Woman's

Financial Assistance Application

Please contact a Financial Counselor at 225-924-8354 for assistance completing this application

Name:_____ SS#_____ DOB:_____

Mailing Address:_____

City:_____ State: _____ Zip:_____

Home Phone Number_____ Cell Phone Number:_____

Employer:_____ Are you married? ☐ Yes ☐ No

Spouse's Name:_____ Spouse's Date of Birth:_____ Spouse's Employer:_____

Do you receive Supplemental Nutritional Assistance (SNAP)? ☐ Yes ☐ No

Have you applied for Medicaid in the last 3 months? ☐ Yes ☐ No ☐ Pending ☐ Denied

What is your household size? _____*(Household members are family members included on most recent federal tax return)*

List names and date of birth of all other household members besides you and your spouse:

_____

_____

Household Income

Patient Salary: $_____Spouse Salary: $_____ Other Household Salary: $_____

Other Household Income:

Alimony	$_____	Survivor Benefits	$_____
Child Support	$_____	Unemployment	$_____
Interests/Dividends	$_____	Veteran's Payments	$_____
Pension/Retirement income	$_____	Workers' Compensation	$_____
Public Assistance	$_____	Other (explain)_____	$_____
Social Security/Disability	$_____		

PLEASE SUBMIT THE FOLLOWING WITH THIS FORM:

- Copy of Photo identification
- Proof of Residency; Utility bill or a lease/rental agreement (in patient or spouse's name)
- Last 30 days of income for each member in household ; most recent 1040 Federal Tax Return; current Social Security Award Letter (most recent tax return may be substituted)
- Copy of Supplemental Nutritional Assistance verification (if applicable)
- Patients applying for medical hardship - *Applicants with annualized gross family income in excess of the Federal Poverty Level threshold may qualify for medical hardship by submitting proof of medical bills (from any healthcare provider) incurred during the six months prior to this application. Medical bills may be submitted for all members of the applicant's family living in the household and included in the most recent federal tax return.*

By signing this document, I understand that patients identified as potentially eligible for Medicaid or other programs are expected to cooperate and apply for such programs. Furthermore, I certify that the information given is correct to the best of my knowledge.

Applicant Signature_____ Date_____

Please return this application to:

Woman's Hospital Financial Assistance Counselor
100 Woman's Way • Baton Rouge, LA 70817
Or email to: financial.counselor@womans.org
Or fax to: 225-928-8831 • 225-922-3395