For LA HAP Staff Use Only

Reviewer's Initials ______________ Data Entry's Initials ____________

Date Complete Form Received: ___________________ Date Changes Updated: ____________________________

LOUISIANA HEALTH ACCESS PROGRAM (LA HAP) INFORMATION CHANGE FORM

Please print clearly. If you need assistance completing this form, please contact LA HAP at 504-568-7474. The form may be mailed to 1450 Poydras St, Suite 2136, New Orleans, LA 70112 or faxed to 504-568-3157. Remember to include all 3 pages & required documents.

Complete this form if you are an active LA HAP member and need to update your information.
Check the box and complete only the section(s) that need to be updated. Submit all three (3) pages.

First Name:	Last Name:	Date of Birth: ___/___/_____

☐ REPORT LOSS OF INSURANCE AND CHANGE APPROVED SERVICES

Required Documents: Fill in the insurance information in questions 1 and 2 below. A copy of the termination or cancellation notice is preferred but not required. No additional documentation is required to change your assistance type.

NOTE: If you have new insurance or are switching insurance and you are requesting LA HAP assistance with your insurance coverage, do NOT use this form. Use the LA HAP Insurance Change form available at www.lahap.org.

1. Type of policy lost *(check all that apply)* ☐ Health ☐ Dental ☐ Vision ☐ Medicare Part D

2. When did your insurance end? ________/_________/____________. **(must be completed)**

3. Why did your insurance coverage end? **(must be completed)**

☐ I had insurance through my job but I no longer work for that company.

☐ My insurance coverage ended because the premium was not paid.

☐ My insurance coverage ended because of another reason.
Explain: ____

☐ CHANGE LEGAL NAME

Required Documents: Social Security card in new legal name, government issued ID/driver's license in new legal name, legal affidavit stating former and new legal name, **or** marriage license

1. Former or Old Legal Name (first and last name)

2. New Legal Name (first and last name)

☐ CHANGE RESIDENCE ADDRESS

Required Documents: Fill in your updated residential address in questions 1 to 12 below. No additional documentation is required to change your residence address.

1. Are you currently homeless? **(residential address, mailing address, & proof of state residency still required)** ☐ Yes ☐ No

2. Residential Address (where you sleep; no PO Boxes)		3. Apartment/Unit #
4. City	5. State	6. ZIP Code

7. Do you want mail, **including your LA HAP card**, sent to your new residential address? ☐ Yes. Send mail and my card to my new residential address. ☐ No. Do not send mail or my card to my new residential address. **Fill** in your mailing address in questions 7 to 11.

8. Mailing Address (if different than residential address; can use provider's address)		9. Apartment/Unit #
10. City	11. State	12. ZIP Code

☐ CHANGE MAILING ADDRESS

Required Documents: Fill in your updated mailing address in questions 1 to 5 below. No additional documentation is required to change your mailing address.

1. Mailing Address (if different than residential address; can use provider's address)		2. Apartment/Unit #
3. City	4. State	5. ZIP Code

Once completed, this form contains confidential information that is legally privileged and must be protected in compliance with HIPAA regulations.

First Name:	**Last Name:**

☐ CHANGE DEMOGRAPHIC INFORMATION

Required Documents: Fill in your updated demographic information in questions 1 to 5 below. No additional documentation is required to change your demographic information.

1. Gender: ☐ Male ☐ Female ☐ Transgender (Male to Female) ☐ Transgender (Female to Male) ☐ Transgender (transition unknown)

2. Are you currently pregnant? ☐ Male - Not Applicable ☐ Yes – Due Date: ________/_________ ☐ No

3. Race: **(both race and ethnicity must be provided)**
☐ Amer. Indian or AK Native ☐ Asian ☐ Black / African American ☐ Native Hawaiian or Pacific Islander ☐ White / Caucasian ☐ Other

4. Ethnicity: **(both race and ethnicity must be provided)** ☐ Hispanic ☐ Non-Hispanic

5. Relationship Status: **("Partnered" can be checked in addition to "Divorced," "Separated," <u>or</u> "Widowed," if applicable.)**
- ☐ Single: *never married and not living with girlfriends, boyfriends, partners, or significant others*
- ☐ Married: *legally married and living with legal spouse*
- ☐ Divorced: *was legally married but is no longer legally married*
- ☐ Separated: *legally married but living apart from legal spouse* **Date Separated:** ___________
- ☐ Partnered: *not legally married and living with girlfriends, boyfriends, partners, or significant others*
- ☐ Widowed: *was legally married but spouse became deceased and surviving spouse has not legally remarried*

☐ CHANGE HOUSEHOLD INFORMATION

Required Documents: Fill in your updated household information in questions 1 to 2 below. No additional documentation is required to change your household information.

