LCMC Health
Tulane Medical Center
Tulane Lakeside Hospital
Lakeview Regional Medical Center

FINANCIAL ASSISTANCE, BILLING AND COLLECTION POLICY
EXHIBIT A: APPROVED DOCUMENT LIST

We will review and consider household financial income for possible discounted services. Qualification for Financial Assistance depends upon a number of things including but not limited to employment, income level, and the number of dependents the applicant may have. To apply, you must provide certain documents from each category from the list below. For more information, please visit our website www.tulanehealthcare.com/patient-financial

Acceptable Forms of Identification (Must bring 1)

- Valid Driver's License
- Valid Identification Card
- LCMC Facility Badge with picture
- Alien Resident Card (Form I-551)
- Alien Resident Green Card (Form I-688) Valid Passport
- Military Identification Card

Acceptable Forms of Residency

- Valid Louisiana Driver's License
- Valid Louisiana Identification Card
- Current Utility Bill showing name and address and/or Utility receipt showing name and address
- Current Medicaid, GNOCHC or Take Charge Eligibility Letter
- Current Social Security Award Letter, check, and/or printout
- Current school records verifying address
- Current billing statement or business mail from State/Parish/City
- Current lease agreement, and/or verification letter on proper letterhead which indicates address
- Voter Registration Card
- Vehicle Registration

Acceptable Dependent Verification Items (Including Spouse as a Dependent)

- Current Medicaid Eligibility Letter
- Social Security Card
- Birth Certificate
- Prior Year Income Tax Return
- Custody Records or Legal Guardianship documents
- School Records
- Any Reasonable Document that shows the parent (guardian) and child relationship

Acceptable Forms of Income Verification

- Thirty consecutive days or one month of paycheck stubs
- Trusts, dividends, interest income by providing document with Gross Income Amount
- Current Retirement Income Check stub(s)
- Current Social Security Award letter for both spouses and any children Current Letter from Employer on (only if paid in cash)
- Current Veterans Administration Award Letter(s)
- Current Child Support Statement or Divorce Decree
- Current proof of direct deposit of fixed income by providing document with Gross Income Amount
- Current self-employed individual - previous year 1040 Income Tax Form with all attachments (Verified
- IRS transcript copy)
- Current letter of support if unemployed/have no source of income and living with a relative or friend
- Current bank statement if living off savings and no other source of income by providing most recent bank statements
- Alimony or spousal support income

Resource/Asset Information (In addition to above documents)

- Most Recent Income Tax (For self-employed individuals, see below*) If you did not file an income tax return for the most recent year, it will be necessary to get a statement from the IRS via the same method as the IRS Transcript to confirm.
- Most current Profit and Loss Statements (at least 2 quarters) for Business Owners
- Most Recent Income Tax of Business if applicant owns more than 5% of Partnership or Corporation
- Most recent statements for each checking account, savings account, mutual fund/money market accounts, IRA accounts, Certificate of Deposit accounts (CD), and any other security accounts or investment accounts
- Most recent statements for Stocks, bonds, etc.
- Parish appraisal documents for all real properly excluding homestead. Finance documents with loan or mortgage balance to determine equity value
- All motor vehicle information, including cars, trucks, RV's, motorcycles, boats, ATV, and aircraft that are in your household

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FINANCIAL ASSISTANCE APPLICATION FORM

SECTION ONE: PATIENT INFORMATION

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

Account Number_____Date(s) of Service _____

Name:_____

Address: _____

City:_____ State: _____ Zip: _____

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 insurance:____/____/ ____

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		
Wages/Self Employment, Child support and alimony	$	$	$	Copy of most recent pay stubs or income award letters (for three 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 reported $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 of 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 of 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: _____

Return your completed application to:

LCMC Health
Attn: Manager, Financial Assistance
PO Box 292289
Nashville, TN 37229-2289

Copies of our Financial Assistance Policy, Application Form and Summary are available in English, Spanish and Vietnamese.

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THIRD-PARTY SUPPORT AND VERIFICATION STATEMENT

Patient Name: _____

Date of Birth: _____

MRN #: _____

PENALTY CLAUSE, CONFIRMATION STATEMENT AND AUTHORIZATION FOR RELEASE OF INFORMATION

I certify that the information provided to complete this application is true. Additionally, I understand that in accordance with Louisiana State Statute 1924, providing false information can be considered "Health Care Fraud" in an attempt to defraud a hospital for the purpose of obtaining goods and services, including pharmacy items, is a felony.

FINANCIAL SUPPORT

☐ I,_____, provided $_____last month to the patient referenced below.

THIRD-PARTY SUPPORT OF LIVING ARRANGEMENT

☐ I,_____(supporter), provide room and board and other support for the patient referenced below. The person does not pay rent to me. I must provide prove of address for verification purpose. I am providing the patient with a current expense bill or other household document for him/her to show you my current address.

THIRD-PARTY PAYMENTS to patient's credit accounts

☐ I,_____(responsible party), certify I am the person responsible for making the payments in connection to the following expense(s) which are in the name of referenced patient. I understand that I must provide proof of payments. Please send documented proof with patient to his/her financial assessment. (Provide additional information on separate sheet.)

Expense Name:_____Amount:_____

Expense Name:_____Amount:_____

Expense Name:_____Amount: _____

Reference Loan Type or Loan #: _____

***Signature is required if third-party person not present at time of Financial Assessment**

_____	_____	_____
Patient/Representative Signature	Patient/Representative Printed Name	Date
_____	_____	_____
*Third-Party Supporter Signature	Third-Party Supporter Printed Name	Date
_____	_____	_____
LCMC Healthl Representative Signature	LCMC Health Representative Printed Name	Date Form Received