Singing River
Foundation

Patient Application for Assistance Instructions

Singing River Health System Foundation strives to make a difference by providing assistance with health related needs. If you are a patient of Singing River Health System and demonstrate a financial need for assistance, you are eligible to apply. However, **all other available resources** such as insurance, disability coverage, savings and local assistance programs should be used before applying for assistance from Singing River Foundation. Any assistance provided by the Foundation is generally limited to one recipient per household, and the level of any support that might be provided will be determined based on household income criteria.

Please complete the application in its ***entirety*** and ***provide documentation of the need*** for assistance. Incomplete applications will be returned.

Applications will be reviewed by the Singing River Foundation Board of Directors and Executive Director. ***Please allow 3-4 business days for a decision to be made.***

Email, mail, or fax the completed application to:

Singing River Foundation
3109 Bienville Blvd
Ocean Springs, MS 39564

Phone: (228) 818-4011
Fax: (228) 818-4014

SingingRiverFoundation@mysrhs.com

Singing River Foundation

Patient Application for:

○ *Durable Medical Equipment - DME* ○ *Medication Assistance*
○ *Emergency Assistance* ○ *Other* _____

Please print clearly.

Date Submitted:

Patient Name:

Amount Requested:

Patient Date of Birth:

Patient SSN:

Patient Address:
_____
_____

Spouse Name: *(include address, if different.)*
_____
_____

Patient Phone:
Work _____
Home _____
Cell _____

Spouse Phone:
Work _____
Home _____
Cell _____

Patient Employer: *(name and address.)*
_____
_____
Length of Employment _____ yrs. _____ mo.

Spouse Employer: *(name and address.)*
_____
_____
Length of Employment _____ yrs. _____ mo.

Income:
Patient Salary - Before deductions - $_____
○ hourly ○ weekly ○ bi-weekly ○ monthly ○ yearly
Patient Salary - after deductions - $_____

Spouse Salary - Before deductions - $_____
○ hourly ○ weekly ○ bi-weekly ○ monthly ○ yearly
Spouse Salary - after deductions - $_____

Other Income: *(social security, VA, workman's comp, retirement, child support, food stamps, disability, etc.)*
Source _____
Amount _____
Source _____
Amount _____
Source _____
Amount _____

Dependents:
Name _____ Age _____
Name _____ Age _____
Name _____ Age _____
Name _____ Age _____
Name _____ Age _____

Banking Information:
Checking Balance_____
Bank _____
Savings Balance
Bank _____
Other Balance _____
Source _____
Other Balance _____
Source _____
Other Balance _____
Source _____

Creditors:

Name	Monthly Pmt	Balance
_____	_____	_____
_____	_____	_____

Housing Expenses:
Own - mortgage payment $_____
Rent - monthly payment $_____

Other Monthly Expenses: Cable $_____
Utilities $_____ Food $_____
Clothing $_____ Vehicle $_____
Cell $_____ Misc $_____

Patient Height: _____ ft _____ in
Patient Weight: _____ lbs

Only for Durable Medical Equipment requests.

Total Combined Income _____
Total Combined Assets: _____
Total Combined Expenses _____

Have you ever received assistance from Singing River Health System Foundation before? ◯ yes ◯ no
If yes, when and how much? _____

Do you have health insurance? ◯ yes ◯ no

Have you applied for Medicaid? ◯ yes ◯ no Date applied: _____

Have you been denied Medicaid or disability? ◯ yes ◯ no

Description of Need: *Describe the assistance you're requesting and why it is needed in detail. Attach any relevant documentation that supports your need.*

I hereby certify, to the best of my knowledge and belief, the above information to be true and correct and give my permission for the Singing River Health System Foundation (Foundation) to verify this information, including accessing my health record and/or collaborating with Singing River Health System staff assisting with my care relative to this request for assistance. I understand any intentional false statements will be considered an attempt to commit fraud upon the Foundation and will result in denial of my request for assistance. Additionally, I authorize Singing River Health System to disclose any confidential and/or financial information to the Foundation and Foundation Board of Directors as it pertains to my request for assistance. I further authorize the Foundation to disclose any confidential and/or financial information to other community agencies or required persons/organizations to determine if I am eligible to receive assistance from such agency.

Signature of applicant: _____ **Date:**_____

Witness: _____ **Date:**_____

FOR FOUNDATION USE ONLY

Date: ◯ **Approved** ◯ **Denied**

Comments:

Signature: