Name:_____ MR #: _____Admit Date _____

To the Financial Assistance Applicant:

Below please find a Financial Assistance Application. Please complete and return the application to the address listed on the bottom of page three of this form along with any of the supporting documentation requested below that pertains to your financial situation.

PROOF OF INCOME (please include all that apply)

Social Security:

- Copy of Social Security Award Letter or Social Security Yearly Benefit Statement
- Copy of your most recent Social Security Check

Veterans Benefits:

- Copy of award letter or benefit statement
- Copy of most recent benefit check

Pensions:

- Copy of pension benefit statement
- Copy of most recent pension check

Name:_____ MR #: _____ Admit Date _____

ADDITIONAL VERIFICATION REQUIRED
(Copies of the most recent statement or other verification for)

Income /Assets:

- Certificate of Deposits
- 401K, 403B, Keogh, IRA and other Retirement Accounts
- Annuities
- Cash value of life insurance policies
- Trusts
- Brokerage accounts
- Dividend/interest income
- Child Support
- Alimony
- Stocks, bonds and/or mutual funds
- Other investments

Liabilities/Expenses:

- Copy of your most recent mortgage or rent payment
- Copies of insurance premiums paid (homeowners' policy, car insurance, etc.)
- Copies of medical payments and/or prescription payments
- Copies of other liabilities/expenses paid by you
- Copies of most recent bank statements for all bank accounts

Federal and State Income Tax Return:

- A complete copy of your most recent Federal and State Income Tax return complete with all applicable schedules

Other Pertinent Financial Data:

- Copies of Bankruptcy petitions, property settlements, etc.

If you are unable to provide copies of any of the above items, please send a letter explaining the specific reasons why the requested information was not enclosed. Additional information may be requested depending upon individual circumstances.

If you have any questions regarding the enclosed document, you may reach us at 985-626-6555.

Sincerely,

Patient Accounts Representative

Business Office
Northlake Behavioral Health System
23455 Sparrow Rd
Mandeville, LA 70448

Northlake Behavioral Health
System
FINANCIAL ASSISTANCE APPLICATION

Information About You

Name _____
First Middle Last

Social Security Number ___-___-___ Marital Status ☐ Single ☐ Married ☐ Separated ☐ Widowed ☐ Divorced

U.S. Citizen ☐ Yes ☐ No Permanent Resident ☐ Yes ☐ No

Home Address _____ Phone _____

_____

_____ _____
City State Zip Code Country

Employer Name _____ Phone _____

Work Address _____

_____

_____
City State Zip Code

Household Members

Name	Age	Relationship

Have you applied for Medical Assistance? ☐ Yes ☐ No If yes, what was the date you applied? _____

If yes, what was the determination? _____

Do you receive any type of state or county assistance? ☐ Yes ☐ No

Name _____

First Middle Last

I. Family Income– List the amount of your monthly income from all sources. You may be required to supply proof of income, assets, and expenses. If you have no income, please provide a letter of support from the person providing your housing and meals.

	Monthly Amount
Employment	
Retirement/pension benefits	
Social Security benefits	
Disability benefits	
Unemployment benefits	
Veterans benefits	
Alimony	
Rental property income	
Strike benefits	
Military allotment	
Farm or self-employment	
Other income source	
Total	

II. Liquid Assets

	Current Balance
Checking account	
Savings account	
Stocks, bonds, CD, or money market	
Other accounts	
Total	

III. Other Assets– If you own any of the following items, please list the type and approximate value.

Home	Loan Balance _____			Approximate value	
Automobile	Make _____	Year _____		Approximate value	
Additional vehicle	Make _____	Year _____		Approximate value	
Additional vehicle	Make _____	Year _____		Approximate value	
Other property				Approximate value	
				Total	

IV. Monthly Expenses

	Amount
Rent or Mortgage	
Utilities	
Car Payment(s)	
Credit card(s)	
Car Insurance	
Health Insurance	
Other medical expenses	
Other expenses	

Do you have any other unpaid medical bills? ☐ Yes ☐ No Total _____

For what service? _____

If you have arranged a payment plan, what is the monthly balance? _____

If you request that the hospital extend additional financial assistance, the hospital may request additional information in order to make a supplemental determination. By signing this form, you certify that the information provided is true and agree to notify the hospital of any changes to the information provided within ten days of the change.

Applicant Signature Relationship to Patient Date