Financial Assistance Application

Anderson Regional Medical Center
2124 14th Street
Meridian, MS 39301
Phone: 601-553-6850

Applicant Identification:

Applicant's Full Name ____
(First) (Middle) (Maiden) (Last)

Social Security #:____________________ If none, has one been applied for? ____________

Date of Birth: _______/______/______ Sex: _____Male _____ Female
(Month) (Date) (Year)

Marital Status: ______Single ______ Widowed _____ Married _____ Divorced ______ Separated

Home Address: ____
(Street)
____
(City) (State) (zip)

Telephone Number: ( ) _________________________
How long has applicant lived at this address? _________________________

List members of applicant's household that you are financially responsible for.

Name of Household Members	Age	Relationship to Applicant	Does this person still live in the household
			_____Yes _____ No
			_____Yes _____ No
			_____Yes _____ No
			_____Yes _____ No

Employment Information:

Name of Employer:____
Total Wages (Before Deduction) $______________ How often are you paid?________________________
Spouse Employer: ____
Total Wages (Before Deductions): $____________ How often are you paid? ____________________

Income Information:

Did applicant file State or Federal Income Tax* last year? _____ Yes _____ No
***Note:** A **copy of last year's Federal tax return or other supporting verification is required.**
Does applicant currently receive a SSI check? ____ Yes _____ No
Has the applicant ever received a SSI check? ____ Yes _____ No If yes, when was the last month/year a check was received?____
Medicaid I.D. Number (If ever received Medicaid) ____

Financial Assistance Application

Other Income:

List below all other types of money received by the applicant, his/her spouse, or any dependent child. If this is an application for a child, each parent must account for his/her income.

			Give Monthly Amounts		
		Source of Income	Applicant	Spouse	(Under 18) Children
Yes	No	Social Security	$	$	$
Yes	No	SSI	$	$	$
Yes	No	VA Pension or Compensation	$	$	$
Yes	No	VA Insurance	$	$	$
Yes	No	Railroad Retirement	$	$	$
Yes	No	State Retirement	$	$	$
Yes	No	Municipal Retirement	$	$	$
Yes	No	Civil Service Retirement	$	$	$
Yes	No	Private Retirement	$	$	$
Yes	No	Rental Income	$	$	$
Yes	No	Interest Income	$	$	$
Yes	No	Dividends	$	$	$
Yes	No	Oil, Gas, Mineral Royalties	$	$	$
Yes	No	Cash Contributions	$	$	$
Yes	No	Other	$	$	$

Banking Information:

Does the applicant's name appear or has it appeared in the last 24 months (either alone or with a spouse or any other person) on any individual or joint:

Savings Account _____ Yes _____ No
Checking Account _____ Yes _____ No
Credit Union Account _____ Yes _____ No
Savings Certificate _____ Yes _____ No
Promissory Note _____ Yes _____ No

Safe Deposit Box _____ Yes _____ No
Bonds _____ Yes _____ No
Stocks _____ Yes _____ No
Savings Bond _____ Yes _____ No
Patient Acct at NH _____ Yes _____ No

If yes, complete the following:

Type of Account			
Name, Address of bank S&L, or Credit Union			
How accounts listed (names on accounts)			
Account numbers			
Is account now open? If no, give date closed or date applicant's name removed.	_____ Yes _____ No	_____ Yes _____ No	_____ Yes _____ No
Balance in Account			

Income information:

Remember: You must include proof of income with your application.
You must provide information on your family's income. Income verification is required to determine financial assistance.
All family members 18 years old and older must disclose their income. If you cannot provide documentation, you may submit a written signed statement describing your income. Please provide proof for every identified source of income.

Proof of Income includes:

- Current pay stubs
- A "W-2" withholding statement
- Last year's income tax return
- Social Security / SSI Statement
- Written, signed statements from employers or others
- Approval/denial of eligibility for Medicaid and/or state-funded medical assistance
- Approval/denial of eligibility for unemployment compensation
- Bank Statements

If you have no proof of income or no income, please attach an additional page with an explanation.

Responsibility of Applicant:

1. I affirm that all information given in this document or in support of it is true.

2. I hereby authorize Anderson Regional Health System to contact resources listed herein to support, clarify, and/or verify the financial circumstances stated in this application.

3. I agree to reimburse Anderson Regional Health System for hospital services rendered in the event that insurance claims should later be made available to me for same such services.

Signature:______________________________________ Date: ________________