118 North Hospital Drive
P. O. Box 580
Abbeville, LA 70511

Financial Assistance Program

The Financial Assistance Program is designed to help you with the balance on your Abbeville General Bill. This program is available to all Abbeville General Patients.

If you are interested in applying for financial assistance, please complete all sections of the attached application form and send the documents that are applicable as listed on the following page. You may also come into the office and sign up or provide application along with your documents.

After I receive the documents, your application will be reviewed. The determination will be made based on your level of income. I will mail you a letter with the application decision.

Please contact me directly if you have any questions or concerns.

** ***Please let us know if you are interested in Medicaid, as you will need an appointment. If you have insurance, please let us know.***

<u>Return application and supporting documents to:</u>

Abbeville General Hospital
Attn: Business Office – Financial Aid Coordinator
118 N. Hospital Drive
Abbeville, LA 70510

Application for Financial Assistance

118 North Hospital Drive
P. O. Box 580
Abbeville, LA 70511

Patient Information

Name: ____ Birthdate: ____/____/________

Address: ____ Social Security #: _______-____-_________

____ Home Phone: (______) _______-_________

City/State/Zip: ____ Cell Phone: (______) _______-_________

Marital Status: Single Married Divorced
Circle Selection

Employer: ____ Phone: (______) _______-_________

Spouse Employer: ____ Phone: (______) _______-_________

Guarantor Information

Guarantor Same As Patient: Yes No *Circle Selection* Relationship to Patient: ________________________

Name: ____

Address: ____ Phone: (______) _______-_________

____ Marital Status: Single Married Divorced
Circle Selection

City/State/Zip: ____

Employer: ____ Phone: (______) _______-_________

Family Size:

Members Of Household

Name	Relationship	Birthdate	Monthly Income
______________________	______________	____/____/________	____,_______.____
______________________	______________	____/____/________	____,_______.____
______________________	______________	____/____/________	____,_______.____
______________________	______________	____/____/________	____,_______.____
______________________	______________	____/____/________	____,_______.____
______________________	______________	____/____/________	____,_______.____
______________________	______________	____/____/________	____,_______.____
______________________	______________	____/____/________	____,_______.____

(Application Continues to Page 2)

Application for Financial Assistance

118 North Hospital Drive
P. O. Box 580
Abbeville, LA 70511

Required Documents

Federal Tax Return (1040) For The Last Calendar Year

Paycheck Stubs For The Most Recent Three (3) Months

Social Security Benefits Letter

Disability Benefits Letter

Unemployment Benefits Letter

Workman's Compensation Letter

SNAP (Food Stamps) Letter

Child Support Letter

Alimony Letter

Proof of Identification

If You Have No Income Of Your Own, A Letter From Person Providing For Your Needs For Past Year To Present

(Must Provide Name, Address, And Phone Number On Letter)

Have You Applied For Medicaid To Cover your Medical Expenses: Yes No Circle Selection

Would You Consider Applying For Medicaid: Yes No Circle Selection

If You Have Been Denied Medicaid Or Other Public Assistance, What Reason Was Given?

____

____

I am applying for Financial Assistance for health care services rendered at Abbeville General. I certify that the data given is complete and accurate to the best of my knowledge.

Signature: ____________________________________ **Date:** ____/____/________

*** * * FOR OFFICE USE ONLY * * ***

"Access To Quality Care Close To Home"

118 North Hospital Drive
P. O. Box 580
Abbeville, LA 70511

Income for past three months times four: ____,______.____ Family size:

Approved **Reason Denied:** ____

Denied ____

Circle Selection

"Access To Quality Care Close To Home"

118 North Hospital Drive
P. O. Box 580
Abbeville, LA 70511

Declaration of

I, ______________________________, the responsible party for __________________________
(Guarantor) (Patient)
am providing proof of the following information to Abbeville General:

1. My family income for the last three months times four (4) was $ _________________________

2. Family size as determined by dependents defined by the internal revenue code is __________

I understand that this declaration is being provided to the Louisiana Department of Health and Hospitals in connection with services provided by Abbeville General. I understand that if I qualify for this program, only hospital billings will be paid and that I will still be responsible for any billings related to this service from any physician, radiologist, pathology service, etc.

Under the penalties of perjury, I declare that I have examined this declaration, as to the best of my knowledge and belief it is true, correct and complete.

Signature: ____

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