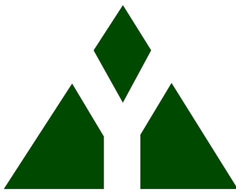

Yalobusha Health Services
CHARITY APPLICATION

630 S Main St.,
P.O. Box 728,
Water Valley, MS 38965
Phone: 662-473-5257
Fax #: 662-473-4922

Patient Name: ______________________ DOB: ______________ Date: ______________

Permanent Address: ______________________ City: ______________ ZIP: ______________

State: ______________________ Hm Phone: ______________ Wk Phone: ______________

Mailing Address if Different:

Address: ______________________ City: ______________

State: ______________________ ZIP: ______________

All patients seeking health care services at Yalobusha Health Services are assured that they will be served regardless of ability to pay. No one is refused service because of lack of financial means to pay. This program is designed to provide discounted care to those who have no means, or limited means, to pay for their medical services (uninsured or underinsured). Yalobusha Health Services will base program eligibility on a person's ability to pay and will not discriminate on the basis of an individual's race, color, sex, national origin, disability, religion, age, sexual orientation, or gender identity. The Federal Poverty Guidelines are used to create the sliding fee schedule (SFS) to determine eligibility.

For the following table, please list the patient and all family members living in the same household as the patient (family unit). A family unit a group of two people or more (one of whom is the householder) related by birth, marriage, or adoption and residing together; all such people (including related subfamily members) are considered as members of one family. Non-related household members are included when calculating family size.

Income includes: gross wages; salaries; tips; income from business and self-employment; unemployment compensation; workers' compensation; Social Security; Supplemental Security Income; veterans' payments; survivor benefits; pension or retirement income; interest; dividends; royalties; income from rental properties, estates, and trusts; alimony; child support; assistance from outside the household; and other miscellaneous sources.

Family Member (Name)	Relationship to Patient	Age	Source of Income	Last Three Months Pay Stubs	Income for 12 Months Tax Return
Total Family Members			Total Income		

Your application cannot be processed unless you provide the following documents to support each source of income listed above.

- **Pay stubs for the last three months**
- **W2 Form for the previous year**
- **Legal documents/Child Support**
- **Income Tax return for the previous year**
- **Federal & State Assistance Documents**
- **Pension/retirement statements**

Please return this application and the requested information to the Business Office where services were received.

I certify that the information provided is true and accurate to the best of my knowledge.

______________________________ ______________________________
Signature of Patient, or Person Authorized to Sign for Patient **Relationship to Patient**

______________ **Location of Service** ______________________
Date

FOR PROVIDER USE ONLY

Account Number ______________________ Date of Service ______________

Effective Date ______________________ Expiration Date ______________

Date Received ______________ Received by ______________

Date Processed ______________ Processed by ______________

Patient is eligible for:		Patient Responsibility
	Plan 1	$15
	Plan 2	20%
	Plan 3	40%
	Plan 4	60%
	Plan 5	80%

Form #1.3 (12/22) System Insurance: