Financial Assistance Process & Application

Slidell Memorial Hospital (SMH) is committed to providing financial assistance for patients with a demonstrated financial need or hardship, who have received medically necessary healthcare services provided by SMH. 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
- Complete SMH 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, 4506-T 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.
f. Copy of Social Security Administration monthly award letter
g. Copy of Disability monthly award letter

B. Copy of healthcare insurance card/information

C. Proof of Residency (Please provide 1 of the following):

a. Valid Louisiana or Mississippi 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. All other income (Please provide 1 of the following):

a. Spousal/Child Support (Copy of letter stating monthly award amount)
b. Rental Property
c. Investment Income

E. Proof of Dependents (Please provide 1 of the following if applicable):

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

Income Information: Please complete the income information below. If married, please include spouse income information under the Co-Applicant fields.

Income Sources	Applicant	Monthly Gross	Co-Applicant	Monthly Gross Income
Employment	$		$	
Social Security	$		$	
Disability	$		$	
Unemployment	$		$	
Rental Support	$		$	
Investment Income	$		$	
Spousal Support	$		$	
Child Support	$		$	
			Total Combined	$

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SMH Ochsner

Applicant/Guarantor Information

Relationship to patient:

☐ Self ☐ Spouse ☐ Parent

Marital Status (*):

☐ Single ☐ Married ☐ Divorced ☐ Separated

Last Name	**First Name**	**Middle Initial**	**Social Security Number**
Date of Birth	**Number of Dependents**	**Age of Dependents**	**Current Telephone Number**
Street Address	**City**	**State**	**ZIP**
Current Employer			**Position**

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

Co-applicant Information

Relationship to patient:

☐ Self ☐ Spouse ☐ Parent

Marital Status (*):

☐ Single ☐ Married ☐ Divorced ☐ Separated

Last Name	**First Name**	**Middle Initial**	**Social Security Number**
Date of Birth	**Number of Dependents**	**Age of Dependents**	**Current Telephone Number**
Street Address	**City**	**State**	**ZIP**
Current Employer			**Position**

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

Attachment(s)
Attestation
No Income Verification

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Attestation

- I have complied with the SMH 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)

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No Income Verification/Statement of Support

_____ & _____

(Applicant) **(Co-applicant, if applicable)**

is applying for financial assistance with the SMH. 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 are not receiving income from any source or if you are married and your spouse is unemployed, please sign below****

I,_____ am not receiving income or financial support from any source currently.

I,_____ am unemployed and not receiving external income. I am receiving financial support from my spouse_____ (spouse's name).

Signature_____ **Date**_____

Applicant/Co-Applicant (if applicable)

Please Mail Completed Info to:

Slidell Memorial Hospital
1001Gause Blvd.
Medicaid Eligibility Office
MOB1 - Box #35
Slidell, LA 70458-2987

Applications can also be emailed or faxed to:

Email: OchsnerFADocs@Ochsner.org
Fax: (504) 842-0322