

**Request Form—NEW**

*(Please Complete Separate Form for Each Physical Host Location)*

**DHH On-site Medicaid Eligibility Staff**

**Host Location Name:** \_\_\_\_\_

**Physical Address (Include Parish):** \_\_\_\_\_

**Mailing Address:** \_\_\_\_\_

**Host Primary Point of Contact, Title, Phone #, Fax #, E-Mail:** \_\_\_\_\_

# of Medicaid Eligibility Analysts Requested \_\_\_\_\_

First Month Host Will Be Ready for Placement of On-site Worker (MM/YY) \_\_\_\_\_

Please Note: If more than 3 Medicaid Analysts are requested, DHH will determine how many Medicaid Eligibility Supervisors and Administrative Support Staff are needed to support the requested Analysts. The additional supervisor(s) and support staff will be billed to the host site.

**Statement of Agreement:**

By signing this form, I am confirming that our organization is prepared to provide adequate office space, office furniture, telephone line and secure internet connection for a minimum of one (1) year with a thirty (30) day notice before ending agreement.

**Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Phone #:** \_\_\_\_\_ **E-mail Address:** \_\_\_\_\_

**E-mail completed form to [outstation@la.gov](mailto:outstation@la.gov) or Fax to (225) 242-0443.**

***Process to Implement:***

1. Complete this request form and submit via email or fax.
2. A Medicaid Regional Administrator (MRA) or designee will reach out to the primary contact to schedule a site visit.
3. Once the site is approved, a DHH employee will be assigned to your location.
4. A Memorandum of Agreement (MOA) will be customized for your organization & sent for review and approval.
5. A mutually agreed upon start date will be determined.

**Thank you for your assistance in promoting a Healthy Louisiana!**