SOUTH CENTRAL
REGIONAL MEDICAL CENTER

Date:

To:

Account #:

Financial Assistance

Enclosed you will find an application for financial assistance for South Central Regional Medical Center. Please complete all information requested and mail back to us within 15 days. Please be sure to include all of the requested documentation. Any application submitted without all supporting documentation will be denied. It is the responsibility of the patient or family to provide the hospital with any necessary information so eligibility can be determined.

In the State of Mississippi, a person under the age of 21, excluding emancipated minors who are married and/or self-supporting, is considered a minor and requires parent/legal guardian(s) financial information/signature on the application.

Financial applications are open to individuals incurring hospital bills which they cannot readily pay, without regard to race, color, creed, national origin, sex, age, handicap, or religious preference. Applications for emergency and medically necessary services may be submitted up to 240 days after the first post discharge statement. The applicant must be willing to apply for any and all assistance resources recommended by the hospital and accept assistance from these resources.

DO NOT WRITE BELOW THIS LINE

SOUTH CENTRAL REGIONAL MEDICAL CENTER
PO BOX 607, LAUREL MISSISSIPPI 39441

MISC

PATIENT LABEL HERE

Supporting Documentation Checklist

All income sources:

- ☐ Last 3 months Pay Stubs – or – Unemployment Statements
- ☐ Past two year tax returns
- ☐ Disability Letter (most recent)
- ☐ Social Security Income
- ☐ Retirement/Pension
- ☐ Child Support
- ☐ Any other form of income listed
- ☐ Letter of Support (if no income, you must submit a letter signed by whoever is supporting you financially – see page 7)

Expenses

- ☐ Current Electric Bill and other utilities (must show current address)
- ☐ Current Phone bill
- ☐ Property of Ownership (all properties)
- ☐ Property Taxes
- ☐ Mortgage Loan or Notarized Affidavit from landlord (page 8)

Miscellaneous

- ☐ Denial Letter of Medicaid or Presumptive Eligibility Assessment (you must apply for Medicaid and send copy of your denial letter stating you are not eligible for Medicaid before your charity application will be processed)
- ☐ Last 3 month bank statements for all accounts
- ☐ If someone was legally appointed to act as your authorized representative, submit proof with this application (see page 6)
- ☐ If separated from spouse, please submit legal documentation (this must be on file at the court house)

**** If all above required information is not received and there is no explanation given, your application may be denied *****

Applicant Name (First, Middle, Last)	Location	SCRMC FIN #:

Instructions: Fill out application form completely with a black or blue pen. Do not leave questions blank. If questions are not applicable, enter "NA".

Have you applied for/will apply for federal or state medical assistance or have verified healthcare exchange plan eligibility?

☐ Yes ☐ No Reason_____

Do you have a lawsuit, settlement, personal injury, or liability claim pending?

☐ Yes ☐ No Reason_____

Do you have the availability of insurance through your employer or your spouse's employer?

☐ Yes ☐ No Reason_____

Have you previously applied for financial assistance at another SCRMC facility?

☐ Yes ☐ No ☐ Not Sure

When? _____ When? _____

Patient/Responsible Party

Name *(First, Middle, Last)*	Social Security Number	Birth Date *(Month, DD, YYYY)*

Address	City	State	Zip Code

Phone	Household Size (Patient, Spouse and Dependents)	Marital Status
		☐ **SINGLE** ☐ **MARRIED** ☐ **SEPERATED** ☐ **DIVORCED** ☐ **WIDOWED** *** If separated, you must submit legal documentation**

Employment Status	Employer Name
☐ Full Time ☐ Part Time ☐ Self Employment ☐ Unemployed ☐ Student	

Employment Length	Unemployed Date/Length (Month DD, YYYY)	Are you claimed on another tax return?
		☐ Yes ☐ No (If yes, provide tax returns of those being claimed)

Spouse/Partner

Name *(First, Middle, Last)*	Social Security Number	Birth Date *(Month, DD, YYYY)*

Employment Status	Employer Name
☐ Full Time ☐ Part Time ☐ Self Employment ☐ Unemployed ☐ Student	

Employment Length	Unemployed Date/Length (Month DD, YYYY)	Are you claimed on another tax return?
		☐ Yes ☐ No (If yes, provide tax returns of those being claimed)

Applicant Name (First, Middle, Last)	Location	SCRMC FIN #:

Household Dependents (If more room is needed, please provide separate page.)

