Ochsner Lafayette General

Financial Assistance Process & Application

Ochsner Lafayette General ("OLG") is committed to providing financial assistance for patients with a demonstrated financial need or hardship, who have received medically necessary healthcare services provided by OLG. 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:

- OLG Financial Assistance Application
- OLG Patient Attestation

Documentation to include:

1. Copy of most recently filed income tax return, or
2. Copy of three (3) most recent pay stubs.
   a. 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
3. Copy of Social Security Administration monthly award letter
4. Copy of Disability monthly award letter
5. Copy of healthcare insurance card/information
6. Any and all other income:
   a. Spousal/Child Support
   b. Rental Property
   c. Investment Income
7. Medicaid denial letter from state administrator Proof of dependents

Please Mail Completed Info to: Ochsner Lafayette General Patient Accounts
900 East St. Mary Blvd., Suite 106, Lafayette, LA 70503

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 information 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	**$**

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Applicant(s) Information

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. Resident ☐ 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 ____________ Position ____________

If you are not working, how long have you been unemployed? ____________

Co-applicant Information

Relationship to patient: ☐ Self ☐ Spouse ☐ Parent

Last Name ____________ First Name ____________ Middle Initial ____________

U.S. Citizen ☐ 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 ____________ Position ____________

If you are not working, how long have you been unemployed? ____________

Ochsner Lafayette General

Attestation

- I understand that balances due to non-medically necessary services, such as purely elective orcosmetic 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) ____________________

No Income Verification / Statement of Support

______________________________ (Applicant) is applying for financial assistance with Ochsner Lafayette General. 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.

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 ______________________________

Address ______________________________ City, State, Zip ______________________________

Phone ______________________________

Relationship to the applicant (For example: Shelter, Mother, Father, Other) ______________________________

If you have any questions or concerns, you may contact the Patient Accounts Customer Service Department by phone at 337-289-7287.

Ochsner Lafayette General Patient Accounts
900 East St. Mary Blvd., Suite 106, Lafayette, LA 70503

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