JENNINGS AMERICAN LEGION HOSPITAL
FINANCIAL ASSISTANCE APPLICATION

Patient(s) Name: _____ Account Number: _____

PERSONAL DATA:

RESPONSIBLE PARTY:	SPOUSE:
Name: _____	Name: _____
Date of Birth: _____	Date of Birth: _____
Social Security # _____	Social Security # _____
Phone # _____	Phone # _____
Address: _____	Address: _____

EMPLOYMENT INFORMATION:

Employer Name: _____	Employer Name: _____
Address: _____	Address: _____
Phone #_____	Phone #_____
Wages $___HR/WK/MONTH/YR	Wages $___HR/WK/MONTH/YR
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, 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 are meeting basic needs.

_____ _____
Signature: Date:

Return To:

Jennings Hospital
1634 Elton Rd.
Jennings, La 70546
Phone (337)616-7148 Fax (337)616-724
Attn: Financial Counselor

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 Hospital Financial Assistance.

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