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 100% UCC)
- 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.

For questions or to obtain a copy of our policy: 337.494.4637
1701 Oak Park Blvd., Lake Charles, LA 70601

Family Income Guidelines

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 2025 FPG and are subject to change.

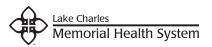
To qualify for Financial Assistance your gross family income must be at or below these quidelines.

Financial Assistance Application

YOU MAY QUALIFY FOR FINANCIAL ASSISTANCE

TO QUALIFY YOU
MUST SUBMIT
THIS APPLICATION





Application for Financial Assistance

Street Address:		City:		_ State: Zip:			Telephone #:	
Please list all members of the house	hold and place a Y in the	Apply for FA Coverage fo	or all family member	s requesting co	verage through i	the Financial A		<i>ı</i> .
			Dolationship				Other Health	Apply for EA
Household Member Name	Date of Birth	Social Security #	Relationship to Applicant	Age	Med Re	cord #	Coverage	Apply for FA Coverage
Tiouseriola Merriber Name	Date of biltil	Social Security #	to Applicant	Age	ivieu ne	coru #	Coverage	Coverage
			<u> </u>				ı	
Are all Members of Your Ho	usehold Legal United State	s Residents?						
		·	YES NO					
Are you a Resident of the St	ate of Louisiana?	,	YES NO					
Are any Members of your He	ousehold that are applying							
currently pregnant or disabl	ed?	,	YES NO	-				
Household Member Income For	Income Type	Gross Monthly	Fm	nlover Name	,		Occupation	
Trousenold Member Income Por	meome Type	dross Monthly	LII	Employer Name		Occupation		
I certify that the information provided	d is an accurate and true i	representation of my fin	ancial information.	I also certify th	at there is no a	dditional insur	rance coverage fo	r this patient other
than what was listed at the time of	registration. I understand	l that providing false in	formation will resu	lt in denial of	the application	for any type	of assistance thr	ough Lake Charles
Memorial Hospital. I will take any acti receipt will pay to Lake Charles Memo								
including but not limited to motor vel								
requested by Lake Charles Memorial								
bureau to verify my eligibility for this purposes. I understand that it is the re								
par posesi i andersama macre is the re	soponoiomicy of the patient	ty applicant to report wil	en enere are any ene	inges in the fai	iniy ume meem	s, employment	and, or mouranes	
Adult Applicant Number 1	Date	Applicant Number 2	Date	!	Hospit	al Representativ	re	Date
	All Adult	Members of the Household	l Applying for Coverag	ge must sign the	application			