SURGICAL SPECIALTY CENTER OF BATON ROUGE

FINANCIAL ASSISTANCE APPLICATION

Patient Name: _____ Date of Birth: _____ Social Security #: _____

Current Address: _____ Home phone #: _____

Marital Status: _____ Employment Status: _____ Alt phone #: _____

If Married, Complete Below:

Spouse's Name: _____ Date of Birth: _____ Social Security #: _____

Spouse's Employment Status: _____

Below List all Dependents Claimed on Tax Return (if additional space is needed, attach a separate document):

Name: _____ Date of Birth: _____ Income: _____

Name: _____ Date of Birth: _____ Income: _____

Name: _____ Date of Birth: _____ Income: _____

Name: _____ Date of Birth: _____ Income: _____

Mark Below if You Meet Any of the Listed Conditions: (Attach documentation)

[ ] Receiving State Medicaid

[ ] Homeless/Indigent

[ ] Deceased with no spouse/estate

[ ] Receiving Food Stamps/Subsidized School Meals/WIC/LACHIP/HUD

[ ] Receiving State-Funded Prescriptions

[ ] Liability and/or Victim of Violent Crime

Income Considerations: (working gross income, unemployment, SSI/SSDI, retirement, all other sources of income)

Patient Gross Monthly Income: _____ Hrly rate / Hrs per wk: _____ Income Source: _____

Spouse Gross Monthly Income: _____ Hrly rate / Hrs per wk: _____ Income Source: _____

Other Family Members Living in the House:

Gross Monthly Income: _____ Hrly rate / Hrs per wk: _____ Income Source: _____

Family Income is considered when making a financial assistance determination. The following is used when computing income and family income:

* Includes earnings, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources
* Determined on a before-tax basis, includes the income of all family members who reside together and dependents claimed on the income tax return. (Non-relatives, such as housemates, do not count.) For dependents who live outside the home, family income shall include the dependent's income, along with the income of those who claim the dependent on their tax return.
* Family income also includes resources or property that are easily convertible to cash; including but not limited to checking accounts, savings accounts, stocks, bonds, certificates of deposits, and cash. IRA's and 401K's are excluded until money is removed

By signing this document, I, the patient or caregiver, certify that the above information is true and accurate to the best of my knowledge. Further, if it is determined that the applicant may qualify for Medicare, Medicaid, or other insurance coverage, I will take any action reasonably necessary to obtain such assistance and will assign or pay the hospital the amount recovered for hospital charges. If any information I have given proves to be untrue, I understand that the hospital may reevaluate my financial status and take whatever action becomes appropriate. It is also understood that completing this application is not a guarantee of approval into the hospital financial assistance program. If applicable, I give my consent to release my information to Pharmaceutical Companies for auditing purposes only in the Bulk Replacement Patient Assistance Medication Programs. I certify I will contact/notify the facility in the event I have an insurance and/or income change.

Applicant's Signature _____ Date: _____

INCOME VERIFICATION AND SUPPORTING DOCUMENTATION

Verification of income is required for any financial assistance request. The following documents must be provided:

1. Completed financial assistance application
2. Photo ID or legal ID
3. Most recent tax returns for the patient/guarantor, family members living in the house, and dependents claimed on the patient's/guarantor's tax return. If patient/guarantor is not required to file federal taxes (because of low income or no income), a statement from the IRS is required.

   IRS Toll Free: 1-800-908-9946 or 800-829-1040
4. Proof of Income for the patient/guarantor, family members living in the house, and dependents claimed on the patient's/guarantor's tax return.
   i. If employed: Last 3 paystubs, last 3 month's bank statements, last available W-2's.
   ii. If self-employed: Monthly income statement for self-employment or a copy of general business ledger/business checking account summary.
   iii. If not employed: A copy of benefit information from Social Security disability, other Social Security income/benefits, 1099R, pension, public assistance, worker's compensation, trust fund, unemployment, military support, child support, and alimony; public assistance checks; retirement checks; and/or notarized statement of support.
5. If applicant is deceased and has no other responsible party then a copy of the death certificate is needed to prove that the patient is deceased before the application for financial assistance will be reviewed.

FINANCIAL ASSISTANCE DETERMINATION

1. A completed application along with supporting documentation must be received within 30 days of the request for financial assistance.
2. Applications not meeting these conditions may be returned or considered denied.
3. Requests for financial assistance shall be processed promptly and hosptial shall notify the patient or applicant in writing within 30 days of receipt of a completed application.
4. If approved, financial assistance will be applied to the date of service for which the financial assistance application was initiated and for future dates of services within the following six months.

You may deliver your information to the Admissions Department or mail it to the following locations:

Surgical Specialty Center
Attention: Admissions Dept / Financial Counseling
8080 Bluebonnet Boulevard
Baton Rouge, LA 70810