WHITE RIVER HEALTH SYSTEM
The Care You Need. Where You Need It.

Patient Financial Assistance Application

Patient Name: _____

Medical Record Number(s): _____

Date of Birth:_____ Social Security Number: _____

Address: _____

City: _____ State: _____ Zip code: _____ Phone Number: _____

Marital Status: _____

Employer: _____

Address: _____

City:_____ State: _____ Zip Code: _____Phone Number:_____

Supervisor: _____

Spouse Name: _____ Spouse Employer: _____

Spouse Company Address: _____

City: _____State: _____ Zip Code: _____Phone Number: _____

Supervisor: _____

Please list all dependents with their date of birth who live in your household:

_____

_____

_____

_____

_____

Is anyone handicapped living in your home? _____

Please provide a copy of your latest tax return, payroll stub, or copy of Social Security award letter/check.

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Please answer ALL of the questions to the best of your ability.

1. What is the market value of your house/trailer? $ _____ .00

2. List any vehicles you own with their market value.

Year	Make	Model	
			$ _____ .00
			$ _____ .00

3. List all of your bank account and investment balances

Bank	Account #	
		$ _____ .00
		$ _____ .00

4. List any other property you own (land, rental property, boat, motorcycle, camper, etc.) with its market value.

_____ $ _____ .00
_____ $ _____ .00

TOTAL ASSETS (add 1 through 4) $ _____ .00

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5. What are the loan balances for the property listed above?
   House/Trailer: _____ $ _____ .00
   Vehicle(s): _____ $ _____ .00
   Other: _____ $ _____ .00
   Other: _____ $ _____ .00
   Other: _____ $ _____ .00

6. List all your medical bills with your balances after insurance has paid (list names & phone number or attach copy of the bill)

_____ $ _____ .00
_____ $ _____ .00
_____ $ _____ .00
_____ $ _____ .00
_____ $ _____ .00
_____ $ _____ .00
_____ $ _____ .00

TOTAL LIABILITIES (add 5 & 6) $ _____ .00

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The information provided is correct to the best of my knowledge and belief. You are hereby authorized to contact any of the above listed employers, creditors, banks, and others for the purposes of confirming my assets, debt, and financial status. Any information provided on this application which is found to be materially false, or that cannot be confirmed, may result in denial of this application for financial assistance.

Signature of Applicant: _____ Date: _____

**********For White River Health System use only**********

Assets verified	Yes	No	Were all required copies included?	Yes	No
Liabilities verified	Yes	No	The adjusted gross income per application is	$_____ .00	
Income verified	Yes	No	{(Assets – Liabilities) *10% + Total Annual Income}	$ _____ .00	

Financial Advocate: _____ Date _____

PFS Director/Patient Accounts Supervisor: _____ Date _____

Approved Discount: _____ Posted Date_____

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Required Supporting Documentation

Required Supporting Documentation	Examples of Acceptable Documentation
Confirmation of Annual Income	Most Recent Federal Income Tax Return Last 4 pay stubs Most recent W-2 or 1099 Social Security Award Letter Full Bank Statements for recent 3 months Unemployment Statement Workers Compensation Award Letter Pension or Retirement Statement Investment Income
Verification of Social Security Number and/or Date of Birth	Driver's License State Issued Identification Card Social Security Card Birth Certificate Baptismal Certificate Military Discharge Papers School Records
Verification of Residency	Mortgage Statement Rental Agreement/Lease Tax Bill Room & Board Statement Utility Bill Written Verification from Landlord