FINANCIAL ASSISTANCE APPLICATION

Date Submitted _____

Guarantor (person responsible for the bill)

Guarantor_____

Guarantor Address_____

Guarantor Social Security Number _____Phone # _____

The federal government prohibits health care providers from waiving Medicare deductible and coinsurance amounts or giving discounts to Medicare patients, except in certain limited situations, such as proven financial hardship. Many non-government payers also prohibit healthcare providers from discounting patient bills without passing the discount along to the payer.

It is the policy of Thibodaux Regional Medical Center to abide by federal and state laws and its agreements with payers, such as insurance companies.

Thibodaux Regional Medical Center will consider financial assistance if the following information is provided:

	Supplied with application	
	Yes	**No**
1. Copy of the most recent tax return for the patient, guarantor, and/or spouse		
2. Copy of the last income checks for the patient, guarantor, and/or spouse to determine year to date income		
3. Copy of the bank statement or statements		
4. Copy of the savings statement or statements		
5. Copy of investment statement or statements		
6. Household information worksheet (attached)		
7. Copy of the patient's death certificate will be needed if the patient is deceased and there is no estate to satisfy the debt		
8. Letter stating why financial assistance is needed		

HOUSEHOLD INFORMATION WORKSHEET

Individuals in the household. This information is used to determine family size	Relationship	Date of Birth
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		

Note: A dependent will be considered if included on the tax return or legal document is provided.

EMPLOYMENT INFORMATION	Employer	Type of Income (See list below)
Patient		
Spouse		
Guarantor		
Other individuals providing income to the household		
Other type of Income		

(Alimony, Child Support, Dividends, Interest Income, Wages, Investment Income, Pension Income, Receipt of Estates, Rental Income, Retirement Income, Social Security Income, Unemployment, Veterans Compensation, Wages, Workers Compensation)

Asset Information:

Type of Asset	Amount
Cash/Checking	
Savings/CD's	
Investments (Stocks, Bonds, Etc)	
Real Estate (Estimate Fair Value)	
Real Estate (Estimate Fair Value)	
Vehicle – 1	
Vehicle – 2	
Settlements	

Medical Expense Information:

Medical Expense	Balance Amount

- **Copies of current outstanding medical bills must be included.**

Household Expense Information:

Household Expense	Monthly Amount

(If additional space is needed, please include on an additional sheet.)

Attestation:

I _____ on _____

(name) (date)

understand that the above information can be verified by Thibodaux Regional Medical Center and subject to review by Federal and State Enforcement Agencies. I certify that the above information is true and correct. Upon receipt of the above mentioned information and the signed attestation, your outstanding balance will be **considered** for possible financial assistance. We thank you for your understanding and cooperation with this policy.

_____

Signature of person requesting Financial Assistance.

Specific Instructions
Mail completed application and required documentation to the following address: **Thibodaux Regional Medical Center-Financial Counselor** **P.O. Box 1118** **Thibodaux, LA 70302**
Notification of approval or denial of application will be by mail.
We will allow you 30 days to complete the assistance application process.