Application for
Medicare Waiver Medicare Bad Debt Financial Assistance

DATE:_____ **Date First Statement:**_____

NAME: _____

Medicare ID: _____ **Medicaid ID**: _____

ACCOUNT NUMBER:	**BALANCE:**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

(Please use back of this page, if needed.) Total: $ _____

1. Complete the next three pages of the application in full. Do not leave any pages blank. If it does not apply put N/A in that space.

2. You must provide proof of income such as a current check stub, W-2, or Disability.

3. You must provide proof of all bills.

4. Sign and date the 4th page of the application.

5. Business Office will make copies, if you do not have access to a copier.

6. The application is due back within two weeks of receiving this application. The application and required information is due: _____

After you turn in all information needed you will receive a letter by mail in 60-90 days showing if you were approved and for how much. If you owe any remaining balance after financial assistance is applied you may call or come in and set up on a payment arrangement.

If you have any questions or need assistance please call: **479-495-2241 Ext 355**

Physical address: 719 Detroit Ave, Danville, AR 72833
Mailing address: P.O. Box 639, Danville, AR 72833

NAME:

_____

(Last) (First)

Mailing Address: _____

_____

_____

Telephone Number: _____

Social Security#: _____

Spouse's Name: _____

Spouse's Social Security#: _____

Spouse's Phone#: _____

List all family members that live in your household including yourself

Name (Last, First)	**Date of Birth**	**Relationship**
1.		
2.		
3.		
4.		
5.		
6.		

Assets

(Please include names of financial institutions and copies of recent bank statements)

Checking Account: _____

Savings Account: _____

Real Estate: _____

Stocks / Bonds: _____

Other Assets (such as boats, motorcycles, etc.): _____

_____

_____

_____

_____

Income (Gross)

	Monthly	**Last 12 Months**
Wages:	**$**_____	$_____
Spouse's Wages:	**$**_____	**$** _____
Other Household Wages:	**$**_____	**$** _____
Social Security:	**$**_____	**$** _____
Child Support / Alimony:	**$**_____	**$** _____
Unemployment:	**$**_____	**$** _____
Other Income:	**$**_____	**$** _____
Total Income:	**$** _____	**$** _____

Expenses

	Monthly	Last 12 Months
House Payment / Rent:	**$**_____	**$** _____
Electric / Gas:	**$**_____	**$** _____
Water:	**$**_____	**$** _____
Car Payment:	**$**_____	**$**_____
Telephone:	**$**_____	**$** _____
Child Support / Alimony:	**$**_____	**$** _____
Insurance:	**$**_____	**$** _____
Car	**$**_____	**$**_____
Home	**$**_____	**$**_____
Life & Health	**$**_____	**$**_____
Other:	**$**_____	**$**_____
Total Expenses:	**$** _____	**$** _____

I certify that the above information is true and accurate to the best of my knowledge. As part of the application process, Chambers Memorial Hospital may verify information contained in my application and of other documents required in connection with the application either before the application is approved or as part of its quality control program. Further, I will make application for any assistance (Medicaid, Medicare, Insurance, etc.) which may be available for payment of my hospital charges, and I will take any action reasonably necessary to obtain such assistance and will assign or pay to the hospital the amount recovered for hospital charges. If any information I have given proves to be untrue, I understand that the hospital may re-evaluate my financial status and take whatever action becomes appropriate.

_____ ____/____/____

SIGNATURE OF APPLICANT **DATE**