FRANKLIN COUNTY MEMORIAL HOSPITAL
P.O.BOX 636
MEADVILLE, MS 39653
APPLICATION FOR ASSISTANCE

NAME: ____
Last First Middle

ADDRESS: ____
Street City, State Zip Code

____
Social Security Number Home Phone Employer

	Last 12 Months	**Last 3 Months**	**Family Size**
Patient's Gross Income	__________________	_______________	____________
Other Family Income	__________________	_______________	____________
Total Family Income	_____________________	_______________	____________

Type and Date of Service Rendered/Requested ______________________________________

I certify that the above information is true and to the best of my knowledge. If any information I have given proves to be untrue, I understand that the hospital may re-evaluate my financial status and take whatever action becomes appropriate.

Date of request: ___________________ Applicant Signature______________________________

ELIGIBILITY DETERMINATION (Office use only)

Date Application Received: ___________________________

Income Verified: ____YES _______NO

Type of Verification: ____

______ Applicant Approved _______Conditionally Approved

Amount provided as uncompensated services is __________. Condition(s) if applicable:

____The applicant's request for free or reduced charge services has been denied for the following reasons:
____

Date of Conditional Determination: ____

Date of Final Determination: ____

Date Applicant Notified: ____

Approved By: ____

LIST EACH MEMBER OF HOUSEHOLD

NAME	AGE	SS#	INCOME	EMPLOYER

Please Provide Documentation of Income

Documents may include at least one of the following; last year's tax forms or last three check stubs, or last three bank statements showing direct deposit.

Include all monies received from Welfare, Food Stamps, SSL, Child Support, etc.

ELIGIBILITY DETERMINATION (Office use only)

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AUTHORIZATION OF BENEFIT INFORMATION

By my signature below, I am authorizing ____

County DHS to release my AFDC, FOOD STAMP, OR MEDICAID benefits to me. The use of this information is left at by discretion.

______________________________	______________________________
Franklin County Memorial Hospital P.O. Box 636 Meadville, MS 39653	Signature
	______________________________ Date
	______________________________ CASE #

TO WHOM IT MAY CONCERN:

By the signature above, our client has authorized us to release the following benefits that are issued by this Agency:

AFDC CHECK________________________________

C S SUPPLEMENT ___________________________

C S DISREGARD_____________________________

F S ALLOTMENTS# __________________________

MEDICAID # ______________________________	______________________________ CHILD'S NAME
______________________________	______________________________ CHILD'S NAME
______________________________	______________________________ CHILD'S NAME
______________________________	______________________________ CHILD'S NAME
______________________________	______________________________ CHILD'S NAME

______________________________	______________________________
COUNTY DIRECTOR	DATE