MISSOURI DELTA MEDICAL CENTER

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

Please be sure to include the following information listed below, if applicable.
Failure to provide information that applies to your situation could result in a delay of processing your application.

1. **Complete copies of last year's Federal Income Tax Forms including Schedule C if self-employed.**
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. Pay stub should 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. **Medicaid rejection or acceptance letter and a copy of the card.**
7. **Proof of any out of pocket prescription expense.**
8. **Statement reflecting amount of child support and food stamps received each month.**
9. **List any rental property, CD's/dividends you receive or own.**

<u>All applicable information is required before the application can be reviewed.</u>

If you have any questions please do not hesitate to contact a Patient Accounts Representative at one of the numbers listed below.

If your last name starts with A-H… call Pauline at 573.472.7144

If your last name starts with I-O….. call Tonya at 573.472.6059

If you last name start with P-Z……..call 573.472.7657

Sincerely

Patient Accounts Department
Missouri Delta Medical Center
1008 North Main
Sikeston, MO 63801
573.471.1600
Fax: 573.4727178

MISSOURI DELTA MEDICAL CENTER

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: _____ Husband _____Wife

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*