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	Date of Birth	Relationship to You	Employer/Income Source

Required Supporting Documentation for Household:

_____ Most recent Federal Income Tax Return

_____ Proof of Monthly Gross Income for All Household Income

_____ Social Security Award Letter

_____ Most recent two (2) Bank Statements (Checking and Savings) for all Household Accounts

_____ Most Recent Personal Property Assessment

_____ Most Recent Home Assessment Documentation

Applications cannot be processed without required supporting documentation and will be returned to you. White River Health System reserves the right to request verification and/or to adjust monthly living expenses during verification process.

WHITE RIVER HEALTH SYSTEM

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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

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

Date Received in Office: _____

	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