

John Bel Edwards  
GOVERNOR



Rebekah E. Gee MD, MPH  
SECRETARY

**State of Louisiana**  
Louisiana Department of Health  
Office of Aging and Adult Services

Thank you for your interest in the Traumatic Head and Spinal Cord Injury Trust Fund.

The Application for Services packet includes the application and the Medical Eligibility forms. Please make sure when you return this application the Medical Eligibility form is included. The **Medical Eligibility Form** MUST be completed and signed by a MEDICAL DOCTOR before sending the application back to us.

**PLEASE DO NOT FAX THIS APPLICATION BACK TO US**

Return the completed forms to:

THSCI Trust Fund Program  
P.O. Box 2031 – BIN #14  
Baton Rouge, LA 70821-2031

If you have any questions, or need any additional information, please feel free to contact our office at: 1-888-891-9441 or (225) 219-2410.

For additional resources, please contact:

The Traumatic Head and Spinal Cord Injury Resource Center  
8325 Oak Street,  
New Orleans, La 70118  
1-504-982-0685  
Info@biala.org

Sincerely,

A handwritten signature in cursive script, appearing to read "Alicia Smith".

Alicia Smith  
Program Manager

## **Traumatic Head and Spinal Cord Injury (THSCI) Trust Fund Program**

### **What is the purpose of the THSCI Program?**

The THSCI program was created to provide services in a flexible, individualized manner to Louisiana citizens who survive traumatic head or spinal cord injuries. The THSCI program assists people to return to a reasonable level of functioning and independent living in their communities.

The trust fund is designed to be a program of last resort. A person must seek assistance from all available resources before the trust fund can provide financial assistance or services.

### **If I qualify, what services can be paid for by this program?**

- Evaluations
- Post-acute medical care rehabilitation
- Therapies
- Medication
- Attendant care
- Equipment necessary for activities of daily living
- Other goods and services deemed appropriate and necessary

### **What limitations apply to this program?**

- The service providers must be approved by the THSCI Trust Fund Advisory Board; in-state facilities/programs are given priority for approval as service providers.
- Services are provided on a first-come, first-served basis.
- Expenditures shall not exceed \$15,000.00 for any 12-month period with a \$50,000.00 life time maximum per person.

## Who can qualify for THSCI services?

People who meet the definition for *Traumatic Head Injury* or *Spinal Cord Injury* defined as:

- *Traumatic Head Injury*: An insult to the head, affecting the brain, not of a degenerative or congenital nature, but caused by an external physical force that may produce diminished or altered state of consciousness which results in an impairment of cognitive abilities or physical functioning.
- *Spinal Cord Injury*: An insult to the spinal cord not of a degenerative or congenital nature, but caused by an external physical force resulting in paraplegia or quadriplegia.

### AND

People who meet the following criteria:

- Are medically stable, including normal vital signs, no progression of deficits and/or no deterioration of physical/cognitive status; do not require acute daily medical intervention
- Have a reasonable expectation to achieve a predictable level of outcome to achieve improvement in quality of life and/or functional outcome
- Are willing to accept treatment from an advisory board approved facility/program
- Are residents of Louisiana and have official domicile in Louisiana at the time of injury and during the provision of services
- Have exhausted all other governmental and private resources
- Provide proof of denial from other sources
- Complete and submit an application for services

### AND

The person and family must:

- Provide information required to determine whether the person meets the eligibility criteria
- Ask questions if they do not understand
- Be willing to participate in the development of an Individualized Service Plan that outlines the services that will be provided by the Trust Fund
- Have made every effort to seek other sources of funding, such as private insurance, Social Security, Supplemental Security Income, Medicare, Medicaid, and personal resources

**For more information about the THSCI program or  
to apply for services, please call 1-888-891-9441.  
The call is free.**

