OCH Regional Medical Center
CENTER FOR BREAST HEALTH AND IMAGING
P.O. BOX 1506
STARKVILLE, MS. 39760

CHARITY CARE ALLOCATION APPLICATION

INDIVIDUAL COMPLETING APPLICATION _____

RELATIONSHIP TO PATIENT_____

ADDRESS _____ PHONE# _____

_____ _____

PATIENT'S NAME _____

ADDRESS _____ DATE OF BIRTH _____

_____ SOCIAL SECURITY #_____

PHONE# _____ ACCOUNT#_____

HEALTH INSURANCE STATUS/THIRD PARTY PAYOR INFORMATION

PRIVATE/GROUP INSURANCE _____

MEDICARE/MEDICAID/CHIP/VOCATIONAL REHABILITATION _____

OTHER_____

INCOME

INCOME _____ WEEK/MONTH/YEAR

_____ WEEK/MONTH/YEAR

_____ WEEK/MONTH/YEAR

INCOME VERIFICATION_____
(W2, TAX RETURN, CHECK STUBS, ETC. MUST BE ATTACHED)

#PEOPLE LIVING IN HOUSEHOLD _____

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HOUSEHOLD EXPENSES

HOUSE PAYMENT/RENT _____

UTILITIES _____

AUTO/TRUCK PAYMENT _____

OTHER EXPENSES _____ _____

_____ _____

_____ _____

I ATTEST THAT THE INFORMATION PROVIDED IN THIS APPLICATION IS CORRECT. I UNDERSTAND THAT MISREPRESENTATION OF ANY INFORMATION PROVIDED WILL RESULT IN DENIAL OF CHARITY CARE ALLOCATION. I ACKNOWLEDGE THAT IF ANY INFORMATION I HAVE GIVEN IS FALSE OR MISLEADING AND RESULTS IN APPROVAL OF CHARITY CARE ALLOCATION, THE HOSPITAL MAY TAKE WHATEVER ACTION IT DEEMS APPROPRIATE WHICH MAY INCLUDE REVOCATION OF CHARITY ALLOCATION APPROVAL AND REINSTITUTING PATIENT / GUARANTOR LIABILITY FOR PAYMENT OF HOSPITAL ACCOUNT IN FULL.

SIGNATURE_____ DATE_____

WITNESS_____ DATE_____

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Annual income must be calculated in order to determine if an individual qualifies for charity care. Copies of check stubs, W-2 forms, or a Tax Return, should accompany the application for the purpose of income verification. If an individual has no income, a letter from the individual who is providing support to the individual must accompany the application. The letter should include the amount and type of support provided.

The application must be signed. It must be returned within 30 days. Information needed to verify income must be received in the Social Services Department within 30 days of receipt of the application. Failure to provide information needed will result in the application being denied.

The Patient Billing Office should be contacted at 662-615-2605 if there are questions regarding the charity care program or the application process.