Financial Assistance
Process & Application

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
- Proof of US Residency

Please include all applicable documents listed below:

A. **Proof of Income (Please reference acceptable documentation section)**
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. **Proof of Dependents ((Please reference acceptable documentation section)**
   a. Copy of tax return (Form 1040) for current tax year
   b. School records or statements
   c. Health provider statements

Please make sure to complete all sections of the form and attach all required documentation so that we can further research your account for any assistance we may be able to provide. Every reasonable effort will be made to process your application promptly and once your application has been reviewed you will receive a letter confirming the outcome. Failure to fully complete all sections of the application or furnished required documentation could further delay a final decision.

Return Completed Application to:

Ochsner Medical Center
Attention: Patient Financial Services
1514 Jefferson Hwy
Jefferson, LA 70121
Fax: (504)842-0322
Email: OchsnerFADocs@ochsner.org

Acceptable Forms of Documentation

Type of Income	Acceptable documentation
Employment Income	• Copy of Individual tax return (Form 1040) for current tax year (If claiming dependents, complete tax return is required) ***OR*** • Copy of three most recent consecutive paystubs (for applicant and co-applicant, if applicable)
Self-Employment	• Copy of Individual tax return (Form 1040) for current tax year
Social Security/ Retirement	Copy of Individual tax return (Form 1040) for current tax year ***OR*** • Copy of Award Letter from Social Security Administration stating monthly payment ***AND*** Copy of monthly payment notification or Pension award letter.
Disability	• Copy of Individual tax return (Form 1040) for current tax year ***OR*** • Copy of Award Letter from disability stating monthly disability payment
Unemployment	• Copy of Individual tax return (Form 1040, for current tax year ***OR*** • Copy of Award Letter from unemployment stating daily, weekly, or monthly benefit amount • If No Income; a letter of support written by the person or persons who is providing financial support (signed & dated) **OR** • Letter stating you are not receiving income or financial support from any source. (signed & dated)
Spousal Support	• Copy of Individual tax return (Form 1040) for current tax year showing this income. ***OR*** • Copy of court official letter stating monthly award amount
Rental Property /Other Investment Income	• Copy of Schedule 1 Form **OR** • Copy of individual tax return (Form 1040 for current tax year)
Other	**Acceptable documentation**
Proof of Dependents *(Please include name of applicant on these documents)*	• Copy of Individual tax return for current tax year • School Records or statement • Health care provider statement or copy of health insurance card

Financial Assistance Application

DATE OF APPLICATION: _____

Please fill out all information completely.

PLEASE NOTE

- *All applicable sections of this form must be completed*
- *Application must be signed and dated.*

1. APPLICANT (GUARANTOR) INFORMATION

Marital Status: ❑ Single ❑ Married ❑ Domestic Partner ❑ Divorced ❑ Separated ❑ Widow

Last Name	**First Name**	**Middle Initial**	**U.S. Citizen:** ❑ Yes ❑ No
Date of Birth	**No. of Dependents**	**Ages of Dependents**	**Home Phone** ( )
Street Address	**City**	**State**	**County** / **Zip**
Current Employer	**Street Address**	**City** / **State** / **Position**	

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

2. CO-APPLICANT INFORMATION

Relationship to Patient: ❑ Spouse ❑ Parent

Applicable if this person is also applying for Financial Assistance

Last Name	**First Name**	**Middle Initial**	**U.S. Citizen:** ❑ Yes ❑ No
Date of Birth	**No. of Dependents**	**Ages of Dependents**	**Home Phone** ( )
Street Address	**City**	**State**	**County** / **Zip**
Current Employer	**Street Address**	**City** / **State** / **Position**	

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

3. FAMILY INFORMATION
(PLEASE PROVIDE NAMES OF ALL PEOPLE TO BE CONSIDERED FOR FINANCIAL ASSISTANCE)

Last Name	**First Name**	**Middle Initial**	**Date of Birth**
Last Name	**First Name**	**Middle Initial**	**Date of Birth**
Last Name	**First Name**	**Middle Initial**	**Date of Birth**

If the patient is a minor, please list parent(s)/guardian(s) as applicant and co-applicant.

4. INCOME INFORMATION

Monthly Income Sources	**Applicant**	**Co-Applicant**	**Combined Monthly Income (Applicant + Co Applicant)**
Employment Income	$	$	$
Social Security	$	$	$
Disability	$	$	$
Unemployment	$	$	$
Spousal Support	$	$	$
Rental Property Income	$	$	$
Investment Income	$	$	$
Other[s] use these spaces	$	$	$
	$	$	$
Total Combined Monthly Income			

5. 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 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.
- I have provided all requested documentation from page 1 & 2 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.

6. SIGNATURE

I certify that all information is valid and complete and hereby authorize Ochsner Health to request and/or verify any of the above information as deemed necessary.

Applicant	**Date**	**Co-Applicant**	**Date**