White River Medical Center
1710 Harrison Street
Batesville, AR 72501
www.WhiteRiverHealthSystem.com

Dear:

White River Health System is a tax-exempt organization committed to caring for our community. We will not refuse medically necessary services to any patient who can not afford to pay. White River Health System's hospital-based Financial Assistance Program is available for qualifying patients.

To apply for Financial Assistance, you must contact one of the Financial Counselors to determine the documents to submit for income verification. This process will take about ten minutes and will help to ensure that you provide the information we need to determine your eligibility.

Financial Counselors:

White River Medical Center	Stone County Medical Center
Main Phone (870) 262-1253	(870) 262-5021 - Vickie
A----L (870) 262-3234 Polley	
M----Z (870) 262-1281 Linda	

Sincerely,

Tom S.
Supervisor, Financial Counseling
870-262-1913

<u>Required Documentation:</u> Please provide copies of the following documentation with your **<u>completed Financial Assistance Application by:</u>**

TODAY DATE:

NAME:

PATIENT #:

Number of Persons in Household: ______________

Adults: ______________

Children: ______________

- ❑ WRMC FINANCIAL COUNSELOR DISCOUNT BRIEFING

Medicaid Screening Requirement

- ❑ Proof of filing for Medicaid from your local County Department of Human Services.
- ❑ Proof of filing for Medicaid from the Medical Advocacy Services for Healthcare Program (MASH). Contact MASH by calling 870-698-8912

Income Documentation Required for Each Working Member in your Household

- ❑ All pages of most recent filed Federal Tax return form
- ❑ Past 3 months check stubs or current gross to date earnings -OR-
- ❑ Past 3 month income statement from employer on company letterhead or stamp with tax identification number and signature -OR-
- ❑ Past 3 months Profit & Loss Statements if self employed for all business types: logging, farming, rental properties etc.
- ❑ All pages of three current months bank statements on All Checking and/or Savings Accounts in household. Blacked out data is not accepted, statements must have banking facility letterhead or stamp.
- ❑ If no bank accounts - 3 months paid utility bills with cash receipts
- ❑ Social Security Income or Social Security Disability Income Statements for each household member receiving SSI / SSD
- ❑ Pension or Retirement earnings
- ❑ Proof of food stamps /Housing Allowance Report from DHS
- ❑ Child support and/or Alimony Report
- ❑ Maternity Leave / Short Term Disability / Long Term Disability Income / Workers Compensation
- ❑ Proof of filing, if recent application for Social Security/Disability
- ❑ Unemployment income / Severance Pay / TRA Benefits
- ❑ FAFSA application (Students) or school printout showing any loans/grants/school expenses, and any refunds given
- ❑ Proof of Workers Comp
- ❑ Other

APPLICATION FOR FINANCIAL ASSISTANCE*

Schedule of Current Income and Expenditures

Patient: ______________________ Spouse/Other: ______________________

Address: ____

____

Home Phone: ______________________ Cell Phone: ______________________

Social Security Number: ______________________ ______________________

(patient) *(spouse/other)*

FAMILY STATUS

Other Members of Household

Name	Age	Relationship

EMPLOYMENT AND OCCUPATION

Patient Employer: ______________________ Position: ______________________

Contact Person: ______________________ Phone: ______________________

If self-employed, give name of business: ______________________

Spouse/Other's employer: ______________________ Position: ______________________

Contact Person: ______________________ Phone: ______________________

If self-employed, give name of business: ______________________

*Any financial assistance obtained through approval of this application is limited to hospital charges and does not include charges for professional and/or physician charges.

CURRENT HOUSEHOLD MONTHLY INCOME

* Include all income for anyone residing in the household of legal age	Patient	Spouse	Other
Gross pay from employment (before deductions)	$______________	$______________	$______________
Income from operating business (If self-employed)	$______________	$______________	$______________
Interest and dividend income	$______________	$______________	$______________
Real estate or personal property income (rental/lease property or land)	$______________	$______________	$______________
Unemployment income	$______________	$______________	$______________
Social Security income or SSD	$______________	$______________	$______________
Workmen's Compensation	$______________	$______________	$______________
Pension earnings	$______________	$______________	$______________
Maternity Leave / Short Term /Long Term Disability Income	$______________	$______________	$______________
Student loans/grants/scholarships	$______________	$______________	$______________
Alimony and/or Child Support payments	$______________	$______________	$______________
Food Stamps and/or HUD Allowance	$______________	$______________	$______________
Total current monthly income (add all figures from above)	$______________	$______________	$______________

MONTHLY HOUSEHOLD EXPENSES

* List only bills that are paid on a regular basis. If not paid monthly, please indicate how often. (i.e. monthly, quarterly, annually)

Rent or mortgage	$______________
Food	$______________
Utilities (electricity, water, propane gas, cable, etc.)	$______________
Automobile payment	$______________
Transportation expense - gasoline	$______________
Medical/Dental (amount paid per month)	$______________
Home phone and/or cell phone	$______________
Insurance (home, automobile, medical, life, etc.)	$______________
Credit Cards	$______________
Childcare	$______________
Other – specify	$______________
Total monthly household expenses (add all figures from above)	$______________

UNUSUAL EXPENSES OR INCOME
Please provide information on any unusual expenses or income such as previous medical bills, a recent bankruptcy, court judgments or one-time earnings. You may want to write on the back of this page or attach a separate listing.

HOUSEHOLD ASSETS AND DEBTS

Banking
Accounts:

a. Savings account balance $_______________

Name of institution: _______________________________________

b. Primary checking account balance $_______________

Name of institution: _______________________________________

c. Other checking account balance $_______________

Name of institution: _______________________________________

d. Other checking account balance $_______________

Name of institution: _______________________________________

e. Other checking account balance $_______________

Name of institution: _______________________________________

f. Investments/other (specify) $_______________
(stocks, bonds, CD's, etc.)

I hereby certify that the above information is true and correct. I also agree to apply for any entitlement assistance such as Medicare, Medicaid, insurance, etc., which may be available to help pay my account balances. I further agree that if any of the information provided in my application is found to be untrue, White River Health System may revoke my financial assistance and take whatever legal action is necessary to obtain full payment for all of my account balances. My/our signature on this form authorizes WRHS to verify the information on this form including permission to contact employers and to check my/our credit history.

All information provided to the WRHS financial assistance program is kept confidential and used for the sole purpose of assessing the applicant's need for hospital-based financial assistance.

Signature of patient/guardian: ___________________________________ Date: ______________________

Signature of spouse/other: ______________________________________ Date: ______________________