**APPLICATION FOR SERVICES**

**TRAUMATIC HEAD AND SPINAL CORD INJURY TRUST FUND PROGRAM**

P.O. Box 2031-BIN #14, BATON ROUGE, LA 70821-2031 • PHONE 1-888-891-9441 OR (225) 219-2410

Name: (Last, First, MI) _____		Social Security Number: _____ / /		Telephone Number: _____ ( ) -	
Home Address: _____					
City: _____		State: <u>LA</u>		Zip Code: _____	
Mailing Address (If different from home address) _____					
City: _____		State: <u>LA</u>		Zip Code: _____	
<small>Please Note if your address or phone number changes before we contact you and you fail to notify us every reasonable attempt will be made to contact you. If we cannot contact you, your name will be skipped and the next person on the waiting list will be contacted. I understand this statement.</small>					
Signature _____					
Parish: _____		Contact Person: _____		Telephone: ( ) -	
<small>Someone who will know how to contact you in the event you do move.</small>					
Date of Birth: _____ / /	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		Highest Grade Completed	
How did you hear about the program?					
List services you are requesting: <input type="checkbox"/> Attendant Care <input type="checkbox"/> Post Acute Medical Care <input type="checkbox"/> Evaluations <input type="checkbox"/> Therapies <input type="checkbox"/> Equipment Necessary for Daily Living <input type="checkbox"/> Other					
IF OTHER – PLEASE BE MORE SPECIFIC ABOUT SERVICES YOU ARE REQUESTING:					
Primary Diagnosis: <input type="checkbox"/> Traumatic Brain Injury <input type="checkbox"/> Spinal Cord Injury					
Primary Treating Physician's Name: _____			Other Physician's Name: _____		
Mailing Address: _____			Mailing Address: _____		
City: _____ State: _____ Zip: _____			City: _____ State: _____ Zip: _____		
How were you injured?				Date of Injury: _____ / _____ / _____	
Where were you living <b>AT TIME</b> of the injury? City: _____ State: _____					
Is this where the <b>ACCIDENT TOOK PLACE</b> ? ( ) YES ( ) NO					
If NO – City: _____ State: _____					
Were you employed at the time of your injury? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, give name and address of employer:					
Are you presently employed? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, give name and address of employer:					
Please check off all services you are currently receiving:					
<input type="checkbox"/> SSI	<input type="checkbox"/> Medicaid	<input type="checkbox"/> NOW Waiver			
<input type="checkbox"/> SSDI	<input type="checkbox"/> Medicare	<input type="checkbox"/> Supports Waiver			
<input type="checkbox"/> Veteran's Benefits	<input type="checkbox"/> Private Medical Insurance	<input type="checkbox"/> Long Term Personal Care			
<input type="checkbox"/> Vocational Rehabilitation Services	<input type="checkbox"/> EDA Waiver	<input type="checkbox"/> Community and Family Support			
<input type="checkbox"/> Private Disability Insurance Benefits	<input type="checkbox"/> ADHC Waiver	<input type="checkbox"/> State Personal Assistance Services			

PLEASE READ CAREFULLY – DO NOT SIGN UNLESS YOU UNDERSTAND. CALL IF YOU HAVE QUESTIONS. CHECK THE APPROPRIATE BOX IF YOU WANT A COPY

I hereby apply for services through the Louisiana Traumatic Head and Spinal Cord Injury (TH/SCI) Trust Fund. **I will voluntarily provide information relative to my disability/injury/accident and resources available to me.** Refusal to provide such information could affect my eligibility for services. I understand that such information will be held confidential and will be used only insofar as it affects my eligibility for the program and the delivery of services. Information will be released only with my authority and written consent or as otherwise authorized by the policy of the Louisiana Traumatic Head and Spinal Cord Injury Trust Fund.

I understand that eligibility decisions will be made without regard to sex, race, creed, color or national origin. I further understand that eligibility decisions will be made without regard to disability unless, and only to the extent necessary, authorized by law to comply with Act 654 of the 1993 Louisiana Legislature.

I have been advised that if I am dissatisfied with any Louisiana Traumatic Head and Spinal Cord Injury Trust Fund Program action regarding either eligibility or the provision of services, I may request an Administrative Review with the Program Manager of the Trust Fund Program. The Administrative Review process generally provides for a more timely resolution of disagreements. If the disagreement is not adequately resolved through the Administrative Review, I may request an Advisory Board Review. My request for either an Administrative Review or Advisory Board Review must be made in writing to the Program Manager of the Trust Fund Program, P.O. Box 2031-BIN #14, Baton Rouge, LA 70821-2031, within ten (10) days of learning of the decision with which issue taken.

I certify that the information I have given is true, correct and complete to the best of my knowledge and that knowingly providing false or incorrect information is cause for immediate termination of benefits. I agree to notify my Case Manager or the program office within 30 days if I have a change in my financial condition, my physical or mailing address(es). I understand that if I knowingly provide information which is incorrect, I may be required to reimburse, in whole or in part, the TH/SCI Trust Fund for funds provided to pay for the cost of certain services I have received.

