MRN: _____

Visit ID: _____

Date of Service: _____

Lawrence General Hospital
Financial Assistance Qualification Form

Requirements for discount:

1. Complete Medicaid application in the patients' state of residency. Provide documentation of state issued determination.
2. Patient/responsible party can set up a payment plan.
3. Discount does **not** apply to co-pays, co-insurance, or deductibles.
4. If patient qualifies for coverage as determined by their state of residency, the patient needs to show proof of enrollment.
5. If patient does **not** qualify for a program in their state of residency, or the date of coverage does **not** include the date of service(s), the patient will qualify for free care or a discount.
    a. 100%-300% of the Poverty Guideline= Freecare
    b. >300%= 55% discount

I _____, understand that this information is used to determine if I qualify for a discount with Lawrence General Hospital, LGH Ambulance Services and/or LGH General Primary Care (GPC).

_____ _____

Patient name (please print) Date of Birth

_____ _____

Patient signature Date

HOSPITAL USE ONLY

LGH Representative _____ _____

Date

Documents received ***(initial each box as they are reviewed/verified)***

Medicaid application determination _____

Patient qualifies for: Circle One

a. 100%-300% of the Poverty Guideline= Freecare
   Or
b. >300%= 55% discount

Coverage start date verified _____

EOB to determined non-covered services_____