NORTH MISSISSIPPI HEALTH SERVICES

Date:

To:

Account #:

Dear Patient,
Enclosed you will find an application for financial assistance. Please complete all information and mail back to us **within 14 days** along with **all the requested supporting documentation (see page 3)**. **Applications received without supporting documents will result in delay or denial.** You may use the enclosed postage paid envelope for returning your application to us.

North Mississippi Health Services will review your application to see if any assistance can be given on your hospital and/or related clinic charges. If you have any questions about this application, please contact us at 662-377-3219.

We want to help you! You need to help us by providing as much information as possible. We understand most people cannot pay a large healthcare balance. In order for us to forgive all or part of your balance, we need your cooperation!

If we do not hear from you, we will continue to look to you to pay the balance of the account in full. Failure to respond within 14 days of your first bill for services will result in further collection activity up to and including assignment to an outside collection agency.

In the State of Mississippi, a person under the age of 21 is considered a minor, therefore the parents / legal guardians must fill out the application using their financial information, except for emancipated minors who are married and/or self-supporting. For Alabama residents a person under the age of 19 is considered a minor.

The enclosed income guidelines, along with other information you provide, will be used to make the charity determination. A patient will be considered for financial assistance if their household income does not exceed the attached guideline. However, if under extraordinary circumstances, income exceeds these guidelines partial assistance may still be granted at the sole discretion of North Mississippi Health Services.

Sincerely,
Financial Assistance Department
North Mississippi Health Services

NORTH MISSISSIPPI HEALTH SERVICES

2025 Federal Poverty Income Guidelines

Number of household members: Yearly Gross Income

1	2	3	4	5	6	7	8
23475	31725	39975	48225	56475	64725	72975	81225

For families/households with more than 8 persons, add $8,250 (annual) for each additional person.

NORTH MISSISSIPPI HEALTH SERVICES

SUPPORTING DOCUMENTATION REQUEST & CHECKLIST

We ask that you provide **copies** of the following requested information within 14 days or contact NMHS Business office if more time is needed. Please use this as a checklist of items we need. Please complete each line whether it applies or not so that your charity application can be processed timely. If you are under the age of 21 (a minor) (or 19 if you live in Alabama), information should be provided by Parents/Legal Guardians. You will be informed by letter once your application is approved or denied.

1. ALL SOURCES OF MONTHLY INCOME FOR PATIENT AND/OR SPOUSE AS APPLICABLE •
   Employed: Two, consecutive current pay stubs-both patient and spouse or Statement from employer _____
   - Unemployed: Proof of Unemployment Income (if none, please explain) _____
     _____
   - Disability letter(most recent)-Must have proof if receiving benefits _____
   - Social Security income-Must have proof of amount deposited _____
   - Retirement/Pension-Must have proof of monthly income amount _____

2. Payment App Statements (CashApp, PayPal, Venmo, Zelle, etc) _____

3. ENTIRE COPY OF LAST FILED INCOME TAX RETURN _____

4. COPY OF MOST RECENT BANK STATEMENT _____

5. MEDICAID:
   - Have you applied for Medicaid? Yes____ No____
   - Would you like assistance in applying for Medicaid? Yes____ No____

6. DISABILITY: Have you applied for disability? Yes____ No____ If yes, you must provide a copy of your application or correspondence dated within the last year verifying that you have applied and the status.

7. LETTER OF SUPPORT (see page 5) - If you have no means of income, you must send a letter signed by whoever is supporting you financially. _____

8. Property Ownership: Do you own property? Yes____ No____

IF ALL THE ABOVE REQUIRED INFORMATION IS NOT RECEIVED, YOUR APPLICATION MAY BE DELAYED OR DENIED.

Additional information may be requested to process application.

Please mail or bring information requested to:

North Mississippi Health Services
Attn: Financial Assistance
1494 Cliff Gookin Blvd
Tupelo, MS 38801

Telephone: (662)377-3219
Information can be faxed to: (662)377-3318
Information can be emailed to: financialassist@nmhs.net

NORTH MISSISSIPPI HEALTH SERVICES

APPLICATION FOR FINANCIAL ASSISTANCE

PATIENT INFORMATION

Name _____ Social Security #_____
Date of Birth _____ Phone # Cell _____ Home_____
Address_____City_____State_____Zip_____
County_____ Marital Status _____
Employer (Name, Address, & Phone#) _____
_____
Income (Gross) _____ Are you disabled_____ If so how long? _____
Have you applied for disability? _____
Can you return to work_____ Estimated Date of return _____
Name of insurance Company _____
Do you have Medicaid Coverage? _____ Have you applied for Medicaid? _____

SPOUSE INFORMATION

Name_____ Social Security #_____
Date of Birth_____ Employer_____ Monthly Income (Gross) _____

GUARANTOR INFORMATION (or responsible party)

Name _____Relationship to patient _____
Address _____Phone # _____
Social Security #_____ Date of birth _____
Guarantor employer _____ Income (Gross) _____

Number of family members in household (If more space is needed you may attach a separate sheet**)**

NAME (Last, First)	DATE OF BIRTH	RELATIONSHIP

CREDIT REFERENCES	Bank Name	Balance
Checking Account		
Savings Account		

I hereby request financial assistance to be granted for services received at NMHS. I certify that the information given on this application is accurate and complete and may be used by NMHS to determine the amount, if any, of assistance to be granted. I understand that you will retain this statement in a confidential file for future reference. You are authorized to check my credit and employment history. I understand and agree that any false statement or misinformation will disqualify me from receiving financial assistance. **I agree to reimburse NMHS for any amount provided in financial assistance by NMHS if I later receive payment by a thirdparty source for my illness or injury. I understand I have a duty to inform NMHS if I receive any payment by a third-party source for my illness or injury. Failure to disclose third party sources of payment will result in loss of eligibility for financial assistance and a reversal of any financial assistance previously approved.**

Patient/Guarantor Signature _____Date_____
Spouse Signature_____Date_____

Parents/Legal Guardians are responsible for bills of patients under the age of 21 (minors) (or 19 if patient lives in Alabama) unless proof of emancipation is provided.

NORTH MISSISSIPPI HEALTH SERVICES

LETTER OF SUPPORT

DATE_____

FINANCIAL NUMBER _____ DATES OF SERVICE _____

PATIENTS NAME _____ PHONE NUMBER _____

ADDRESS _____

_____

Remainder of form to be completed by person paying living expenses or providing living assistance to patient.

NAME: _____ RELATIONSHIP _____

ADDRESS: _____

PHONE#: Cell _____ Home _____

I_____ provide shelter and financial assistance to
(Name of person assisting patient)
_____. I have provided assistance from _____
(Name of patient) (Start date)

to _____.

SIGNATURE of person providing shelter and assistance:

_____

PLEASE FILL OUT THIS FORM AND RETURN WITHIN 14 BUSINESS DAYS TO:

NORTH MISSISSIPPI HEALTH SERVICES
ATTN: FINANCIAL ASSISTANCE
1494 CLIFF GOOKIN BLVD
TUPELO, MS 38801