

Louisiana Department of Children and Family Services Information about the Application for Assistance

What kind of assistance does the Department of Children and Family Services Economic Stability offer?

- Family Independence Temporary Assistance Program (FITAP) – Provides temporary cash assistance to eligible low-income families who need assistance for children. FITAP recipients also receive Medicaid benefits through the Louisiana Department of Health.
- Supplemental Nutrition Assistance Program (SNAP) (formerly the Food Stamp Program) – Provides monthly benefits that help low-income households buy the food they need for good health.
- Kinship Care Subsidy Program (KCSP) – Provides cash assistance for eligible children who reside with qualified relatives other than parents. KCSP recipients also receive Medicaid benefits through the Louisiana Department of Health.
- For more information about programs and services or for specific information about your case, call 1-888-LAHELPU (1-888-524-3578).

How do you apply for assistance?

- Complete the Application for Assistance, form OFS 4APP.
- The Application for Assistance may be completed online and submitted electronically on the DCFS website at www.dcfslouisiana.gov.
- You may also apply online or pick up a paper application at one of your [local community partners or DCFS office](#).
- Return the completed form to any parish DCFS office, if a paper application is completed.
- Call 1-888-LAHELPU (1-888-524-3578) and apply over the telephone.
- One form may be used to apply for the FITAP, SNAP, and KCSP.
- You may file a separate application for SNAP. Whether you file a SNAP application (paper or online) with another program or separately, your SNAP application will be processed according to the same SNAP procedures, including timeliness, notice, and fair hearing requirements.
- If you file an application for SNAP jointly with another program and are denied benefits from the other program, you do not have to turn in another application for SNAP. You may not be denied SNAP benefits just because you may not be eligible for benefits from another program.

- We will determine your eligibility for all programs for which you apply.
- You need to be interviewed if you are applying for FITAP, SNAP, or KCSP.
- You need to provide verification to DCFS. Verification is explained below.

Submit your application or verification through one of the following ways:

Mail	Fax	Online	In Person
DCFS ES Document Processing Center P. O. Box 260031 Baton Rouge, LA 70826-9918	(225) 663-3164	CAFÉ' Customer Portal www.dcfs.la.gov/CAFE	Any DCFS Office

Do you need help completing the application form?

- You may ask someone to help you fill out the form, or
- You may ask the worker during your interview to help you fill out the application.

What happens after we receive your application form?

- You will receive an appointment letter to schedule your interview.
- You will receive a list of verification that is required.
- Your eligibility will be determined within 30 days from the date of application.
- If you applied for FITAP, you may be required to participate in the Strategies to Empower People (STEP) Program. The STEP Program provides opportunities for work-eligible FITAP families to receive job training, employment, and supportive services to enable them to become self-sufficient.

What will we do with the information that you provide?

- Information you give us on your application form will be verified by federal, state, and local offices including computer cross-matching with other agencies. Someone from our agency may contact other people in order to verify your eligibility for benefits.
- The alien status of household members is subject to verification through the United States Citizenship and Immigration Service (USCIS) and may affect eligibility and benefit amount.

- You will not have to provide immigration status information or documents for any household members who are not eligible because of immigration status and who are not asking for benefits. If a member of your household does not wish to provide information about his/her citizenship or immigration status, he or she will not be eligible for benefits. Other family or household members may still receive benefits, if they are otherwise eligible. You can apply for and get benefits for eligible household members even if your household includes other members who are not eligible because of immigration status.

Why do we need your Social Security Number and are you required to provide it?

- The collection of information requested on the application form, including Social Security Numbers (SSNs) of household members, is voluntary and authorized under the Food and Nutrition Act of 2008, (7 U.S.C. 2011-2036), as amended. Failure to provide required information including SSNs or proof you have applied for an SSN for household members may result in that person's ineligibility for SNAP and cash assistance. You will not have to provide Social Security Numbers for any household members who are not eligible because of immigration status and who are not asking for benefits.
- SSNs are used to:
 - collect information from other sources,
 - check identity of household members,
 - determine whether your household is eligible, and
 - prevent households from getting more benefits than they are entitled to receive.
- SSNs are used in state and federal program reviews, audits, and computer-matching with other agencies such as Louisiana Workforce Commission, Social Security Administration, Internal Revenue Service, etc., through the State Income and Eligibility Verification System.
- Under the Privacy Act of 1974(P.L. 93-579), SSNs may be released for various reasons including those directly connected to the administration of the Child Support Enforcement Program.

What type of verification do you need to provide?

Verification means proof of the information you report. The following table lists the information that must be verified by each program and the examples of the proof that is required. Let your worker know if you have any questions about what you must provide or if you need help in getting the proof. It is our responsibility to help you get the proof that you need.

What Must be Verified and Examples of Proof	SNAP	FITAP (Cash)	KCSP (Cash)
Identity – driver’s license, work or school ID, ID for health benefits or another social services program, voter’s registration card, check stub, or birth certificate	✓		
Age/Relationship - birth certificate, baptismal certificate, or hospital birth records of the person to be included. If not your own child, birth records to prove how the child is related to you		✓	✓
Social Security Number - copy of the social security card or papers you received at the hospital for a newborn. A Social Security number is not required for any household member who is not eligible due to immigration status.	✓	✓	✓
Alien status - if not a U.S. citizen, forms or cards from USCIS that prove the person is a legal alien (unless you choose not to apply for this person)	✓	✓	✓
Wages - last 4 pay check stubs or employer’s statement for each person who works	✓	✓	✓
Self-employment - income tax returns, sales records, quarterly tax records, personal wage record	✓	✓	✓

Other income such as contributions, child support, alimony, Social Security, SSI, VA, retirement checks, Unemployment Compensation (UCB) - award letters, court orders, statements from contributors	✓	✓	✓
Income that stopped within the last 2 months – pink slip, termination notice, or statement from former employer, termination notice or statement from source of any income that ended	✓	✓	✓
Medical expenses - receipts, pharmacy printouts for last 3 months, doctor bills or other papers that show medical expenses for household members who are disabled or over age 59	✓		
Child support payments made to someone outside your home - court order or other legal papers and proof that you are making payments such as cancelled checks or wage withholding statements	✓		
Immunization - shot, school, or doctor's records		✓	✓
Custody - court order, other legal papers, or provisional custody by mandate			✓
Home - proof of who lives in the home; such as current school records, landlord's written statement or the name and phone number of two people (not related to you) who know your situation		✓	✓

Rights and Responsibilities

When you receive benefits from the Louisiana Department of Children and Family Services, you have certain rights and responsibilities that are explained below. Keep this important information for future reference.

