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 Health System to abide by federal and state laws and its agreements with payers, such as insurance companies.

Thibodaux Regional Health System 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 most recent bank statement or statements, ALL PAGES		
4. Copy of the most recent savings statement or statements, ALL PAGES		
5. Copy of most recent investment statement or statements, ALL PAGES		
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. SIGNED 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 Health System 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.

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Signature of person requesting Financial Assistance.

Specific Instructions
Mail completed application and required documentation to the following address: **Thibodaux Regional Health System-Financial Counselor** **P.O. Box 1118** **Thibodaux, LA 70302** **Please contact our Financial Counselor at (985)435-4808 for additional information.**
Notification of approval or denial of application will be by mail.
We will allow you 30 days to complete the assistance application process.