Singing River

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

Guarantor Name _____

Date of Birth _____ Social Security # _____

Address _____ City/State _____ Zip _____ County _____

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 _____