What are your rights?

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the agency (state or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at:

<https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf>,

from any USDA office, by calling (833) 620-1071, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to:

1. **mail:**

Food and Nutrition Service, USDA
1320 Braddock Place, Room 334
Alexandria, VA 22314; or

2. **fax:**

(833) 256-1665 or (202) 690-7442; or

3. **email:**

FNSCIVILRIGHTSCOMPLAINTS@usda.gov

This institution is an equal opportunity provider.

You may file a civil rights complaint with the Department of Children and Family Services (DCFS) by completing the Civil Rights Complaint Form. Turn the form in to a local office; mail it to DCFS Civil Rights Section, P O Box 1887, Baton Rouge, LA 70821; email DCFS.BureauofCivilRights@LA.GOV, or; call (225) 342-0309. You may file a civil rights complaint with DCFS and USDA or only DCFS.

A program complaint may be filed with the Department of Children and Family Services (DCFS) by emailing LaHelpU.DCFS@LA.GOV or by calling 225-342-2342.

- Fair Hearing - If you do not agree with any decision made on your case, you have the right to ask that your case be reviewed. You can tell us that you want a fair hearing in writing, in person, or by calling the office. You have the right to look at your case record before the hearing.
- Confidentiality – All the information you give us is confidential. This means that we cannot give information about your case to other people except under special conditions. Examples of those conditions include official review by other State and Federal agencies or Federal, State and private collection agencies for the collection of claims against SNAP benefits. Information from your case may also be given to law enforcement officials for the purpose of catching persons fleeing to avoid the law and for investigation of a felony or probation/parole violation.
- Voter Registration - If you are not registered to vote where you live now, you may indicate that you would like to apply to register to vote on the Application for Assistance. Please note that the information you give to the agency will remain confidential and will be used only for voter registration purposes. Applying to register or refusing to register to vote will not affect the amount of assistance or services that you may receive from the Department of Children and Family Services. DCFS will assist you with completing a Louisiana Voter Registration Application unless assistance is refused. You may fill out the application form in private.

What are your responsibilities?

- Cooperation - You have to cooperate by providing the information we need to determine your eligibility for benefits for you and others for whom you are applying. You also have to provide proof of the information you report. You will be expected to cooperate if a home visit is necessary to determine your eligibility. If your case is selected for a quality control review by state or federal reviewers, you have to cooperate with them.
- Report changes – If you receive SNAP benefits, you must report if:
 - Your household's monthly income increases to more than 130% of the Federal Poverty Level for your household size. This includes reporting the income of a person who moves into your home if that person's income combined with your SNAP household's income is more than 130% of the Federal Poverty Level for your household.
 - Your household includes an Able-Bodied Adult Without Dependent (ABAWD), you must report changes in work or training hours of the ABAWD who is subject to the SNAP time limit if the change results in the ABAWD working or participating in training an average of less than 20 hours per week or less than 80 hours per month.
 - Your household receives lottery or gambling winnings of \$4,250 or more, won in a single game before taxes or other withholdings.

These changes must be reported by the 10th of the month following the month in which the change occurs.

In addition, if you are receiving:

- FITAP – You have to:
 - Follow the reporting requirements explained in your Family Success Agreement and report these changes within 10 days of your knowledge of the change.
 - Report within 10 days if the only eligible child receiving FITAP benefits moves out of your home.
- KCSP – You have to report within 10 days if the only eligible child receiving KCSP benefits moves out of your home.

If you are **not** receiving SNAP benefits, **and are** receiving:

- FITAP or KCSP – You have to report within 10 days if:
 - There is a change in the source of any income received in your household. This includes changes in employers and new sources of income such as child support, Social Security, SSI, etc.

- The amount of your household's unearned income changes by more than \$100 per month.
- The amount of your household's earned income changes by more than \$100 per month.
- Someone moves into or out of your household.
- You move.
- FITAP or KCSP - In addition to the changes listed above, you have to report within 10 days any changes in:
 - School attendance of any 18 year old in your household.
 - Marital status of anyone in your household.

If you are receiving Post-FITAP benefits, you must also report within 10 days if:

- You stop working.
- The only child in the home moves out of the home.
- You move out of state.

Information on Non-Cash Services

Your household may be authorized to receive the following non-cash TANF/MOE funded services. For additional information, please visit our website at www.dcfslouisiana.gov or contact your local DCFS Office.

- **Jobs for America's Graduates LA (JAGS-LA) Program** - Helps keep in school students (age 12 through 21) at risk of failing who face at least two barriers to success which may include economic, academic, personal, environmental, or work related barriers; assists out-of-school youth in need of a high school education; provides an avenue for achieving academically; and assists students in ultimately earning recognized credentials that will make it possible for them to exit school and enter post-secondary education and/or the workforce. Call 225-219-0368.
- **Nurse Family Partnership Program** - Serves low-income, first-time mothers who are no more than 28 weeks pregnant by providing nurse home visitation services beginning early in pregnancy and continuing through the first two years of the child's life. Call 504-219-9520 or 337-898-6097.
- **Court Appointed Special Advocates (CASA)** - Enhances family stability by facilitating links between the particular child/family and community resources/systems through trained, qualified, and supervised advocates who provide skilled communication, necessary transportation, efficient and thorough information

gathering, and other services identified in an individual case. Call 225-930-0305 and 1-888-567-2272.

- **Drug Court Programs** - Combines both treatment and educational components with the ability of a supervising judge to award incentives and sanctions based upon the performance of the clients while in treatment. Treatment is community-based and drug court participants are required to meet with the judge on a regular basis to review progress. Call 504-568-2020.
- **Alternatives to Abortion** - Provides intervention services including crisis intervention, counseling, mentoring, support services, and pre-natal care information, in addition to information and referrals regarding healthy childbirth, adoption, and parenting to help ensure healthy and full-term pregnancies as an alternative to abortion.
- **LA 4 Public Pre-Kindergarten Program** - Provides high quality early childhood education for low income 4-year-olds in participating public school districts and Charter schools.

*******PENALTIES*******

If you knowingly report incorrect information, your SNAP benefits or cash assistance may be denied, reduced, or ended and you may be subject to criminal prosecution.

What penalties apply in SNAP?

If you do the following:	You will:
<ul style="list-style-type: none"> • Hide information or give false information • Trade or sell SNAP benefits or EBT cards • Use SNAP benefits to buy ineligible items, which includes alcohol, tobacco, hot food, and any food sold for on-premises consumption. Nonfood items are also not allowed. • Use someone else’s SNAP benefits • Pay for food purchased on credit with SNAP benefits 	<p>Lose your SNAP benefits for:</p> <ul style="list-style-type: none"> • 1 year for the first violation • 2 years for the second violation • Permanently for the third violation <p>You may also be fined up to \$250,000 or imprisoned for up to 20 years or both.</p>
<ul style="list-style-type: none"> • Trade SNAP benefits for illegal drugs 	<p>Lose your SNAP benefits for:</p> <ul style="list-style-type: none"> • 2 years for the first violation

	<ul style="list-style-type: none"> • Permanently for the second violation
<ul style="list-style-type: none"> • Trade SNAP benefits for firearms, ammunition, or explosives • Trade, buy, or sell SNAP benefits of \$500 or more 	<ul style="list-style-type: none"> • Lose your SNAP benefits permanently
<ul style="list-style-type: none"> • Give false information about who you are or where you live in order to receive benefits in more than one case at the same time 	<ul style="list-style-type: none"> • Lose your SNAP benefits for 10 years

What penalties apply in FITAP and KCSP?

If you do the following:	You will:
<ul style="list-style-type: none"> • Hide information or give false information 	<p>Lose your benefits for:</p> <ul style="list-style-type: none"> • 1 year for the first violation • 2 years for the second violation • Permanently for the third violation <p>You may also be fined up to \$50,000 or imprisoned for up to 20 years or both.</p>
<ul style="list-style-type: none"> • Use your EBT card: <ul style="list-style-type: none"> ➢ in a liquor store, ➢ in a gambling casino or gaming establishment, ➢ in a retail establishment that provides adult entertainment in which performers disrobe or perform in an unclothed state for entertainment purposes, ➢ at any adult bookstore, any adult paraphernalia store, or any sexually oriented business, ➢ at any tattoo, piercing, or commercial body art facility, ➢ at any nail salon, ➢ at any jewelry store, ➢ at any amusement or video arcade, ➢ at any bail bonds company, 	<p>Lose your benefits for:</p> <ul style="list-style-type: none"> • 1 year for the first violation • 2 years for the second violation • Permanently for the third violation

<ul style="list-style-type: none"> ➤ at any night club, bar, tavern, or saloon, ➤ on any cruise ship, ➤ at any psychic business; or ➤ at any establishment where persons under age 18 are not permitted, or ➤ at an ATM in any of these establishments. ● Use your EBT card: <ul style="list-style-type: none"> ➤ at any retailer for the purchase of an alcoholic beverage, ➤ at any retailer for the purchase of tobacco products, or ➤ at any retailer for the purchase of lottery tickets, ➤ at any retailer for the purchase of jewelry. 	
<ul style="list-style-type: none"> ● Give false information about where you live in order to receive benefits in two or more states at the same time 	<ul style="list-style-type: none"> ● Lose your benefits for 10 years

Louisiana Department of Children and Family Services

Application for Assistance

Check **only** those programs for which you are applying:

- Family Independence Temporary Assistance Program (FITAP)
 Kinship Care Subsidy Program (KCSP)
 Supplemental Nutrition Assistance Program (SNAP) (formerly the Food Stamp Program)

You can begin to apply and establish your application date by filling in your name, address and signature below and give this form to us today. It will help us to process your application faster if you also give us a telephone number where you can be reached during the day and **provide a copy of a photo ID or other proof of identity.**

Can you read and understand English? (¿Puede leer usted y poder comprender ingles?) Yes (Sí) No

If No, what language can you read and understand?
(¿Si no, qué idioma le puede lee y comprende?) _____

(Last Name)	(First Name)	(Middle)	Social Security #	
Street or Rural Route	Apt. or Lot#	City and State	Zip	Phone#

Mailing Address if different from above: _____

I certify under penalty of perjury, the truth of the information contained in this application, including the information concerning citizenship and alien status of the members applying for benefits.

Your Signature

What if you need SNAP benefits right away?

We may be able to get SNAP benefits to you within 7 days of the date you apply if you qualify. You may qualify if:

- The total amount of money you have received or expect to receive this month is less than \$150 and you have \$100 or less in liquid resources such as cash, savings or checking accounts; or
- Your household's rent/mortgage and utilities are more than your total income and resources; or
- Your household includes migrant or seasonal farm workers.

If any of the above describes your household, answer the following questions:

1. What is the total amount of money that your household will receive this month? Include money from all sources such as earned income, contributions, Social Security, SSI, VA, etc. \$ _____
2. How much money does your household have in liquid resources? Include cash on hand, checking accounts, savings accounts, etc. \$ _____
3. How much is your household's monthly rent or mortgage? \$ _____
4. Do you pay for utilities, such as electricity, gas, water, etc.? Yes
 No
5. Do you pay utility costs for heating or air conditioning? Yes
 No
6. Do you pay telephone expenses? Yes
 No
7. Is anyone in your household a migrant or seasonal farm worker? Yes
 No

A. Tell Us About You

This information is requested solely for the purpose of determining DCFS compliance with Federal civil rights laws. Your response will not affect consideration of your application and may be protected by the Privacy Act. The information is being collected to assure that program benefits are distributed without regard to race, color, or national origin.

Do you need a new Louisiana Purchase Card? Yes No

First Name _____ Middle Initial _____ Last Name _____ Maiden or Other Name _____

Mailing Address _____ Apt/Lot No. _____ City _____ State _____ Zip Code _____

Home Address (If different from mailing) _____ Apt/Lot No. _____ City _____ State _____ Zip Code _____
() () ()

Home Telephone Number _____ Cell Telephone Number _____ Work or Other Telephone Number _____

Social Security Number _____

Parish of Residence _____

Date of Birth _____

E-mail Address _____

Sex:

Male

Female

Marital Status:

Married

Separated

Divorced

Widowed

Never Married

Student? _____

Yes No

Highest grade level completed in school? _____

Ethnicity: Hispanic/Latino? _____

Yes No

Racial Heritage (check all that apply):

Asian

White

American Indian/ Alaskan Native

Black or African American

Native Hawaiian/Pacific Islander

U.S. Citizen? Yes No
 If no, do you have Immigration papers? Yes No
 Date of entry in U.S.: _____
 Would you like a copy of your application? Yes No
 If yes, what format would you like the copy of your application?
 Paper Electronic

B. Tell Us If You Have An Authorized Representative

An Authorized Representative is someone you allow us to talk with about your SNAP. You can name someone, but it is not required.

Would you like to have an Authorized Representative? Yes No
If yes, tell us about your Authorized Representative.

Name of Authorized Representative		Relationship to Applicant	() Telephone Number
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Address	City	State	Zip Code
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C. Tell Us About The Other People In Your Household – Do Not Include Yourself

List everyone else who lives in your household, even if you are not applying for them. This information is requested solely for the purpose of determining DCFS compliance with Federal civil rights laws. Your response will not affect consideration of your application and may be protected by the Privacy Act. The information is being collected to assure that program benefits are distributed without regard to race, color, or national origin.

Don't miss out on No Cost Health Insurance. If you answer the question below, we will share what you entered on this application with the Louisiana Department of Health (LDH). LDH will sign up anyone who qualifies and send you a letter with more information about the Medicaid program. Children and adults (under age 65 without Medicare) may qualify.

PLEASE ANSWER THE QUESTION BELOW.

- Yes, please share my information with LDH so I do not need to complete another application.
- No, please do not share my information. Do not help me get Medicaid.

Household Members (Enter Name)	Relation to you (NR=Not Related)	Birth Date	Social Security Number	Sex (M/F)	US Citizen? (Yes/No)	ED Level *	Marital Status	Race /Ethnic Code **
Last First MI	Complete these sections only for those who need benefits							

**Race: (You may select more than one race)	**Ethnicity:
AN = Alaskan Native WH = White BL = Black or African American	Y = Hispanic or Latino
AI = American Indian AS = Asian PI = Native Hawaiian or other Pacific Islander	N = Not Hispanic or Latino

***ED Level:** List highest grade completed or GED/college

If you need more space for additional household members, you can write the information on plain paper or ask for an "Additional Household Members Form." If anyone for whom you are applying is not a U. S. citizen, your worker will complete an Alien Addendum and Checklist with you during your interview for those for whom you are applying.

D. Tell Us About Your Household

Please answer the following questions for yourself and everyone else in your home.

- Are you or anyone in your household a fleeing felon? Yes No
- Are you or anyone in your household in violation of their probation or parole? Yes No

3. Have you or anyone in your household been convicted as an adult for a felony that occurred after February 7, 2014, for one of the following crimes? Yes No

Aggravated sexual abuse under section 2241 of title 18, U.S.C.; Murder under section 1111 of title 18, U.S.C.; Sexual exploitation and other abuse of children under chapter 110 of title 18, U.S.C.; A Federal or State offense involving sexual assault, as defined in section 40002(a) of the Violence Against Women Act of 1994 (42 U.S.C. 13925(a)); An offense under State law determined by the Attorney General to be substantially similar to an offense listed above.

If yes, who?

Is this person in compliance with terms of their sentence? Yes No

4. Have you or anyone in your household been disqualified or had their benefits reduced or stopped for breaking the rules of SNAP, FITAP, KCSP, or SSI? Yes No

5. Do you or anyone in your household have a disability? Yes No

6. Does anyone in your household attend high school, college, vocational or technical school? Yes No
If **yes**, complete the following for each student:

a. _____
Name of Student Name of School and Program of study
How many hours does the student attend school each week? _____
Is this considered full or part-time? Full-time Part-time

b. _____
Name of Student Name of School and Program of study
How many hours does the student attend school each week? _____
Is this considered full or part-time? Full-time Part-time

7. Do you usually buy food and prepare your meals with everyone who lives with you? Yes No
If **no**, who buys and prepares their _____

food separately? _____

8. Have you or anyone in your household received cash assistance or SNAP benefits in Louisiana or from another state? Yes No

a. **If yes**, who? _____

b. When? _____

c. What state(s)? _____

9. Do you or anyone in your household have an application pending for any benefits that you are not receiving yet? Yes No

E. Tell Us About Your Household's Work

Tell us about any money received by you or anyone in your household for work including full-time, part-time, temporary, or seasonal jobs, self-employment, training, military reserve pay, or work study. This includes money received from wages, salaries, tips, or commissions.

1. Do you or anyone in your household work? Yes No

*Complete the following information for **each person** who works for an employer. If anyone works for more than one employer, complete a separate block for each employer. Use plain paper if you need more space.*

2. Person Who Works For An Employer

Name _____ Start Date _____

Employer's Name _____ Phone # _____

Address _____

How often paid? Weekly Every two weeks Twice monthly
 Monthly Other

Are reimbursements received? Yes No

of hours worked per week _____ Hourly wage _____

of days worked per week _____

Do you ever work overtime? Yes No

If yes, how often? _____ How many hours? _____

Are tips earned? Yes No

If yes, how much? _____ How often? _____

Is this Work Study? Yes No

3. Person Who Works For An Employer

Name _____ Start Date _____

Employer's Name _____ Phone # _____

Address _____

How often paid? Weekly Every two weeks Twice monthly
 Monthly Other

Are reimbursements received? Yes No

of hours worked per week _____ Hourly wage _____

of days worked per week _____

Do you ever work overtime? Yes No

If yes, how often? _____ How many hours? _____

Are tips earned? Yes No

If yes, how much? _____ How often? _____

Is this Work Study? Yes No

4. Is anyone on strike? Yes No

5. Has anyone in your household (including you) stopped working in the last 60 days? Yes No

*Complete the following information for **each person** who is self-employed. This includes fishermen, child care providers, hair dressers, and people who do odd jobs such as cutting grass, picking up cans, etc. Use plain paper if you need more space.*

6. Persons Who Are Self-Employed

Name	Name
Type of Business	Type of Business
Monthly Business Income	Monthly Business Income
Monthly Business Expenses	Monthly Business Expenses
# Hours Worked Per Week	# Hours Worked Per Week

7. Is anyone in your household (including you) looking for work? Yes No

8. Is anyone in your household a migrant or seasonal farm worker? Yes No

9. Do you or anyone in your household rent a room? Yes No

10. Do you or anyone in your household pay Yes No

someone else in your home for meals?

F. Tell Us About Other Income

1. Do you or anyone in your household receive money from a source other than work? Yes No **If yes**, check each type of income.

- | | |
|--|---|
| <input type="checkbox"/> Annuity Income | <input type="checkbox"/> Roomer/Boarder |
| <input type="checkbox"/> Child Support Income | <input type="checkbox"/> Social Security |
| <input type="checkbox"/> Contributions From Family/Friends | <input type="checkbox"/> Scholarships/Grants/School Loans |
| <input type="checkbox"/> Disability Insurance Benefits | <input type="checkbox"/> SSI |
| <input type="checkbox"/> Energy Check | <input type="checkbox"/> Spousal Support/Alimony |
| <input type="checkbox"/> Interest Income | <input type="checkbox"/> Tribal Money |
| <input type="checkbox"/> Loans | <input type="checkbox"/> Training Allowance (WIOA) |
| <input type="checkbox"/> Military Allotment | <input type="checkbox"/> Trust Income |
| <input type="checkbox"/> Oil Lease/Royalties | <input type="checkbox"/> Unemployment Benefits |
| <input type="checkbox"/> Railroad Benefits | <input type="checkbox"/> Veterans Benefits |
| <input type="checkbox"/> Rental Income | <input type="checkbox"/> Workers Compensation |
| <input type="checkbox"/> Retirement Pension | <input type="checkbox"/> Other |

2. For each box checked in #1 of this section above or on page 8, complete the following information. Include any money you expect to receive in the next 30 days.

Name	Type Of Income	Amount	How Often (Weekly, Monthly, etc)	Do You Expect This Income To End <input type="checkbox"/> Yes <input type="checkbox"/> No If yes , when?
				<input type="checkbox"/> Yes <input type="checkbox"/> No If yes , when?
				<input type="checkbox"/> Yes <input type="checkbox"/> No If yes , when?
				<input type="checkbox"/> Yes <input type="checkbox"/> No If yes , when?
				<input type="checkbox"/> Yes <input type="checkbox"/> No If yes , when?

<p>3. Is someone court-ordered to pay child support to you or anyone in your household? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>4. Do you or anyone in your household receive any money from a child's parent who is not court-ordered to pay? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>			

G. Tell Us About Your Expenses

In order to receive the most benefits possible, you need to tell us about your household expenses. Failure to report any of the expenses listed below will be seen as a statement by your household that you do not want to receive a deduction for the unreported expense.

HOUSING EXPENSES

1. Check each type of housing expense that you or anyone in your household has.

<input type="checkbox"/> Rent	<input type="checkbox"/> Electricity
<input type="checkbox"/> Mortgage(s), (if buying)	<input type="checkbox"/> Gas
<input type="checkbox"/> Lot Rent	<input type="checkbox"/> Sewer
<input type="checkbox"/> Homeowner's Insurance	<input type="checkbox"/> Water
<input type="checkbox"/> Flood Insurance	<input type="checkbox"/> Garbage
<input type="checkbox"/> Property Tax	<input type="checkbox"/> Telephone
<input type="checkbox"/> Condominium Fees	<input type="checkbox"/> Other

2. *For each box checked in #1 of this section, complete the following information.*

Type Of Housing Expense	Name and Phone Number of Person or Company Paid	Amount Paid	How Often Paid (Weekly, Monthly, Etc.)

3. Do you pay housing expenses for a home you are no longer living in but plan to return to? Yes No

4. Is your household responsible for paying a utility bill for using a heater or air conditioner? Yes No

5. Does anyone help you pay your housing expenses? Yes No

6. Do you receive energy assistance? Yes No
If yes, is the assistance through the Low-Income Home Energy Assistance Program (LIHEAP)? Yes No
7. Is any of the rent you pay used to pay utilities? Yes No

DEPENDENT CARE EXPENSES

1. Do you or anyone in your household pay someone to care for a child, or an adult who is elderly or disabled, so that you or a household member can work, attend training or school, or look for work? Yes No
2. **If yes**, complete the following information.

Paid For Whom	Name And Telephone Number Of Person Paid	Amount Paid	How Often Paid (Weekly, Monthly, Etc.)

CHILD SUPPORT EXPENSES

1. Does anyone in your household pay court-ordered child support? Yes No
If yes, complete the following information.

Who Pays	Paid to Whom	Amount Paid	How Often Paid (Weekly, Monthly, Etc.)

