LOUISIANA HEALTH ACCESS PROGRAM CERTIFICATION OF LOUISIANA RESIDENCY

Please print clearly. If you need assistance completing this form, please contact LA HAP at 504-568-7474. The form may be attached to your LA HAP application and mailed to 1450 Poydras St, Suite 2136, New Orleans, LA 70112 or faxed to 504-568-3157.

If no other documentation of Louisiana residency is available, this form can be used to certify residency when applying to or recertifying for the Louisiana Health Assistance Program (LA HAP).
First Name:
Last Name:
Date of Birth: __________/__________/______________________

LOUISIANA RESIDENCY VERIFICATION (to be completed by applicant)

☐ **I certify that I currently reside in the State of Louisiana.**

The address at which I currently reside is:

Address: ____ **Apt. or Suite #:** ____________

City: ____ **State:** ____________ **ZIP Code:** _________________

If you are in a situation of homelessness, enter above the address that best approximates your residence.

CERTIFICATION (to be completed by applicant)

By initialing to the left of each statement and signing below, I agree that:

_______I understand that verification of Louisiana residency is required to determine eligibility for all Ryan White programs, including the Louisiana Health Access Program (LA HAP) components Louisiana Drug Assistance Program (LDAP) and Health Insurance Program (HIP).

_______I understand that the program I am applying for may verify the information on this form and I may be required to submit additional documents, if requested. Failure to do so within the specified deadline will result in my file being closed to the program.

_______I understand that if my address changes, I must notify LA HAP immediately.

_______I understand that if I deliberately misrepresent information on this form, I may be required to repay benefits to the program and I may be prosecuted under applicable state and federal statutes.

_______To the best of my knowledge the above information is accurate and complete as of today’s date. I understand that in order to confirm my eligibility for LA HAP, my information may be shared with but is not limited to the following: physician, health department personnel, treatment center personnel, pharmacy services provider, referral source, clinic, insurance broker and/or insurance carrier, Medicare, Medicaid CMS, SSA, SSDI, and other Louisiana agencies from which I receive Ryan White services.

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Applicant (Print Name) Applicant Signature Date

Entity Representative: By signing below, I certify that the purpose of this form and the above Client Certification & Release has been explained to the client, and that to the best of my knowledge the above information is accurate and complete as of today’s date.

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Entity Representative or Witness (Print Name) Entity Representative or Witness Signature Date

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