



**COASTAL MISSISSIPPI  
HEALTHCARE FUND, INC**  
*A Charity Affiliated with Singing River Health System*

**Application for Assistance**

<b>Patient Name:</b>	<b>Amount Requested:</b>
<b>Patient Date of Birth:</b>	<b>Patient SSN:</b>
<b>Patient Address:</b>	<b>Spouse Name</b> (include address if different):
<b>Patient Phone:</b> Work _____ Home _____ Cell _____	<b>Spouse Phone:</b> Work _____ Home _____ Cell _____
<b>Patient Employer</b> (Name and Address):  Length of employment _____ years _____ months	<b>Spouse Employer</b> (Name and Address):  Length of employment _____ years _____ months
<b>Income:</b> Patient Salary _____ before deductions _____ after deductions per hour per week per month Spouse Salary _____ before deductions _____ after deductions per hour per week per month	<b>Other income</b> (Social Security, VA, Workman's Comp, Retirement, etc.) Source: _____ Amount _____ Source: _____ Amount _____ Source: _____ Amount _____ Source: _____ Amount _____
<b>Dependents:</b> Name _____ Age _____ Name _____ Age _____ Name _____ Age _____ Name _____ Age _____ Name _____ Age _____	<b>Banking information:</b> Checking balance _____ Bank _____ Savings balance _____ Bank _____ Other balance _____ Source _____ Other balance _____ Source _____ Other balance _____ Source _____
<b>Housing Expenses:</b> <input type="checkbox"/> Own Monthly payment \$ _____ <input type="checkbox"/> Rent Mortgage balance \$ _____	<b>Additional Monthly Obligations:</b> Utilities \$ _____ Food \$ _____ Clothing \$ _____ Misc \$ _____
<b>Creditors:</b> Name Monthly payment Balance _____ _____ _____ _____	<b>Total Combined Income:</b>  <b>Total Combined Assets:</b>  <b>Total Combined Expenses:</b>

**Description of Need**

Please describe your need in detail and include any supporting documentation. Continue on separate sheet if necessary.

I hereby certify, to the best of my knowledge and belief, the above information to be true and correct and give my permission for the Coastal Mississippi Healthcare Fund, Inc. to verify this information. I understand any intentional false statements will be considered an attempt to commit fraud upon the Coastal Mississippi Healthcare Fund, Inc and may result in denial of my request for assistance. Additionally, I authorize Coastal Mississippi Healthcare Fund to disclose any confidential and/or financial information to the Coastal Mississippi Healthcare Fund Board of Directors as it pertains to the above request for assistance.

Signature of applicant: \_\_\_\_\_

Witness: \_\_\_\_\_

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**FOR CMHF/PRM USE ONLY**

DATE APPROVED		DATE DISAPPROVED	
LOS	COC	SNF/HOME	
COMMENTS/PHYSICIAN RECOMMENDATION			
SIGNATURE			