Financial Assistance
Process & Application

Ochsner LSU Health System ("OLHS") is committed to providing financial assistance for patients with a demonstrated financial need or hardship, who have received medically necessary healthcare services provided by OLHS. 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.

Application must include:

- All required documents for you and your co-applicant if applicable.
- Proof of Dependents for anyone listed on application.
- Completed Ochsner LSU Financial Assistance Application
- Signed & Dated Patient Attestation Form
- Proof of US Residency

Please include all applicable documents listed below:

A. Proof of Income (Please provide 1 of the following):
- a. Copy of tax return (Form 1040) for current tax year, 4506-T or
- b. Copy of three (3) most recent pay stubs.
- c. 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.
- d. If no income can be provided, please complete, and sign the No Income Verification/Statement of Support (view attachment)
- e. If separated, please submit a copy of tax return (Form 1040) for current tax year.
- f. Copy of Social Security Administration monthly award letter
- g. Copy of Disability monthly award letter

B. Copy of healthcare insurance card/information

C. Proof of Residency (Please provide 1 of the following):
- a. Valid U.S. Driver's License/Identification Card
- b. Current Utility Bill (shows name and address of applicant)
- c. Lease Agreement (shows name and address of applicant)
- d. Voter Registration

D. All other income (Please provide 1 of the following):
- a. Spousal/Child Support (Copy of letter stating monthly award amount)
- b. Rental Property
- c. Investment Income

E. Proof of Dependents (Please provide 1 of the following if applicable):
- a. Copy of tax return (Form 1040) for current tax year
- b. School records or statements
- c. Health provider statements

Please Mail Completed Info to:
Ochsner LSU Health System
Financial Counseling Department
1541 Kings Highway, Shreveport, LA 71103

Applications can also be emailed or faxed to:
Fax: (318)698-8191; Email:Financial_Counseling@ochsner.org

Financial Assistance Application

MRN: _____

Income Information: Please complete the income information below. ***If married, please include spouse income information under the Co-Applicant fields.***				
Income Sources	**Applicant**	**Monthly Gross Income**	**Co-Applicant**	**Monthly Gross Income**
Employment	$		$	
Social Security	$		$	
Disability	$		$	
Unemployment	$		$	
Rental Property	$		$	
Investment Income	$		$	
Spousal Support	$		$	
Child Support	$		$	
			Total Combined Income	$

Applicant(s) Information

Applicant/Guarantor Information	
Relationship to patient:	**Marital Status (*):**
[ ] Self [ ] Spouse [ ] Parent	[ ] Single [ ] Married [ ] Divorced [ ] Separated

Last Name	**First Name**	**Middle Initial**	**Social Security Number**

Date of Birth	**Number of Dependents**	**Age of Dependents**	**Current Telephone Number**

Street Address	**City**	**State**	**ZIP**

Current Employer	**Position**

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

Co-applicant Information

** If Married, please include spouse information and income*

Relationship to patient:

[ ] Self [ ] Spouse [ ] Parent

Last Name	**First Name**	**Middle Initial**	**Social Security Number**

Date of Birth	**Number of Dependents**	**Age of Dependents**	**Current Telephone Number**

Street Address	**City**	**State**	**ZIP**

Current Employer	**Position**

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

Attachment(s)

Attestation

No Income Verification

Attestation

- I have complied with the Ochsner LSU Health System screening process to determine if I may be eligible for alternate resources (COBRA, Social Security, Medicaid, and Victim of Crime).
- I understand that until I have complied with the financial counseling eligibility process, or applicable application process, I will not be eligible for financial assistance.
- I understand that balances due to non-medically necessary services, such as purely elective or cosmetic services are not eligible for financial assistance. I also understand that balances over 240 days from the date of the first post discharge bill for an episode of care will not be included 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)** **(Co-applicant) if applicable**

The above applicant is applying for financial assistance with Ochsner LSU Health System and has stated that 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

_____

(Relationship to the applicant-for example: Shelter, Mother, Father, Other)

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/Contact**

_____

Address (Street Address, City, State, Zip)

******If you are not receiving income from any source please sign here******

I, _____ am not receiving income or financial support from any source currently**.**

I, _____ am unemployed and not receiving external income. I am receiving financial support from my spouse _____ (spouse's name).

Signature_____Date_____

Applicant/Co-Applicant (*if applicable*)

Ochsner LSU Health System
Financial Counseling Department
1541 Kings Highway, Shreveport, LA 71103