ATTACHMENT A

Advanced Care Hospital of White County
1200 South Main
Searcy, AR 72143

Patient Name:_____

Patient Number:_____

Dear Patient or Guarantor:

You may qualify for the Financial Assistance Program at Advanced Care Hospital!
Our records indicate that you had no insurance coverage at the time of service.

Please fill out this application and submit it back to Advanced Care Hospital as soon as possible to see if you qualify for a discount on your healthcare costs.

*Application must be complete to be considered for financial assistance.
Please submit this information within 14 days.

☑ TOTAL HOUSEHOLD INCOME TO DATE-_____
☑ COPY OF _____ INCOME TAX RETURN

If you have any questions about the financial assistance program, please call or come by the Advanced Care Hospital of White County.

Sincerely,

Social Worker, Case Manager
(501) 278-3487

ATTACHMENT A

APPLICATION FOR FINANCIAL ASSISTANCE

Name of Head of Household:_____
(LAST) (FIRST) (MIDDLE)

Current Mailing Address: _____
(Street / PO Box) (CITY) (STATE) (ZIP)

Home Telephone:_____ Mobile/Cell Phone: _____

Employer: _____ Employer's Phone: _____

Employer's Address:_____
(Street / PO Box) (CITY) (STATE) (ZIP)

Social Security Number (Head of Household):_____

Spouse's Name: _____
(LAST) (FIRST) (MIDDLE)

Spouse's SS#: _____Employer:_____

Employer's Address: _____
(Street / PO Box) (CITY) (STATE) (ZIP)

Employer's Phone Number: _____

Do you have any Insurance Coverage? ___ Yes ___ No

If Yes, what kind? _____

PLEASE LIST ALL FAMILY MEMBERS THAT LIVE IN YOUR HOUSEHOLD INCLUDING YOURSELF AND SPOUSE:

	Name: (Last, First, Middle)	Date of Birth	Relationship
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____

Patient Number:

ATTACHMENT A

Total Household Income for the last 12 months

INCOME: List all GROSS INCOME including CASH for all members listed on Page 1:

EMPLOYMENT EARNINGS:
(Including Self Employment)

Head of Household: $_____

Spouse: $_____

Other working family members: $_____

Farm Income: $_____

SOCIAL SECURITY Income: $_____
(Any family members)

Child Support / Alimony: $_____

Military Family Allotments: $_____

Retirement / Pension: $_____

Other Income not listed: $_____
(Any family members)

TOTAL INCOME: $_____

Patient Number:

ATTACHMENT A

Advanced Care Hospital of White County
Application for Financial Assistance

EXPENSES WORKSHEET

		Monthly	**Annual**
Electric Bill		$_____	$_____
Water Bill		$_____	$_____
Telephone Bill		$_____	$_____
Automobile Expenses		$_____	$_____
Clothing		$_____	$_____
Entertainment		$_____	$_____
Food (do not include food stamps)		$_____	$_____
Insurance:	Automobile	$_____	$_____
	Home	$_____	$_____
	Life & Health	$_____	$_____
Installment Payments:	House	$_____	$_____
	Car	$_____	$_____
	Other	$_____	$_____
Other Payments:	Hospital	$_____	$_____
	Doctor	$_____	$_____
	Other	$_____	$_____
TOTAL EXPENSES:		**$**_____	**$**_____

I certify that the above information is true and accurate to the best of my knowledge. As part of the application process, Advanced Care Hospital of White County may verify information contained in my application and in other documents required in connection with the application, either before the application is approved or as a part of its quality control program. Further, I will make application for any assistance (Medicaid, Medicare, insurance, etc.) which may be available for payment of my medical charges, and I will take action reasonably necessary to obtain such assistance and will assign or pay to Advanced Care Hospital of White County the amount recovered for medical charges. If any information I have given proves to be untrue, I understand that Advanced Care Hospital of White County may reevaluate my financial status and take whatever action becomes appropriate.

_____ _____
Applicant's Signature Date of Request

Patient Number: