Main Street Medical Clinic
MORTON
A Division of Lackey Memorial Hospital

347 South 4th Street
Morton, MS 39117

FINANCIAL ASSISTANCE/SLIDING FEE APPLICATION

Patient Name: ______________________ DOB: ______________ Date: ______________

Permanent Address: ______________________ City: ______________ ZIP: ______________

State: ______________________ Hm Phone: ______________ WkPhone: ______________

Mailing Address if Different:

Address: ______________________ City: ______________

State: ______________________ ZIP: ______________

All patients seeking health care services at Main Street Medical Clinic of Morton are assured that they will be served regardless of ability to pay. No one is refused service because of lack of financial means to pay. This program is designed to provide discounted care to those who have no means, or limited means, to pay for their medical services (uninsured or underinsured). Main Street Medical Clinic of Morton will base program eligibility on a person's ability to pay and will not discriminate on the basis of an individual's race, color, sex, national origin, disability, religion, age, sexual orientation, or gender identity. The Federal Poverty Guidelines are used to create the sliding fee schedule (SFS) to determine eligibility.

For the following table, please list the patient and all family members living in the same household as the patient (family unit). A family unit is a group of two people or more (one of whom is the householder) related by birth, marriage, or adoption and residing together; all such people (including related subfamily members) are considered as members of one family. Non-related household members are included when calculating family size.

Income includes: gross wages; salaries; tips; income from business and self-employment; unemployment compensation; workers' compensation; Social Security; Supplemental Security Income; veterans' payments; survivor benefits; pension or retirement income; interest; dividends; royalties; income from rental properties, estates, and trusts; alimony; child support; assistance from outside the household; and other miscellaneous sources.

Family Member (Name)	Relationship to Patient	Age	Source of Income	Last Three Months Pay Stubs	Income for 12 Months Tax Return
Total Family Members			Total Income		

Your application cannot be processed unless you provide the following documents to support each source of income listed above.

Pay stubs for the last three months
Income Tax return for the previous year
W2 Form for the previous year
Federal & State Assistance Documents
Legal documents/Child Support
Pension/retirement statements

Please return this application and the requested information to the Business Office where services were received. I certify that the information provided is true and accurate to the best of my knowledge.

____ ______________________

Signature of Patient, or Person Authorized to Sign for Patient | Relationship to Patient

Date______________________ Location of Service ______________________

FOR PROVIDER USE ONLY

Account Number ______________________ Date of Service ______________

Effective Date ______________________ Expiration Date ______________

Patient is eligible for:	Patient Responsibility
Plan 1	$10
Plan 2	20%
Plan 3	40%
Plan 4	60%
Plan 5	80%

Date Received ______________ Received by ______________

Date Processed ______________ Processed by ______________