WHITE ROCK MEDICAL CENTER

Patient Account Number

White Rock Medical Center
Financial Assistance Application

RETURN TO: White Rock Medical Center
9440 Poppy Drive
Dallas, Tx 75218
Attn: Monetta Ingram, Revenue Dept.
214-324-6014

Patient Name (Last, First, MI) Social Security Number

Patient Address City State Zip Code

Birth Date (Month/Date/Year) Telephone Number

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Separated ☐ Divorced

Employed: ☐ Yes ☐ No
Patient's Employer _____

Telephone #_____

Spouse's Name: _____ Employed: ☐ Yes ☐ No
Spouse's Employer _____

Telephone# _____

Other White Rock Medical Center accounts for your household with an unpaid balance (Please list patient's NAME, DOB and FACILITY NAME)

****If unemployed, please include the previous employer's name and telephone number****

A. ***Income:*** Please provide the income for each of the following persons in your household.

Patient ☐ Full Time ☐ Part Time – Hours/Week = _____
$_____ ☐ HR ☐ Wk ☐ Bi-Wk ☐ Month ☐ Year
$_____ Additional Income
Spouse ☐ Full Time ☐ Part Time – Hours/Week = _____
$_____ ☐ HR ☐ Wk ☐ Bi-Wk ☐ Month ☐ Year
$_____ Additional Income
Total Household Income $ _____

Please complete only if patient is a minor (if not leave blank)
Patient's Father ☐ Full Time ☐ Part Time – Hours/Week = _____
$_____ ☐ HR ☐ Wk ☐ Bi-Wk ☐ Month ☐ Year
$_____ Additional Income
Patient's Mother ☐ Full Time ☐ Part Time – Hours/Week = _____
$_____ ☐ HR ☐ Wk ☐ Bi-Wk ☐ Month ☐ Year
$_____ Additional Income
Total Household Income $ _____

B. ***Income Verification:*** Please provide verification ***(send only copies, no original documentation)*** for all sources of household income (acceptable documentation listed below). Check attached documents:

☐ Pay Check Remittance ☐ Employer Verification ☐ Credit Inquiry (completed by CHWR)
☐ IRS Form W-2 ☐ Tax Return ☐ Governmental Assistance (food stamps, CDIC, Medicaid, TANF)
☐ Bank Statement ☐ Other (describe below) ☐ Social Security, Workers Compensation or Unemployment Compensation Determination Letters

If you are unable to provide one of the sources of income documentation listed above, please explain why this information is not available:
_____

C. Family Members: Please provide the total number of people in the patient's household.
(This number should only include the patient, patient's spouse, and the patient's dependents)

D. Assets and Other Resources:

Do you have any assets or other resources available to you? ☐ Yes ☐ No If Yes, current amount available: $_____
(Examples include savings accounts, trusts, stocks, bonds, retirement accounts, mutual funds, etc.)
Do you have medical insurance: ☐ Yes ☐ No If Yes, please list provider name: _____
Do you have a Health Savings Account or Flexible Spending Account ☐ Yes ☐ No If Yes, current amount available: $_____.

I understand White Rock Medical Center ("WRMC" may verify the financial information contained in this Financial Assistance Application ("Application") in connection with CHWR's evaluation of this Application, and by my signature hereby authorize my employer or any individual listed on this Application to certify or provide additional details with respect to the information provided in this Application. I also authorize WRMC to request reports from credit reporting agencies and the Social Security Administration. I certify that the statements made in this Application are true and correct, to the best of my knowledge and belief, and are made in good faith. I am aware that falsification or misrepresentation of information on this Application may result in denial of financial assistance. I further understand that some physicians and providers may not be employees of WRMC. I understand that I may receive separate bills from those providers and this financial assistance application will not apply to those balances due.

_____ _____ ----------
Signature of Patient or Responsible Party **Printed Name** **Date**

For Hospital Use Only
☐ Application information obtained by WRMC Employee in person or over The phone, no patient signature required.

_____ _____
Electronic Signature of WRMC Employee or WRMC Representative Date

Notes Regarding Income Verification/Number in the Household: _____
_____

☐ Patient is part of community care program Program Name: _____