TIPPAH COUNTY HOSPITAL
FINANCIAL SCREENING FOR CHARITY CARE

Please return completed form with proof of household income- such as check stub, w-2 form.

Proof of income must be obtained within 7 days or application is null and void.

PATIENT/GUARDIAN INFORMATION

Patient Name: _____ DOB: _____

Address: _____

_____ SS#: _____

_____

Telephone #: _____

ARE YOU CURRENTLY EMPLOYED? (Circle One) YES NO

NAME OF EMPLOYEER: _____

EMPLOYEER TELEPHONE NUMBER: _____

GROSS INCOME: $ _____ (Must show Proof of Income)

PAID: WEEKLY BI-WEEKLY MONTHLY **DEPENDENTS:** _____

(Circle One)

ADDITIONAL HOUSEHOLD CONTRIBUTORS INFORMATION

Name(s) of Contributor(s) to Household Income: _____

Relationship: _____ Income: $ _____

(Must show Proof of Income)

Employer: _____ Emp. Telephone: _____

GOVERNMENT ASSISTANCE

Social Security Income: $ _____ (must show proof)

Social Security Income Dependents: $ _____ (must show proof)

Supplemental Social Security Income: $ _____ (must show proof)

Food Stamps (Amount): $ _____ (must show proof)

POVERTY REPORT

HOUSING: RENT OWN BUYING PAID Monthly Payment: _____

(Circle One)

AUTOMOBILE: (Type and Year) _____ Monthly Payment: _____

FINANCIAL REFERENCES

Bank(s): $ _____ Checking Amt.:(s): $ _____

Savings Amt.: $ _____ Other: $ _____

ATTESTATION STATEMENT

I ATTEST THAT THE FINANCIAL INFORMATION PROVIDED ABOVE IS CORRECT. I understand that this information must be true and accurate to the best of my knowledge and that the Tippah County Hospital may take any reasonable action to verify it. If it proves to be untrue, the Tippah County Hospital may review my case again and take whatever action becomes suitable.

_____ _____ _____

Signature of Applicant Date Reviewed By: