



***To apply for HOSPITAL financial assistance, please complete the following form and return it to the address below.***

Please include the following documentation. Failure to provide information 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 self prepare we will need ALL W2'S. If you did not file a return, call the IRS at 800-829-1040**
- 2. Last 4 payroll stubs for both spouses, for all jobs held, along with any other family members of the household with an applicable income for the current year. Pay 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. Signed Letter of Support if you live with someone who provides shelter and utilities.**
- 9. 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 you divorce decree.**

**All documentation must be provided before the application can be reviewed.**

If you have any questions please do not hesitate to contact Patient Financial Services at 573-258-8591.

Sincerely

Patient Financial Services  
Missouri Delta Medical Center  
1008 North Main  
Sikeston, MO 63801  
Phone: 573-258-8591  
Fax: 573-472-7178



# 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)

	<i>Total for 12 months</i>
_____ Wages	\$ _____
_____ Self-employment	\$ _____
_____ Public assistance	\$ _____
_____ Social Security	\$ _____
_____ Pensions	\$ _____
_____ Strike benefits	\$ _____
_____ Unemployment compensation	\$ _____
_____ Workers compensation	\$ _____
_____ Military family allotments	\$ _____
Income from :	
_____ Dividends	\$ _____
_____ Interest	\$ _____
_____ Rent	\$ _____
	<hr style="width: 100%;"/>
<i>Total annual income</i>	\$ _____

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: \_\_\_\_\_
Phone Bill \$ \_\_\_\_\_ 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