MEDICAL EXPENSES

*We can allow a medical deduction in your SNAP case for each household member who has a disability or is over the age of 59. A deduction may be given for medical expenses that are **more than \$35.00 per month.***

1. Is there anyone in your household who has a disability or is over the age of 59? Yes No
If yes, answer the questions in this section.
If no, skip to the Household Resources section on the next page.
2. Does this person have to pay medical expenses? Yes No

- a. **If yes**, do you want to verify these expenses so that you can receive a medical deduction? Yes No
- b. Check each medical expense that this person has.
- | | |
|--|---|
| <input type="checkbox"/> Dental Bills | <input type="checkbox"/> Prescribed Medicine |
| <input type="checkbox"/> Hospital Bills | <input type="checkbox"/> Prescription Drug Plan |
| <input type="checkbox"/> Health Insurance Or Medicare Premiums | <input type="checkbox"/> Premium |
| <input type="checkbox"/> Medical Appliances | <input type="checkbox"/> Nursing Home |
| | <input type="checkbox"/> Other |

3. For each box checked in # 2 above, complete the following information.

Names	Type of Expense	Amount Paid	How Often Paid (Weekly, Monthly, Etc.)

Medical Transportation Expense is money spent for trips to the doctor, hospital, drug store, etc. This includes miles driven in your own vehicle.

4. Does any elderly or disabled person listed on previous page have medical transportation costs? Yes No
- a. Does this person use their own vehicle or a household member's vehicle? Yes No
- b. **If yes**, complete the following information.

Name Of Person	List All Places Visited For Medical Purposes (Ex. Doctors, Drug Store, Hospital, Etc.)	# Of Miles Traveled Round Trip	Number Of Visits Per Month

- c. Does this person pay someone other than a household member for medical transportation? Yes No
- d. **If yes**, complete the following information.

Name Of Person	Who Is Paid	Where Does This Person Go	How Much Does This Person Pay	How Many Trips Does This Person Pay For Each Month

			Per Trip	

If you need more space, you can write the information on plain paper.

5. Will you or anyone in your household be reimbursed for any of the medical expenses listed above? Yes No
6. Does anyone help pay the medical expenses? Yes No

H. Tell Us About Your Household's Resources

Resources include cash, money in the bank, Certificates of Deposit, stocks, and bonds. Resources do not include personal property such as jewelry, furniture, electrical equipment, or clothing.

1. Check each resource listed below that you or anyone in your household has.
- | | |
|---|--|
| <input type="checkbox"/> Bank/Credit Union Account (Checking) | <input type="checkbox"/> Cash On Hand |
| <input type="checkbox"/> Bank/Credit Union Account (Saving) | <input type="checkbox"/> Certificate Of Deposit (CD) |
| <input type="checkbox"/> Joint Account | <input type="checkbox"/> Money Market Account |
| <input type="checkbox"/> Bonds | <input type="checkbox"/> Mutual Funds |
| | <input type="checkbox"/> Savings Bond |
| | <input type="checkbox"/> Stocks |

2. *For each box checked above, complete the following information.*

In Whose Name Is The Resource Listed	Type Of Resource	How Much Is It Worth	Where Is The Resource (Include Name Of Bank Or Company, Where Money Is Held, Address Of Property, Etc.)

3. Have you or anyone in your household received a Federal tax refund in the last twelve months? Yes No
4. Have you or anyone in your household received or do you or anyone in your household expect to receive a lump sum of money? Yes No
5. Does your name or the name of anyone in your household appear on a bank/credit union account with someone else? Yes No

a. If yes , whose names are on the account?	_____
b. Why is this name on the account?	_____
c. Does someone else make deposits into this account?	<input type="checkbox"/> Yes <input type="checkbox"/> No
d. If yes , who and how much per month?	_____
6. Have you or anyone in your household sold, traded, given away, or transferred a resource in the last three months?	<input type="checkbox"/> Yes <input type="checkbox"/> No

IF YOU ARE APPLYING FOR SNAP BENEFITS ONLY, SKIP TO PAGE 15.

**COMPLETE THIS PAGE ONLY IF YOU ARE APPLYING
FOR FITAP OR KCSP**

I. FITAP or KCSP		
1. Are you applying for FITAP or KCSP? If yes , complete this page. If no , skip to page 17.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Do you or anyone in your household need to get away from an abusive situation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Are immunizations current on all children? If no , who? _____ Why? _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. Are you or anyone in your household pregnant? If yes , who? _____ Due date: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No

HEALTH INSURANCE		
5. Can you or anyone in your household get health insurance through an employer?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

COLLATERALS		
6. Please complete the following information for two people who are not related to you who can verify your household situation.		
Name	Address	Daytime Phone Number

CUSTODY		
7. If you are not the parent of the child(ren) for whom you are applying, do you have custody?		<input type="checkbox"/> Yes <input type="checkbox"/> No
a. If yes , complete the following information.		
Children For Whom You Have Custody	Type Of Custody	Effective Date Of Custody

A non-custodial parent is a parent who does not live in the home with his/her child. Tell us about the non-custodial parent(s) of each child living in your home. This includes both mother and father if you are not the parent of the child(ren). If a child's biological father and legal father are not the same person, give the requested information for both fathers. Use plain paper if you need more space.

8. Non-Custodial Parent Information

Name Social Security Number Date of Birth

Street Address

City State Phone Number

Employer

Name(s) of Children

Parental Relationship (relationship of children's parents):

Married Widowed Never Married Divorced

9. Non-Custodial Parent Information

Name Social Security Number Date of Birth

Street Address

City State Phone Number

Employer

Name(s) of Children

Parental Relationship (relationship of children's parents):

Married Widowed Never Married Divorced

10. Non-Custodial Parent Information

Name Social Security Number Date of Birth

Street Address

City State Phone Number

Employer

Name(s) of Children

Parental Relationship (relationship of children's parents):

Married Widowed Never Married Divorced

Read Carefully And Sign Below

I certify under penalty of perjury that the information I have given on this application is true, complete, and correct to the best of my knowledge, including the information I have given regarding the felony conviction of certain crimes and the U.S. citizenship or immigration status of all household members. I understand that I and any adult household member will be subject to disqualification and prosecution and will be required to repay ineligible benefits if we knowingly give false, incorrect, or incomplete information in order to obtain or try to obtain financial or food assistance. By signing this application, I give permission for the release of information to the Department of Children and Family Services by any persons or agencies who have knowledge of my circumstances.

Remember, you must turn in proof of the information you reported on this application form and verification of your

_____ Your Signature (or mark)	_____ Date Signed
_____ Signature (or mark) of your wife or husband	_____ Date Signed
_____ Signature of Minor Unmarried Parent	_____ Date Signed

If you, or your wife or husband, sign with an “X” mark, ask two people to witness the mark; if applicant is blind, ask three people to witness.

_____ Witness	_____ Date Signed
_____ Witness	_____ Date Signed
_____ Witness	_____ Date Signed

**Signature of Person Who Helped You Complete this Form and
His or Her Relationship to You**

Signature

Relationship

Signature of Agency Representative

Date

I want to withdraw my _____ application because _____

Signature of Applicant

Date

**How to submit the Application for Assistance to The
Department of Children and Family Services (DCFS):**

**By Mail: Department of Children and Family Services ES
Document Processing Center
P. O. Box 260031
Baton Rouge, LA 70826-9918**

By Fax: (225) 663-3164

In Person: Any DCFS Office

**If you have any questions regarding the application
process, please contact the Customer Service Center at
1-888-LAHELPU (1-888-524-3578).**

Voter Registration

If you are not registered to vote where you live now, would you like to apply to register to vote here today? (Check one)

I want to register to vote. I do not want to register to vote.

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. Voter eligibility requirements are found on the voter registration application form.

Note: If you do register to vote, the location where your application was submitted will remain confidential. If you decline to register to vote, this fact will remain confidential. Applying to register or declining to register to vote will be used **only** for voter registration purposes.

If you would like help in filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private. (Check one)

Yes, I would like help. **No, I do not want help.**

For assistance in completing the voter registration application form outside our office, contact the Department of Children and Family Services at 1-888-LAHELPU or 1-888-524-3578.

Voter Registration continued

If completed outside our office, this declaration form and your completed voter registration application form (if you filled one out) should be returned to the DCFS ES Document Processing Center at P.O. Box 260031, Baton Rouge, LA 70826-9918.

Signature or Mark	Name Typed or Printed	Date
-------------------	-----------------------	------

Signatures of Two Witnesses If Signed With Mark:

1) _____ 2) _____

COMPLAINTS

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 the Louisiana Secretary of State, Commissioner of Elections, P.O. Box 94125, Baton Rouge, LA 70804-9125 or by calling (225)922-0900 or 1-800-883-2805.



Louisiana Voter Registration Application

(LA-VRA - Rev. 3/19)

SEE THE OTHER SIDE OF THIS PAGE FOR INSTRUCTIONS →
 QUESTIONS? - Call your parish Registrar of Voters Office or call the Secretary of State at 1-800-883-2805 or (225) 922-0900.

OFFICIAL USE ONLY: **WD:** _____ **PCT:** _____ **REG. TYPE:** _____ **IN/OUT:** _____ **REG #** _____

Please print clearly in ink, preferably black. Reason for Application: New Voter Registration Updating Voter Registration

Eligibility 1. Are you a citizen of the United States of America? Yes No
 Will you be 18 years of age on or before election day? Yes No

If you answered "No" to these questions, do not complete this form. You are not eligible to vote at this time. (Please see application instructions for information regarding eligibility to register prior to age 18.)

Name 2. LAST NAME: _____ FIRST NAME: _____
 FULL MIDDLE OR MAIDEN NAME: _____ SUFFIX (Sr., Jr., II) _____

Residence Address (Where you live and claim homestead exemption, if any)
 HOUSE # & STREET (NO P.O. BOX): _____ UNIT/APT #: _____
 CITY/TOWN: _____ STATE: LA ZIP CODE: _____

Give Location (If Necessary)

Mailing Address (If different from Residence Address)
 3. Check if no postal service at your residence address above and supply mailing address here.
 HOUSE # & STREET/P.O. BOX: _____ UNIT/APT #: _____
 CITY/TOWN: _____ STATE: _____ ZIP CODE: _____

Birthdate 4. MM / DD / YYYY 5. *SSN XXX - XX - XXXX 6. Sex M F 7. Race (Optional) WHITE BLACK ASIAN
 HISPANIC AMERICAN INDIAN
 OTHER _____

Party Affiliation 8. DEM GRN IND LBT
 REP NO PARTY
 OTHER (Specify) _____

Place of Birth 9. CITY/TOWN: _____ STATE: _____
 PARISH/COUNTY: _____ COUNTRY: _____

Mother's Maiden Name 10. _____ 11. Email (Optional) _____ 12. Phone (Optional) Home: (____) _____ - _____
 Other: (____) _____ - _____

LA DL/ID Card # 13. _____ 14. Do you need assistance in voting? No
 I do not have a LA DL/ID card Yes, Reason: _____

Place of Last Residence 15. HOUSE # & STREET: _____ STATE: _____
 CITY: _____ STATE: _____

Place of Last Registration 16. STATE: _____ PARISH/COUNTY: _____

Former Registered Name, if any 17. _____

Affirmation and Signature (read and sign or make your mark)
 18. 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 have not been incarcerated pursuant to an order of imprisonment for conviction of a felony within the past five years, nor am I under an order of imprisonment for a felony offense of election fraud or other election offense pursuant to R.S. 18:1461.2, 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.

Applicant Signature: Date: _____

Witnesses (If your signature is a mark, you must have two witnesses sign)
 19. Witness #1 Signature: Witness #1 Print Name: _____
 Witness #2 Signature: Witness #2 Print Name: _____

* Last 4 digits of the social security number are required, if issued, and you have no LA driver's license or LA special ID; full SSN number is preferred but optional.
 Note: 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. You may request a copy of your voter registration form at any time from the registrar of voters.

OFFICIAL USE ONLY

New Registration Updated Registration: Address Change Name Change Party Change Change to Assistance in Voting

REMARKS: _____

CIRCLE ONE: PA MV RG SDA SS (Disability)

Received by: _____ Date: _____



Louisiana Voter Registration Application

(LA-VRA - Rev. 3/19)

QUESTIONS? - Call your parish Registrar of Voters Office or call the Secretary of State at 1-800-883-2805 or (225) 922-0900.

