Ochsner
University Hospital & Clinics

Your financial assistance application can be found on our website: ochsnerlg.org/financial-assistance-policies or visit the Financial Screening Department at the Medicaid Enrollment Center, Building #7. You can mail or email your application with the required documents no more than 5 days prior to expiration date.

Please mail or email to:
OUHC Financial Screening Department
2390 West Congress St.
Lafayette, LA 70506
UHCFinancialScreening@lgh.org

It should take approximately 7-10 business days for the review of your application. Application must be completed prior to the date of your appointment. You will be contacted by mail once the review has been completed.

Please call 337-261-6745 between the hours of 7 a.m. and 4 p.m. if you have any questions or concerns regarding the application process.

Thank you,
Ochsner University Hospital & Clinics
Financial Screening Department

Ochsner University Hospital & Clinics

Financial Assistance Application

Date of Application _____

Patient Information* Please Print All Information

Last Name _____ First Name _____ Middle Initial _____

Medical Record Number _____

* If the patient is a minor, please list parent(s)/guardian(s) as applicant

Applicant/Guarantor/Responsible Party Information

Relationship to patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other _____

Marital Status (*): ☐ Single ☐ Married/Domestic Partner ☐ Divorced ☐ Separated

Last Name _____ First Name _____ Middle Initial _____

U.S. Citizen ☐ Yes ☐ No

Date of Birth _____ Number of Dependents _____ Age of Dependents _____

Home Phone _____

Street Address _____ City, Parish, State** _____ ZIP Code _____
(Do Not List PO Box)

Current Employer _____ Address, City, State _____ Position _____

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

** Note that any person seeking financial assistance must be a S resident.

Immediate Family Members

Last Name	First Name	Date of Birth	Age	Relationship to Patient	Occupation	Social Security Number	Annual Worked Wages

Agreement

Please read before signing. I CERTIFY that the information I have provided is true and accurate to the best of my knowledge. I will make application for ANY and ALL ASSISTANCE which may be available through federal, state, local government and private sources to help pay this hospital bill and will take all action necessary to obtain assistance from the above sources. By signing this form, I understand that I must cooperate with OLG **within 10 business days** of the date of my signature to be eligible for any financial assistance deemed by the hospital. I hereby grant permission and authorize any accredited agent of the Department of Children and Families to disclose to OLG ALL INFORMATION regarding the status of my Medicaid application and if the application is not approved the reason for disapproval. I will ASSIGN to OLG ALL FUNDS received from the above sources which are provided to help with the HOSPITAL BILL. I understand that the information which I submit is subject to verification by OLG including credit reporting agencies, and subject to review by FEDERAL and/or STATE AGENCIES and others as required. I AUTHORIZE my employer to release to OLG proof of my/our income. I UNDERSTAND that if any information I have given proves to be untrue, OLG will re-evaluate my financial sta us and take whatever action becomes appropriate. I authorize OLG to obtain my credit report from any credit reporting agencies, and understand that the information which I submit is subject to verificatio by OLG, including with credit reporting agencies, and subject to review by FEDERAL and/or STATE AGENCIES and others as required. By signing this form, I authorize reimbursement specialist(s) employed by OLG or its agents to sign any and all forms and applications on my behalf and to access and release any personal demographic, diagnostic, therapeutic, and/or financial information required elating to applications for pharmaceutical manufacturer assistance programs. This authorization may be revoked at any time by contacting the reimbursement office. I, my own behalf, and for my immediate family member(s), authorized representative(s), physician(s), counselor(s) (including clergy), and attorney(s), agree to hold and maintain in strictest confidence any written communication and/or oral discussions between me and OLG regarding matters relating to services provided to me by OLG.

_____ _____

Signature of Applicant Date

Ochsner University Hospital & Clinics

Financial Assistance Application

FOR OFFICE USE ONLY

Family Size _____ Financial Recommendation _____

(12 Month) Approval Period From _____ To _____

Account #	DOS	Balance Due	IP	OP	BD	Committee Disposition
Total Due $						

_____ _____

Authorized Signature Date

HOUSEHOLD GROSS INCOME INFORMATION***

(Please attach a list of additional income if needed)

Yearly Income Sources****	Amount
Social Security Income	$
State Aid-SSI, AFDC, Medicaid	$
Food Stamps	$
Pension Income	$
Savings Interest	$
Workers' Compensation Income	$
Unemployment Compensation	$
Child Support / Alimony Received	$
Rental Income	$
Money from Family / Other	$
Last 4 weeks Income HCRA	$
Last 8 weeks Income Medicaid/DCF	$
TOTAL ANNUAL WAGES	**$**

