Dear Patient/Responsible Party.

We are providing this application, because you may qualify for our *Financial Assistance Program.*

The attached form only applies to hospital bills, and does not include any other medical bills you may have; such as physician, radiology, ambulance, etc.

In order to be considered for a full or partial assistance, you **must** complete the Financial Assistance Application. The responsible party **must sign** the bottom, and return the completed application within fourteen (14) days of receipt

Inpatient Visits: If you were admitted into the hospital as an inpatient, it is necessary for you to provide us with your **latest Federal Tax Return** for supporting documentation. If you did not file a tax return, please indicate and attach any two of the documents listed below.

State Income Tax Return
Employer Pay Stubs
Written documentation from income sources
Copies of all bank statements for the past three months

Medicare Patients: If you are covered by Medicare, it is necessary for you to provide us with your **latest Federal Tax Return** for supporting documentation. If you did not file a tax return, please indicate and attach any of the documents listed below.

Supporting W-2 Supporting 1099's
Most recent bank and broker statements
Qualified Medicare Benefits

If, for any reason, you cannot provide us with the requested information, please attach a written statement explaining why you cannot provide the information requested.

Please allow ten (10) business days for our review process. We will notify you of our charity determination by letter. If you have any questions or concerns, please feel free to contact Customer Service at any time.

Remember if you return this form your bill may be included in our Financial Assistance Program

FSO.PT.COLL.638

Resource Corporation of America
Phone: 504-988-5752
Fax: 504-988-5038

Tulane University Hospital & Clinic
1415 Tulane Avenue, New Orleans, Louisiana 70112

FINANCIAL STATEMENT

Date:_____ Patient Account #:_____

Patient's Name:_____

Patient's Address:_____
Street Address City State Zip

Patient's Date of Birth: _____Social Security #:_____

Debtor Information (verification must be provided):

Present Bills	Monthly Note	Present Bills	Monthly Note
Rent or Own	$	Utilities	$
Car(s)	$	Medical	$
Bank Loan	$	Personal Loan(s)	$
Other	$		$
	$		$

Income (verification must be provided):

Family Members (Including Self)	Relation	Age	Place of Employment	

Numbers of Members in Household

Other Sources of Income (verification must be provided):

Other Employment	$	Property	$
Investments, Savings, Life Ins.	$	Stocks	$
Social Security/Retirement	$	Rental Income	$

Assets

Item	Value	Item	Value

Banking Information

Name of Bank:	Checking Acct No.:
Address:	Savings Acct No.:
	Other

I certify that the above information is true and accurate to the best of my knowledge. Further, I will make application for any assistance (Medicare, Medicaid, Insurance, etc.) which may be available for payment of my hospital charges, 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. I understand that this statement is being provided to the Louisiana Department of Health and Hospitals in connection with the TUHC Medicaid Program. I further understand that all information provided, though confidential, may be made available for review by appropriate authorities.

_____ _____

Signed Date

ELIGIBILITY DETERMINATION (For office use only)

Date application received: _____ Dates of Service:_____

Income verified: _____Yes _____No

Income for previous 12 months: $_____

_____ The applicant is approved for care at no charge, or with a deductible payment of $

_____ Amount provided as uncompensated services is $

_____ The applicant is conditionally approved for uncompensated services. Conditions:_____

_____ The applicant's request for free or reduced charge services has been denied for the reason(s):

_____

_____Income level exceeds defined levels
_____Failure to provide proof of income
_____Other

Determination Date:_____ Notification Date:_____

_____ _____

Authorization Signature Authorization Signature