



**NORTH MISSISSIPPI  
HEALTH SERVICES**

Date:

To:

Account #:

**Re: Financial Assistance**

Enclosed you will find an application for financial assistance. Please complete all information and mail back to us **within 14 days** along with **all of the requested supporting documentation** (see page 3). **Applications received without supporting documents will result in delay or denial.** You may use the enclosed postage paid envelope for returning your application to us.

North Mississippi Health Services (Parent Corporation of Clay County Medical Center, North Mississippi Medical Center, Marion Regional Medical Center, Pontotoc Health Services, Tishomingo Health Services, Webster Health Services and North Mississippi Medical Clinics, Inc.) will review your application to see if any assistance can be given on your hospital charges and/or related clinic charges.

**In the State of Mississippi, a person under the age of 21 is considered a minor, therefore the parents / legal guardians must fill out the application using their financial information, except for emancipated minors who are married and/or self-supporting. For Alabama residents a person under the age of 19 is considered a minor.**

In order to provide consistency to the financial assistance policy the attached income guideline will be observed. The income guideline along with the other information obtained on the credit statement will be used to make the charity determination.

Generally, a patient will be considered for financial assistance if their household income does not exceed the attached guideline. However, if under extraordinary circumstances, income exceeds these guidelines partial assistance may still be granted at the sole discretion of North Mississippi Health Services.

Sincerely,  
Financial Assistance Department  
North Mississippi Health Services



**NORTH MISSISSIPPI  
HEALTH SERVICES**

**2017 Federal Poverty Income Guidelines**

Number of household members: Yearly Gross Income

1	2	3	4	5	6	7	8
12,060	16,240	20,420	24,600	28,780	32,960	37,140	41,320

For families/households with more than 8 persons, add \$4,180 (annual) for each additional person.



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**SUPPORTING DOCUMENTATION REQUEST**

We ask that you provide **copies** of the following requested information within 14 days or contact NMHS Business office if more time is needed. Please complete each line whether it applies or not so that your charity application can be processed timely. If you are under the age of 21 (a minor) (or 19 if you live in Alabama), information should be provided by Parents/Legal Guardians. You will be informed by letter once your application is approved or denied.

1. ALL SOURCES OF MONTHLY INCOME FOR PATIENT AND/OR SPOUSE
  - A. Employed: Two, consecutive current pay stubs-both patient and spouse or Statement from employer \_\_\_\_\_
  - B. Unemployed: Proof of Unemployment Income (if none, please explain) \_\_\_\_\_
  - C. Disability letter(most recent)-Must have proof if receiving benefits \_\_\_\_\_
  - D. Social Security income-Must have proof of amount deposited \_\_\_\_\_
  - E. Retirement/Pension-Must have proof of monthly income amount \_\_\_\_\_
  - F. Student Financial Aid letter-Itemized receipt from Financial Aid \_\_\_\_\_
  - G. Child Support \_\_\_\_\_
2. ENTIRE COPY OF MOST RECENT INCOME TAX RETURN FILED \_\_\_\_\_
3. BANK STATEMENTS-PREVIOUS 3 CONSECUTIVE MONTHS OF CHECKING/SAVINGS \_\_\_\_\_
4. COPY OF CURRENT ELECTRIC BILL SHOWING CURRENT ADDRESS – PLEASE EXPLAIN IF THE BILL IS IN SOMEONE ELSE’S NAME \_\_\_\_\_
5. DENIAL LETTER OF MEDICAID or Presumptive Eligibility Assessment: You must apply for Medicaid and if denied you must send a copy of your denial letter or a letter stating that you are not ELIGIBLE for Medicaid before your charity application will be processed. \_\_\_\_\_
6. DISABILITY: Have you applied for disability? Yes\_\_\_\_ No\_\_\_\_ If yes, you must provide a copy of your application or correspondence verifying that you have applied and status. \_\_\_\_\_
7. LETTER OF SUPPORT (see page 5) - If you have no means of income you must send a letter signed by whoever is supporting you financially. \_\_\_\_\_
8. PROPERTY OWNERSHIP – You must disclose all property owned \_\_\_\_\_

**IF ALL THE ABOVE REQUIRED INFORMATION IS NOT RECEIVED AND THERE IS NO EXPLANATION GIVEN, YOUR APPLICATION WILL BE DELAYED OR DENIED.**

