STEP 1 Tell us about yourself

(We need one adult in the family to be the contact person for your application.)

1. First name, Middle name, Last name, & Suffix Portia Buckley			
2. Home address (Leave blank if you don't have one) Ap #707-3611 Massa. Road			3. Apartment or suite number 585-41-8201
4. City Cleveland	5. State OH	6. ZIP code 11223	7. Parish
8. Mailing address (if different from home address) P.O. Box 641, 2548 Quisque Ave			9. Apartment or suite number 643-01-3340
10. City Shreveport	11. State LA	12. ZIP code 78558	13. Parish
14. Phone number (822) 549-1269		15. Other phone number (230) 308-6613	

16. Do you want to get information about this application by e-mail? ■ Yes ☐ No

E-mail address: integer@yahoo.org

17. What is your preferred spoken or written language (if not English)?

Urdu

STEP 2 Tell us about your family

Who do you need to include on this application?

Tell us about all the family members who live with you. If you file taxes, we need to know about everyone on your tax return. (You don't need to file taxes to get health coverage).

DO Include:

- Yourself
- Your spouse
- Your children under 21 who live with you
- Your unmarried partner who needs health coverage
- Anyone you include on your tax return, even if they don't live with you
- Anyone else under 21 who you take care of and lives with you

You DON'T have to include:

- Your unmarried partner who doesn't need health coverage
- Your unmarried partner's children
- Your parents who live with you, but file their own tax return (if you're over 21)
- Other adult relatives who file their own tax return

The amount of assistance or type of program you qualify for depends on the number of people in your family and their incomes. This information helps us make sure everyone gets the best coverage they can.

Complete Step 2 for each person in your family. Start with yourself, then add other adults and children. If you have more than 4 people in your family, you'll need to make a copy of the pages and attach them. You don't need to provide immigration status or a Social Security Number (SSN) for family members who don't need health coverage. We'll keep all the information you provide private and secure as required by law. We'll use personal information only to check if you're eligible for health coverage.

NEED HELP WITH YOUR APPLICATION? Visit www.medicaid.la.gov or call us at **1-888-342-6207**. If you need help in a language other than English, call **1-888-342-6207** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-800-220-5404**.

STEP 2: PERSON 1 (Start with yourself)

Complete Step 2 for yourself, your spouse/partner, and children who live with you and/or anyone on your same federal income tax return if you file one. See page 1 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you.

1. First name, Middle name, Last name, & Suffix

Clarke Walter

2. Date of birth (mm/dd/yyyy)

04/27/1970

3. Sex ☒ Male ☐ Female

4. Social Security number (SSN) 363-27-0478

We need this if you want health coverage and have an SSN. We only use SSNs to check income and other information from other government agencies, financial institutions, and other sources to see who's eligible for help with health coverage costs. Providing your SSN can be helpful even if you don't want health coverage, and can speed up the application process. If someone wants help getting an SSN, call **1-800-772-1213** or visit **www.socialsecurity.gov**. TTY users should call **1-800-325-0778**.

5. **If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)**

☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

6. **Race (OPTIONAL—check all that apply.)**

☐ White
☐ Black or African American
☐ American Indian or Alaska Native
☐ Asian Indian
☐ Chinese
☐ Filipino
☐ Japanese
☐ Korean
☐ Vietnamese
☐ Other Asian
☐ Native Hawaiian
☐ Guamanian or Chamorro
☐ Samoan
☐ Other Pacific Islander
☐ Other _____

7. **Do you plan to file a federal income tax return NEXT YEAR?**
(You can still apply for health insurance even if you don't file a federal income tax return.)

☐ **YES. If yes,** answer questions a–c. ☐ **NO. If no,** skip to question c.

a. Will you file jointly with a spouse? ☐ Yes ☐ No
If yes, name of spouse: _____

b. Will you claim any dependents on your tax return? ☐ Yes ☐ No
If yes, list name(s) of dependents: _____

c. Will you be claimed as a dependent on someone's tax return? ☐ Yes ☐ No
If yes, please list the name of the tax filer: _____
How are you related to the tax filer? _____

8. Are you pregnant? ☐ Yes ☐ No **If yes,** how many babies are expected during this pregnancy? _____

9. **Do you need health coverage?**
(Even if you have insurance, there might be a program with better coverage or lower costs.)

☐ **YES. If yes,** answer all the questions below. ☐ **NO. If no,** SKIP to the income questions on page 3.

10. Do you have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.)? ☐ Yes ☐ No **If yes,** you'll need to complete and include Appendix D.

11. Do you live in a medical facility or nursing home? ☐ Yes ☐ No **If yes,** you'll need to complete and include Appendix D.

12. Do you want help paying for medical bills (paid or unpaid) for medical care received in the past 3 months? ☐ Yes ☐ No

13. Do you live with at least one child under the age of 19, and are you the main person taking care of this child? ☐ Yes ☐ No

14. Were you in foster care at age 18 or older? ☐ Yes ☐ No
a. **If yes,** in which state? _____ b. Were you on Medicaid? ☐ Yes ☐ No c. How old were you when you left foster care? _____

15. Did you have insurance through a job and lose it within the past 6 months? ☐ Yes ☐ No
a. **If yes,** end date: _____ b. Reason the insurance ended: _____

16. Are you a full-time student? ☐ Yes ☐ No

17. Are you a U.S. citizen or U.S. national? ☐ Yes ☐ No
If yes, were you born in the U.S. or a U.S. territory? ☐ Yes ☐ No **If no,** fill in your information below (if it applies to you).
a. Alien number _____ b. Certificate type _____ c. Certificate number _____
If no, do you have eligible immigration status? ☐ Yes ☐ No **If yes,** fill in your information below (if it applies to you).
a. Document type _____ b. Document expiration date (mm/dd/yyyy) _____
c. Alien, I-94, or SEVIS ID number _____ d. Card or Passport number _____
e. Have you lived in the U.S. since 1996? ☐ Yes ☐ No f. Are you or your spouse or parent a veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

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