HP LONG
A Service of RAPIDES REGIONAL MEDICAL CENTER

FINANCIAL ASSISTANCE APPLICATION

Date: _____ Patient Acct #: Place sticker here

Patient's Name: _____

Patient's Date of Birth: _____ Social Security #:_____

Responsible Party Name: _____

Responsible Party's Social Security #: _____

TOTAL HOUSEHOLD INCOME: $_____

TOTAL NUMBER OF DEPENDENTS IN HOUSEHOLD_____

FIRST AND LAST NAME	AGE OF PERSON

Have you ever applied for Medicaid? _____ Were you approved? _____

I, the undersigned, certify that the above information is true and accurate to the best of my knowledge. I understand that the information submitted is subject to verification. In the review process, a credit report may be requested to verify information provided in this application. I understand that falsification of information submitted may jeopardize my consideration for the program. Furthermore, to qualify for this program, I understand I must apply for any and all assistance that may be available to help pay this hospital bill prior to completing this application.

Signature_____ Date_____