West Jefferson Medical Center

PROUD MEMBER OF LCMC HEALTH

FINANCIAL ASSISTANCE APPLICATION FORM

SECTION ONE: PATIENT INFORMATION

Print your full name, your address at the time you received medical service and other information noted in this section.

Account Number _____ Date(s) of Service _____

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Parish: _____

Social Security Number: _____ – _____ – _____ Date of Birth: ___ / ___ / ___

Home Phone: (_____) _____ Other Phone: (_____) _____

Marital Status: ❑ Single ❑ Married ❑ Divorced Are you a legal resident of the United States? ❑ Yes ❑ No

Did you have health insurance (other than Medicaid) at the time of your service? If yes, please provide your insurance information and a copy of your insurance card. ❑ Yes ❑ No

Name of insurance: _____
Effective date of insurance: ___ / ___ / ___

Subscriber Name: _____
Subscriber Date of Birth: ___ / ___ / ___

Subscriber ID: _____Group Number: _____

SECTION TWO: FAMILY INCOME

Provide income for yourself, your spouse and all other family members (if applicable.)

Monthly Income Source	Current Monthly Gross Income Amount		Total Family Income for 3 months prior to date of service	Type of income verification attached – proof of income is requested to process your application
	Patient	Spouse/Other		
Wages/Self Employment, Child support and alimony	$	$	$	Copy of most recent pay stubs or income award letters (for three previous months)
Social Security	$	$	$	Social Security award letter
Pension, Dividends, Interest, Rental Income	$	$	$	Pension benefits letter, Dividend/Interest Statement
Unemployment, Workers' Compensation	$	$	$	Unemployment benefit letter, Workers' Compensation benefit letter

NOTE: If you reported $0 income, please provide a brief explanation of how you (or the patient) are meeting basic living needs:

_____

_____

_____

(Must provide a support statement.)

SECTION THREE: FAMILY INFORMATION

List all family members in your household named on the most recent federal income tax return and their date of birth.

Please provide the following information for all of the people in your immediate family who live in your home. For purposes of this policy, family is defined as the patient, the patient's spouse, and all of the patient's children under 18 (natural or adoptive) who live in the patient's home. If the patient is under the age of 18, the family shall include the patient, the patient's natural or adoptive parent(s), and the parent(s) children under 18 (natural or adoptive) who live in the patient's home.

Name of family members, including patient	Date of Birth	Relationship to Patient
1.		
2.		
3.		
4.		
5.		
6.		

By signing below, I certify that everything I have stated on this application and on any attachments is true.

Responsible Party's Signature _____ Date: _____

Return your completed application to:

West Jefferson Medical Center Patient Financial Services
Attn: Financial Counseling
1101 Medical Center Blvd.
Marrero, LA 70072

Copies of our Financial Assistance Policy, Application Form and Summary are available in English, Spanish and Vietnamese.