**Additional information may be requested to process application.**

Please mail or bring information requested to:

North Mississippi Health Services  
Attn: Financial Assistance  
1494 Cliff Gookin Blvd  
Tupelo, MS 38801

Telephone: (662)377-3219

Information can be faxed to: (662)377-3318



# NORTH MISSISSIPPI HEALTH SERVICES

## APPLICATION FOR FINANCIAL ASSISTANCE

### PATIENT INFORMATION

Name \_\_\_\_\_ Social Security # \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Phone # Cell \_\_\_\_\_ Home \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 County \_\_\_\_\_ Marital Status \_\_\_\_\_  
 Employer (address & phone #) \_\_\_\_\_  
 Income (Gross) \_\_\_\_\_ Are you disabled \_\_\_\_\_ If so how long? \_\_\_\_\_  
 Have you applied for disability? \_\_\_\_\_ Nature of Disability \_\_\_\_\_  
 Can you return to work \_\_\_\_\_ Estimated Date of return \_\_\_\_\_  
 Name of insurance Company \_\_\_\_\_  
 Do you have Medicaid Coverage? \_\_\_\_\_ Have you applied for Medicaid? \_\_\_\_\_

### SPOUSE INFORMATION

Name \_\_\_\_\_ Social Security # \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Employer \_\_\_\_\_ Monthly Income (Gross) \_\_\_\_\_

### GUARANTOR INFORMATION (or responsible party)

Name \_\_\_\_\_ Relationship to patient \_\_\_\_\_  
 Address \_\_\_\_\_ Phone # \_\_\_\_\_  
 Social Security # \_\_\_\_\_ Date of birth \_\_\_\_\_  
 Guarantor employer \_\_\_\_\_ Income (Gross) \_\_\_\_\_

**Number of family members in household (If more space is needed you may attach a separate sheet)**

NAME (Last, First)	DATE OF BIRTH	RELATIONSHIP

### CREDIT REFERENCES

	Bank Name	Balance
Checking Account		
Savings Account		
IRA (Individual Retirement )		
Home Value\$		
Other Real Estate Value		

I hereby request financial assistance to be granted for services received at NMHS. I certify that the information given on this application is accurate and complete and may be used by NMHS to determine the amount, if any, of assistance to be granted. I understand that you will retain this statement in a confidential file for future reference. You are authorized to check my credit and employment history. I understand and agree that any false statement or misinformation will disqualify me from receiving financial assistance. **I agree to reimburse NMHS for any amount provided in financial assistance by NMHS if I later receive payment by a third party source for my illness or injury. I understand I have a duty to inform NMHS if I receive any payment by a third party source for my illness or injury. Failure to disclose third party sources of payment will result in loss of eligibility for financial assistance and a reversal of any financial assistance previously approved.**

Patient/Guarantor Signature \_\_\_\_\_ Date \_\_\_\_\_

Spouse Signature \_\_\_\_\_ Date \_\_\_\_\_

\*Parents/Legal Guardians are responsible for bills of patients under the age of 21 (minors) (or 19 if patient lives in Alabama) unless proof of emancipation is provided.



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**LETTER OF SUPPORT**

DATE \_\_\_\_\_

FINANCIAL NUMBER \_\_\_\_\_

DATES OF SERVICE \_\_\_\_\_

PATIENTS NAME \_\_\_\_\_

PHONE NUMBER \_\_\_\_\_

ADDRESS \_\_\_\_\_

\_\_\_\_\_

**Remainder of form to be completed by person paying living expenses or providing living assistance to patient.**

NAME: \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE#: Cell \_\_\_\_\_ Home \_\_\_\_\_

I \_\_\_\_\_ provide shelter and financial assistance to  
(Name of person assisting patient)

\_\_\_\_\_. I have provided assistance from \_\_\_\_\_  
(Name of patient) (Start date)

to \_\_\_\_\_.

**SIGNATURE** of person providing shelter and assistance:

\_\_\_\_\_

PLEASE FILL OUT THIS FORM AND RETURN WITHIN 14 BUSINESS DAYS TO:

**NORTH MISSISSIPPI HEALTH SERVICES  
ATTN: FINANCIAL ASSISTANCE  
1494 CLIFF GOOKIN BLVD  
TUPELO, MS 3880**