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 – 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 - The Medical Center Charity Application

90 days period_________________to _________________

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 #: ___________________________________

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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)

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Total Amount: _______________________________________

REMARKS AND RECOMMENDATIONS:

Eligibility Service Advocates

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