SINGING RIVER HEALTH SYSTEM FOUNDATION

Application for Assistance Instructions

Singing River Health System Foundation strives to make a difference by providing assistance with healthcare related needs. If you are a patient of Singing River Health System and demonstrate a financial need for assistance, you are eligible to apply. However, **all other available resources** such as insurance, disability coverage, savings and local assistance programs should be used before applying for assistance from Singing River Health System Foundation. Any assistance provided by the Foundation is usually limited to one recipient per household, and the level of any support that might be provided will be determined based on household income criteria.

Please complete the application in its entirety and provide any documentation of the need for assistance. Incomplete applications will be returned.

The application will be reviewed by the Singing River Health System Foundation Executive Director and the Singing River Health System Foundation Board of Directors as soon as possible. Once a decision has been made for approval or disapproval you will be notified. Please allow 3-4 business days for a decision to be made.

Email, mail, or fax the completed application to:

Laura Sessum
Executive Director
Singing River Health System Foundation
3109 Bienville Blvd, Ocean Springs, MS 39564
Phone: 228.818.4011
Fax: 228.818.4014
Laura.Sessum@mysrhs.com

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Patient Application for

- ○ ***Durable Medical Equipment - DME***
- ○ ***Emergency Assistance***
- ○ ***Medication Assistance***
- ○ ***Other*** _____

Please print clearly.

Date Submitted:

Patient Name:

Amount Requested:

Patient Date of Birth:

Patient SSN:

Patient Address:

_____

_____

Spouse Name: (include address, if different)

_____

_____

Patient Phone:

Work _____

Home _____

Cell _____

Spouse Phone:

Work _____

Home _____

Cell _____

Patient Employer: (name and address)

_____

_____

Length of Employment _____ yrs. _____ mo.

Spouse Employer: (name and address)

_____

_____

Length of Employment _____ yrs. _____ mo.

Income:

Patient Salary - before deductions - $_____

○ hourly ○ weekly ○ bi-weekly ○ monthly ○ yearly

Patient Salary - after deductions - $_____

Spouse Salary - before deductions - $_____

○ hourly ○ weekly ○ bi-weekly ○ monthly ○ yearly

Spouse Salary - after deductions - $_____

Other Income: (social security, VA, workman's comp, retirement, child support, food stamps, disability, etc.)

Source _____

Amount _____

Source _____

Amount _____

Source _____

Amount _____

Dependents:

Name _____ Age _____

Name _____ Age _____

Name _____ Age _____

Name _____ Age _____

Name _____ Age _____

Banking Information:

Checking Balance _____

Bank _____

Savings Balance _____

Bank _____

Other Balance _____

Source _____

Other Balance _____

Source _____

Creditors:

Name	Monthly Pmt	Balance

Housing Expenses:

Own - mortgage payment $_____

Rent - monthly payment $_____

Other Monthly Expenses: Cable $_____

Utilities $_____ Food $_____

Clothing $_____ Vehicle $_____

Cell $_____ Misc $_____

Patient Height: ____ ft ____ in

Patient Weight: _____ lbs

Only for Durable Medical Equipment requests.

Total Combined Income: _____

Total Combined Assets: _____

Total Combined Expenses: _____

Have you ever received assistance from Singing River Health System Foundation before? ○ yes ○ no

If yes, when and how much? _____

Do you have health insurance? ○ yes ○ no

Have you applied for Medicaid? ○ yes ○ no Date applied: _____

Have you been denied Medicaid or disability? ○ yes ○ no

Description of Need - Please describe your emergency and/or equipment needed in detail and include any supporting documentation. Continue on a separate sheet if necessary.

I hereby certify, to the best of my knowledge and belief, the above information to be true and correct and give my permission for the Singing River Health System Foundation to verify this information. I understand any intentional false statements will be considered an attempt to commit fraud upon the Singing River Health System Foundation and may result in denial of my request for assistance. Additionally, I authorize Singing River Health System Foundation to disclose any confidential and/or financial information to the Singing River Health System Foundation Board of Directors as it pertains to the above request for assistance. I further authorize the Singing River System Health Foundation to disclose any confidential and/or financial information to other community agencies (i.e. Red Cross, United Way) or required persons or organizations to determine if I am eligible to receive assistance from such agency.

Signature of applicant: _____ Date: _____

Witness: _____ Date: _____

FOR FOUNDATION USE ONLY

Date: ○ Approved ○ Denied

Comments:

Signature: