

LAFAYETTE GENERAL HEALTH - FINANCIAL ASSISTANCE APPLICATION

Customer Service: 1-337-643-8300



FINANCIAL ASSISTANCE APPLICATION

FACILITY: ABROM KAPLAN MEMORIAL HOSPITAL ("HOSPITAL")

DATE OF APPLICATION: _____

1. PATIENT INFORMATION* - PLEASE PRINT ALL INFORMATION

Last Name	First Name	Middle Initial	Medical Record Number

* If the patient is a minor, please list parent(s)/guardian(s) as applicant

2. APPLICANT (GUARANTOR/RESPONSIBLE PARTY) INFORMATION	RELATIONSHIP TO PATIENT <input type="checkbox"/> Self <input type="checkbox"/> Spouse/Domestic Partner <input type="checkbox"/> Parent <input type="checkbox"/> Other _____
	MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married/Domestic Partner <input type="checkbox"/> Divorced <input type="checkbox"/> Separated

Last Name	First Name	Middle Initial	U.S. Citizen <input type="checkbox"/> Yes <input type="checkbox"/> No

Date of Birth	No. of Dependents (other than self & co-applicant)	Ages of Dependents	Home Phone ()

Street Address (Do Not List PO Box)	City	State**	Parish	Zip

Current Employer	Street Address, City, State	Position

If you are not working, how long have you been unemployed?

** Note that any person seeking financial assistance must be a Louisiana resident.

3. IMMEDIATE FAMILY MEMBERS

Last Name	First Name	Date of Birth	Age	Relation to Patient	Occupation	Social Security Number	Annual Worked Wages

4. AGREEMENT

Please read before signing. I CERTIFY that the information I have provided is true and accurate to the best of my knowledge. I will make application for ANY and ALL ASSISTANCE which may be available through Federal, state, local government and private sources to help pay this hospital bill and will take all action necessary to obtain assistance from the above sources. By signing this form, I understand that I must cooperate with LGH within 10 business days of the date of my signature to facilitate prompt processing of my application. I hereby grant permission and authorize any accredited agent of the Department of Children and Families to disclose to LGH ALL INFORMATION regarding the status of my Medicaid application and, if the application is not approved the reason for disapproval. I will ASSIGN to LGH ALL FUNDS received from the above sources which are provided to help with the HOSPITAL BILL. I understand that the information which I submit is subject to verification by LGH, including credit reporting agencies, and subject to review by FEDERAL and/or STATE AGENCIES and others as required. I AUTHORIZE my

LGH- Financial Assistance Application

LAFAYETTE GENERAL HEALTH - FINANCIAL ASSISTANCE APPLICATION

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employer to release to LGH proof of my/our income. I UNDERSTAND that if any information I have given proves to be untrue, LGH will re-evaluate my financial status and take whatever action becomes appropriate. I authorize LGH to obtain my credit report from any credit reporting agencies, and understand that the information which I submit is subject to verification by LGH, including with credit reporting agencies, and subject to review by FEDERAL and/or STATE AGENCIES and others as required. By signing this form, I authorize reimbursement specialist(s) employed by LGH or its agents to sign any and all forms and applications on my behalf and to access and release any personal demographic, diagnostic, therapeutic, and/or financial information required relating to applications for pharmaceutical manufacturer assistance programs. This authorization may be revoked at any time by contacting the reimbursement office. I, on my own behalf, and for my immediate family member(s), authorized representative(s), physician(s), counselor(s) (including clergy), and attorney(s), agree to hold and maintain in strictest confidence any written communications and/or oral discussions between me and LGH regarding matters relating to services provided to me by LGH.

Signature of Applicant _____	Financial Assistance <input type="checkbox"/>	Date _____	Medical Bill Financial Assistance <input type="checkbox"/>
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5. FOR OFFICE USE ONLY

Family Size _____ Finc Recomm _____ (6 Month) Approval Period From _____ TO _____

