Financial Assistance Application Cover Letter

Dear Patient,

This application will be used to determine if you qualify for financial assistance at the University of Mississippi Medical Center.

In addition to completing the financial assistance application, the following documentation is also required to verify your eligibility. Please mail in your application along with your supporting documentation.

Proof of Identity:

☐ A state or federally issued identification: driver's license, state ID, or passport

Proof of Income- Any of the following that applies.

☐ IRS 1040 or 1099 – same year
☐ Proof of employment – most recent check stub
☐ Unemployment compensation
☐ Worker's compensation
☐ Social Security or Supplemental Security Income
☐ Alimony and/or child support
☐ Public assistance
☐ Veteran's payments
☐ Survivor's benefits
☐ Pension / retirement benefits
☐ Interest, dividends, rents, royalties, estates, and/or trust
☐ Educational assistance
☐ Any assistance from outside the household and other miscellaneous sources

If you have not filed a federal tax return, please send the following:

☐ IRS Non-filing Letter – To obtain an IRS Non-filing letter contact the IRS at 1-800-829-1040 or visit www.irs.gov.

Proof of Residency:

☐ Lease agreement or utility bill
☐ Voter's registration card

Other Information:

☐ Divorce decree - If divorce date is after date of the submitted tax return
☐ Notarized marital letter of separation - if within the last 12 months
☐ Proof of third-party coverage exhaustion – auto accident or worker's compensation

Submission Information:
You have 30 days to submit your completed application with the requested documentation. If the information is not received within 30 days from the date on the completed application, the application will be denied.

Your deadline is: 30-Days from the date of the application

Mail application to:
If you are receiving services from the University of Mississippi- Main Hospital and Ambulatory Clinics, mail your application and documentation to the below address:

University of Mississippi Medical Center
Health Care Benefit Coordinators
2500 North State Street
Jackson, MS 39216-4505

Deliver in person:
University Hospital (main hospital)
Health Care Benefit Office, Room H144
2500 North State Street
Jackson, MS 39215

UMMC – Cancer Center
Jackson Medical Mall
250 W. Woodrow Wilson Drive, Suite 600
Jackson, MS 39216

For assistance dial: 601-815-9430

If you are receiving services at the University of Mississippi Medical Center - Holmes County, mail or deliver your application and documentation to the below address:

University of Mississippi Medical Center-Holmes County
239 Bowling Green Rd
Lexington, MS 39095

If you have questions, call 662-834-1321

If you are receiving services at the University of Mississippi Medical Center - Grenada, mail or deliver your application and documentation to the below address:

University of Mississippi Medical Center – Grenada
960 JK Avent Drive
Grenada, MS 38901

If you have questions, call 662-227-7160

You will receive written notification of your eligibility within 15 days of UMMC receiving your completed application and documentation.

If English is not your first language, a translated version of the financial assistance application is available upon request. Contact 601-815-9340.

THE UNIVERSITY OF MISSISSIPPI MEDICAL CENTER™

2500 North State Street
Jackson, Mississippi 39216
umc.edu | 601.984.1000

APPLICATION FOR FINANCIAL ASSISTANCE

First Name | Middle | Last | Suffix

Medical R | Account #, if known | Social Security # | Gender: Male Female

Date of birth | Preferred language | Email

Home/ Cell Phone # | Work Phone# | If no phone - alternate # for contact | Relationship to patient

Patient's current living arrangement: Own Rent Lives with Others Homeless

Home address | City

State | Zip | County

Mailing address, if different | City

State | Zip | County

Marital status: Married Single Divorced Separated Widowed

US Citizen? ---------- Yes No

If no, what is immigration status

Does patient have children under age 21 living in their home? ---------- Yes No

Is patient between the ages of 19-26 and currently in school? ---------- Yes No

Will patient file taxes this year? ---------- Yes No

Will patient's spouse file taxes this year? ---------- Yes No

Will patient file taxes jointly with spouse? ---------- Yes No

Will patient claim anyone as a tax dependent? ---------- Yes No

APPLICATION FOR FINANCIAL ASSISTANCE

COVERAGES

Does the patient have health insurance? Yes No

Insurance company

Insurance Policy number

Is patient covered by Medicaid? Yes No

Medicaid #

Is patient covered by our Financial Assistance Program? Yes No

Is patient pregnant? Yes No

If Yes, # children expected:

