Dear Customer:

Thank you for choosing Magee General Hospital for your healthcare needs. We strive to serve all our patients with the best care possible. Attached is an application for Charity assistance to cover your recent hospital expense. Please complete the entire form, attach the required proof of eligibility and return to Magee General Hospital as soon as possible.

The charity committee will review your application and you will be notified of the determination made by the committee. If you have any questions, please contact a Patient Financial Counselor.

Please mail completed application to Magee General Hospital, 300 3rd Avenue SE, Magee, MS 39111.

****TO QUALIFY FOR CHARITY CARE COVERAGE ALL QUESTIONS ON THE APPLICATION MUST BE COMPLETED****

Sincerely,

Magee General Hospital

Patient Financial Services Department

CHARITY PROOF OF INCOME

1. **If patient/guarantor is on Social Security-will need a copy of what he/she earns monthly, and if patient/guarantor is married, we will also need a copy of what his/her spouse earns monthly. If you have any other income, please send in a copy of that also.**

-OR-

2. **If you filed Taxes for previous year, please send a copy for proof of income.**

-OR-

If patient/guarantor is unemployed, have no income coming in, patient/guarantor will need to write a letter stating that and have the letter notarized. If patient/guarantor is also married, we will need a written letter stating that spouse has no income coming in and have the letter notarized also.

If patient/guarantor is unemployed, have no income coming in and live with either a parent(s)/friend/relative, they will have to send in a copy of their income for you to qualify for charity.

MAGEE GENERAL HOSPITAL
300 3RD AVENUE SE
MAGEE, MS 39111
APPLICATION FOR CHARITY CARE COVERAGE

Patient Name: _____ Social Security Number: _____

Address: _____ Birthdate: _____

Phone Number: _____ County: _____

Does patient have Medical Insurance? _____ Y/N

Is the patient a Medicare or Medicaid beneficiary? _____ Y/N

If patient is a minor, the following questions apply to the legal guardians or parents

Guarantor's Income: _____

Patient's Employer: _____

Spouse Name: _____

Spouse Employer: _____

Spouse's Income: _____

Household Income: _____

Dependents: Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Please attach your last tax return or other Proof of Income

Signature: _____Date:_____

Do not fill out, for Patient Financial Services Use Only.

Approved _____ Denied_____

Reason for Denial _____