Financial Counselors located at:
1710 Harrison Street, Batesville, AR
Phone: 870.262.1118 Fax: 870.262.6547
Stone County Medical Center: 870.262.5062

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

__________ Unemployment Statement

__________ Most recent three (3) Pay Stubs

__________ Work History Report from the Social Security Office

__________ Social Security Award Letter

__________ Most recent three (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

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Please provide supporting documentation for each field.

Assessed value of your house/trailer: $________________

List all vehicle(s) 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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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 Health System 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

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