Saline Health Systems
1 Medical Park Drive
Benton, AR 72015
501-776-6040 or 501-776-6049

Application for Financial Assistance

PATIENT NAME _____ DOB _____ SSN _____
SPOUSE NAME _____ DOB _____ SSN _____
NUMBER OF DEPENDENTS _____ MARITAL STATUS _____ PHONE _____
ADDRESS (Do not enter P.O. Box) _____
EMPLOYER _____ PHONE _____
EMPLOYER ADDRESS _____
SPOUSE EMPLOYER _____ PHONE _____
EMPLOYER ADDRESS _____

LIST ALL HOUSEHOLD MEMBERS BELOW: (Include applicant if different from patient.)

NAME	BIRTHDATE	EMPLOYER	RELATION	SSN

Total Household Income: **Annual Amount**

WAGES (GROSS) _____
SOCIAL SECURITY INCOME _____
UNEMPLOYMENT INCOME _____
CHILD SUPPORT INCOME _____
PENSION INCOME _____
OTHER INCOME _____

Assets:

CHECKING ACCOUNT _____
SAVINGS ACCOUNT _____
CASH/OTHER LIQUID ASSETS _____
STOCKS/BONDS _____
REAL ESTATE _____
OTHER _____

DO YOU HAVE HEALTH INSURANCE? ☐ **YES** ☐ **NO**

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Expenses:

RENT/MORTGAGE _____
MEDICAL BILLS _____
TELEPHONE (HOME &/OR CELL) _____
UTILITIES _____
FOOD _____
LOANS _____
CREDIT CARDS _____

AUTOMOBILES/PAYMENTS:

MAKE	MODEL	YEAR	MONTHLY PAYMENT

ADDITIONAL INFORMATION OF COMMENTS YOU WOULD LIKE TO PROVIDE: _____
_____
_____

I hereby certify that I am of legal age and that the foregoing statements are true and complete to the best of my knowledge and are made for the purpose of determining my eligibility for financial assistance at Saline Health Systems. I authorize Saline Health Systems to make all inquiries that it deems necessary to verify the accuracy of the statements made herein. I understand that if I give any false information in the application, I may be denied financial assistance.

PATIENT'S SIGNATURE _____ DATE _____

SPOUSE'S SIGNATURE _____ DATE _____

BEFORE APPLICATION CAN BE CONSIDERED, A COPY OF YOUR MOST RECENT INCOME TAX RETURN AND CHECK STUB MUST BE ATTACHED. (IF NOT INCOME, INDICATE MEANS OF SUPPORT.)

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