FRANKLIN COUNTY MEMORIAL HOSPITAL
FAMILY MEDICAL GROUP
FAMILY MEDICAL GROUP OF BUDE
P.O.BOX 636
MEADVILLE, MS 39653
APPLICATION FOR ASSISTANCE

It is the policy of Franklin County Memorial Hospital, Family Medical Group, and Family Medical Group of Bude to provide essential services regardless of the patient's ability to pay. All our facilities offer discounts based on family size and annual income.

Please complete the following information and return to the front desk to determine if you or members of your family are eligible for a discount.

The discount will apply to all services received at our facilities, but not those services or equipment purchased from outside, including reference laboratory testing, drugs, X-ray interpretation by a consulting radiologist, and other such services. You must complete this form every 12 months or if your financial situation changes.

NAME: _____
Last First Middle

ADDRESS: _____
Street City, State Zip Code

_____
Date of Birth Home Phone

Please list all household members, including those under age 18.

	NAME	DATE OF BIRTH
SELF		
OTHER		
OTHER		
OTHER		
OTHER		
OTHER		

Revised 12/06/22

Please list yearly household income amounts.

SOURCE	SELF	OTHER	TOTAL
Gross wages, salaries, tips, etc.			
Unemployment compensation, worker's compensation, Social Security, Supplemental Security Income, Veteran's payments, survivor benefit, pension, or retirement income			
Interest, dividends, royalties, income from rental property, estates, trusts, alimony, child support, assistance from outside the household			
Other Miscellaneous Sources			
Total Income			

I certify that the family size and income information shown above is correct.

Date of request: _____ Applicant Signature_____

Along with this completed application, please provide identification and documentation of proof of income for each household member.

Proof of identification include:
Driver's license
Utility bill
Employment ID

Proof of income includes at least one of the following:
last year's tax return
last three check stubs
other

ELIGIBILITY DETERMINATION (Office use only)

Date Application Received: _____

Income Verified: ____YES _____NO

Type of Verification utilized: _____

_____ Applicant Approved _____Conditionally Approved

Discount _____% Valid date _____ Through _____

_____ The applicant's request for reduced account balances has been denied for the following reasons:

_____

Date of Conditional Determination_____

Date of Final Determination: _____

Date Applicant Notified: _____

Approved By: _____