

Bogalusa Medical Center
433 Plaza St.
Bogalusa, LA 70427
985-730-6700

Patient Name: _____
Medical Record #: _____
Today's Date: _____



The following information must be provided in order to process an application for the Medically Indigent Program. Eligibility is per eligible family unit which includes self, spouse, and dependents under 18 yrs of age. **Approved eligibility is valid at all LSU HCSD hospitals.**

REQUESTED INFORMATION MUST BE SUPPLIED WITHIN 10 CALENDAR DAYS FROM THE DATE OF SERVICE (FOR INPATIENTS THE 10 DAYS WILL BE FROM DISCHARGE).

I understand the benefits of the Medically Indigent Program and decline applying for eligibility.

Date of Service/Discharge Date: _____ 10 Day Return Date: _____

HAT/Acct. Specialist: _____ Patient Signature _____

Please Supply The Documents Requested Below:

Proof of Patient Identification (provide one of the following)

- Valid Drivers License or Office of Motor Vehicle ID or Military picture ID
- Current School Identification card with picture
- Current Employee identification card with picture
- Valid Passport or Immigration documentation for legal stay in the US

Proof of LA Residency and Intent to Remain in LA (provide one of the following)

- Voter Registration Card or other recent Government item with your address
- Utility or other bill in your name at your address Rent Contract or Lease Agreement
- Valid LA drivers license or LA Office of Motor Vehicle ID card

Social Security (SS) Cards

- For all eligible family unit members
- Other Government documents with SS numbers for eligible family unit members
- Valid Passport or Immigration documentation to validate legal stay in the US

Proof of Employment/Income (provide one of the following for all members of the family unit including yourself and spouse)

- Check Stub(s) for prior 30 days from date of application.
- Food stamp document for the family unit
- Verification of income from current employer covering prior 30 days or a termination letter on the employer's letter head.
- SSI award letter for current year or bank statements (checking/savings) from the last 30 days showing direct deposit records for any Social Security/SSI or Unemployment deposits
- Court orders/check for child Support/Alimony or verification of Workman's Compensation income

Patient Name / MR # _____

Proof of Self Employment income (provide one)

- Most current year Federal Income Tax Form, Include all 1040 schedules.
- Receipts, check stubs, contracts or sub-contract agreements.

Verification sources of no income

- You will be required to complete a formal "Statement of Support" form at the time of application.

Insurance cards (including Medicare and Medicaid)

- Self, Spouse and eligible family unit members

If any information provided in the application process is found to be untrue the Medically Indigent Eligibility will be revoked without notification and the patient will become responsible for all charges incurred. The information contained in this application may be made available for review of eligibility for all applicable programs.

Inpatient Campus
433 Plaza St.
24 hrs
Phone 985-730-6810
Fax 985-730-6815

Outpatient Campus
400 Memphis St.
7:30 to 4:30 M-F
Phone 985-730-7188
Fax 985-730-7191

Thomas Community Health Center
51704 Hwy 438, Franklinton, LA
8:00 to 4:30 M-F
Phone 985-848-9955
Fax 985-848-9964 (Attn: Angela)

If any information is returned by mail or fax you are responsible for verification that the information was sent to our office within the given time frame.

If you are approved for the Medically Indigent Program you will need to reapply after 183 days (approximately 6 months) in order to continue your medically indigent/free care.

Date Application Received _____

- APPROVED for Indigent Care:**
 - Eligible from _____ to _____
- DENIED for Indigent Care:**
 - Reason for Denial _____

Determination Date _____ **HAT/Account Specialist** _____

If you do not qualify for Indigent Care because of income, you may be eligible if you have medical bills (paid or unpaid) from the past 12 months that are more than 20% of your yearly income. Please supply the information above and present medical bills for processing and approval. If approved, you will be eligible to receive free care services for the next 12 months.

- APPROVED: (based medical bills) Eligible from** _____ **to** _____
- DENIED: Reason for Denial** _____
 - **Comments** _____

Determination Date _____ **HAT/Account Specialist** _____