The following documentations are required to complete processing of your application:

- Social Security Cards for all individuals that are part of the household
- One month's verification of income for all household income
- Copy of LA Drivers License or ID for the adult members of the household

Upon request the below documents may also be required

- If unemployed a letter of support
- Copies of all outstanding medical bills (for individuals who do not qualify for Full Coverage FAP)
- Proof of Louisiana Residency
- If self employed a copy of your previous years completed income tax return

Patients who are covered under Medicare are also required to provide the following:

- Documentation of Assets
- Documentation of Liabilities and Expenses
- Most current statement for checking and savings accounts

Please mail your completed application to:

Lake Charles Memorial Hospital
Attn: Financial Counseling
1701 Oak Park Blvd
Lake Charles, LA 70601

You may also turn in your application in person at any of our campuses.

Financial assistance is available to eligible patients who cannot afford to pay for their healthcare services. Eligibility is determined by family income, size and other factors. Patients whose gross family income is at or below 500% of the federal poverty guidelines for their family size will be eligible for financial assistance and will not be charged more than the current amounts generally billed (more information regarding this calculation is available in the full financial assistance policy). Financial assistance is always considered secondary to all other sources of coverage.

You may call our screeners at 337-494-4637 or visit at 1701 Oak Park Blvd, for questions or to obtain a copy of our policy.

Household Size	Tier 1	Tier 2	Tier 3	Tier 4	Tier 5
	Maximum Yearly Income				
1	$21,597	$23,630	$27,542	$31,455	$43,192
2	$29,187	$31,934	$37,222	$42,509	$58,372
3	$36,777	$40,239	$46,901	$53,564	$73,551
4	$44,367	$48,543	$56,581	$64,618	$88,731
5	$51,957	$56,848	$66,260	$75,673	$103,910
6	$59,547	$65,152	$75,940	$86,727	$119,090

Amounts are based on the 2024 FPG and are subject to change.

To qualify for Financial Assistance your gross family income must be at or below these guidelines.

Lake Charles Memorial Hospital

YOU MAY QUALIFY FOR FINANCIAL ASSISTANCE.

TO QUALIFY YOU MUST SUBMIT THIS APPLICATION.

Lake Charles Memorial Hospital

Application for Financial Assistance

Street Address:_____ City: _____ State: _____ Zip:_____Telephone #:_____

Please list all members of the household and place a Y in the Apply for FA Coverage for all family members requesting coverage through the Financial Assistance Program.

Household Member Name	Date of Birth	Social Security #	Relationship to Applicant	Age	Med Record #	Other Health Coverage	Apply for FA Coverage

Are all Members of Your Household Legal United States Residents? ☐ YES ☐ NO _____

Are you a Resident of the State of Louisiana? ☐ YES ☐ NO _____

Are any Members of your Household that are applying for coverage currently pregnant or disabled? ☐ YES ☐ NO _____

Household Member Income For	Income Type	Gross Monthly	Employer Name	Occupation

I certify that the information provided is an accurate and true representation of my financial information. I also certify that there is no additional insurance coverage for this patient other than what was listed at the time of registration. I understand that providing false information will result in denial of the application for any type of assistance through Lake Charles Memorial Hospital. I will take any action necessary or requested by Lake Charles Memorial Hospital to obtain such assistance and will assign to Lake Charles Memorial Hospital, and upon receipt will pay to Lake Charles Memorial Hospital, all amounts recovered up to the total amount of the outstanding balance on my bill. This includes any settlement from third party payers including but not limited to motor vehicle insurance. My failure to apply for such assistance or to follow through with the application process or take those actions reasonable necessary or requested by Lake Charles Memorial Hospital will result in the denial of this application. I also authorize Lake Charles Memorial Hospital to check my credit history through the credit bureau to verify my eligibility for this program. I also authorize this facility to release my information to pharmaceutical manufactures and/or its designee's to review records for audit purposes. I understand that it is the responsibility of the patient/applicant to report when there are any changes in the family unit income, employment and/or insurance.

_____ _____ _____

Adult Applicant Number 1 Date | Applicant Number 2 Date | Hospital Representative Date

All Adult Members of the Household Applying for Coverage must sign the application