JEENNINGS AMERICAN LEGION HOSPITAL
FINANCIAL ASSISTANCE APPLICATION

Patient(s) Name: _____ Account Number:_____

PERSONAL DATA: **RESPONSIBLE PARTY** **SPOUSE**

Name: _____ _____
Date of Birth: _____ _____
Social Security # _____ _____
Telephone # _____ _____
Address: _____ _____

EMPLOYMENT INFORMATION:

Employer Name: _____ Employer Name:_____
Street Address: _____ Street Address:_____
Telephone #_____ Telephone # _____
Wages $_____ HR/WK/Monthly/Yearly Wages $_____ HR/WK/Monthly/Yearly
Unemployed___ Unemployed___

OTHER HOUSEHOLD MEMBERS:

Name:_____Age_____DOB_____ Relationship:_____
Name:_____Age_____DOB_____ Relationship:_____
Name:_____Age_____DOB_____ Relationship:_____
Name:_____Age_____DOB_____ Relationship:_____

OTHER RESOURCES/ ASSETS: Please provide the total amount of other resources available to you including, stocks, bonds, trust funds, interest income, dividends and rental income._____

YOU MUST PROVIDE AT LEAST 1 OF THE FOLLOWING:

__ Most recent Federal/State Income Tax Return
__ Last (3) consecutive check stubs
__ Last (2) months bank statements-
(Checking and/or savings)
__ Social Security letter (SSI/ SSD/SSA)
__ Food Stamp letter
__ Unemployment Compensation letter
__ Retirement Check
__ If you report a $0 income, please attach a brief explanation of how you or the patient are meeting basic needs.

_____ _____
Signature of Patient or Responsible Party Date

Return To: Jennings American Legion Hospital
1634 Elton Rd Jennings, LA 70546
ATTN: Financial Counselor

Phone# (337)616-7148
Fax # (337)616-7241

I understand that the information, which I submit, is subject to verification by Jennings American Legion Hospital, I clarify that the above information is true, correct and complete. I give Jennings American Legion Hospital permission to obtain a copy of my credit report to be used in determining eligibility for Jennings American Legion Hospitals financial assistance.

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