Financial Assistance Application

PLEASE COMPLETE AND RETURN TO mdavis@mmrcrehab.org OR FAX TO (601) 364-3312

In order for patient to be approved as a Financial Assistance, the patient or family member must arrange for a meeting with Financial Counselor prior to admission, and submit completed application and supporting documentation at that time.

Patient's Name: ____________________ Current Hospital: ____________ Date of Accident: _______________

Age and DOB: ______________________________ Social Security #: _________________________________

Person Giving information: __________________ Relationship: _______________ Phone#: ________________

Diagnosis: ____________________________________

1. Details of the injury or accident: ____
   A. Where drugs or alcohol involved? ____
   B. Was an illegal act/crime being committed at time of the injury/accident? _________________________
2. Annual Income $________________ Number of Dependents in your household that pt. is financially responsible for: ____________ (Please Provide supporting documentation of your income, i.e. prior year tax return, W2, pay stub, bank statement, etc.)
3. Do you own a home? ___Yes ____No ____ I rent — Monthly Payments: _____________________
4. Do you own a vehicle? ____Yes ____No — Make and Year: ________________________
   Payment Monthly: _____________________
5. Do you have monthly bills such as:
   Electric: $_____________________________
   Phone: ____________________________
   Child Support: _______________________
6. Do you have any outstanding loans?
   Company: ____________________________
   Item: ______________________________
   Payment: ___________________________
7. Do You Have any other assets? ____Yes _______No----If so list_______________________________________
8. What are your discharge Plans? ____
   a. Where will you live and with whom? ____
9. Do you have **good family support**? ____Yes _____No
10. Who will be available for **family teaching and education**: ____
11. Are you a Mississippi Resident? ____
12. Are you employed? ______Yes _____No
    a. With whom: ____ how long? __________________________
    b. If no, how long have you been unemployed? ____ _____
13. Have you applied for **SSI Disability/Medicaid**: _______Yes _______No
    a. Date applied __________________
    b. Appointment pending for: __________________________

Signature: ____ Date: __________________________