Financial Assistance
Process & Application

The Ochsner Health (“Ochsner”) is committed to providing financial assistance for patients with a demonstrated financial need or hardship, who have received medically necessary healthcare services provided by OHS. 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 Financial Assistance Application
- Signed & Dated Patient Attestation Form
- Proof of LA or MS 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 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.

B. Copy of Social Security Administration monthly award letter
C. Copy of Disability monthly award letter
D. Copy of healthcare insurance card/information
E. Proof of Residency
   a. Valid Louisiana 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
F. All other income:
   a. Spousal/Child Support (Copy of letter stating monthly award amount)
   b. Rental Property
   c. Investment Income

G. Proof of Dependents
   a. Copy of tax return (Form 1040) for current tax year
   b. School records or statements
   c. Health provider statements

Did you know you can now access your medical records and billing information online? To get started with your online MyChart access and paperless billing, please visit our site at https://my.ochsner.org.
Please Mail Completed Info to:
Ochsner Health
Attn: ________________
1514 Jefferson Hwy
New Orleans, LA 70121

Applications can also be emailed or faxed to:
Fax- (504)-842-0322 Email- OchsnerFADocs@ochsner.org

Financial Assistance Application
MRN: ________________

<table>
<thead>
<tr>
<th>Income Sources</th>
<th>Applicant Monthly Gross Income</th>
<th>Co-Applicant Monthly Gross Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employment</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Social Security</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Disability</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Unemployment</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Rental Property</td>
<td>$</td>
<td>$</td>
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<tr>
<td>Investment Income</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Spousal Support</td>
<td>$</td>
<td>$</td>
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<tr>
<td>Child Support</td>
<td>$</td>
<td>$</td>
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<tr>
<td><strong>Total Combined Income</strong></td>
<td>$</td>
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Applicant(s) Information

**Relationship to patient:**

- [ ] Self
- [ ] Spouse
- [ ] Parent

**Marital Status (*):**

- [ ] Single
- [ ] Married
- [ ] Divorced
- [ ] Separated

<table>
<thead>
<tr>
<th>Applicant/Guarantor Information</th>
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<tbody>
<tr>
<td><strong>Last Name</strong></td>
</tr>
<tr>
<td><strong>Date of Birth</strong></td>
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<tr>
<td><strong>Street Address</strong></td>
</tr>
<tr>
<td><strong>Current Employer</strong></td>
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</tbody>
</table>

If you are not working, how long have you been unemployed?
Co-applicant Information  
* If Married, please include spouse information and income

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<thead>
<tr>
<th>Relationship to patient:</th>
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<tbody>
<tr>
<td>[ ] Self  [ ] Spouse  [ ] Parent</td>
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<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Middle Initial</th>
<th>Social Security Number</th>
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<table>
<thead>
<tr>
<th>Date of Birth</th>
<th>Number of Dependents</th>
<th>Age of Dependents</th>
<th>Current Telephone Number</th>
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<table>
<thead>
<tr>
<th>Street Address</th>
<th>City</th>
<th>State</th>
<th>ZIP</th>
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<table>
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<tr>
<th>Current Employer</th>
<th>Position</th>
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</table>

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

Attachment(s)
Attestation
No Income Verification
Attestation

- I have complied with the **Ochsner Medical Cost Assistance Program ("MCAP")** 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 MCAP 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

----------------------------------------------------------
(Associate) ____________________________

& ____________________________

& ____________________________

is applying for financial assistance with the Ochsner Health. The applicant has stated 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

(Releasement 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 have any questions or concerns, you may contact the Patient Accounts Customer Service department by phone at 504-842-4190.

Please Mail Completed Info to:

Ochsner Health

Attn: ____________________________

1514 Jefferson Hwy

New Orleans, LA 70121

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Email- OchsnerFADocs@ochsner.org