Financial Assistance

Process & Application

The Ochsner Health System ("OHS") 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.

Forms to include:

- **OHS Financial Assistance Application**
- **OHS Patient Attestation**

Documentation to include:

1) Copy of most recently filed income tax return, or
2) Copy of three (3) most recent pay stubs.
    a. 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
3) Copy of Social Security Administration monthly award letter
4) Copy of Disability monthly award letter
5) Copy of healthcare insurance card/information
6) Any and all other income:
    a. Spousal/Child Support
    b. Rental Property
    c. Investment Income
7) Medicaid denial letter from state administrator Proof of dependents

Please Mail Completed Info to:
Ochsner Health System
Attn: _____
1514 Jefferson Hwy
New Orleans, LA 70121

Income Information: Please complete the income information below. Please state if the income listed is per month or per year.
If married, please include spouse income information under the Co-Applicant fields

Income Sources	Applicant	Per Month/Year	Co-Applicant	Per Month/Year
Employment	$		$	
Social Security	$		$	
Disability	$		$	
Unemployment	$		$	
Rental Property	$		$	
Investment Income	$		$	
Spousal Support	$		$	
Child Support	$		$	
			Total Combined Income	$

Applicant(s) Information

Applicant/Guarantor Information

Relationship to patient:

[ ] Self [ ] Spouse [ ] Parent

Marital Status (*):

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

** If Married, please include spouse information and income*

[ ] Yes [ ] No

Last Name	First Name	Middle Initial	U.S. Citizen

Date of Birth	Number of Dependents	Age of Dependents	Current Telephone Number

Street Address	City, Parish, State	ZIP

Current Employer	City, Parish, State	Position

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

Co-applicant Information

Relationship to patient:

[ ] Self [ ] Spouse [ ] Parent

[ ] Yes [ ] No

Last Name	First Name	Middle Initial	U.S. Citizen

Date of Birth	Number of Dependents	Age of Dependents	Current Telephone Number

Street Address	City, Parish, State	ZIP

Current Employer	City, Parish, State	Position

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

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, and I have not included any of those balances 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)

Attachment(s)

Ochsner

Financial Assistance Program

No Income Verification / Statement of Support

_____ (**Applicant**) is applying for financial assistance with the Ochsner Health System. 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 _____ _____

(Relationship 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.

Ochsner Health System
Attn: _____
1514 Jefferson Hwy
New Orleans, LA 70121