**\*DO NOT SIGN UNLESS YOU FULLY UNDERSTAND THE ABOVE THREE PARAGRAPHS\***

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date of Application

\_\_\_\_\_  
Signature of Guardian (required if applicant is under 18 yrs of age)

**THIS IS FOR YOUR USE AS A REMINDER. PLEASE CHECK OFF EACH FORM BELOW TO ASSURE THE FOLLOWING FORMS ARE ATTACHED TO THIS APPLICATION.**

MEDICAL ELIGIBILITY FORM

**APPLICATIONS WITHOUT THE ABOVE DOCUMENTATION WILL NOT BE PROCESSED.**

Please mail me a copy of this form

Mailed \_\_\_\_\_  
Date

MEDICAL ELIGIBILITY FORM

**\*\* FORM MUST BE COMPLETED BY TREATING PHYSICIAN \*\***

**\*\*Please RETURN to the client – to be mailed back WITH the application\*\***

REFERRED INDIVIDUAL: \_\_\_\_\_ SOCIAL SECURITY NO.: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

I. MEDICAL STABILITY (Please check one of the following:)

\_\_\_\_ Patient is medically stable. (Has normal vital signs, no progression of deficits and/or deterioration of physical/cognitive status. Does not require acute medical intervention.)

COMMENTS: \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_ Patient is medically unstable. (Has fluctuating vital signs requiring acute medical attention. Progression of neurologic deficits and/or deterioration of medical condition.)

COMMENTS: \_\_\_\_\_  
\_\_\_\_\_

II. SPINAL CORD INJURY

A. Did the injury result from an insult to the spinal cord caused by external force? \_\_\_\_ YES \_\_\_\_ NO (If NO, go to Item III)

B. Cause of injury: \_\_\_\_\_  
\_\_\_\_\_

C. \_\_\_\_ Paraplegia \_\_\_\_ Quadriplegia

D. COMMENTS: \_\_\_\_\_  
\_\_\_\_\_

E. RECOMMENDATIONS: EXPLANATIONS FOR OTHER: (Please be specific)

____ Evaluation	_____
____ Attendant Care	_____
____ Post Acute Medical Care	_____
____ Equipment necessary for Daily Living	_____
____ Therapies	_____
____ Other	_____

III. TRAUMATIC HEAD INJURY

A. Did the injury result from an insult to the head, affecting the brain, caused by an external force? \_\_\_\_ YES \_\_\_\_ NO

B. If YES to the above, which of the following were produced by the injury? \_\_\_\_ Altered state of consciousness  
\_\_\_\_ Motor deficit present \_\_\_\_ Sensory deficit present \_\_\_\_ Cognitive/behavioral deficit

C. \_\_\_\_ Other, please be specific: \_\_\_\_\_

D. Circle RANCHO Level: 1 2 3 4 5 6 7 8

E. DIAGNOSIS: \_\_\_\_\_  
\_\_\_\_\_

F. COMMENTS: \_\_\_\_\_  
\_\_\_\_\_

G. RECOMMENDATIONS: EXPLANATIONS FOR OTHER: (Please be specific)

____ Evaluation	_____
____ Attendant Care	_____
____ Post Acute Medical Care	_____
____ Equipment necessary for Daily Living	_____
____ Therapies	_____
____ Other	_____

PHYSICIAN'S SIGNATURE

PHYSICIAN'S PRINTED NAME

DATE

PRINT PHYSICIAN'S ADDRESS

PHYSICIAN'S PHONE NUMBER

**NOTE: This form is invalid without signature and readable contact information from the completing physician.**

**ACADIA**  
568 NW Court Circle  
Crowley, LA 70526-4363  
(337) 788-8841

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

**ASCENSION**  
828 S. Irma Blvd., Rm. 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., Ste. 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 71163-1253  
(318) 226-6891

**CALCASIEU**  
1000 Ryan St., Rm. 7  
Lake Charles, LA 70601-5250  
(337) 721-4000

**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 St., Ste. 1  
Homer, LA 71040-3914  
(318) 927-3332

**CONCORDIA**  
4001 Carter St., Ste. K  
Vidalia, LA 71373-3021  
(318) 336-7770

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

**E. BATON ROUGE**  
222 St. Louis St., Rm. 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) 435-4489

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

**IBERIA**  
300 S. Iberia St., Ste. 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., Rm. 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 70546-5361  
(337) 824-0834

**LAFAYETTE**  
1010 Lafayette St., Ste. 313  
Lafayette, LA 70501-6885  
(337) 291-7140

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

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

**LINCOLN**  
100 W. Texas Ave., Rm. 10  
Ruston, LA 71270-4463  
(318) 251-5110

**LIVINGSTON**  
P. O. Box 968  
Livingston, LA 70754-0968  
(225) 686-3054

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

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

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

**ORLEANS**  
1300 Perdido St., Rm. 1W23  
New Orleans, LA 70112-2127  
(504) 658-8300

**OUACHITA**  
1650 Desiard St., Ste. 125  
Monroe, LA 71201  
(318) 327-1436

**PLAQUEMINES**  
P. O. Box 989  
Port Sulphur, LA 70083-0989  
(504) 934-3620

**POINTE COUPEE**  
211 E. Main St., Flr. 2  
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., Rm. 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) 783-5120

**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**  
415 Saint Martin St.  
St. Martinville, LA 70582-4549  
(337) 394-2204

**ST. MARY**  
500 Main St., Ste. 301  
Franklin, LA 70538-6144  
(337) 828-4100, ext. 360

**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**  
8026 Main St., Ste. 101  
Houma, LA 70360  
(985) 873-6533

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

**VERMILION**  
100 N. State St., Ste. 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., #105  
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**  
119 W. Main St., Rm. 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(Disability)

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 17 years old (16 years old if registering to vote in person at the Registrar of Voters' Office or the Office of Motor Vehicles) 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 the election day in which you are eligible to vote.

**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' if it is different from the 'Residence Address' or if mail is not delivered to your residence address.

**Boxes 5 & 13:** You must provide your LA driver's license number or LA special identification card 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 LA driver's license number or LA special identification card 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 7, 11 & 12:** The items 'race/ethnic origin', 'email' and 'phone' are not required but are helpful. Email is protected from disclosure by law.

**Box 8:** If you do not complete this item, your party affiliation will be listed as 'no party', 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 'no party'. The recognized political parties are Democrat, Green, Libertarian, Reform and Republican or you may specify any other party affiliation.

**Box 17:** If you are using this form to request a change of name, you must print the name to be changed here.

**Box 18:** 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 CUT HERE BEFORE MAILING.**

LOUISIANA VOTER REGISTRATION APPLICATION		OFFICIAL USE ONLY	
LR-1 & 1M, FORM #100		Wd _____	Pct _____
		Reg Type _____	In/Out _____
		REG # _____	
<b>1 Are you a citizen of the United States of America?</b> YES <input type="checkbox"/> NO <input type="checkbox"/> <b>Will you be 18 years of age on or before election day?</b> YES <input type="checkbox"/> NO <input type="checkbox"/> If you checked 'no' in response to either of these questions, DO NOT COMPLETE THIS FORM.			
<b>2 NAME OF APPLICANT (PLEASE PRINT NAME)</b> LAST _____ FIRST _____ FULL MIDDLE OR MAIDEN _____			<b>GIVE LOCATION</b> 
<b>3 RESIDENCE ADDRESS (MUST BE ADDRESS WHERE YOU CLAIM HOMESTEAD EXEMPTION, IF ANY)</b> HOUSE OR APT. NO. & STREET (IF RURAL, ROUTE & BOX NO.) _____ CITY OR TOWN _____ STATE _____ ZIP _____			
If NO mail delivery to residential address, check here ( )		MAILING ADDRESS, IF DIFFERENT _____	
<b>4 DATE OF BIRTH</b> MONTH _____ DAY _____ YEAR _____	<b>5 * SOCIAL SECURITY #</b> (CIRCLE ONE) NO _____ YES # _____	<b>6 SEX</b> (CIRCLE ONE) MALE _____ FEMALE _____	<b>7 ** RACE / ETHNIC ORIGIN</b> (CIRCLE ONE) WHITE _____ BLACK _____ ASIAN _____ HISPANIC _____ AMER. INDIAN _____ OTHER _____
<b>8 PARTY AFFILIATION</b> (CIRCLE ONE) DEM GRN LBT RFM REP NO PARTY _____ OTHER (SPECIFY) _____	<b>9 APPLICANT'S PLACE OF BIRTH</b> CITY OR TOWN _____ PARISH OR COUNTY _____ STATE _____ COUNTRY _____		<b>10 MOTHER'S MAIDEN NAME</b> _____
<b>11 **EMAIL</b> _____	<b>12 **PHONE</b> HOME ( ~ ) _____ DAY ( ) _____	<b>13 LA DRIVER'S LICENSE / I.D. #</b> (CIRCLE ONE) NO _____ YES # _____	<b>14 Will you require assistance at the polls?</b> (CIRCLE ONE) NO _____ YES _____ IF YES, GIVE REASON _____
<b>15 LAST RESIDENCE ADDRESS</b> ADDRESS _____		<b>16 PLACE OF LAST REGISTRATION</b> PARISH OR COUNTY _____ STATE _____	
<b>17 FORMER REGISTERED NAME, IF APPLICABLE</b> _____			
<b>AFFIRMATION:</b> 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 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 \$2,000 (\$5,000 for subsequent offense) or imprisonment for not more than 2 years (5 years for subsequent offense), or both. Any false statement may constitute perjury.			
<b>18 SIGN YOUR NAME IN BOX AT RIGHT.</b> 			
<b>DATE:</b> _____ / _____ / _____		<b>19 IF YOU ARE UNABLE TO SIGN YOUR NAME, TWO WITNESSES TO YOUR MARK MUST SIGN HERE.</b> 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-1 & 1M (REV. 2/16) R.S. 18:104; FORM #100