Est. due date:

Has the patient been diagnosed with breast or cervical cancer? Yes No

Diagnosing hospital or clinic

Was patient formerly in foster care? Yes No

Has physician determined patient to be disabled? Yes No

List medical conditions including current

Is patient a veteran? Yes No

Was patient referred by Dept. of Veterans Administration? Yes No

Auth #

Is patient's reason for requesting financial assistance related to the following?

Was patient involved in auto accident? Yes No

Is liability coverage available? Yes No

Was patient involved in job-site related injury? Yes No

Worker's compensation coverage? Yes No

Was patient a victim in of a violent crime? Yes No

If Yes, has patient filed charges? Yes No

HOUSEHOLD INFORMATION (additional pages may be attached if necessary)

First name	Last name	DOB	SSN	Gender	Relationship to patient	US CITIZEN	Pregnant	Is this person in patient's household >6 mo. Of year?	Is patient financially responsible for this person?	Will this person claim patient on their taxes?

APPLICATION FOR FINANCIAL ASSISTANCE

INCOME INFORMATION (additional pages may be attached if necessary)

Household member name	Currently employed	Employer name	Income type	Pay frequency	Gross pymt amount

GOVERNMENT ASSISTANCE PROGRAMS (indicate which programs you are enrolled in)

None SNAP WIC SSI SSDI CHIP Medicaid Medicare

Has patient applied for SSI or SSDI?-- Yes No

If yes is the SSI/ SSDI active?-- Yes No

Is the patient's SSI/ SSDI case being managed by an attorney?-- Yes No

Attorney name

Attorney Phone #

ADDITIONAL CONTACT INFORMATION

Is patient the responsible party?.. Yes No

If No, what is name of responsible Party

Responsible Party Phone #

Relationship to patient

Emergency contact name

Emergency contact phone #

Relationship to patient

APPLICATION FOR FINANCIAL ASSISTANCE

* This **FINANCIAL ASSISTANCE PROGRAM** covers medically related charges necessary for hospital and physician services.

Not all services are covered under the financial assistance program. If you have any questions, please call (601) 815-9430

*Elective or experimental procedures may not be covered.

* Failure to complete required application processes for Medicaid or other available funding sources if applicable, may result in a denial of financial assistance. If that occurs, patient will be responsible for all charges.

If supplemental information is requested you will have an additional 15 days to submit information.

* You will receive written notification of your eligibility for our financial assistance program within 15 days of receiving your completed application and documentation.

*This financial assistance application must be completed and returned no later than 30 days from mailing or the application will be denied for non-compliance.

SIGNATURE OF PATIENT / APPLICANT OR GUARANTOR

I authorize applications to be submitted on my behalf, for Medicaid and/or any other type of potential coverage available to me, based upon the information provided on this application.

I understand the processing of such applications may require that additional information be provided to state or federal agencies, regarding my past or present eligibility for government programs.

I authorize any person, employer, financial institution, or credit reporting agency with records regarding any of the requested information on the application to release this information.

I understand that should this request for financial assistance be denied for any reason, I will be fully responsible for financial obligations arising from hospital and physician services.

I hereby certify that I have read and understood the above statements. The information contained in this application is true, correct, and complete.

I understand that legal action may be taken against me if any information provided on the application has been knowingly falsified.

Signature of patient/applicant or responsible party/guarantor (r i d) Date

Printed Name Relationship to patient Contact Phone #

** Please note that all private medical information contained herein is treated confidentially as required by state and federal law