OUACHITA COUNTY MEDICAL CENTER
Financial Assistance Application

Name of patient:	SSN:
Name of spouse:	SSN:
Number of dependents:	Phone number:
Address:	
Employer:	Phone number:
Employer's Address:	
Spouse's Employer:	Phone number:
Employer's Address:	

Monthly Household Income: ____
Please attach a copy of a recent pay stub, tax return, social security or disability statement, or other documentation of income.

Assets: Please include names of financial institutions and copies of recent bank statements.

Checking Account:	Savings
Other liquid assets:	Stocks/bonds
Real estate	
Other	

Monthly bills: Please attach documentation such as a copy of payment coupon or monthly statement.

Mortgage/Rent:	Credit cards:
Car payment:	Other:

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 Ouachita County Medical Center. I understand that this application is and shall remain the property of Ouachita County Medical Center. I authorize Ouachita County Medical Center to make all inquiries that it deems necessary to verify the statements made herein. I understand that if I give any false information in this application, I may be denied Financial Assistance.

____ ____________________
Applicant's signature Date