MISSOURI DELTA MEDICAL CENTER

To apply for HOSPITAL financial assistance, please complete the attached application and return to the address below.

Please include the following documentation. Failure to provide this information in a timely manner will delay the determination of your eligibility.

1. **Complete copies of previous year's federal income tax return, including Schedule C if self-employed. If you did not file a return, call the IRS at 800-829-1040 and request a letter of non-filing.**
2. **Current payroll stubs for both husband and wife, for all jobs held, along with any other members of the household with an applicable income for the current year. Paycheck stub must show current YTD earnings.**
3. **Social Security Benefits – Must show benefit amount received each month.**
4. **Disability Benefits – Must show amount of benefit received each month.**
5. **Unemployment Benefits – Must show amount of benefit received each month.**
6. **If you have been approved for Medicaid, please bring your card or letter of approval which should include your Medicaid number used for filing claims.**
7. **Statement reflecting amount of child support, alimony or any other support received each month. If you receive food stamps, please provide approval letter.**
8. **If you have filed a joint tax return with a spouse you are currently separated from, we will need a copy of your separation agreement showing the date of separation. If you are divorced, please provide a copy of your divorce decree.**

<u>All documentation must be provided before the application can be reviewed.</u>

If you have any questions please do not hesitate to contact a Patient Financial Counselor at the numbers listed below.

Call Marie at 573.472.7144

Sincerely

Patient Accounts Department
Missouri Delta Medical Center
1008 North Main
Sikeston, MO 63801
Phone 573.471-1600
Fax 573-472-7710

MISSOURI DELTA MEDICAL CENTER

HOSPITAL FINANCIAL ASSISTANCE APPLICATION FOR ELIGIBILITY DETERMINATION

Patient Name: _____ Date: _____

Address: _____

Phone Number: _____

Financial Assistance requested by: _____

List income for family: (Check "X" where applicable)

	Total for 12 months
_____ Wages	$ _____
_____ Self-employment	$ _____
_____ Public assistance	$ _____
_____ Social Security	$ _____
_____ Pensions	$ _____
_____ Strike benefits	$ _____
_____ Unemployment compensation	$ _____
_____ Workers compensation	$ _____
_____ Military family allotments	$ _____
Income from :	$ _____
_____ Dividends	$ _____
_____ Interest	$ _____
_____ Rent	$ _____
Total annual income	$ _____

TOTAL NUMBER OF FAMILY MEMBERS RESIDING IN HOME _____

If you are seeking financial assistance for services already rendered at Missouri Delta Medical Center, please list the dates of service.

_____

If you are seeking financial assistance for services not yet rendered, please check type of service:

_____ Emergency Room _____ Outpatient Clinic _____ Inpatient _____ Medical/Surgical
Other _____

I understand the information I submit is subject to verification by Missouri Delta Medical Center. I certify the above information is true and correct.

_____

Signature (person making request)

MISSOURI DELTA MEDICAL CENTER

FINANCIAL STATEMENT

Name of responsible party: _____

Address: _____

Phone: _____ Relationship to patient: _____ Birthdate: _____

Please check source and amount of income from each source:

___ Your Employment	$ _____	___ SSI	$ _____
___ Spouse's Employment	$ _____	___ ADC	$ _____
___ VA Pension	$ _____	___ Disability SS	$ _____
___ Other	$ _____		

Please indicate dependents: _____ Self _____Spouse
Number of children _____ Other dependents: Explain _____

Employer: _____ Phone: _____
Address: _____ Length of Employment: _____
Spouse's Employment: _____ Phone: _____
Address: _____ Length of Employment: _____

Please indicate all of the following payments made by you:

House payment	$_____	Paid to: _____
Rent	$_____	Paid to: _____
Car Payments	$_____	Paid to: _____
Loan Payments	$_____	Paid to: _____
Alimony or Child Support	$_____	Paid to: _____
Hospital or Physician	$_____	Paid to: _____
Food Stamps	$_____	Paid to: _____
Gas Bill	$_____	Paid to: _____
Electricity/water	$_____	Paid to: _____

Checking or savings account _____ Yes _____ No Account # _____

Banking Institution: _____

Please indicate which of the following you own:

_____ Land _____ House _____ Car _____ Truck _____ Boat _____ Business_____

I certify that to the best of my knowledge the above statements are true.

_____ _____

Signature of responsible party *Relationship to patient*