APPLICATION INSTRUCTIONS

Failure to follow Instructions could cause a delay in processing your application. Please read carefully and respond accordingly.

PLEASE COMPLETE AND RETURN ASAP TO ENSURE YOUR ACCT DOES NOT GO TO COLLECTIONS

FINANCIAL ASSISTANCE: Baxter Health will provide services without charge or at amounts less than our established rates, to patients who meet the criteria for financial assistance through our uncompensated care program.

The criteria for financial assistance are based on household income, net worth, and extent of financial obligations paid to healthcare providers over the past 12 months. Discounts are provided on a sliding scale based on the "Federal Poverty Level Guidelines."

If you wish to apply for financial assistance and\or allow the Hospital to determine your eligibility for financial assistance, you must complete the attached Financial Statement in its entirety (SIGN AND DATE) and return it with* CLEAR AND PRECISE COPIES *of the following information attached.

1 ➢ **Most Current FEDERAL TAX RETURN** (complete with all attachments)

2 ➢ **VERIFICATION OF HOUSEHOLD INCOME**

- (i.e.: copies of last two paycheck stubs, monthly social security or public aid checks, food stamps, government housing, HUD, unemployment or workers' compensation, statement of gross wages from employer, alimony & child support income (divorce decree), etc.)
- **PLEASE EXPLAIN RANDOM CASH DEPOSITS** in the income sources section of the application.

3 ➢ **LAST TWO BANK STATEMENTS**

- **ALL Bank Accounts. Ex:** Checking, Savings, Christmas Club Etc.
- **EVERY PAGE of Bank Statement- even those intentionally left blank.**

4 ➢ **MEDICAID DENIAL** - You must be **SCREENED** for Medicaid to qualify for financial assistance. ***Please call (870) 508-7058 or (870)508-3064 for screening.***

5 ➢ **OPTIONAL- Verification of Out of Pocket expenses PAID BY YOU over the past 12 months, for medications & medical care.** Print outs from your pharmacy and\or physician office, are required for verification.

- **Please Do NOT Send BILLS- We are reducing your income by subtracting any amount PAID BY YOU for medical expenses from your income. We are not trying to determine how much medical debt you have.**

If you have any questions, please call your counselor at 870-508-1080

PLEASE RETURN TO:

Baxter Health
Attention Cashier
624 Hospital Drive
Mountain Home AR 72653

FINANCIAL STATEMENT

RESPONSIBLE PARTY / PATIENT

_____
NAME

_____
MAILING ADDRESS

_____
CITY STATE ZIP

_____ _____
PHONE NUMBER SOCIAL SECURITY

DATE OF BIRTH: _____

_____
EMPLOYER EMPLOYER PHONE

_____
OCCUPATION / POSITION / TITLE

_____ _____
YEARS OF EMPLOYMENT SUPERVISOR

HOUSEHOLD INFORMATION/DETAILS

Total Number of Dependents _____
(# claimed on Tax Return)

HOME: Rent ____ / Own____ / Buying ___

Home Value: _____

Have you filed bankruptcy in the past 14 years?
YES or NO

HOUSEHOLD PARTNER INFO-

If you have a partner, they MUST complete this:

NAME: _____

DATE OF BIRTH: _____

SOCIAL SECURITY NUMBER: _____

MONTHLY GROSS INCOME FOR ENTIRE FAMILY (Household Application- All Income must be disclosed)			
NAME:	*SOURCE:	AMOUNT:	DEPOSITED WHERE: Name of Bank and Last 4 of Account #
NAME:	*SOURCE:	AMOUNT:	DEPOSITED WHERE: : Name of Bank and Last 4 of Account #
NAME:	*SOURCE:	AMOUNT:	DEPOSITED WHERE: : Name of Bank and Last 4 of Account #
NAME:	*SOURCE:	AMOUNT:	DEPOSITED WHERE: : Name of Bank and Last 4 of Account #

***EXAMPLES OF SOURCE:** Wages, Pension, Social Security, Child Support, Alimony, Short/Long Term Disability, Unemployment, Workers Compensation, Public Assistance, Food Stamps, Trusts, Dividends, Interest, Rental Income Etc. **PLEASE LIST ADDITIONAL SOURCES ON BACK**

PLEASE USE THE FOLLOWING CHECK-LIST TO ENSURE EVERYTHING IS ENCLOSED/COMPLETE

☐ LAST FEDERAL (IRS) TAX RETURN
☐ HOUSEHOLD INCOME VERIFICATION
☐ LAST TWO BANK STATEMENTS
☐ MEDICAL RECEIPTS FOR HOUSEHOLD
☐ **MEDICAID SCREENING** - You must be **SCREENED** for Medicaid to qualify for financial assistance.

- ***For Medicaid screening, please call (870) 508-3064 or (870)508-7058.***

FOR QUESTIONS PLEASE CALL (870) 508-1080 / Ask to speak with a Financial Counselor

All information provided herein is correct to the best of my knowledge and belief, and I have been given opportunity to ask questions that I might have regarding this document. I understand that by signing below I am giving authorization for Baxter County Regional Hospital 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 any information provided on this application, which is found to be materially false or which cannot be confirmed may result in denial of this application.

_____ _____
Applicant Signature Date Partner/Spouse Signature Date

Household Partner/Spouse MUST Sign and Date Above