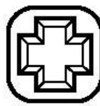


NORTH MISSISSIPPI
HEALTH SERVICES

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, Monroe 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.

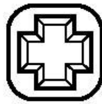
In order for us to complete your Charity Application, you will need to demonstrate to us that you are not entitled to any government program such as Medicaid or Medicare or have any health insurance or other insurance coverage. If we do not hear from you, we will continue to look to you to pay the balance of the account in full. Failure to respond within 120 days of your first bill for services will result in further collection activity up to and including assignment to an outside collection agency.

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



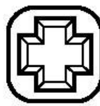
NORTH MISSISSIPPI
HEALTH SERVICES

2021 Federal Poverty Income Guidelines

Number of household members: Yearly Gross Income

1	2	3	4	5	6	7	8
12880	17420	21960	26500	31040	35580	40120	44660

For families/households with more than 8 persons, add $4,480 (annual) for each additional person.



NORTH MISSISSIPPI
HEALTH SERVICES

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 AS APPLICABLE
    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___________________

2. ENTIRE COPY OF LAST FILED INCOME TAX RETURN _______________________________

3. COPY OF MOST RECENT BANK STATEMENT ____________________________________

4. DENIAL LETTER OF MEDICAID (**Not applicable for males**) 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. _______________

5. 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. ___________________

6. 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.______________________________________

7. PROPERTY OWNERSHIP – You must disclose all property owned______________________

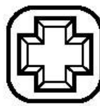
IF ALL THE ABOVE REQUIRED INFORMATION IS NOT RECEIVED AND THERE IS NO EXPLANATION GIVEN, YOUR APPLICATION WILL BE DELAYED OR DENIED.

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

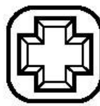
CREDIT REFERENCES	Bank Name	Balance
Checking Account		
Savings Account		
IRA (Individual Retirement)		
Home Value$		
Other Real Estate Value		

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.**



NORTH MISSISSIPPI
HEALTH SERVICES

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