ALLEN PARISH HOSPITAL
P. O. BOX 1670
KINDER, LA 70648
337-738-2527

APPLICATION FOR FINANCIAL ASSISTANCE

Patient Name:
Last: _____ **First:** _____ **MI:** _____

Guarantor:
Last: _____ **First:** _____ **MI:** _____

Address:
Street: _____

City: _____ **State:** _____ **Zip:** _____

Telephone #: _____ **Soc. Sec. #:** _____

Employer: _____

Income: $_____ $_____ $_____
Patient **Other Family** **Total Family**

(Proof of income is necessary for completion of eligibility determination. Provide copies of Form W-2, Income Tax returns, two copies of your most recent paycheck stubs, etc.). If you are claiming no income or there is a recent change in your financial situation, attach a letter of explanation.

Assets: **Fixed & Liquid** $_____
(Submit copies of your most recent bank statement showing balance)

Liabilities: $_____

Family Size: _____

You are required to apply for Louisiana Medicaid and submit a copy of the determination letter from stating if you were approved or denied. The denial cannot be for failure to submit required documentation to Louisiana Medicaid. **Letter attached:** ☐ **Yes** ☐ **No**

Services: _____
Type Rendered/Requested **Date**

I certify that the above information is true and accurate to the best of my knowledge. Further, I will make application for any assistance (Medicaid, Medicare, Insurance, etc.) which may be available for payment of my hospital charge, and I will take any action reasonably necessary to obtain such assistance and will assign or pay to the hospital the amount recovered for hospital charges. If any information I have given proves to be untrue, I understand that the hospital may re-evaluate my financial status and take whatever action becomes appropriate.

Applicant's Signature: _____ **Date:** _____

Witness Signature: _____ **Date:** _____