Name	Social Security Number	Date of Birth	Relationship
			SELF
			SPOUSE

Health Insurance Information

Covered Person / Guarantor	Type of Coverage	Insurance Name	Policy Number

Bank Account/Credit Reference

Bank Name	Account Type	Bank Phone	Balance
	Checking		
	Savings		
	Other Investment/Securities		

Expenses

Type	Payment	Type	Payment
Residence	$	Medical Insurance Premium	$
Water Bill	$	Child Support	$
Cable/Television/Internet	$	Gas/Propane	$
Electricity Bill	$	Medical Bills	$
Credit Cards	$	Car Note	$
Other (please specify below)	$	Phone Bill	$

*** For every expense listed above, please provide a copy of the bill ***

Applicant Name (First, Middle, Last)	Location	SCRMC FIN #:

Property

Type	Detail	Est. Value	Unpaid Balance
Primary Residence		$	$
Vehicle		$	$
Land	# of Acres:	$	$
Rental Property/Secondary Residence		$	$
Business/Farm Equipment		$	$
Other/Recreational Vehicle		$	$

Employment Income / Assistance / Other Income

Employer & Type of Work	Rate of Pay	Gross Paid	How Often (weekly, biweekly, etc.)?	Source (Self, Spouse or other)
				SELF
				SPOUSE
TOTALS:	**$**	**$**		

Other Source	Applicant Amount	Spouse Amount	Child Amount
Social Security	$	$	$
SSI	$	$	$
VA / Pensions	$	$	$
Retirement	$	$	$
Rentals/Property	$	$	$
Child Support	$	$	$
Other (Please list income detail):	$	$	$
TOTALS:	**$**	**$**	**$**

**** PLEASE PROVIDE DOCUMENTATION FOR THE ABOVE INCOME SOURCES****

CERTIFICATION

I certify that all information listed above is true and correct to the best of my knowledge. I hereby grant permission to South Central Regional Medical Center and all affiliates and representatives or agents to investigate the information contained herein, and to obtain credit reports. I understand any incomplete, misinformed or false statements will disqualify me from receiving financial assistance.

Patient/Guarantor Signature: _____ **Date**: _____

Patient Representative: _____**Date:** _____

SOUTH CENTRAL
REGIONAL MEDICAL CENTER

AUTHORIZED REPRESENTATIVE (Optional)

You can name a person you trust to act as your authorized representative, giving them permission to see your application and to act for you on matters relating to this application, including providing information needed to complete this application. You must complete and sign this portion of the application to name someone to act for you. If someone is legally appointed to act for you, submit proof with this application.

Patient Name *(First, Middle, Last)*	Patient SCRMC FIN #:	*Patient* Birth Date *(Month, DD, YYYY)*
Name of Representative *(First, Middle, Last)*	Relationship to Patient	Birth Date *(Month, DD, YYYY)*

Address	City	State	Zip Code

Phone	Alternate Phone

By Signing, you allow the person listed above to sign your application, get official information about this application and act for you in all future matters related to this application.

Patient Signature: _____ Date: _____

Witness: _____ Date: _____

SOUTH CENTRAL
REGIONAL MEDICAL CENTER

Letter of Support

Patient Information

Patient Name *(First, Middle, Last)*	Patient SCRMC FIN #:	*Patient* Birth Date *(Month, DD, YYYY)*

The remainder of this form's information is to be completed by person paying living expenses or providing living assistance to the patient.

Supporter Name *(First, Middle, Last)*	Relationship to Patient	Birth Date *(Month, DD, YYYY)*

Address	City	State	Zip Code

Phone	Alternate Phone

I, _____, provide shelter and financial
(Name of person assisting patient)

assistance to _____ in the amount of _____
(Name of Patient)

every month. I have provided assistance from _____ to _____.
(start date) (end date)

_____ _____
(Signature of person providing shelter and assistance) (date)

SOUTH CENTRAL
REGIONAL MEDICAL CENTER

Landlord Affidavit of Residence

Patient Information

Patient Name *(First, Middle, Last)*	Patient SCRMC FIN #:	*Patient* Birth Date *(Month, DD, YYYY)*

The remainder of this form's information is to be completed the landlord of patient.

Landlord's Name *(First, Middle, Last)*	Date	Birth Date *(Month, DD, YYYY)*

Address	City	State	Zip Code

Phone	Alternate Phone

I, _____, the landlord of, _____, formally
(Name of Landlord) (Name of Patient)

acknowledge that he/she resides at the street address of _____,

City of _____, State of _____ since _____, 20____

As my tenant. Furthermore, I swear and affirm under penalty of perjury that the facts set forth

in this statement are true and accurate.

_____ _____
(Signature of Landlord) (date)

THE STATE OF MISSISSIPPI

COUNTY OF _____
Personally appeared before me, the undersigned authority in and for the said county and state, on this _____ day of _____ in the year 20___, within my jurisdiction, the within named _____, who acknowledged that he/she executed the above and foregoing instrument.

_____
Notary Public Signature
Print _____ (SEAL)