Baton Rouge General
A Community of Caring

Financial Assistance Application

PATIENT INFORMATION DATE _____
Name: _____ Account Number: _____
Address: _____
Phone: ( ) _____ Social Security Number: _____
Date of Birth: _____ Sex: F M Marital Status: _____ No. of Dependents: ____
Employer Name: _____ Employer Address: _____

SPOUSE/PARENT INFORMATION
Name: _____
Address: _____
Phone: ( ) _____ Social Security Number: _____
Date of Birth: _____ Sex: F M Marital Status: _____ No. of Dependents: ____
Employer Name: _____ Employer Address: _____

CREDIT INFORMATION/GUARANTOR

Bank Name: _____ Checking Account Balance: _____

Savings Account Balance: _____

Annual Income: Guarantor _____ Spouse _____

Income Source: Paycheck, Social Security, etc.
Guarantor: _____ Spouse: _____

Please note that you must include a copy of your most current tax return.

DETERMINATION OF ELIGIBILITY CANNOT BE MADE UNLESS COMPLETE INFORMATION IS OBTAINED.

I certify the above data is true and correct. I agree to apply for financial assistance that may be available to pay for Hospital charges. I agree to assign or pay to the hospital any amounts recovered for the services. I understand the information furnished has been provided for the hospital to determine eligibility. I grant Baton Rouge General permission to verify any of my information and will assist by providing payroll data, income tax information, or other data. I understand if I have a portion of this bill to pay out of pocket and default on that payment, the entire bill becomes payable and due.

_____ Date Signed: _____
Signature of Patient (Parent or Guardian of Minor)

Authorized by: _____ Date Signed: _____

To be completed by PFS at Baton Rouge General.
Completed Application ☐ Check Stub ☐ Income Tax Return ☐
Approved ☐ Amount approved for Charity adjustment: _____
Rejected ☐ Reason for rejection:_____