**Financial Assistance Program**

 The Financial Assistance Program is designed to help you with the balance on your Abbeville

 General Bill. This program is available to all Abbeville General Patients.

 If you are interested in applying for financial assistance, please complete all sections of the

 attached application form and send the documents that are applicable as listed on the

 following page. You may also come into the office and sign up or provide application along

 with your documents.

 After I receive the documents, your application will be reviewed. The determination will be

 made based on your level of income and family size.

 I will mail you a letter with the application decision.

 Please contact me directly if you have any questions or concerns.

 ***\*\* Please let us know if you are interested in Medicaid, as you will need an appointment.***

  ***If you have insurance, please let us know.***

 **Return application and supporting documents to:**

 **Abbeville General Hospital**

 **Attn: Business Office – Financial Aid Coordinator**

 **118 N. Hospital Drive**

 **Abbeville, LA 70510**

 **Application for Financial Assistance**

 **Page 1 Patient Information**

 Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_

 Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security #: \_\_\_\_\_\_‑\_\_\_\_‑\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone: (\_\_\_\_\_\_) \_\_\_\_\_\_‑\_\_\_\_\_\_\_\_

 City/State/Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: (\_\_\_\_\_\_) \_\_\_\_\_\_‑\_\_\_\_\_\_\_\_

 Marital Status: Single Married Divorced

 *Circle Selection*

 Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: (\_\_\_\_\_\_) \_\_\_\_\_\_‑\_\_\_\_\_\_\_\_

 Spouse Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: (\_\_\_\_\_\_) \_\_\_\_\_\_‑\_\_\_\_\_\_\_\_

 **Guarantor Information**

 Guarantor Same As Patient: Yes No *Circle Selection* Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: (\_\_\_\_\_\_) \_\_\_\_\_\_‑\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Marital Status: Single Married Divorced

 Circle Selection

 City/State/Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: (\_\_\_\_\_\_) \_\_\_\_\_\_‑\_\_\_\_\_\_\_\_

 **Family Size:**

 **Members Of Household**

 **Name Relationship Birthdate Monthly Income**

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_ \_\_\_\_,\_\_\_\_\_\_.\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_ \_\_\_\_,\_\_\_\_\_\_.\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_ \_\_\_\_,\_\_\_\_\_\_.\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_ \_\_\_\_,\_\_\_\_\_\_.\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_ \_\_\_\_,\_\_\_\_\_\_.\_\_\_\_

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 ***( Application Continues to Page 2 )***

**Application for Financial Assistance**

 **Page 2 Required Documents**

 Federal Tax Return (1040) For The Last Calendar Year

 Paycheck Stubs For The Most Recent Three (3) Months

 Social Security Benefits Letter

 Disability Benefits Letter

 Unemployment Benefits Letter

 Workman's Compensation Letter

 SNAP (Food Stamps) Letter

 Child Support Letter

 Alimony Letter

 Proof of Identification

 If You Have No Income Of Your Own, A Letter From Person Providing For Your Needs For Past Year To Present

 ( Must Provide Name, Address, And Phone Number On Letter )

 Have You Applied For Medicaid To Cover your Medical Expenses: Yes No Circle Selection

 Would You Consider Applying For Medicaid: Yes No Circle Selection

 If You Have Been Denied Medicaid Or Other Public Assistance, What Reason Was Given?

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**I am applying for Financial Assistance for health care services rendered at Abbeville General. I certify that the data**

 **given is complete and accurate to the best of my knowledge.**

 **Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_**

 **\* \* \* FOR OFFICE USE ONLY \* \* \***

Income for past three months times four: **\_\_\_\_,\_\_\_\_\_\_.\_\_\_\_** Family size:

**Approved Reason Denied: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Denied \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Circle Selection

Declaration of

 I, , the responsible party for

 (Guarantor) (Patient)

 am providing proof of the following information to Abbeville General:

 1. My family income for the last three months times four (4) was $

 2. Family size as determined by dependents defined by the internal revenue code is

 I understand that this declaration is being provided to the Louisiana Department of Health and

 Hospitals in connection with services provided by Abbeville General. I understand that if I

 qualify for this program, only hospital billings will be paid and that I will still be responsible for

 any billings related to this service from any physician, radiologist, pathology service, etc.

 Under the penalties of perjury, I declare that I have examined this declaration, as to the best of

 my knowledge and belief it is true, correct and complete.

 Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_