FIELD HEALTH SYSTEM
Hospital and Rural Health Clinics
Financial Hardship Program

Dear Applicant:

It shall be the policy of Field Memorial Community Hospital that patients seeking medical services that can be provided by our Hospital and/or clinics shall not be denied access to those services based solely on an inability to pay. Discounts are offered to the underinsured and uninsured solely based on family size and annual income.

Please complete the following application and return to the front desk to determine the level of eligibility for discounted services.

This form must be completed anytime that your financial situation changes due to more or less people living in the household or income increases or decreases.

When applying for financial assistance we must have the following information:

- Income Documentation on all household income, (Employment check stub(s), SSI check and or Interest income, Royalties, rent and Child support documentation.
- Names of all household members with age

Completed application must be returned within fifteen (15) days to Field Health System or one of the following clinics: Catchings, Centreville, Gloster, Liberty, and Field Specialty Clinic. All applications not completed with the necessary information will be returned to the applicant.

Financial Counselor
(601) 890-0500

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APPLICANT INFORMATION

Name					
Address					
City		**State**		**Zip**	
Phone		**Phone (2nd)**			

List all persons living within the household including Applicant

Name	Date of Birth	Relationship	

EMPLOYMENT / INCOME

All Members of Household

Employer Name / Type of Work	$ per Wk/Mon	$ Received	$ per Year

Other Income / Assistance

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Source	$ Amount			
	Applicant	**Spouse**	**Child**	**Other**
Social Security				
SSI				
VA / Pension				
Retirement				
Rentals				
Other				

I declare that the answers I have given are true and correct to the best of my knowledge.
I understand that my statements and eligibility may be subject to verification.
I understand that if I DO NOT qualify, I am responsible for the full amount of charges.

Patient/Guarantor: _____ Date: _____