DELTA HEALTH SYSTEM
The Medical Center

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 #: _____

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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

_____

_____

_____

_____

_____

_____