Lane Regional Medical Center

Care You Can Count On

FINANCIAL ASSISTANCE APPLICATION FORM

SECTION ONE: PATIENT INFORMATION

Print your full name, your address at the time you received medical service and other information notes in this section.

Account Number:_____ Date(s) of Service:_____

Name:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Parish:_____

Social Security Number:_____-_____-_____ Date of Birth: ____/____/_____

Home Phone: (_____) _____ Other Phone:_____

Marital Status: ___Single ___Married ___Divorced

Are you a legal resident of the United States? ___Yes ___No

Did you have health insurance (other than Medicaid) at the time of your service? If yes, please provide your insurance information and a copy of your insurance card. ___Yes ___No

Name of Insurance:_____

Effective date of service: ____/____/____

Subscriber Name:_____

Subscriber Date of Birth: ____/____/____

Subscriber ID: _____ Group Number: _____

SECTION TWO: FAMILY INCOME

Provide income for yourself, your spouse and all other family members (if applicable)

Monthly Income Source	Current Monthly Gross Income Amount		Total Family Income for 3 months prior to date of service	Type of income verification attached – proof of income is requested to process your application
	Patient	Spouse/Other		
Wage/Self Employment, Child support and alimony	$	$	$	Copy of most recent pay stubs or income award letters (for 3 previous months)
Social Security	$	$	$	Social Security Award letter
Pension, Dividends, Interest, Rental Income	$	$	$	Pension benefits letter, Dividend/Interest Statement
Unemployment, Workers' Compensation	$	$	$	Unemployment benefit letter, Workers' Compensation benefit letter

Note: If you report $0 income, please provide a brief explanation of how you (or the patient) are meeting basic living needs:

_____
_____
_____
_____

(Must provide a support statement)

SECTION THREE: FAMILY INFORMATION
List all family members in your household named on the most recent federal income tax return and their date of birth.

Please provide the following information for all the people in your immediate family who live in your home. For purposes of this policy, family is defined as the patient, the patient's spouse, and all the patient's children under 18 (natural or adoptive) who live in the patient's home. If the patient is under the age of 18, the family shall include the patient, the patient's natural or adoptive parent(s), and the parent(s) children under 18 (natural or adoptive) who live in the patient's home.

Name of family members, including patient	Date of Birth	Relationship to Patient
1.		
2.		
3.		
4.		
5.		
6.		

By signing below, I certify that everything I have stated on this application and on any attachments is true.

Responsible Party's Signature_____ Date_____

Call to make an appointment and return the completed application to:

Lane Regional Medical Center
Attention: Financial Assistance Office
6300 Main Street
Zachary, LA 70791
225.658.4511