Lackey Pediatric Clinic
A Division of Lackey Memorial Hospital

1129 Hwy 35 South, Suite 1
Forest, MS 39074

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 Lackey Pediatric Clinic 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). Lackey Pediatric Clinic 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 _____