DARDANELLE
REGIONAL MEDICAL CENTER

FINANCIAL ASSISTANCE APPLICATION

NAME: _____

ACCOUNT NUMBER: BALANCE:

_____ _____

_____ _____

_____ _____

_____ _____

TOTAL: $_____

1. Complete the next three pages of the application in full. Do not leave any pages blank. If it does not apply, put N/A in that space.

2. You must provide proof of all income expected proof may include but not be limited to most recent Income Tax Return or W-2, most recent paycheck stubs, proof of disability income, social security, checking/savings account statements, food stamps, etc.

3. You must provide proof of all bills including, but not limited to, proof of mortgage or rent, utilities, medical expenses, insurance and any other schedule or monthly payments.

4. Sign and date the 6th page of the application.

5. The application is due back within two weeks of receiving this application.

   The application and required information is due: _____

   After you turn in all information needed, we will place all accounts allowed by financial assistance on a hold status. You will receive a letter by mail in 60-90 days showing if you were approved and for how much. If you owe any remaining balance after financial assistance is applied, you may call or come in and set up on a payment arrangement.

If you have any questions or need assistance, please call:
Jamie Taylor at (479) 229-6134 in Patient Accounts.
Address: 200 N. 3RD STREET, DARDANELLE AR 72834

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Application for Financial Assistance

NAME: _____
(Last) (First)

Mailing Address: _____

_____

Telephone Number: _____

Social Security #:_____

Employer:_____How long? _____

Spouse's Name: _____

Spouse's Social Security #:_____

Spouse's Phone #: _____

Spouse's Employer:_____How long: _____

List all family members that live in your household. Include yourself.

Name (Last, First)	Date of Birth	Relationship
1.		
2.		
3.		
4.		
5.		
6.		

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Assets

(Please include names of financial institutions and copies of recent bank statements)

Checking Account: _____

Savings Account: _____

Real Estate: _____

Stocks / Bonds: _____

Other Assets (such as boats, motorcycles, etc.): _____

_____

***If you are applying for Financial Assistance on behalf of a deceased family member, please complete the following information:

Date of Death: _____

Is there an estate: Yes _____ No _____

In what county/state is the estate filed: _____

Executor's name: _____

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Income (Gross)

	Monthly	Yearly
Wages:	$_____	$_____
Spouse's Wages:	$_____	$_____
Other Household Wages:	$_____	$_____
Social Security:	$_____	$_____
Child Support / Alimony:	$_____	$_____
Unemployment:	$_____	$_____
Other Income:	$_____	$_____
Total Income:	$_____	$_____

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Expenses

	Monthly	Yearly
House Payment/Rent:	$_____	$_____
Electric/Gas:	$_____	$_____
Water:	$_____	$_____
Car Payment:	$_____	$_____
Telephone:	$_____	$_____
Child Support/Alimony:	$_____	$_____
Insurance:		
Car	$_____	$_____
Home	$_____	$_____
Life & Health	$_____	$_____
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, Dardanelle Regional Medical Center may verify information contained in my application and of other documents required in connection with the application either before the application is approved or as 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 hospital charges, and I will take any action reasonably necessary to obtain such assistance and will assign or pay to the hospital the amount recovered for hospital charges. If any information I have given proves to be untrue, I understand that the hospital may re-evaluate my financial status and take whatever action becomes appropriate.

_____ _____

Signature of Applicant Date