



www.whiteriverhealthsystem.com

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 Medical Center (WRMC) and Stone County Medical Center (SCMC) hospital-based Financial Assistance Program is available for qualifying patients.

To determine your eligibility for financial assistance, we need to have a completed Application for Financial Assistance along with a copy of the requested items for income verification.

If your attached checklist does not have any required items checked off, you have not been pre-screened for possible assistance. Please contact one of the Financial Counselors below so we can pre-screen your household. This is a very important step to insure that you bring all of the necessary items in for your evaluation.

WRMC Financial Counselors

Last Names beginning with:

A----L (870) 262-3234

M----Z (870) 262-1281

SCMC Financial Counselors

Call 870-269-4361

Sincerely,

Supervisor, Financial Counseling
870-262-1913

Required Documentation: Please provide copies of the following documentation with your **completed Financial Assistance**

Application by:

TODAY DATE: _____

Number of Persons in Household: _____

NAME: _____

PATIENT #: _____

WRHS FINANCIAL COUNSELOR DISCOUNT BRIEFING

Medicaid Screening (Applicant)

Proof of Medicaid filing for assistance from your local County Department of Human Services.

Proof of Medicaid filing for assistance from the Medical Advocacy Services for Healthcare Program called (MASH) contact them by calling 870-698-8912

Total Household Income (Each Working Member of Household)

Most recent filed Federal Tax return form

Past 3 months check stubs with or without gross to date earnings

-OR-

3 month income statement from employer

-OR-

Past 3 months Profit & Loss Statements (If self employed)

Three current months bank statements (All Checking and/or Savings Accounts)

Social Security Income or SSD

Pension earnings

Proof of food stamp earnings and/or HUD Allowance from DHS

Child support earnings and/or Alimony

Maternity Leave / Short Term Disability / Long Term Disability Income

Proof of filing, if recent application for Social Security/Disability

Unemployment income

FAFSA application (Students)

-OR-

School Business printout showing any loans/grants/school expenses, and any refunds given

Proof of Workers Comp

All Rental Property Income

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 physician, anesthesiologists or professional charges not billed by hospital.

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 of 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
Assets:

- 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 Systems may revoke my financial status and take whatever legal action is necessary to obtain full payment for all of my account balances. My/our signature on this form allows WRHS authorization to verify the information on this form including permission to contact employers and to check my/our credit history.

ALL INFORMATION PROVIDED TO THE FINANCIAL ASSISTANCE PROGRAM IS KEPT CONFIDENTIAL AND IS USED FOR THE SOLE PURPOSE OF ASSESSING AN APPLICANTS FINANCIAL NEED FOR PROGRAM SERVICES

Signature of patient/guardian: _____ Date: _____

Signature of spouse/other: _____ Date: _____