FINANCIAL ASSISTANCE APPLICATION

301 Memorial Drive • Donaldsonville, LA 70346
Phone: 225-473-7931

To Our Valued Patient:

Thank you for selecting West Ascension Parish Hospital for your healthcare needs. Enclosed is an application for hospital financial assistance, which applies only to hospital-related charges and does not cover services provided by independent or contracted physicians.

Patients who are uninsured or underinsured with a household income at or below 400% of the Federal Poverty Level (FPL) may qualify for assistance. Additionally, individuals facing substantial medical expenses may be considered for financial relief regardless of income.

We understand and respect your right to privacy. All information submitted in the application will be treated as confidential and used solely for the purpose of verifying eligibility.

Upon receipt of your completed application and all required supporting documentation, our Financial Services team will review your information to determine potential eligibility. You will be notified in writing of our determination.

If you have any questions regarding the application or need assistance with the process, please contact the Business Office at 225-473-7931 and ask to speak with the Patient Access Supervisor or Chief Administrative Officer.

Please return the completed application and documentation to:

West Ascension Parish Hospital
Attn: Business Office
301 Memorial Drive
Donaldsonville, LA 70346

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Patient Name: _____ **Account Number: _____**

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 account statements
____ Food Stamp, WIC, or other needs-based program award letter

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 Number		
Date of Birth		
Street Address/Apt#		
City, State, Zip		
Phone Number		

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:**
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ADDITIONAL INCOME:

2ND Job:(N)(Y): $_____/month
Other: (ex. Investments, savings, child support, other aid: $_____/month

EXPENSES:

Home Mortgage: $_____ Medical Bills: $_____
Pharmacy Bills: $_____ Other (food, utilities): $_____

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

I hereby certify that I am unable to pay for the costs of medically necessary services and that I have provided true and complete information regarding my financial status. I understand that West Ascension Parish Hospital will use this information to determine my eligibility for financial assistance. I also agree to report any changes in my financial situation promptly. I authorize the Hospital and/or credit reporting agencies to verify any information provided in this application.

Patient/Guarantor Signature: _____ Date: _____