Lady of the Sea General Hospital will provide Financial Assistance to the medically indigent based upon the recipient's ability to pay. Within this provision, management will approve the application according to the economic resources to the patient's/ guarantor's ability to fulfill his/her financial obligation to Lady of the Sea General Hospital.

PATIENT INFORMATION

Visit Number:

Name:

Address:

City/ State/ Zip Code:

Telephone Number:

Social Security Number:

Date of Birth:

Age:

Date(s) of Service:

Physician:

Service Type:

Total Balance on Account(s):

GUARANTOR/ SPOUSE INFORMATION

Name:

Address:

City/ State/ Zip Code:

Telephone Number:

Social Security Number:

Date of Birth:

Age:

Relationship to Patient:

DEPENDENTS OF GUARANTOR

NAME	DATE OF BIRTH	AGE	RELATIONSHIP TO GUARANTOR
1.			
2.			
3.			
4.			
5.			

EMPLOYMENT INFORMATION

Patient's Employer:

Employer's Address:

City/ State/ Zip Code:

Phone Number:

Occupation:

Rate of Pay: Hour Weekly Monthly

Years of Employment:

Hours per week/month:

Guarantor's/ Spouse's Employer:

Employer's Address:

City/ State/ Zip Code:

Phone Number:

Occupation:

Rate of Pay: Hour Weekly Monthly

Years of Employment:

ASSETS

Cash

Bank Name and Phone Number:

Savings Account Number:

Total Savings: $

Bank Name and Phone Number:

Total Checking: $

Real Property

Estimated Appraisal: $

Personal Property

CD's/ Stocks/ Bonds: $

Life Insurance Cash Value: $

Auto

Estimated Value: $

Make: Year: Model:

Mileage:

Estimated Value: $

Make: Year: Model:

Mileage:

Other Assets:

Other Information:

INCOME

	Patient	Guarantor
Wage/ Salary	$ _____ Month	$_____ Month
Social Security	$ _____ Month	$ _____ Month
Interest/ Dividend	$ _____ Month	$ _____ Month
Railroad Retirement/ Other Pension	$ _____ Month	$ _____ Month
Military Service Allotment	$ _____ Month	$ _____ Month
Alimony	$ _____ Month	$ _____ Month
Child Support	$ _____ Month	$ _____ Month
Public Housing Allowance	$ _____ Month	$ _____ Month
Renal Income/ Tenants	$ _____ Month	$ _____ Month
Welfare Public Assistance	$ _____ Month	$ _____ Month
Unemployment Compensation	$ _____ Month	$ _____ Month
Workman's Compensation	$ _____ Month	$ _____ Month
Union Benefits	$ _____ Month	$ _____ Month
Insurance	$ _____ Month	$ _____ Month
Friend/ Relative	$ _____ Month	$ _____ Month
Other	$ _____ Month	$ _____ Month

Total Gross Family Income for the Previous Month: $ _____

***** This application must be submitted with verification of income for the three previous months and/ or a complete copy of your most current filed taxes and your Louisiana Medicaid determination letter. *****

EXPENSES

Mortgage Company:	Monthly Payment: $
Medical Insurance Company Name:	Monthly Payment: $
Home Insurance Company Name:	Monthly Payment: $
Car Insurance Company Name:	Monthly Payment: $
Life Insurance Company Name:	Monthly Payment: $
Phone:	Monthly Payment: $
Electricity:	Monthly Payment: $
Gas:	Monthly Payment: $
Water/ Sewage:	Monthly Payment: $

Installments

Name:	Monthly Payment: $
Name:	Monthly Payment: $
Name:	Monthly Payment: $
Name:	Monthly Payment: $
Name:	Monthly Payment: $
Name:	Monthly Payment: $
Name:	Monthly Payment: $
Name:	Monthly Payment: $
Name:	Monthly Payment: $
Name:	Monthly Payment: $

TOTAL GROSS FAMILY EXPENSES FOR THE PREVIOUS MONTH: $_____

NET INCOME LESS EXPENSES: $ _____

I recognize that Lady of the Sea General Hospital or its successors have the privilege (assignment) to all claims, demands, entitlements, and the proceeds thereof, and all causes of action which I now have or had, and which may have thereafter, by reason of any liability of third parties entitling the patient to hospital care, or medical, surgical and/ or clinical treatment or recovery of damages for all or part thereof based on contract rights under a group hospitalization plan or under any insurance contract or plan which provides for payment or reimbursement for the cost of hospital care, medical, surgical and/ or clinical treatment as well as payment or reimbursement based on statue, state, or federal, and regulations promulgated pursuant thereto, partially enumerated here as (1) "worker's compensation" statues; (2) "employer's liability" statues; (3) right to "maintenance and cure" in admiralty.

I understand that the information, which I have given, is subject to verification by the hospital and subject to review by federal and/ or state agencies and others as required which may include the investigation of my credit history. If any or part of the information furnished by the applicant is found to be fraudulent, Lady of the Sea General Hospital maintains the right to take necessary action against the applicant, which may result in denial or reversal of charity care.

I certify that the above information is true and correct.

_____ _____

Applicant's Signature Date

Information taken and witnessed by: _____

2025 Charity Care Guidelines

Family Size	Annual Income	Monthly Income
1	$31,300	$2,608
2	$42,300	$3,525
3	$53,300	$4,442
4	$64,300	$5,358
5	$75,300	$6,275
6	$86,300	$7,192
7	$97,300	$8,108
8	$108,300	$9,025
*	$11,000	$917
For families/households with more than 8 persons, add $10,760 for each additional person for annual income.		