***Include income attributable to the applicant and the members of his or her immediate family on an annual basis.

**** If the applicant indicates he or she has earned no income, he or she must complete a Statement of Support Form.

Ochsner University Hospital & Clinics

Financial Assistance Application

ASSETS (Please attach a list of additional assets if needed)

Home Address (Not P.O. Box) _____

Homestead ☐ Yes Mobile Home ☐ Yes Rent ☐ Yes

Yrs. Paid On Home _____

Bal. Owed $ _____ Tax Assessed Value $ _____ Market Value $ _____

1st Car _____ Yr. _____ Model _____ Value $ _____

2nd Car _____ Yr. _____ Model _____ Value $ _____

Motor Home _____ Yr. _____ Model _____ Value $ _____

Boat _____ Yr. _____ Model _____ Value $ _____

Other Property _____ Bal. Owed $ _____ Value $ _____

Rental ☐ Yes Vacant Land ☐ Yes

Other Property _____ Bal. Owed $ _____ Value $ _____

Rental ☐ Yes Vacant Land ☐ Yes

Bank Name / Credit Union _____ ACCT # _____ Average Checking/Savings Balance $ _____

Bank Name / Credit Union _____ ACCT # _____ Average Checking/Savings Balance $ _____

The Value Of All Assets Listed Above **Total $** _____

Additional Information & Comments

If you need more space, please use the back of this page.

Signature

I certify that all information is valid and complete and hereby authorize Ochsner University Hospital and Clinics to request a credit check report and/or verify any of the above information as deemed necessary.

Applicant _____ Date _____

Co-Applicant _____ Date _____

Return completed application to:

Ochsner University Hospital & Clinics
Attn: Financial Screening Dept.
2390 West Congress St.
Lafayette, LA 70506

Ochsner University Hospital & Clinics

Financial Assistance Application Requirements

The following information must be provided in order to process an application for the Indigent Program. Eligibility is per eligible family unit which includes self, spouse and dependents under 18 years of age.

Please Supply the Documents Requested Below:

Proof of Patient Identification (provide one of the following)

- ☐ Valid Driver's License or Office of Motor Vehicle ID or Militar Picture ID
- ☐ Current School Identification Card with pictur
- ☐ Current Employee Identification Card with picture and expiratio date
- ☐ Valid Passport or Immigration documentation for legal stay in the US

Proof of LA Residency and Intent to Remain in LA (one of the following)

- ☐ Voter's Registration Card or other recent Government item with your address
- ☐ Utility or other bill in your name at your address, Rent or Lease contract
- ☐ Valid LA Driver's License or LA Office of Motor Vehicle ID ca

- ☐ **Social Security (SS) Cards for Family Unit (Clear copy)**

Proof of Income (one of the following for all family members)

Last year's completed tax return is required if self-employed.

- ☐ Check Stub(s) for prior 30 days from date of application.
- ☐ Food Stamp document for the family unit.
- ☐ Verification of income from current employer covering prior 30 ays or a termination letter on the employer's letterhead.
- ☐ Current year SSI award letter.
- ☐ Last 30 days **bank statement** showing direct deposit records for any Social Security/SSI or Unemployment deposits. **(Required for Medicare recipients)**
- ☐ Court orders/child support income/alimony or verification of Wo kman's Compensation income.
- ☐ No Income Verification/Statement of Support

This information must be returned in order for application to be processed.
Return application to the facility below in which you are applying for assistance.

Please check the appropriate facility:

- ☐ **Ochsner University Hospital & Clinics**
  Financial Screening Department
  2390 West Congress St.
  Lafayette, LA 70506

Ochsner University Hospital & Clinics

Medically Indigent (MI) Application

Medicare Income And Insurance Attestation

MR# _____

Full Name of Patient: _____

Is the patient listed above covered by any health insurance plan? ☐ Yes ☐ No

I authorize this facility to release my information to pharmaceutical manufactures and/or its designee's to review records for audit purposes. I understand it is the responsibility of the patient/applicant to report to this department when there are any changes in the family unit income, employment and/or insurance. Any false statements could lead to the denial or revocation of this application and the patient shall be held responsible for all charges incurred.

_____ _____

Signature of Applicant Date

Ochsner University Hospital & Clinics

No Income Verification / Statement of Support

_____ (Applicant) is applying for financial assistance with Ochsne University Hospital & Clincs. 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 belo

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 _____

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

If you have any questions or concerns, you may contact or visit the Financial Screening Department.

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Lafayette, LA 70506
uhcfinancialscreening@lgh.org
337-261-6745