| **White River Health System Financial Assistance Request Application** | White River Health System will not discriminate against any patient because of race, creed, national origin, physical disability or because the patient is covered by a particular program or insurance. |
|---|---|

I hereby request the hospital to make a determination of my eligibility for financial assistance.

Patient/Guarantor Name__________________________ Social Security Number_________________________________

Date of Birth__________________________

Telephone Number

Address__________________________________________

City, State, Zip _________________________

Marital Status Married ( ) Divorced ( ) Widowed ( ) Single ( )

Spouse Name_____________________________________

Your Employer______________________________Spouse Employer________________________________

Spouse SS#_________________________________Spouse Date of Birth_____________________________

**Dependents- Members of your family whom you provide more than half of their support**

| Name | Social Security # | Age | Relationship |
|---|---|---|---|
| ______________________________ | ___________________ | __________ | __________________ |
| ______________________________ | ___________________ | __________ | __________________ |
| ______________________________ | ___________________ | __________ | __________________ |
| ______________________________ | ___________________ | __________ | __________________ |
| ______________________________ | ___________________ | __________ | __________________ |

**Income from all sources**

Earned Income_______________________________________ Retirement___________________________

Social Security Income_________________________________ Other__________________________________

Child Support_______________________________

**Financial Resources**

Checking Account ( ) Rent ( ) Own ( ) Buying ( ) Saving Account ( ) Real Estate/ Property ( )

**Expenses**

Mortgage ( ) Rent ( ) monthly payment____________ Loans Car ( ) Payment ______________

Hospital amount owed ______________ Payment amount ______________

Credit Cards ( ) Monthly Payments _______________ ______________ ____________ _____________

**Medical Insurance**

Company Name:_____________________________________________________________________________

Policy Number:______________________________________________________________________________

Should the patient/guarantor be eligible for partial financial assistance, the balance of the account will be due in full unless satisfactory payments arrangements are made in compliance with hospital policy.

**I affirm the above information is true and correct to the best of my knowledge. Should it be determined that financial assistance has been provided based on false or incorrect information contained in the application I understand that the assistance provided may be reversed and may lead to legal recourse. I hereby authorize the hospital to render the above information available to any government agency as may be required to substantiate any obligation to render such uncompensated services.**

Signature of Individual Making Request Date

Witness Date