*Household is considered all persons related by blood, state defined legal marriage, and/or legal adoption living in the same dwelling. Household size does not include "common law" spouses, girlfriends, boyfriends, partners, or significant others. A legally married couple that is separated and are not living together will be considered separate households.

1. Including you, what is the number of persons in your household*? ________ **Cannot be 0**. If one (1), do not answer question 2.

2. If the number of persons in your household is greater than 1, list each household member's age and relationship to you below.

Relationship	Age **or** Date of Birth
a.	
b.	
c.	
d.	
e.	
f.	

☐ CHANGE APPLICANT EMPLOYMENT INFORMATION

Required Documents: Fill in your updated employment information in questions 1 to 3 below. No additional documentation is required to change your employment information.

1. What is your current employment status? **<u>Check only one</u>**
- ☐ Employed – Full time ☐ Employed – Part time ☐ Employed – Seasonal/Temporary
- ☐ Student – Employed ☐ Student – Unemployed: **Skip** questions 2-3 ☐ Retired: **Skip** questions 2-3
- ☐ Unemployed: **Skip** questions 2-3 ☐ Medically Unable to Work: **Skip** questions 2-3

2. What is your employer's name? **If you have more than one employer, list all employers' names.** (Example: Bill's Lawn Service)

3. How often are you paid? ☐ Once a week ☐ Every 2 weeks ☐ Once a month ☐ Other, specify: ____________

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First Name:	**Last Name:**

☐ CHANGE HOUSEHOLD INCOME INFORMATION

Required Documents: income documentation must be provided for all sources checked below for all household members age 18 or older. Examples of acceptable forms of income documentation are listed for each income source. If the applicant is younger than 18 years old, income is considered for each parent living in the home unless there are extenuating circumstances.

1. Does your household receive income from any of the following source(s)? **Check all that apply**
   Annual Gross Amount to be calculated by LA HAP staff. Leave blank.

Income Source	Applicant	Household	Annual Gross Amount **(LA HAP staff use only)**	Acceptable Forms of Income Documentation
a. Salary/Wages/Commission/Tips	☐	☐	$	Pay stub indicating time period covered; Current tax year document; or Legal affidavit stating income.
b. Alimony/Child Support	☐	☐	$	Benefit award letter; Legal documentation declaring the amount received on a routine basis; or Bank statement showing gross monthly deposit.
c. Food Stamps/SNAP	☐	☐	$	
d. Supplemental Security Income (SSI)	☐	☐	$	
e. Social Security Retirement/Survivor's Income	☐	☐	$	
f. Social Security Disability Insurance (SSDI) **SSDI start date ______/______/_________**	☐	☐	$	
g. Retirement/Pension	☐	☐	$	
h. Unemployment Benefits	☐	☐	$	
i. Veterans Administration (VA) Pension/Benefits	☐	☐	$	
j. No Income of any kind	☐	☐	$ 0	Legal affidavit stating lack of income; Certification of No Income; or Statement from unemployment office verifying no record of employment;
k. Other Income, fill in source below: ____________________________________	☐	☐	$	If other, must specify source and provide income documentation.
Total Annual Household Income **(LA HAP staff use only)**			$	

2. Have you applied for Social Security Income (SSI)? ☐ Yes – application date ______/_______ ☐ No
3. Have you applied for Social Security Disability Income (SSDI)? ☐ Yes – application date ______/_______ ☐ No

ADDITIONAL COMMENTS

Please provide any additional comments you feel may be helpful in the review of this information change form.

CURRENT PROVIDER (case manager, social service staff, etc.) INFORMATION (if applicable)

______________________________________ __________________________
PRINT First and Last Name of Provider — Provider Phone Number and Extension

______________________________________ __________________________
Provider Entity/Agency Name — Provider Fax Number

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