Financial Counselors located at:
1710 Harrison Street, Batesville, AR
Phone: 870.262.1118 or 870.262.1188
Fax: 870.262.6547

Application for Financial Assistance

Patient Name: _____ Medical Record Number: _____

Social Security Number: _____

Please answer all questions as completely and accurately as possible. If you do not have enough space for your answer(s), please attach another piece of paper to this application with complete answers.

Please list everyone in your home, including the patient, and complete each space below:

Last Name	First Name	DOB	Relationship	Employer/Income Source

Required Supporting Documentation for Household:

_____ Most recent Federal Income Tax Return

_____ Most recent W-2 or 1099

_____ Work History Report from the Social Security Office

_____ Social Security Award Letter

_____ Most recent 3 Bank Statements (Checking and Savings)

_____ Pension or Retirement Statement

_____ Child Support Income Documentation

_____ Driver's License (OR State issued ID)

_____ Supporting Documents, requested per Assets and Liabilities

_____ Supporting Documents, requested per Monthly Expenses

WHITE RIVER HEALTH SYSTEM

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Please provide supporting documentation for each field.

Assessed value of your house/trailer: $_____

List all vehicles you own with their assessed value.

_____ $_____

_____ $_____

_____ $_____

List all your bank accounts and investment balances.

Bank Account #

_____ $_____

_____ $_____

List any property you own (land, boat, motorcycle, camper, etc.) and the assessed values.

_____ $_____

_____ $_____

_____ $_____

Total Assets: **$**_____

Loan balances for property listed above:

House/Trailer: $_____

Vehicles(s): $_____

Other: $_____

List all medical bills with your balances after insurance is paid.

_____ $_____

_____ $_____

_____ $_____

Total Liabilities: **$**_____

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Monthly Expenses Worksheet

Please provide supporting documentation for each field. Most recent (3) months' worth of expense documentation, excluding food, unless included and distinguished on your monthly bank statement.

Rent/Mortgage: $_____

Electric Bill: $_____

Water Bill: $_____

Gas (propane) Bill: $_____

Telephone Bill (excluding internet and any additional fees): $_____

Food: $_____

Child Support: $_____

Insurance:

- Auto: $_____
- Home: $_____
- Life & Health: $_____

Medical Bills: $_____

Medication: $_____

Child Care: $_____

Vehicle Payments: $_____

Credit Cards: $_____

Monthly Expense Total: $_____

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For White River Medical Center Use Only

	YES	NO
Assets Verified		
Liabilities Verified		
Income Verified		
Expenses Verified		
All Required Documents Included		

((Assets - Liabilities) x 10% + Total Annual Incomes) $_____

Financial Advocate:

_____ _____

Signature Date

PFS Director/Patient Accounts Supervisor: _____

Signature

APPROVED DISCOUNT: _____ % _____

Approval Date

I certify that the information provided for this financial assistance application is true and accurate to the best of my knowledge. As part of the application process, White River Medical Center may verify information contained in my application and in other documents required in connection with the application before the application is approved. If any information provided proves to be false or incomplete, I understand it could cause my application to be denied.

_____ _____

Patient/Guarantor Signature Date