FRANCISCAN MISSIONARIES OF OUR LADY HEALTH SYSTEM
FINANCIAL ASSISTANCE APPLICATION

Patient Name:_____ Date of Birth:_____ Social Security #:_____

Current Address:_____ Home#_____

Marital Status:_____ Employment status:_____ Alt phone#_____

If Married, Complete Below:

Spouse's Name:_____ Date of Birth:_____ Social Security #:_____
Spouse's Employment status:_____

Below List all TAXABLE Dependents:

Name:_____	Age:_____	Occupation:_____
Name:_____	Age:_____	Occupation:_____
Name:_____	Age:_____	Occupation:_____
Name:_____	Age:_____	Occupation:_____

Mark Below if You Meet Any Of The Listed Conditions: (Attach Documentation)

- ☐ Receiving State Medicaid
- ☐ Homeless/Indigent
- ☐ Deceased with no spouse/estate
- ☐ Receiving Food Stamps/Subsidized School Meals/WIC/LACHIP/HUD
- ☐ Receiving State Funded Prescriptions
- ☐ Incarcerated with no responsible party or estate

Income Considerations: (working gross income, unemployment, SSI/SSDI, retirement, all other sources of income)

Patient Monthly Income: _____ Hrly rate/Hrs per Wk:_____ Income Source:_____
Spouse Monthly Income: _____ Hrly rate/Hrs per Wk:_____Income Source:_____

By signing this document, I, the patient or caregiver, certify that the above information is true and accurate to the best of my knowledge. Further, if it is determined that the applicant may qualify for Medicare, Medicaid, Insurance, etc...), I will take any action reasonably necessary to obtain such assistance and will assign or pay the hospital the amount recovered for hospital charges. If any information I have given proves to be untrue, I understand that the hospital may reevaluate my financial status and take whatever action becomes appropriate. It is also understood that completing this application is not a guarantee of approval into the Franciscan Missionaries of Our Lady Health System financial assistance program.

APPLICANT'S SIGNATURE_____ **DATE:** _____

For Office Use Only

___Approved Total Amt: _____ Elig Amt: _____% Exp Date: _____(valid 6 mths from DOS)
Accounts: _____
___Rejected
___Incomplete

Business Office/PA Manager_____ **Date**_____$1.00-$25,000.00
Hospital Revenue Cycle Director_____ **Date**_____$25,000.00-$49,000.00
System VP of Revenue Cycle_____ **Date**_____ $50,000.00-$99,000.00
Hospital VP of Finance_____ **Date**_____$99,000.00-$249,000.00
Hospital CFO _____ **Date**_____>$250,000.00

Attachment Checklist and Directions

Failure to provide supporting documentation will result in a denial

Proof of Income:

1. Three most current pay stubs, letter from your employer, unemployment check stubs, Social Security verification, and verification from any other income you are currently receiving.
2. If you are currently unemployed with no income, a notarized statement of support is required.
3. Most current year tax return. If you are not required to file taxes, a letter from the IRS is required.
   IRS toll free: **1-800-829-1040**
4. Three current bank statements for savings and checking accounts.
5. Current statement of retirement accounts (401k, IRA, etc...) if applicable.
6. If applicant is married, proof of income for spouse is required as well.
7. Most recent denial letter from State Medicaid program, if applicable.

If there are any other financial assistance conditions that are not listed, the patient may write a letter explaining their situation in addition to supporting documentation. These cases will be reviewed on a case by case basis.

PROOF OF ADDITONAL FINANCIAL ASSISTANCE CONDITIONS/REASONS (OTHER THAN INCOME)

1. A copy of a letter or card showing eligibility for State Medicaid, WIC, HUD, LACARE, Food Stamps, and Subsidized school meals (free or reduced school lunches).
2. If applicant is deceased or incarcerated and has no other responsible party then a copy of the death certificate or proof of incarceration is needed to prove that the patient is deceased or incarcerated before the application for financial assistance will be reviewed.
3. If applicant is receiving free care from a partnering physician/clinic, then the applicant must provide a letter of medical necessity. This must be approved prior to the service date.

INFORMATION SHOULD BE RETURNED TO US WITH IN 10 DAYS

You may personally bring your information back to us or mail your information to the following address:

St. Francis Medical Center
P.O. Box 1901
Monroe, La. 71210-1901

Attn: _____
Financial Counselor

We are here to help you. If you have questions, please call us at 318-966-7351.