MISSISSIPPI

TUNICA COUNTY HEALTHCARE AUTHORITY

CHARITY DISCOUNT APPLICATION

PATIENT NAME:_____ Account Number_____

NAME OF RESPONSIBLE PARTY:_____

RELATIONSHIP TO PATIENT: _____

SPOUSE: _____ TELEPHONE: _____

ADDRESS: _____

NUMBER OF FAMILY MEMBERS (LIVING IN HOUSEHOLD): _____

EMPLOYER: _____ ADDRESS:_____

IF UNEMPLOYED, HOW LONG?: _____

SPOUSE'S EMPLOYER: _____ ADDRESS:_____

IF UNEMPLOYED, HOW LONG?: _____

OTHER FAMILY MEMBER EMPLOYER(S): (INCLUDE MEMBER NAME, EMPLOYER, & ADDRESS:)_____

_____

MONTHLY FAMILY INCOME & SOURCE

	Patient	Spouse	Responsible Party	Children Working
Monthly Salary (Gross)				
Public Assistance Benefits				
Unemployment Benefits				
Social Security Benefits				
Workman's Compensation				
Child Support/ Alimony/Other				

TOTAL FAMILY INCOME $_____

I HEREBY ACKNOWLEDGE THAT THE INFORMATION GIVEN HEREIN IS TRUE AND CORRECT. I AUTHORIZE TCHA TO VERIFY ANY INFORMATION CONTAINED IN THIS DOCUMENT FOR THE SOLE PURPOSE OF ASSESSING FINANCIAL NEED.

_____

SIGNATURE OF PERSON MAKING REQUEST DATE

_____

SIGNATURE OF SPOUSE/OTHER DATE

PLEASE ATTACH SUPPORT DOCUMENTS (TAX RETURN, W-2, OR TWO PAYROLL CHECK STUB).

DO NOT WRITE BELOW THIS LINE – FOR OFFICE PERSONNEL USE ONLY

This document was received on _____ by _____.
(date) (Name/Title)

Approved by Chief Executive Officer_____ on _____
(signature of Chief Executive Officer) (Date)