SPOC2570

APPLICATION FOR FINANCIAL ASSISTANCE

Financial Counselors
870–207–7228 or
870–207–7227

DATE:_________________

Please answer all questions as completely and as accurately as possible. If you do not have enough space for your answer, attach another sheet of paper to this application.

Please list everyone in your home including the patient and complete each space by their name:

Social Security Number	Last Name	First Name	Birth Date	Relationship to you	Employer

INCOME: DOES ANYONE IN YOUR HOME INCLUDING THE PATIENT HAVE INCOME FROM THE FOLLOWING?:

Monthly Income Please Circle Yes or No)		Name of Person's Receiving	How Often Received	Amount After Deductions
Employment/Work	Yes No			
Farming/Self–Employment	Yes No			
Rental of Property	Yes No			
Retirement Benefits	Yes No			
Social Security Benefits	Yes No			
Supplemental Security SSI	Yes No			
Veteran's/Other Pensions	Yes No			
Serviceman's Allotments	Yes No			
Job Corps Allotments	Yes No			
Child Support/Alimony	Yes No			
Contributions/Family, Friends	Yes No			
Unemployment Benefits	Yes No			
Worker's Compensation	Yes No			
Roomers or Boarders	Yes No			
Insurance	Yes No			
Savings or Dividends	Yes No			
Other (Babysitting, Part–time Work)	Yes No			

TOTAL MONTHLY INCOME $_________________________

PROOF OF MONTHLY INCOME AND CURRENT BANK STATEMENTS REQUIRED
Paycheck stubs, copy of monthly benefit checks.

Mail to: Financial Services, P.O. Box 1713, Jonesboro, AR 72403

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File Income Tax___(Yes) Attach a copy of your current 1040 Federal Income Tax Documents.
File Income Tax___(No) Explain:____
If you work ____(Yes) and do not make enough to file Income Tax, attach a copy of your W−2 Forms.
Have Checking account ____(Yes)____(No) If you marked (Yes), attach a current copy of your Bank Statement.
Have Savings account ____(Yes)____(No) If you marked (Yes), attach a current copy of your Savings Statement.
Receive Public Assistance___(Yes)___(No) If (Yes), attach proof of Food Stamps & HUD.

HUD $______________ Per Month Food Stamps $_________________ Per Month

Has anyone in your home worked in the last 6 months who is not working now? If yes, list their name, the last month/year in which the person worked, and the place they worked ________________________________

How have you been meeting your expenses for the past 6 months?_______________________________

MONTHLY EXPENSES:
Monthly House or Rent Payment .... $_________________
Monthly Car or Truck Payments .... $_________________
Monthly Bank Loan Payments .... $_________________
Monthly Credit Card Payments (List minimum amount payable per month) .... $_________________
Monthly Doctor, Dentist, or Hospital Payments .... $_________________
Monthly Utilities (Electric, Gas, Water, Telephone, Cable, Etc.) .... $_________________
Monthly Food, Clothing, Car Fuel, Donations .... $_________________
Monthly Student Loan Payments .... $_________________
Monthly Child Day Care Payment .... $_________________
Monthly Child Support Payment .... $_________________
Monthly Medicine (Amount not paid by Health Insurance Plans) .... $_________________
Insurance Premiums paid every month (Not paid through check deductions) .... $_________________
Insurance Paid every 3 months .... $_________________
Insurance Paid every 6 months .... $_________________
Insurance Paid every 12 months .... $_________________
Personal & Real Estate Tax per year .... $_________________

TOTAL MONTHLY EXPENSES .... $_________________

Please Read Before Signing

The information on this form is for the purpose of considering charity care. I certify that the information furnished is true and accurate to the best of my knowledge. I authorize St. Bernards Medical Center, its agent or any Credit Bureau or other Investigative Agency employed by St. Bernards to investigate the references herein listed, statements made, or other data obtained from me pertaining to my credit and financial responsibility. St. Bernards reserves the right to request verification or to adjust monthly living expenses for reasonableness. Applications cannot be processed without proof of income documents and will be returned to you.

Signed:____ Date:__________________

Telephone Number (Where you can be reached) Area Code ________ Number ________________________
Mailing Address:____
(Street or Post Office) (City) (State) (Zip Code)