SINGING RIVER
HEALTH SYSTEM

Date ______________ **APPLICATION FOR FINANCIAL ASSISTANCE** Account # ______________

Guarantor Name ____________________

Date of Birth ______________ Social Security # ______________

Address ______________ City/State ______________ Zip ______________

How Long at Current Residence: Years ______ Months ______ Home Phone ______________ Cell Phone ______________

Employer ______________ Phone ______________

Address ______________ City/State ______________ Zip ______________

Length of Employment: Years ______ Months ______ Length of Unemployment: Years ______ Months ______

Gross Pay: $ ______________ Per Week $ ______________ Per Month

SPOUSE INFORMATION

Spouse Name ____________________

Date of Birth ______________ Social Security # ______________

Spouse Employer ______________ Phone ______________

Address ______________ City/State ______________ Zip ______________

Length of Employment: Years ______ Months ______ Length of Unemployment: Years ______ Months ______

Gross Pay: $ ______________ Per Week $ ______________ Per Month

OTHER INCOME

VA Benefits: ________ Social Security: ________ Pensions: ________ Worker's Comp: ________ Unemployment: ________

Alimony: ________ Child Support: ________ Other: ______________

Amount: $ ______________ Per Week $ ______________ Per Month

LIST OF DEPENDENTS IN HOUSEHOLD

Name	Date of Birth	Name	Date of Birth

GUARANTOR BANKING INFORMATION

Checking Account: Bank/Credit Union ______________________________

Savings Account: Bank/Credit Union ______________________________

Other Bonds, CDs, etc: Source ______________________________

OUTSTANDING DEBT

(including hospitals, physicians, mortgages, charge accounts, installment contracts, credit cards, rent, etc.)

Creditor	Monthly Payment	Creditor	Monthly Payment

Total Combined Monthly Income: $ ______________ **Total Combined Monthly Expenses: $** ______________

I hereby certify the above information is true and correct. I understand any intentional false statements will be considered an attempt to commit fraud upon the Singing River Health System as a public institution of the State of Mississippi and may result in prosecution to the fullest extent allowed by law. Applicant must provide Singing River Health System with any and all information regarding possible third party coverage, to include but not limited to insurance, liability, worker compensation, voc-rehab or any other coverage resulting from the accounts included in this request for assistance. With the understanding that money received related to accounts included in this request will be due the hospital without regard to reduction.

Signature of Applicant ______________________________ Date ______________

Witness ______________________________ Date ______________

FOR HOSPITAL USE ONLY

Comments ______________________________

Approved ____________ Denied ____________ Singing River Health System Representative ______________________________