Greenwood Leflore Hospital
www.glh.org

P.O. Box 1410
Greenwood, MS
38930-1410
662-459-7000

GREENWOOD LEFLORE HOSPITAL
GREENWOOD, MS
FINANCIAL ASSISTANCE APPLICATION
DATE OF REQUEST: ________________

As provided for in Federal Law, I hereby request that Greenwood Leflore Hospital make written determination of my eligibility for financial assistance. I understand that the information that I submit concerning my annual income and family size is subject to verification by Greenwood Leflore Hospital. I also understand that if the information I submit is determined to be false, such a determination will result in denial of financial assistance.

Name:____
First Middle Last

Address:____
Number and Street City State Zip

Employer:_______________________________________ Telephone:____________________

Income: List Cash Income From:

	Total for Last 3 months	Total for Last 12 months
Wages	________	________
Self-Employment	________	________
Public Assistance	________	________
Unemployment Assistance	________	________
Worker's Compensation	________	________
Alimony	________	________
Pensions	________	________
Child Support	________	________
Income from Dividends, Interest	________	________
Rent paid to you	________	________

Number of Dependents: Count those for which you provide more than one half support. If you have been confirmed as pregnant, then the unborn child should be counted.

Name	Date of Birth and Social Security Number**	
1. ______________________________	_____/_____/_____	______-_____-______
2. ______________________________	_____/_____/_____	______-_____-______
3. ______________________________	_____/_____/_____	______-_____-______
4. ______________________________	_____/_____/_____	______-_____-______

*****Please provide date of birth and social security numbers for each person in household!*****

Residency: I am a resident of ________________ County, Mississippi. Please provide one of the following forms of proof of residency:

1. County property tax assessment statement;
2. Utility bill showing current county address;
3. Rent receipt(s) showing evidence of county of residence;
4. County food stamp letter;
5. Voter registration card; or
6. Valid Mississippi driver's license.

Medicaid Eligibility: I have applied for and been denied Medicaid coverage. _____ Yes or _____ No. If "yes," please provide a copy of the Medicaid coverage denial. If "no," you must first apply for Medicaid coverage. Failure to provide a copy of the Medicaid coverage denial is grounds for disqualification under the Hospital's financial assistance policy.

Declaration:

I declare that the answers I have given are true and correct to the best of my knowledge.

I understand that I may be asked to prove my statements and that my eligibility statements will be subject to verification by contact with employer, bank, credit report, etc.

I understand that if I do not qualify based on the information provided, I would be expected to pay the full amount of services rendered.

I further agree that in consideration for receiving health care services as a result of an accident or injury, I will reimburse Greenwood Leflore Hospital from the proceeds of any litigation or settlement resulting from such act.

Patient/Guarantor ____________________________________ Date __________________________

Attachments:

Please submit ALL that apply to this application:

- Copy of a valid government issued picture ID
- Current Paystubs
- Previous year tax return
- Forms approving or denying unemployment compensation or workers compensation
- Written verification from public welfare agency or other governmental agency attesting to patient income status
    - Food Stamps
    - Housing
    - Welfare cash benefit
- Written verification that patient is disabled
- Medicaid coverage denial confirmation