St. Dominic-Jackson Memorial Hospital
Jackson, Mississippi

APPLICATION FOR FINANCIAL AID

Patient's Name: ______________________________ Account # ______________
Last First Middle

Head of Household ______________________________
Last First Middle

Current Address ______________________________
City State Zip

Phone Numbers: Home: ______________ Alternate Phone: ______________ Work: ______________

Employer's Name & Address ______________________________
City State Zip

Spouse's Name ______________________________ Spouse's SS# ______________
Last First Middle

Spouse's Employer ______________________________ Employer's Phone ______________

Employer's Address ______________________________
City State Zip

Are you currently eligible or have any insurance coverage (ie. commercial, medicare, medicaid)? ☐ Yes ☐ No

If answered yes, please list all: ______________________________

List all Household Family Members including Yourself and Spouse

	Name (Last, First, Middle)	Date of Birth	Relationship
1)			
2)			
3)			
4)			
5)			
6)			
7)			

List all Gross Income for previous 12 months (including all family members)

WAGES	Head of Household	______________
(by employment or self employment)	Spouse	______________
SOCIAL SECURITY	Head of Household	______________
	Spouse	______________
	Children	______________
NON WAGE INCOME	Other	______________
	Alimony	______________
	Child Support	______________
	Military Allotments	______________
	Pension/Dividends	______________
	Other Income	______________
	TOTAL INCOME	______________

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I certify that the above information is true and accurate to the best of my knowledge. As part of this application process, St. Dominic-Jackson Memorial Hospital may verify information contained in my application and of other documents required in connection with the application either before the application is approved or as part of its quality control program. Further, I will make application for any assistance (Medicaid, Medicare, insurance, etc.) which may be available for payment of my hospital charges, and I will take any action reasonably necessary to obtain such assistance and will assign or pay to the hospital the amount recovered for hospital charges. If any information I have given proves untrue, I understand that the hospital may re-evaluate my financial status and take whatever action becomes appropriate.

____________________________ ____________________________

Signature of Applicant(s)