Account #	DOS	Balance Due	IP	OP	BD	Committee Disposition
Total Due \$						

*****Please Attach All Bills In Relation to The Medical Center This Application Is Referencing *****

Authorized Signature: _____ Date: _____

6. FINANCIAL ASSISTANCE QUESTIONS: -- (All answers pertain to the patient) –

	<u>Check appropriate answer</u>
a. Is the patient applying for assistance with bills for past services at Hospital? If yes, please indicate the last service date: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Is the patient applying for assistance with bills for current and/or future services at Hospital? If yes, please describe the types of services that are anticipated: _____ _____ _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. Is the patient applying for a discount off their bills from Hospital?	<input type="checkbox"/> Yes <input type="checkbox"/> No
d. Is the patient applying for 100% assistance with their bills for services provided at Hospital?	<input type="checkbox"/> Yes <input type="checkbox"/> No
e. Does the patient have health insurance? If yes, please provide the following information: Health Insurance Name: _____ Subscriber's Name: _____ Members/Patients Identification Number: _____ Group Number: _____ Group/Employer Name: _____ Effective Date: _____ Health Insurance Telephone Number: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
f. Is the patient eligible for a state medical assistance program? If yes, please provide the following information: Name of program: _____ Parish: _____ Patient Identification Number: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
g. Is the patient being treated for injuries covered by workers compensation? If yes, please provide the following information: Name of workers comp carrier: _____ Adjusters name: _____ Adjusters phone number: _____ Injury date: _____ Claim/Case number: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No

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h.	Is the patient being treated for injuries covered by third party liability, such as an auto insurance company? If yes, please provide the following information: Name of auto insurance or attorney: _____ Auto insurance or attorney phone number: _____ Injury date: _____ Claim/Case number: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
i.	Is the patient a victim of crime? If yes, please provide the following information: Date of injury _____ Name of case worker, if applicable: _____ Case worker's phone number, if applicable: _____ Case number, if applicable _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
j.	Has the patient recently experienced one or more of the following extenuating circumstances: a recent death of a spouse or other immediate family member, recent disability, recently-diagnosed long term illness, or a recent job loss? If the patient has been through another experience that could be considered an extenuating circumstance, please provide an explanation in Section 9, Additional Information & Comments .	<input type="checkbox"/> Yes <input type="checkbox"/> No

7. HOUSEHOLD GROSS INCOME INFORMATION*** (Please attach a list of additional income if needed)

Yearly Income Sources****	Amount
Social Security Income	\$
State Aid-SSI, AFDC, Medicaid	\$
Food Stamps	\$
Pension Income	\$
Savings Interest	\$
Workers' Compensation Income	\$
Unemployment Compensation	\$
Child Support / Alimony Received	\$
Rental Income	\$
Money from Family / Other	\$
Last 4 weeks Income HCRA	\$
Last 8 weeks Income Medicaid/DCF	\$
TOTAL ANNUAL WAGES	\$

***Include income attributable to the applicant and the members of his or her immediate family on an annual basis.
 **** If the applicant indicates he or she has earned no income, he or she must complete a Lafayette General Medical Center No Income Form.

8. ASSETS (Please attach a list of additional assets if needed)

Home Address (Not P.O. Box)		() Yrs Paid On Home
Homestead <input type="checkbox"/> Yes	<input type="checkbox"/> Mobile Home <input type="checkbox"/> Yes	<input type="checkbox"/> Rent <input type="checkbox"/> Yes
Bal. Owed \$	Tax Assessed Value \$	Market Value \$
1 st Car () Yr. () Model ()		Value \$
2 nd Car () Yr. () Model ()		Value \$
Motor Home () Yr. () Model ()		Value \$
Boat () Yr. () Model ()		Value \$
Other Property	Bal. Owed \$	Value \$

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Rental <input type="checkbox"/> Vacant Land <input type="checkbox"/>			
Other Property Rental <input type="checkbox"/> Vacant Land <input type="checkbox"/>		Bal. Owed \$	Value \$
Bank Name / Credit Union	ACCT #	Average Checking/Savings Balance \$	
Bank Name / Credit Union	ACCT #	Average Checking/Savings Balance \$	
THE VALUE OF ALL ASSETS LISTED ABOVE			TOTAL \$ _____
9. ADDITIONAL INFORMATION & COMMENTS			
ADDITIONAL COMMENTS – IF YOU NEED MORE SPACE, PLEASE USE THE BACK OF THIS PAGE			
10. SIGNATURE			
I certify that all information is valid and complete and hereby authorize Hospital to request a credit check report and/or verify any of the above information as deemed necessary.			
Applicant	Date	Co-Applicant	Date
Return completed application to:		ABROM KAPLAN MEMORIAL HOSPITAL	
		Attn: PFS Department	
		1310 WEST 7TH STREET	
		KAPLAN, LA 70548	