Washington Regional

ATTN: Guarantor/Patient

Please complete and return the request for financial assistance with documentation to support and validate income, expenses, and family unit size. Only provide the items that pertain to your situation. After receiving the complete application, we will review your request and provide you a final determination.

Please provide the following:

- Proof of Income
  - Check stubs for the past sixty days (60) for all family members in the household who receive income
  - Social Security income award letter
  - Unemployment Compensation benefits letter showing beginning and end date of payments
  - Real Estate income documents with income amount and terms on payment
  - Retirement Benefits income award letter
  - Child Support or Alimony check copies or legal document showing amount
  - Self-employed: year-to-date income statements as well as information from the prior year tax return

- A necessities letter if someone is providing you with financial assistance to meet your basic needs (example: food, rent or housing, utilities) from a relative or friend with their name, address and phone number.

- 1040 Tax Return – Federal and State from prior year with all schedules. Complete return required.

- Proof of Dependents - Birth Certificate and Social Security Card (both required) or Passport if not listed on the tax return.

- Two (2) most recent bank statements with full detail from ALL Bank Accounts.

- .Please provide a letter explaining your situation, your earning potential and how much longer assistance might be needed. Letters must be signed, dated and include a telephone number or other way that we may contact you if we have questions.

Please return the application with all required documents and information within ten business days to the address listed below.

Washington Regional Medical Center
PO Box 550
Lowell, AR 72745

Thank you,
Washington Regional Medical Center
479-463-6000

Washington Regional

APPLICATION FOR ASSISTANCE

Patient Name _____ Social Security #_____
DOB: _____ Address _____
City _____ State _____ Zip _____ Phone _____
Email Address _____(unable to accept Yahoo accounts)

HOUSEHOLD MEMBERS:

Name	Relationship to Patient	Listed on Taxes	Social Security#	DOB:
1._____	_____	_____	_____	_____
2._____	_____	_____	_____	_____
3._____	_____	_____	_____	_____
4. _____				

INCOME: List Gross Income of Total Household for: Monthly

Wages . . . . . _____
Farm/Self Employed/1099 and Appropriate Schedule . . . . . _____
Social Security/ Disability . . . . . _____ _____
Unemployment . . . . . _____
Workers' Compensation . . . . . _____
Alimony . . . . . _____
Child Support . . . . . _____
Military Family Allotments . . . . . _____
Pensions/ Retirement . . . . . _____
Income From Dividends, Interest, Rent, Etc . . . . . _____
Other . . . . . _____

EXPENSES:

Telephone _____ Electricity _____ Gas _____
Water _____ Food _____ Cable Bill _____
Rent☐ or **Mortgage**☐ _____. . . . . .Vehicle payment (s) _____
OTHER EXPENSES:
_____
_____
Total . . . . . _____ _____

BY SIGNING THIS CREDIT APPLICATION, I AGREE TO ALLOW WRMC TO CONTACT MY EMPLOYER, BANK OR OTHER SOURCES, AS WELL AS REQUEST A CREDIT HISTORY FOR THE PURPOSE OF DETERMINING MY CHARITY CARE ELIGIBILITY. I UNDERSTAND AND ACKNOWLEDGE THAT IF I DO NOT QUALIFY FOR SERVICES UNDER THE CHARITY CARE GUIDELINES THAT I WILL BE RESPONSIBLE AND PERSONALLY HELD LIABLE FOR THE CHARGES OF THE SERVICES RENDERED BY WRMC.

_____ _____
Signature of Person Making Request for Assistance Date