and box number, draw a map in the space labeled 'Give Location.' Write in the names of the crossroads (streets) nearest to where you live. Draw an X to show where you live. Use a dot to show any schools, churches, stores or landmarks near where you live and write the name of the landmark. Check the box provided if mail is not delivered to your residence address by the post office. Complete 'Mailing Address' only if it is different from the 'Residence Address' or if mail is not delivered to your residence address.

Box 4: Provide your age.

Boxes 6 & 14: You must provide your Louisiana driver's license number, if issued. If not issued, you must provide at least the last four digits of your social security number, if issued. The full social security number may be provided on a voluntary basis. If neither a social security number nor a Louisiana driver's license number has been issued, 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, attach either a) a copy of a current and valid photo identification or b) a copy of a current utility bill, bank statement, government check, paycheck, or other government document that shows your name and address.

Boxes 8, 12 & 13: The items 'race/ethnic origin', 'home phone' and 'daytime phone' are not required but are helpful.

Box 9: If you do not complete this item, your party affiliation will be listed as 'none', unless you are presently registered with a party affiliation and no change is being made today. If you are not registering with a political party, circle 'none'. The recognized political parties are Democrat, Green, Libertarian, Reform and Republican or you may specify any other party affiliation.

Box 18: If you are using this form to request a change of name, you must print the name to be changed here.

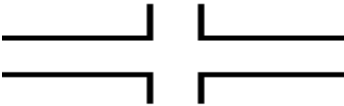
Box 19: Date and sign the card with your signature or mark.

If returned by mail, place in an envelope and mail to the appropriate registrar of voters at the address found on the reverse side of this card. If you have not been issued a social security number or Louisiana driver's license number, you must mail the required documentation with your application. Your application or envelope must be postmarked 30 days prior to the first election in which you seek to vote based on the residence listed on this application.

NOTE: 1. 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. 2. Your social security number will also remain confidential and is intended to be used for voter registration purposes only.

QUESTIONS? Call your Parish Registrar of Voters OR call the Department of State at 1-800-883-2805 or (225) 922-0900.

COMPLETE AND CHECK ALL APPLICABLE BOXES AND TEAR ALONG PERFORATED LINE BEFORE MAILING.

LOUISIANA MAIL VOTER REGISTRATION APPLICATION FORM #04				OFFICIAL USE ONLY COMP REG # _____ Reg Type _____ Wd/ Dist _____ Pct _____ In _____ Out _____			
1 Are you a citizen of the United States of America? YES <input type="checkbox"/> NO <input type="checkbox"/> Will you be 18 years of age on or before election day YES <input type="checkbox"/> NO <input type="checkbox"/> If you checked no in response to either of these questions, DO NOT COMPLETE THIS FORM.							
2 NAME OF APPLICANT (PLEASE PRINT NAME)						GIVE LOCATION 	
LAST		First		FULL MIDDLE OR MAIDEN			
3 RESIDENCE ADDRESS (MUST BE ADDRESS WHERE YOU CLAIM HOMESTEAD EXEMPTION, IF ANY)							
HOUSE OR APT. NO. & STREET				CITY OR TOWN		STATE ZIP	
IF NO mail delivery to residential address, check here: ()				MAILING ADDRESS IF DIFFERENT			
4 AGE		5 DATE OF BIRTH		6 * SOCIAL SECURITY #(CIRCLE ONE)		7 SEX (CIRCLE ONE)	
		MONTH DAY YEAR		NO YES # _____		MALE FEMALE	
8 ** RACE/ ETHNIC ORIGIN (CIRCLE ONE)							
WHITE BLACK ASIAN HISPANIC AMER. INDIAN OTHER: _____							
9 PARTY AFFILIATION (CIRCLE ONE)				10 APPLICANTS'S PLACE OF BIRTH			11 MOTHERS MAIDEN NAME
DEM GRN LBT RFM REP NONE OTHER (SPECIFY) _____				CITY OR TOWN		PARISH OR COUNTY	STATE COUNTRNY
12 ** HOME PHONE			13 ** DAYTIME PHONE		14 LA DRIVERS LICENSE / I.D. #(CIRCLE ONE)		15 Will you require assistance at the polls?(CIRCLE ONE)
()			()		NO YES # _____		NO YES IF YES, GIVE REASON
16 LAST RESIDENCE ADDRESS			17 PLACE OF REGISTRATION			18 FOMER REGISTERED NAME, IF APPLICABLE	
ADDRESS			PARISH OR COUNTY			STATE	
AFFIRMATION : I do hereby solemnly swear or affirm that I am a United States citizen, that I am at least 17 years old, that I am not currently under an order of imprisonment for conviction of a felony, 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 \$1,000 (\$2,500 for subsequent offense) or imprisonment for not more than 1 year.							
19 SIGN YOUR NAME IN BOX AT RIGHT							
DATE: _____ / _____ / _____							
20 IF YOU ARE UNABLE TO SIGN YOUR NAME, TWO WITNESSES TO YOUR MARK MUST SIGN HERE							
WITNESS SIGNATURE				WITNESS SIGNATURE			
* Last 4 digits of the social security number required if no LA driver's license issued; social security number is intended to be used for voter registration purposes only Full # Optional ** OPTIONAL							
LR-1M (REV. 1/11, 7/11) R.S. 18:104 FORM #04							