BAYOU BEND
HEALTH SYSTEM

Bayou Bend Health System's Financial Assistance Application
(BBHS will review your application only after all necessary information is supplied)

GENERAL INFORMATION

Patient Name:_____ Date of Birth:_____

Social Security Number:_____

Address:_____

Patient Phone:_____ Cell:_____

Work:_____

Marital Status (Circle): Single Married Divorced Widowed

Guarantor (If Different From Patient):_____

Guarantor Date of Birth:_____

Guarantor Social Security Number:_____

Guarantor Address:_____

Guarantor Phone:_____ Cell:_____

Work:_____

Do You have any Health Insurance (Circle)? Yes No

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SPOUSE/DEPENDENT INFORMATION

Name	Relationship	Date of Birth

EMPLOYMENT INFORMATION FOR EACH HOUSEHOLD MEMBER

(Last 12 Months)

Employer	Phone Number	Years Employed	Income

Checklist of Copies Needed (Please send copies):

1. You and your spouse's most recent tax returns_____
2. Your last income checks (to calculate annual income)_____
3. Your spouse's last income checks (to calculate annual income)_____
4. Death Certificate (if applicable)_____

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INCOME INFORMATION (Circle all that apply)

Wages	Pension
Alimony	Unemployment
Veteran's Compensation	Retirement Income
Rental Income	Dividents
Social Security	Investment
Child Support	Workers Compensation
Receipt of Estates	Interest Income
Royalties	Other_____

PLEASE CHECK ANY SERVICES YOU RECEIVE (Please send copies)

____State-Funded Prescription Program

____Care from a Homeless Shelter or Clinic

____Participation in WIC

____Food Stamp Eligibility

____Subsidized School Lunch Program

____Eligibility for Medicade Spend-Down or Take Charge

____Low Income/Subsidized Housing

____Children with Medicaid Coverage

____Patient Deceased with No Estate

____Financial Aid for Higher Education

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ATTESTATION

I_____(*name)* on_____(*date)* understand that the above information can be verified by Bayou Bend Health System. I certify that the above information is true and correct. Upon receipt of the above mentioned information and the signed attestation, my outstanding balance will be considered for possible financial assistance.

MAIL APPLICATION TO:

Bayou Bend Health System
1097 Northwest Blvd.
Franklin, LA 70538
Attn: Business Office

You will be notified if your application is approved.

The federal government prohibits health care providers from waiving Medicare deductible and coinsurance amounts or giving disounts to Medicare patients, except in certian limited situations. many non-government payers also prohibit healthcare providers from dscounting patient bills without passing the discount along to the payer. It is the policy of Bayou Bend Health System to abide by federal and state laws and its agreements with payers, such as insurance companies.