



## Acceptable Forms of Income Verification

- Thirty consecutive days or one month of paycheck stubs
- Trusts, dividends, interest income by providing document with Gross Income Amount
- Current Retirement Income Check stub(s)
- Current Social Security Award letter for both spouses and any children Current Letter from Employer on (only if paid in cash)
- Current Veterans Administration Award Letter(s)
- Current Child Support Statement or Divorce Decree
- Current proof of direct deposit of fixed income by providing document with Gross Income Amount
- Current self-employed individual - previous year 1040 Income Tax Form with all attachments (Verified
- IRS transcript copy)
- Current letter of support if unemployed/have no source of income and living with a relative or friend. Current bank statement if living off savings and no other source of income by providing most recent bank statements
- Alimony or spousal support income

## Resource/Asset Information (In addition to above documents)

- Most Recent Income Tax (For self-employed individuals, see below\*) If you did not file an income tax return for the most recent year, it will be necessary to get a statement from the IRS via the same method as the IRS Transcript to confirm.
- Most current Profit and Loss Statements (at least 2 quarters) for Business Owners
- Most Recent Income Tax of Business if applicant owns more than 5% of Partnership or Corporation
- Most recent statements for each checking account, savings account, mutual fund/money market accounts, IRA accounts, Certificate of Deposit accounts (CD), and any other security accounts or investment accounts
- Most recent statements for Stocks, bonds, etc.
- Parish appraisal documents for all real property excluding homestead. Finance documents with loan or mortgage balance to determine equity value
- All motor vehicle information, including cars, trucks, RV's, motorcycles, boats, ATV, and aircraft that are in your household



**NOTE: If you reported \$0 income, please provide a brief explanation of how you (or the patient) are meeting basic living needs:**

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**(Must provide a support statement.)**

### SECTION THREE: FAMILY INFORMATION

List all family members in your household named on the most recent federal income tax return and their date of birth.

Please provide the following information for all of the people in your immediate family who live in your home. For purposes of this policy, family is defined as the patient, the patient's spouse, and all of the patient's children under 18 (natural or adoptive) who live in the patient's home. If the patient is under the age of 18, the family shall include the patient, the patient's natural or adoptive parent(s), and the parent(s) children under 18 (natural or adoptive) who live in the patient's home.

Name of family members, including patient	Date of Birth	Relationship to Patient
1.		
2.		
3.		
4.		
5.		
6.		

**By signing below, I certify that everything I have stated on this application and on any attachments is true.**

Responsible Party's Signature \_\_\_\_\_ Date: \_\_\_\_\_

Return your completed application to:

**West Jefferson Medical Center**  
Attn: Manager, Financial Assistance  
1101 Medical Center Blvd.  
Marrero, LA. 70072

Copies of our Financial Assistance Policy, Application Form and Summary are available in English, Spanish and Vietnamese.

**THIRD-PARTY SUPPORT AND VERIFICATION STATEMENT**

Patient Name: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_  
 MRN #: \_\_\_\_\_

**PENALTY CLAUSE, CONFIRMATION STATEMENT AND AUTHORIZATION FOR RELEASE OF INFORMATION**  
 I certify that the information provided to complete this application is true. Additionally, I understand that in accordance with Louisiana State Statute 1924, providing false information can be considered "Health Care Fraud" in an attempt to defraud a hospital for the purpose of obtaining goods and services, including pharmacy items, is a felony.

**FINANCIAL SUPPORT**

I, \_\_\_\_\_, provided \$ \_\_\_\_\_ last month to the patient referenced below.

**THIRD-PARTY SUPPORT OF LIVING ARRANGEMENT**

I, \_\_\_\_\_ (supporter), provide room and board and other support for the patient referenced below. The person does not pay rent to me. I must provide prove of address for verification purpose. I am providing the patient with a current expense bill or other household document for him/her to show you my current address.

**THIRD-PARTY PAYMENTS to patient's credit accounts**

I, \_\_\_\_\_ (responsible party), certify I am the person responsible for making the payments in connection to the following expense(s) which are in the name of referenced patient. I understand that I must provide proof of payments. Please send documented proof with patient to his/her financial assessment. (Provide additional information on separate sheet.)

Expense Name: \_\_\_\_\_ Amount: \_\_\_\_\_

Expense Name: \_\_\_\_\_ Amount: \_\_\_\_\_

Expense Name: \_\_\_\_\_ Amount: \_\_\_\_\_

Reference Loan Type or Loan #: \_\_\_\_\_

\*Signature is required if third-party person not present at time of Financial Assessment

\_\_\_\_\_  
 Patient/Representative Signature

\_\_\_\_\_  
 Patient/Representative Printed Name

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 \*Third-Party Supporter Signature

\_\_\_\_\_  
 Third-Party Supporter Printed Name

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 West Jefferson Medical Center  
 Representative Signature

\_\_\_\_\_  
 West Jefferson Medical Center  
 Representative Printed Name

\_\_\_\_\_  
 Date Form Received