WINSTON MEDICAL CENTER
FINANCIAL ASSISTANCE PROGRAM
INSTRUCTIONS & APPLICATION

Instructions

Step 1:

To determine your eligibility, you must provide all household income amounts for a 12-month period.

1. Please provide a copy of the most recent **pay stub(s)** verifying year to date earnings. (*This is needed for all jobs that were held within the last year for anyone currently part of your household.)*
2. Please provide a copy of all **W-2 forms** for any job held in the prior year, and/or a copy of last year's completed **income tax return**.

Step 2:

If you are living with someone else but paying rent, you will need to provide written verification from the person you are paying rent to and the amount you pay.

Determination of eligibility is made based on poverty guidelines set by the Federal Government. If false information is given, you will be held responsible for your debt upon rejection from the Financial Assistance Program. **All applicants will be given written verification of eligibility**. A positive verification is good only for current charges on your account in the hospital and for the time frame specified for any clinic services. This application is only good for services provided by Winston Medical Center hospital and clinic locations.

Please make sure you have all the necessary paperwork with you when you apply. If you have any questions or concerns, please call (662) 773-6211.

A copy of the application follows on the next page.

WINSTON MEDICALCENTER
17550 EAST MAIN STREET
PO BOX 967
LOUISVILLE, MS 39339

APPLICATION FOR FINANCIAL ASSISTANCE PROGRAM

NAME_____

ADDRESS_____CITY_____STATE/ZIP_____

PHONE_____ SS#_____ EMPLOYER_____

I certify that the above information is true and accurate to the best of my knowledge. Furthermore, I will make application for any assistance (Medicaid, Medicare, Insurance, etc.) which may be available to pay for my hospital or clinic charges. I will take any action reasonably necessary to obtain such assistance and will assign or pay to the hospital or clinic the amount recovered for hospital or clinic charges.
I understand that this application is made so that the hospital or clinic can judge my eligibility for its Financial Assistance Program. Winston Medical Center reserves the right to verify all given information with any persons or creditors they see fit to verify the information that is given. If any information I have given proves to be untrue, I understand that Winston Medical Center may reevaluate my financial status and take whatever action becomes appropriate.

APPLICANT'S SIGNITURE_____

DO NOT WRITE BELOW THIS LINE. FOR OFFICE USE ONLY

	LAST 12 MONTHS	LAST 3 MONTHS	FAMILY SIZE
Gross Income	_____	_____	_____
Family Income	_____	_____	_____
Total	_____	_____	_____

Dates of Service_____

Date of Request_____

ELIGIBILITY DETERMINATION

Income Verified: Yes No

Type of verification: _____ Date Received_____

Patient Qualifies: Yes No

The applicant's request for Winston Medical Center's Financial Assistance Program has been denied for the following reasons:

_____

Date of Determination of Eligibility:_____

_____ _____

Date Applicant notified Signature of Facility Representative

Winston Medical Center
Notice of Availability of Financial Assistance

To be eligible to receive financial assistance, your family income must be at or below the following levels:

Family Income per Federal Poverty Guidelines				
Household Size	**100%**	**150%**	**200%**	**250%**
1	$11,490	$17,235	$22,980	$28,725
2	15,510	23,265	31,020	$38,775
3	19,530	29,295	39,060	$48,825
4	23,550	35,325	47,100	$58,875
5	27,570	41,355	55,140	$68,925
6	31,590	47,385	63,180	$78,975
7	35,610	53,415	71,220	$89,025
8	39,630	59,445	79,260	$99,075
For each additional person, add	$4,020	$6,030	$8,040	$12,060

Hospital Sliding Scale Discount	90%	75%	50%	25%

Clinic Co-Pay per Visit	$5.00	$10.00	$20.00	$35.00

These figures are the current (2013) poverty income guidelines for all states except Alaska and Hawaii. If you think that you may be eligible for charity care services, you may request an application at the Patient Registration or Patient Accounts Departments in the hospital, the Front Desk Area of the clinic(s) or print off the above application form.

Winston Medical Center will make a final determination of your eligibility for uncompensated services based on your written application within 2 working days following a pre-service request, or by the end of the first full billing cycle following a post-service request.

You must exhaust and show verification on all other potential sources of income including Medical Assistance, Medicare or other Governmental programs.

*Amended 8/19/13