Patient Financial Assistance Application

Critical Access Hospital • Rural Health Clinic

It is the policy of Big Sandy Medical Center (BSMC) to provide essential services regardless of the patient's ability to pay. Discounts are offered based on family size and annual income. Please complete this application and return it to the BSMC Business Office to determine eligibility.

Service exclusions: Certain services are not typically eligible for financial assistance, including but not limited to long-term care and services not medically necessary.

Medicaid requirement: Applicants who may be eligible for Medicaid are required to apply for Medicaid before this financial assistance application can be approved. A written Medicaid denial letter must be submitted with this application. If you need assistance applying for Medicaid, please contact the BSMC Business Office.

Section 1 — Patient Information

Name of Head of Household

Place of Employment

Street Address

Mailing Address (if different)

City

State

ZIP Code

Home Phone

Cell Phone Number

Email Address (optional)

Section 2 — Household Members

List all members of your household, including spouse and dependents under age 18.

Self	Date of Birth	Dependent	Date of Birth
Spouse	Date of Birth	Dependent	Date of Birth
Dependent	Date of Birth	Dependent	Date of Birth
Dependent	Date of Birth	Dependent	Date of Birth

Section 3 — Annual Household Income

Enter gross annual amounts from all sources for each household member.

Income Source	Self	Spouse	Other	Total
Gross wages, salaries, tips, etc.				
Business / self-employment income				
Unemployment, Workers' Compensation, Social Security, SSI, public assistance, veteran's benefits, pension / retirement				
Interest, dividends, rents, royalties, alimony, child support, educational assistance, or other sources				
Total Annual Income				

Note: Copies of tax returns, pay stubs, or other income verification may be required before a discount is approved.

Section 4 — Certification

I certify that the family size and income information shown above is correct and complete to the best of my knowledge.

Signature _____ Date _____

Printed Name _____

For Office Use Only

Applicant Name _____ Approved Discount _____

Approved By _____ Date Approved _____

Verification Checklist

Document	Yes	No
Identification / Address: Driver's license, utility bill, employment ID, or other	☐	☐
Income: Prior year tax return, three most recent pay stubs, or other	☐	☐
Insurance: Insurance card(s)	☐	☐
Medicaid Denial: Written denial letter from Medicaid (required if applicable)	☐	☐