Little River Memorial Hospital
Financial Aid Office
451 West Locke Street
Ashdown, Ar. 71822

Dear Patient:

We at Little River Memorial Hospital want to extend our help to you for possible financial aid for the hospital services that you received. Our financial aid program is based on the need of the patient according to our hospital financial aid guidelines and helps with hospital charges here at Little River Memorial Hospital for qualifying patients.

The following instructions are provided to assist you in completion of the enclosed financial assistance applications. **All sections of the application must be completed, signed, and returned within fourteen (14) days in order for it to be considered.**

Section 1: Personal Information:
Please complete all sections that apply to your situation.

Section 2: Immediate family in the household/income. You will be required to submit copies of proof of income. **Your application cannot be processed without proof of income.** (Copy of your last year's income tax return as submitted to the IRS. Copy of pay stub, monthly social security or public aid checks, unemployment or workman's compensation, statement of gross wages from your employer, etc. If social security check is direct deposited, a copy of bank statement showing deposit).

Section 3: Expenses:
Examples of documentation required are copies of monthly statements, checks, receipts, and/or payment booklets. This includes all utilities, rent, medical expenses, car and insurance payments, life and medical insurance, credit card, and loan payments.

Section 4: Assets:
Examples of documentation required are copies of monthly statements showing current balance on checking and savings accounts.

Section 5: Additional Information:
Please complete all sections applicable to your situation and be sure that all Required signatures have been made.

Little River Memorial Hospital's financial assistance program is administered to determine eligibility for financial assistance for patients in need of temporary assistance. Each applicant must qualify under financial classification guidelines.

IN ORDER TO BE ELIGIBLE FOR ANY ASSISTANCE FROM LITTLE RIVER MEMORIAL HOSPITAL YOU MUST BE CURRENTLY ON MEDICAID OR INELIGIBLE FOR MEDICAID ASSISTANCE. IF YOU ARE INELIGIBLE, PLEASE ATTACH A COPY OF YOUR MEDICAID DENIAL.

Guidelines are based on:

- Monthly income
- Number of household members
- Rent, lease, or mortgage payments
- Utilities (electric, gas, water, phone)
- Medical expenses (Dr. bills, hospital and all medical therapies)
- Transportation (car note, car ins.)
- Life insurance and medical insurance
- Credit card debt or other existing loans
- Guidelines are based on the poverty guideline

If you have any questions or concerns, please contact:
Little River Memorial Hospital
451 W. Locke St.
Ashdown, Ar. 71822
(870) 898-5011
Ext. 3137

LRMH FINANCIAL STATEMENT

RESPONSIBLE PARTY	**SPOUSE**
NAME	NAME
ADDRESS	ADDRESS
CITY STATE ZIP	CITY STATE ZIP
PHONE NO. SS NUMBER	PHONE NO. SS NUMBER
EMPLOYER	EMPLOYER
PHONE NO.	PHONE NO.
NO. YEARS SUPERVISOR	NO. YEARS SUPERVISOR

TOTAL NUMBER OF DEPENDENTS (**CLAIMED ON TAX RETURN**) _____
List dependents (do not list you and your spouse, they are named above)

NAME / SOCIAL SECURITY NO.	**DATE OF BIRTH**

COMPLETE ALL APPLICABLE INCOME

List Gross Income for **ENTIRE** family:	Current Month	Last 12 Months
Wages		
Public Assistance - (Food Stamps/Disability)		
Social Security		
Unemployment Compensation		
Workman's Compensation		
Alimony		
Child Support		
Military Family Allotments		
Pensions		
Trusts, Dividends, Interest, Rent, Etc.		
TOTAL INCOME		

LIST OF EXPENSES

Owed to Whom	Phone No.	Monthly Pmt.	Balance

PERSONAL ASSETS/RESOURCES (Documentation may be required)

Cash in Checking:_____
Cash in Savings/Investments:_____
Real Estate/Property: Value _____ Location _____
Livestock: Value_____ Location _____
RV YES NO Model/Year: _____
3 or 4 Wheeler YES NO Model/Year _____
Boat YES NO Model/Year _____
Motorcycles YES NO Model/year _____
Car/Truck Make:_____ Year _____
Car/Truck Make: _____ Year _____

LIST ONE RELATIVE AND ONE FRIEND NOT LIVING IN YOUR HOME:

NAME	ADDRESS	PHONE
_____	_____	_____
_____	_____	_____

PLEASE ATTACH A COPY OF YOUR LAST YEAR'S INCOME TAX RETURNS AND VERIFICATION OF YOUR TOTAL INCOME STATED ABOVE.
(Copies of paycheck stubs, monthly social security or public aid checks, unemployment or workman's compensation, statement of gross wages from your employer, etc.)

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All information provided herein is correct to the best of my knowledge and belief, and I have been given opportunity to ask any questions that I might have regarding this document. I understand that by signing below I am giving authorization for LRMH to verify the information provided by obtaining my current credit report and/or contacting the listed employer(s) for the purposes of confirming my income and employment history. I understand that if my information provided on this application is found to be materially false or cannot be confirmed may result in denial of this application for financial assistance.

ALL FOUR PAGES MUST BE COMPLETED AND RETURNED, TO ASSURE YOUR REQUEST WILL BE PROCESSED. If you have any questions please call LRMH Patient Accounts Department at (870) 898-5011 Ext. 3137

_____	_____
SIGNATURE OF APPLICANT	SIGNATURE OF SPOUSE
_____	_____
DATE	DATE