ST JAMES PARISH HOSPITAL
LARGE ENOUGH TO SERVE, SMALL ENOUGH TO CARE.

CAREAid

[Community-Assistance-Reaches-Everyone: St. James Parish Hospital's medical bill credit policy which can qualify community members for free or reduced hospital charges based on a brief application and necessary documentation.]

**Please complete and sign the enclosed application for Care Aid which will be used to determine if you qualify for credits paying up to 100% of your medical bills at St. James Parish Hospital.*

In order to review your application, supporting documentation for the family must be included. The family consists of two or more people who reside together and are related by birth, marriage or adoption. Please include your last year's Federal Tax Return, last check stub showing year-to-date income, unemployment income, Social Security benefit amount, child support and/or any other income you have received in the last 12 months. If you are employed and get paid cash, a letter from your employer stating your income would be acceptable. In order to claim a dependent, they must have been listed on your tax return.

If you are a student receiving financial aid, you may also qualify for Care Aid Credits. Please provide documentation of approval for financial aid. Students with no income would need to provide proof of income from parents or guardians who support them.

Only urgent or emergent services provided by St. James Parish Hospital will be eligible for credits. In addition, the patient must be under the care of a physician on the Medical Staff roster of St. James Parish Hospital. You may see a list of our Medical Staff roster on our This may include ER physicians, anesthesiologists, radiologists, pathologists, etc. Any accounts in bad debt are not eligible for Care Aid Credits.

If approved, your eligibility is active for six months from the date of determination. However, we may reevaluate your application for Care Aid if additional information relevant to eligibility becomes known. If you receive any services within six months of approval for Care Aid, it will be your responsibility to bring it to our attention that you have been approved at the time services are being rendered.

A patient may also qualify for medical indigence if medical bills (paid and unpaid) from the past 12 months are more than 20% of their yearly income. These are reviewed case-by-case based on the patient's circumstances, such as catastrophic illness or medical financial need, each at the discretion of St. James Parish Hospital.

You may return this information by mail or deliver it to the Business Office. Please call us at *225.258.5912* if you have any questions about the application.

Sincerely,
K'Maya Franklin, Financial Counselor

*We now submit **MEDICAID APPLICATIONS**. Call us for more info.* **}**

1645 Lutcher Avenue / Lutcher, LA
p 225.258.5912 / f 225.258.5981

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The federal government prohibits health care providers from waiving Medicare deductible and coinsurance amounts or giving discounts to Medicare patients, except in certain limited situations. Many non-government payers also prohibit healthcare providers from discounting patient bills without passing the discount along to the payer. It is the policy of St. James Parish Hospital to abide by federal and state laws and its agreements with payers, such as insurance companies.

St. James Parish Hospital *will review your application* only *after* all necessary *information is supplied.*

GENERAL INFORMATION

Patient Name:_____ Date of Birth:_____ Social Security Number:_____

Physical Address:_____ City:_____ State:_____ Zip:_____

Mailing Address:_____ City:_____ State:_____ Zip:_____

Patient Phone:_____ Cell:_____ Work:_____

Marital Status (Circle One): ***Single*** ***Married*** ***Divorced*** ***Widowed***

Guarantor Information *(complete if different than patient):*

Guarantor Name:_____ Date of Birth:_____ Social Security Number:_____

Physical Address:_____ City:_____ State:_____ Zip:_____

Mailing Address:_____ City:_____ State:_____ Zip:_____

Guarantor Phone:_____ Cell:_____ Work:_____

SPOUSE/DEPENDENT INFORMATION

Name	Relationship	Date of Birth

*A dependent will be considered if included on the tax return.

EMPLOYMENT INFORMATION FOR EACH HOUSEHOLD MEMBER (Last 12 Months)

Employer	Phone Number	Years Employed	Income

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INCOME INFORMATION (Circle All that Apply)

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

Annual Income for Last 12 Months: $_____

***Checklist of Copies Needed:**
1. You and your spouses most recent tax return_____ 2. Your last income checks so that annual amount can be calculated_____
3. Your Spouse's last income checks so that annual amount can be calculated_____ 4. Death Certificate (If Applicable)_____

ASSET INFORMATION

Type of Asset	Amount
Cash	
Savings/CD's	
Investments (Stocks, Bonds, etc.)	
TOTAL ASSETS	

***Checklist of Copies Needed:**
1. Current bank statement_____ 2. Current savings statement_____ 3. Current investment statement_____

MEDICAL INDIGENCE

Medical Bills for last 12 months $_____

*A patient may qualify for medical indigence if medical bills (paid and unpaid) from the past 12 months are more than 20% of your yearly income.

PLEASE CHECK ANY SERVICES YOU RECEIVE

_____ State-Funded Prescription Program
_____ Care from a Homeless Shelter or Clinic
_____ Participation in WIC
_____ Food Stamp Eligibility
_____ Subsidized School Lunch Program
_____ Eligibility for Medicaid Spend-Down or Take Charge
_____ Low Income/Subsidized Housing
_____ Children with Medicaid Coverage
_____ Patient Deceased With No Estate
_____ Financial Aid for Higher Education

ATTESTATION

I _____ *(name)* on _____ *(date)* understand that the above information can be verified by St. James Parish Hospital and subject to review by Federal and State Enforcement Agencies. I certify that the above information is true and correct. Upon receipt of the above mentioned information and the signed attestation, your outstanding balance will be considered for possible financial assistance. We thank you for your understanding and cooperation with this policy.

Do you have any Health Insurance? Yes No

For more information, call our Financial Counselor at 225.258.5912.

MAIL APPLICATION TO: Attention Financial Counselor
1645 Lutcher Ave., Lutcher, LA 70071

You will be notified of application results by phone or mail.