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 a Patient Financial Counselor at the numbers listed below.

Kimberly	573-472-7144 (A-H)	email: kikeller@missouridelta.com
Michelle	573.472.6059 (I-O)	email: mflanigan@missouridelta.com
Brenda	573.472.7657 (P-Z)	email: bbrandell@missouridelta.com

Sincerely

Patient Accounts Department
Missouri Delta Medical Center
1008 North Main
Sikeston, MO 63801
Fax: 573-472-7178

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)

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*