Financial Counselors located at:
1710 Harrison Street, Batesville AR
Phone: 870-262-1118 Fax: 870-262-6547
Stone County: 870-262-5062

Application for Financial Assistance

Patient Name: _____ Medical Record Number: _____
Social Security Number: _____ Phone 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.

Last Name	First Name	Date of Birth	Relationship to you	Employer/Source of Income

Required Supporting Documentation for Household:

_____ Most recent Federal Income Tax Return
_____ Proof of Monthly Gross Income for all household Income
_____ Social Security Benefit Verification Letter
_____ Most recent 2 bank statements for all household accounts

Applications cannot be processed without required supporting documentation and will be returned to you if incomplete.

Verification of household income may include, but is not limited to, the following: Social Security Benefit Verification Letter, retirement/pension, most recent (1) month of pay stubs, alimony/child support, unemployment or workers' compensation benefits, etc. If you report $0 income, please attach a brief explanation of how you are financially maintaining.

White River HEALTH
Caring Beyond Healthcare

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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 requested in connection with the application before the application is approved. Any information provided proves to be false or incomplete, I understand it could cause my application to be denied.

Patient/Guarantor Signature _____ Date _____

*****For White River Health Use Only*****

Date Received in Office: _____

	YES	NO
Income Verified		
All Required Documents Included		

Total Patient Income and Liquid Assets $ _____

Financial Counselor: _____
Signature Date

PFS Director/Patient Accounts Supervisor _____
Signature

APPROVED DISCOUNT: _____ % _____
Approval Date