



1400 East Union Street
Greenville, MS 38704
662-725-2148

This form will be used by the hospital to determine if you qualify for a discount according to Delta Health System – The Medical Center guidelines.

The Charity application covers charges medically urgent to hospital and physician services for 90 days for all eligible visits within that period. Elective or experimental procedures are not covered. Charges that are in collections when the application is received will not be eligible.

In addition to completely filling out the attached Charity Application, the following information is needed to complete your eligibility status for the program.

Listed below is the documentation necessary to support the need for financial assistance:

Tax Information (required):

- Tax Return (1040 form) – most recent year end _____
(If you own your own business, include a profit or loss and the depreciation and amortization forms)
- IRS Letter – notice of non-filing taxes
(Call the IRS at 1-800-829-0922 to obtain legal filing letter)

Proof of Income (required):

- W-2/1099 – (same year as the tax return)
- Current income – 1 month current check stubs to support all wages reported on the tax return
If you no longer work, include hardship letter explaining who is supporting you and their ID.
- Social Security – official government letter or bank statement showing direct deposits.
- Unemployment Benefits – approved or pending letter.
- Food Stamp letter
- Child support, alimony, retirement, etc.

Personal Verification (required):

- Picture I.D. (Mississippi Driver’s License or ID card, Passport, Permanent Residence Card)

Other Information

- College Student – Pell grants, loans, or scholarships in the patient’s name (FT or PT)
- Medicaid denial letter (if applicable)
- Divorce Decree/Separation documents – if date is after date of tax return.
- Proof of address – utility bill, rent, etc. If living with someone, please submit a letter from the person you live with stating he/she provide a place to stay and you are not responsible for expenses at that address.
(Provide valid driver license or state ID of person writing letter)

*****PLEASE RETURN REQUESTED DOCUMENTS AND APPLICATION*****
TO BE PROCESSED BY _____(DATE).

IF COMPLETED DOCUMENTATION IS NOT RECEIVED ON TIME THE APPLICATION WILL NOT BE PROCESSED AND YOU WILL BE RESPONSIBLE FOR PAYMENT.

If you have any questions or need assistance, please call Mary Ann Evans at (662)725-2594



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Date: _____

Delta Health System- The Medical Center Charity

90 days period _____ to _____

Application

Patient Last Name: _____ First: _____ MI: _____

Account Number (s): _____

Dates of Service: _____ Reason: _____

Soc. Sec. #: _____ Birthday: _____ Male _____ Female _____

Marital Status (check one) Married _____ Single _____ Divorced _____ Widowed _____ Separated _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Current Address: _____

City: _____ St: _____ County: _____ Time at address: _____

Name and phone number of nearest relative not living in your household: _____

_____ Relationship to you: _____

Patient's employer: _____ How long: _____

If unemployed, how long: _____ Reason: _____

Responsible Party's Name: _____ Relationship: _____ Phone #: _____

Name of Bank: _____ Savings _____ Checking _____

Are you: Renting _____ Buying _____ Own _____ Live with: _____

Number of **your** dependents (under the age of 18) living in your household? _____

How are they related to you: _____

Ages of children living in the household: _____

Are your children on: Medicaid _____ BCBS Chips _____

Was this an accident _____ Was liability insurance involved _____ List policy # _____

*******Disability Questions if applicable to you*******

Have you ever applied for SSI/Disability? Yes _____ No _____ Date _____

What is your disability? _____

Is the case still open and pending a decision? _____

If denied, have you filed an appeal for reconsideration? Yes _____ No _____ Date _____



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Pending a hearing date or hearing approval? Yes _____ No _____ Date _____

Name of Physician that deemed you disable: _____

Physician Contact #: _____



The Medical Center

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FINANCIAL DISCLOSURE FORM:

GROSS MONTHLY INCOME:

Gross salary for patient:
Gross salary for spouse:
Gross salary for parents:
Soc. Sec. check amount:
Souse's Soc. Sec. check amt:
SSI Income (list amt and who is receiving)

Military retirement income:
VA check amount:
Child support/alimony received:
Unemployment amount:
Education/College loans:
Retirement/pension amount:
AFDC/food stamps:
Church assistance:
Other income/money received:

Applicants Statement: I do hereby certify the information
furnished on this form is correct and true to the best of
my knowledge and that no pertinent items of information
has been concealed or omitted from this application.

Please sign, authorizing your accounts to be processed by
Eligibility Services.

Signature:
Printed Name:
Today's date:

Annual income calculation (office use only)

Blank lines for annual income calculation and Total Amount.

REMARKS AND RECOMMENDATIONS:

Eligibility Service Advocates

Blank lines for remarks and recommendations.