LAFAYETTE GENERAL HEALTH - FINANCIAL ASSISTANCE APPLICATION
Customer Service: 1-337-289-7287

FINANCIAL ASSISTANCE APPLICATION

FACILITY: ST. MARTIN HOSPITAL, INC ("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** ☐ Self ☐ Spouse/Domestic Partner ☐ Parent ☐ Other _____ **MARITAL STATUS** ☐ Single ☐ Married/Domestic Partner ☐ Divorced ☐ Separated		
Last Name	**First Name**	**Middle Initial**				**U.S. Citizen** ☐ Yes ☐ 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

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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 ☐	Date	Medical Bill Financial Assistance ☐

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) –

		Check appropriate answer
a.	Is the patient applying for assistance with bills for past services at Hospital? If yes, please indicate the last service date:_____	☐ Yes ☐ 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: _____ _____ _____ _____	☐ Yes ☐ No
c.	Is the patient applying for a discount off their bills from Hospital?	☐ Yes ☐ No
d.	Is the patient applying for 100% assistance with their bills for services provided at Hospital?	☐ Yes ☐ 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:_____	☐ Yes ☐ 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:_____	☐ Yes ☐ 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:_____	☐ Yes ☐ No

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:_____	☐ Yes ☐ 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_____	☐ Yes ☐ 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***.	☐ Yes ☐ 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) Homestead ☐Yes ☐ Mobile Home ☐ Yes ☐ Rent ☐ Yes		( ) Yrs Paid On Home
Bal. Owed $	Tax Assessed Value $	Market Value $
1st Car ( ) Yr. ( ) Model ( )		Value $
2nd Car ( ) Yr. ( ) Model ( )		Value $
Motor Home ( ) Yr. ( ) Model ( )		Value $
Boat ( ) Yr. ( ) Model ( )		Value $
Other Property	Bal. Owed $	Value $

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Rental ☐ Vacant Land ☐			
Other Property Rental ☐ Vacant Land ☐	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:	St. Martin Hospital, Inc. Attn: PFS Department PO BOX 357 BREAUX BRIDGE, LA 70517