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

PLEASE SUBMIT THE FOLLOWING WITH THIS FORM:

- Copy of Photo identification
- Proof of Residency: Copy of current mortgage, lease, or rental agreement along with proof of payment within last 30 days. The mortgage, lease, or rental agreement must have the primary contact's name and a residential address located in Louisiana.
- 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) The pay stub must have the primary contact's name and a residential address located in Louisiana.
- Copy of utility bill (gas/water/electricity) issued within the past 30 days. The utility bill must have the primary contact's name and a residential address located in Louisiana.
- 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.

**For applicants who don't any of the above documents in order to be approved to use a third-party statement for proof of residency and the statements must come from the person the applicant lives with and include:

- Name of third party
- Relationship of the third party to the beneficiary
- Mailing address of third party
- Telephone number of third party/agency/business
- Third party's statement confirming the beneficiary's physical address
- Signature of third party

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__________ Time__________

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

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