To Our Valued Patient:

Thank you for choosing West Ascension Parish Hospital for your healthcare needs. Enclosed you will find an application for hospital financial assistance. This is for your hospital charges only. Please return the completed application and provide all supporting documentation to the hospital business office.

Uninsured and underinsured patients with a family income at or below 400% of the federal poverty level may be eligible for assistance. Patients with significant medical bills, regardless of income, may also be eligible for assistance.

We understand your desire for privacy. Accordingly, except for verification purposes, the information included in your application will be treated as confidential.

Upon receipt of a completed application, our staff will conduct a review of the application for possible assistance towards the balance on your account(s) with West Ascension Parish Hospital. We will notify you in writing after our review.

Again, we would like to thank you for choosing West Ascension Parish Hospital for your health care needs. If you have any questions regarding the application or the above information, please call the number below and ask for assistance from the Revenue Cycle Director or CFO.

Please return the completed application and provide all supporting documentation to the hospital business office at the address below.

West Ascension Parish Hospital
301 Memorial Drive
Donaldsonville, LA 70346
1-225-473-7931

FINANCIAL ASSISTANCE APPLICATION

*Patient Name:*____ *Account #:* ____________________

Guarantor Name: ____ *Application Date:*________________

Date(s) of Service: ____

YOU MUST PROVIDE ALL OF THE FOLLOWING FOR ALL MEMBERS OF THE HOUSEHOLD:

___ Most recent W-2(s) and Income Tax Return(s)
___ 3 most recent pay check stubs
___ 3 most recent checking/savings/investment account statements
___ Food Stamp, WIC, or other needs-based program award letter (*if applicable*)

YOU MUST PROVIDE PROOF OF IDENTITY WITH AT LEAST 1 OF THE FOLLOWING:

____ Current Driver's License
____ Passport
____ State-issued Identification Card

___ If you report a $0 income, please attach a brief explanation of how you or the patient are meeting basic needs

PERSONAL DATA:

	PATIENT	SPOUSE
Name	________________	________________
Social Security #	________________	________________
Date of Birth	________________	________________
Street Address/Apt. #	________________	________________
City, State, Zip	________________	________________
Phone #	________________	________________

EMPLOYMENT DATA:

Employer Name	________________	________________
Explain, if self-employed	________________	________________
Address	________________	________________
# of Hours Worked/Week	________________	________________
Job Title	________________	________________
Length of Employment	Yrs________Months________	Yrs________Months________
Gross Monthly Salary	________________	________________

OTHER HOUSEHOLD MEMBERS:

Name ____________________ Age ______ DOB ____________ Relationship ____________________

Name ____________________ Age ______ DOB ____________ Relationship ____________________

Name ____________________ Age ______ DOB ____________ Relationship ____________________

ADDITIONAL INCOME:

2nd Job: N Y: $____________/month
Other (ex: investments, savings, child support, other governmental aid) $________/month

EXPENSES:

Home Mortgage: $________/month
Medical Bills: $__________/month
Pharmacy Bills: $_________/month
Other (food/utilities) $______/month

Are any third parties potentially liable for your medical expenses (i.e. auto insurance, workers' compensation, lawsuit)? Yes No

I certify that: (1) I am unable to pay for the costs of necessary services, (2) I have disclosed all my assets and income, and (3) the information I have given to West Ascension Parish Hospital (the Hospital) is true and accurate. I understand that the Hospital will use this information to determine my eligibility for financial assistance. I agree to report any changes in my financial status to the Hospital. I authorize the Hospital, or any credit reporting agency, to investigate any reference, statements, employment, or other data given by me or any other person pertaining to my credit and financial responsibility.

*Patient/Guarantor Signature*_________________________________ *Date* ____________________