



Financial Counselors located at:
 405 E. Monroe, Suite C
 Jonesboro, AR
 (870) 207-7227
 (870) 207-7228

Application for Financial Assistance

PATIENT NAME: _____ DATE: _____

MEDICAL RECORD NUMBER: _____

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.

Application for Financial Assistance

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)