APPLICATION INSTRUCTIONS

USE THIS LOUISIANA VOTER REGISTRATION APPLICATION TO: 1) register to vote; 2) change your address; 3) request a name change; 4) change party affiliation; or 5) request assistance in voting.

TO REGISTER AND BE ELIGIBLE TO VOTE AN APPLICANT MUST: 1) be a U.S. citizen; 2) be at least 17 years old (16 years old if registering to vote in person at the Registrar's Office or with an application for a Louisiana driver's license) but must be 18 years old before actually voting; 3) not be under an order of imprisonment for conviction of a felony or, if under such an order not have been incarcerated pursuant to the order within the last five years and not be under an order of imprisonment related to a felony conviction for election fraud or any other election offense pursuant to R.S. 18:1461.2; 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: the grey section numbers on this page correspond to the grey section numbers on the application.

Reason for Application: Check "New Voter Registration", if this is a first time registration or if a new registration in a new parish after moving. Check "Updating Voter Registration", if you are making any change to your present registration. If new registration, fill out the form completely.

1. *Eligibility* - Federal law requires you to affirm that you are a citizen of the United States of America and that you will be 18 years of age on or before the election day in which you are eligible to vote. If you answered "No" to these questions, do not complete this application form. You are not eligible to vote at this time. If you are registering as a 16 or 17 year old, you may check "Yes" because you will not be allowed to vote until you are 18.
2. *Name* - You **must** provide your full name. Do not use nicknames or initials for middle or maiden name. *If this application is for a change of name, please also complete section 17: "Former Registered Name".*
3. *Residence Address* - "Residence Address" means the address (Number, Street, City, State and Zip) where you live and are registering to vote. Residence address **must** be the address where you claim homestead exemption, if any, except for a resident in a nursing home or veterans' home who may choose to use the address of the nursing home or veterans' home or the home where they have a homestead exemption. A college student may elect to use their home address or their address at school while attending. Do not use a post office box for your "Residence Address". If you use a rural route and box number, you may draw a map in box labeled "Give Location" to provide the exact location. Write in the names of the crossroads (streets) nearest to residence. Draw an X to show residence. Use a dot to show any schools, churches, stores or landmarks near residence and write the name of the landmark.
Mailing Address - If you check that you do not receive postal service at your residence address, you **must** provide your mailing address (Number, Street, City, State and Zip). Otherwise a mailing address may be provided and you may use a Post Office Box for a mailing address.
4. *Birthdate* - Print your date of birth. *The month and day of your birth remains confidential by law.*
5. *Social Security Number* - If you do not have a LA driver's license or LA special identification card, you **must** provide the last four digits of your social security number, if issued. The full social security number is preferred and may be provided on a voluntary basis and will be kept confidential. If you were not issued a social security number, you **must** attach either one or more documents to prove your identity, residence and date of birth. Documents may be: a) a copy of current and valid photo identification and/or b) a copy of a current utility bill, bank statement, government check, paycheck, or other government document. *Your SSN number remains confidential and is only used for registration purposes.*
6. *Sex* - Check male or female (*for statistical purposes only*).
7. *Race* - Race/Ethnic origin is optional (*for statistical purposes only*).
8. *Party Affiliation* - If you are registering for the first time, you may choose a party affiliation of Democrat, Green, Independent, Libertarian or Republican parties. You may specify any other party affiliation by checking "other" and then listing the party you wish to affiliate. If you do not want to register with a political party affiliation check "No Party", or if you do not complete this section, your party affiliation will be listed as "no party". If you are already registered with a party affiliation and no political party change is being made with this application, you may leave this section blank or re-enter your political party affiliation.
9. *Place of Birth* - Print the city/town, parish/county, state and country of your birth place (*for statistical purposes only*).
10. *Mother's Maiden Name* - Print your mother's maiden name, which is her last name at her birth. If unknown, write "unknown".
11. *Email* - Give your email address for election officials to contact you if there is a problem with your registration. *Email addresses are protected from disclosure by law and are for official use only.*
12. *Phone* - Give your phone numbers for election officials to contact you if there is a problem with your registration. *Phone numbers are optional and a public record unless you make a request for your phone numbers to be kept confidential by election officials.*
13. *LA DL/ID Card #* - Print your LA driver's license or LA special identification card number, if issued. If you do not have one, check "I do not have a LA DL/ID card". *This ID number remains confidential and is for official use only.*
14. *Assistance in Voting Needed?* - Indicate if you will need assistance in voting by checking either the "No" or "Yes" box. If "Yes", write the reason for needing assistance. The registrar of voters in your parish may contact you for proof of disability.
15. *Place of Last Residence* - Print the address (number and street), city, and state of your prior residence, if different from residence address in section 3 or write "Same".
16. *Place of Last Registration* - Print the state and parish (or county) of your last registration if you were registered in another parish or state prior to completing this application. **Important:** *Contact the local election office in your prior state and cancel your prior registration. Registering in Louisiana does not automatically cancel or transfer your voter registration from another state.*
17. *Former Registered Name* - If you are using this application to make a name change to your registration, print your former registered name (name you are changing) in this section. If name changed by court order, provide a copy of the order with this application.
18. *Affirmation and Signature* - Read the affirmation and sign your full name or make your mark and print the date this application was signed and completed. *If assistance in registering is being provided, make sure the applicant understands what they are affirming and that they meet the requirements to register to vote.*
19. *Witnesses* - If you are unable to sign your name, you may make your mark, but it **must** be witnessed by two people or it is not valid.

Mailing Instructions - If returned by mail, place in an envelope and mail to your Registrar of Voters Office. You can find your registrar of voters mailing address on the Registrar of Voters Address Page, by visiting our website at www.geauxvote.com or by calling the toll free at 1-800-883-2805. Your application or envelope **must** be postmarked 30 days prior to the first election in which you seek to vote.

Online Voter Registration - Voter registration is also available at www.geauxvote.com and you may register online before the 20th day prior to the election. Please call your registrar of voters if you do not receive your voter information card two weeks after registering.