



AcadianaCares intends to provide services to clients and patients at an affordable price. In order to do this, AcadianaCares must know and document how much money you earn to provide services at appropriate reduced fees, according to the agency's sliding fee scale. Your information also may help AcadianaCares determine if you are eligible for other financial assistance programs. If you have questions about this application, please contact AcadianaCares at 337-233-2437, ext. 176.

Applicant First/Last Name		Social Security #	Date of Birth
Spouse First/Last Name		Social Security #	Date of Birth
Mailing Address		Email Address	
City, State, Zip Code		Phone #	
Employer Name, Address, Phone		Spouse Employer Name, Address, Phone	

Family Income: Indicate amount and frequency (money received per week, month, or year). Please provide a copy of your most recent proof of income statement or payment.

Wages/Tips	Disability Income	Welfare Payments	Veteran's Benefits
Business/Rental Income	Unemployment	Child Support	Checking/Savings
Farm/Seasonal Income	Social Security Benefits	Alimony	Other (describe)
Public Assistance	Pensions/Annuities	Retirement	Total Gross Income/Year

Additional Household Member Information

First/Last Name, Relation, Date of Birth	First/Last Name, Relation, Date of Birth
First/Last Name, Relation, Date of Birth	First/Last Name, Relation, Date of Birth
First/Last Name, Relation, Date of Birth	First/Last Name, Relation, Date of Birth

FOR OFFICE USE ONLY:

Date Received: _____ Status: _____ Initials: _____

Total # in Household

A copy of your proof of income, or proof you do not receive income, is required to process your application.

1. Proof of Income

Proof of household income includes:

1. A copy of the previous year's tax return or W-2 form.
2. Check stubs from your current job or a letter from your employer stating gross earnings.
3. Proof of social security income, food stamps, or other public assistance.
4. Proof of child or spousal support.

2. Proof of No Income

If you currently have no household income, please include one of the following:

1. Statement from Louisiana Workforce Commission approving or denying unemployment compensation.
2. Termination notice from previous employer.
3. Layoff notice from previous employer.
4. Statement from person supplying food and shelter.
5. Proof of Medicaid or welfare cancellation.
6. If there is no income at the time of financial eligibility screening, the family will be designated as a Slide Fee A and financial screening will be reviewed in 90 days. Describe on a separate page how your family is supported financially (i.e. savings, loans, etc.).

3. Other Income

Describe on a separate page any unusual situation not previously described.

Statement of Understanding

The information I provided concerning my family size and my family's gross annual income from all sources is true, accurate, and complete to the best of my knowledge. I have given information concerning my financial situation and my ability to pay for the purpose of obtaining a financial discount for health care services provided to me or my family by the AcadianaCares Community Health and Wellness Center. I understand AcadianaCares will rely on such information to determine an applicable discount rate, if any, for my account. **I understand that knowingly providing false information may result in criminal prosecution.**

I know the information I have given will continue to be relied upon until it is changed. I agree to report any change in either my income or my family size to AcadianaCares before or at the time of my or a family member's next contact with AcadianaCares.

I understand my discount status will be reviewed on a semiannual basis and adjusted according to my family income and size at the time of review. If AcadianaCares has reason to suspect the information I provided is untrue, inaccurate, or outdated, AcadianaCares may initiate a review of my status.

I hereby authorize the investigation of all statements contained herein and authorize the release of all employment records, bank records, and other financial information to an AcadianaCares agent.

My signature below indicates all the information I provided is true to the best of my knowledge.

Applicant Signature/Date

Spouse Signature/Date