Ochsner | LSU Health SHREVEPORT

Attachment B: Financial Assistance Application

Guarantor #:

Financial Assistance Process and Application

The Ochsner LSU Health System (OLHS) is committed to providing financial assistance for patients with a demonstrated financial need or hardship, who have received medically necessary healthcare services provided by OLHS. Medically necessary services are services that are reasonable or necessary for the diagnosis or treatment of an illness or injury. Medical necessity will be determined by the examining physician. This application does not serve as a guarantee of financial assistance or reduction in outstanding liability.

Forms to include:

- OLHS Financial Assistance Application
- OLHS Patient Attestation

Documentation to include:

1. Copy of your most recently filed income tax return OR a copy of three (3) most recent pay stubs for yourself and co-applicant.
    - If unemployed, please provide letter from last employer OR copy of unemployment award letter OR letter certifying denial of unemployment benefits from applicable state department of labor
2. Last two (2) months bank statements for yourself and co-applicant.

****Lines 1 and 2 must be included for your application to be processed; if you do not have these items, please provide a written statement advising of such****

If Applicable:

1. Copy of Social Security Administration monthly award letter
2. Copy of Disability monthly award letter
3. Copy of AFDC award letter or food stamp budget sheet
4. Copy of healthcare insurance card/ information
5. Any and all other income:
    - Spousal/ child Support
    - Rental property
    - Investment income
6. Medicaid denial letter from state administrator
7. Proof of dependents (most recently filed income tax return)

****If any of the above applies, we will not be able to process your application without such documentation****

Please Mail Completed Info to:
OLHS Financial Counseling Department
1541 Kings Highway
Shreveport, LA 71103

If you have any questions or concerns, please contact the Financial Counseling Department at 318-626-1168

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Guarantor #:

Income Information

Please complete the income information below. Please state if the income listed is per month or per year. If married, please include spouse income under the co-applicant fields.

Income Sources	Applicant	Per Month/ Year	Co-Applicant	Per Month/ Year
Employment	$		$	
Social Security	$		$	
Disability	$		$	
Unemployment	$		$	
Rental Property	$		$	
Investment Income	$		$	
Spousal Support	$		$	
Child Support	$		$	
			Total Combined Income	$

Applicant/ Guarantor Information

Relationship to Patient:
[ ] Self [ ] Spouse [ ] Parent

Marital Status (*):
[ ] Single [ ] Married [ ] Divorced [ ] Separated

**If married, please include spouse information and income*

Last Name	First Name	Middle Initial	U.S. Citizen	Social Security Number
			[ ] Yes [ ] No	
Date of Birth	**Number of Dependents**	**Age of Dependents**	**Current Telephone Number**	
Street Address			**City, Parish, State, Zip**	
Current Employer		**City, Parish, State, Zip**		**Position**
If you are not working, how long have you been unemployed?				

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Guarantor #:

Co-Applicant Information

<table>
<tr><td colspan="5"><u>Relationship to Patient:</u>
[ ] Self [ ] Spouse [ ] Parent</td></tr>
<tr><th>Last Name</th><th>First Name</th><th>Middle Initial</th><th>U.S. Citizen</th><th>Social Security Number</th></tr>
<tr><td></td><td></td><td></td><td>[ ] Yes [ ] No</td><td></td></tr>
<tr><th>Date of Birth</th><th>Number of Dependents</th><th>Age of Dependents</th><th colspan="2">Current Telephone Number</th></tr>
<tr><td></td><td></td><td></td><td colspan="2"></td></tr>
<tr><th colspan="3">Street Address</th><th colspan="2">City, Parish, State, Zip</th></tr>
<tr><td colspan="3"></td><td colspan="2"></td></tr>
<tr><th colspan="2">Current Employer</th><th colspan="2">City, Parish, State, Zip</th><th>Position</th></tr>
<tr><td colspan="2"></td><td colspan="2"></td><td></td></tr>
<tr><th colspan="5">If you are not working, how long have you been unemployed?</th></tr>
<tr><td colspan="5"></td></tr>
</table>

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Attachment B: Financial Assistance Application

Guarantor #:

Attestation

- I have complied with the OLHS Financial Counseling screening process to determine if I may be eligible for alternate resources (COBRA, Social Security, Medicaid, and Victim of Crime).
- I understand that until I have complied with the Financial Counseling screening process, or applicable application process, I will not be eligible for financial assistance.
- I understand that balances due to non-medically necessary services, such as purely elective or cosmetic services are not eligible for financial assistance, and I have not included any of those balances in this request.
- If I have included balances due to purely elective or cosmetic services, they will not be adjusted. If they are adjusted in error, they will be reinstated.
- If applicable, I have provided my most recent/current insurance card with appropriate information to submit past, present, and future claims.
- I have provided all requested documentation from page 1 of this application. I attest that all information provided on this application, as well as all supporting documents are accurate and truthful to the best of my knowledge and ability.

______________________	______________________
Printed Name	**Signature**
______________________	______________________
Date of Application	**Phone/Contact**

____

Address (Street Address, City, State, Zip)

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No Income Verification/ Statement of Support

________________________ (**Applicant**) is applying for financial assistance with the Ochsner LSU Health System. The applicant has stated they do not receive any monthly/yearly income. The applicant has listed you as their sole means of support.

To the best of my knowledge, the applicant has no income and I certify this to be true. I am either providing the applicant with food and shelter and/or providing the applicant with financial support as specified below

Relationship to the applicant *For example: Shelter, Mother, Father, Other*

I am providing:

- Food and Shelter $______________ Approximate monthly total
- Financial Support $_______________ Approximate monthly total
- Other $_______________ Approximate monthly total

______________________________ ______________________________

Printed Name (of supporter) **Signature** (of supporter)

______________________________ ______________________________

Date **Phone/Contact**

____

Address (Street Address, City, State, Zip)

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OLHS Financial Counseling Department 1541 Kings Highway, Shreveport, LA 71103

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Attachment C: Amounts Generally Billed Discounts

Facility	Calculated Discount Rate
Academic Medical Center	77%
Monroe Medical Center	79%
St. Mary Medical Center	77%

Physician Charges	Calculated Discount Rate
OLPG	69%

Attachment D: Facilities Covered under Financial Assistance Policy

OLHS.REV.01 applies to the following hospital facilities and the associated provider-based departments of each:

Academic Medical Center
Monroe Medical Center
St. Mary Medical Center