Baptist Health
all our best

Arkansas Health Group
A Baptist Health Affiliate

FINANCIAL ASSISTANCE CHECKLIST

To be eligible for assistance, the following Financial Assistance form requirements must be completed:

- ❑ Attach the required copy of your most recent complete tax return.
  - ❑ or a Social Security benefit letter
  - ❑ or other proof of income
- ❑ Answer all questions completely.
- ❑ Sign and date the Application for Assistance on page 2.
- ❑ Return the Application for Assistance with current tax return in the self-addressed envelope.

MAIL TO: **Baptist Health/Arkansas Health Group Customer Service**
904 Autumn Road, Suite 400
Little Rock, AR 72211

This application is also available in Spanish on the Baptist Health/Arkansas Health Group website or by calling (501) 202-3900.

Esta Solicitud esta disponible en Español, en la página de internet del hospital Baptist Health/Arkansas Health Group.
La dirección de internet es: www.baptist-health.com
O llamenos a: (501) 202-3900.

PLEASE RETURN THE APPLICATION INFORMATION PROMPTLY TO AVOID ADDITIONAL STATEMENTS.

PPS#69338-061418

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Patient Financial Services
904 Autumn Road, Suite 400
Little Rock, AR 72211

FINANCIAL ASSISTANCE GUIDELINES PLAIN LANGUAGE SUMMARY

Since 1920, Baptist Health/Arkansas Health Group has provided patient-centered services with Christian compassion and personal concern. Consistent with our mission, Baptist Health/Arkansas Health Group offers financial assistance to eligible patients. Baptist Health/Arkansas Health Group will provide emergency or medically necessary care to individuals regardless of their ability to pay.

Patients without insurance (who do not qualify for any third party or government health benefits) will receive an automatic discount of 74% off their billed charges. This discount will be taken before a patient's billing statement is sent. Questions about the uninsured discount should be directed to Patient Financial Services at (501) 202-3900.

For insured or non-insured, additional financial assistance discounts are available on a sliding scale based upon income levels of the current Federal Income Poverty Guidelines. Up to 100% of billed charges may be provided based on completion and evaluation of an Application for Financial Assistance, with required supporting documentation. Financial need does not consider age, gender, race, social or immigrant status, sexual orientation, or religious affiliation.

ELIGIBILITY CRITERIA

Baptist Health will perform an assessment of medical necessity and financial ability, and based on the assessment results, may provide free or discounted care to patients who qualify for financial assistance under this policy. Standard procedures will be followed in determining eligibility.

To be eligible for financial assistance, the following steps must be completed:

1. Answer all questions completely
2. Sign and date the Application for Financial Assistance
3. Attach a copy of all required documentation (see below)
4. Return the Application for Financial Assistance with required documentation

Application should be returned to:

Baptist Health Customer Service, 904 Autumn Road, Suite 400, Little Rock, AR 72211

For questions, please call 501-202-3900.

Required Documentation (as applicable):

- Signed Application for Financial Assistance;
- If applicable: Complete copy of most recent Tax Return with attachments;
- If patient does not file taxes: proof of earnings (check stub, payroll record, or letter from employer);
- If applicable: Proof of disability (Social Security Administration Benefits letter)
- In some cases, additional documentation may be required to determine eligibility

Patients who do not provide the requested information may not be eligible for financial assistance. In addition, patients seeking financial assistance are expected to cooperate with any efforts to secure other healthcare coverage prior to financial assistance determination. Applicants of all ages are eligible for financial assistance.

This policy applies to all emergency and medically necessary care provided by the hospital, including, all such care provided in the hospital facility by a substantially related entity. The policy does not apply to physicians, Radiology Consultants, Pathology Labs of Arkansas, or any other outside services.

If you believe you may be eligible for financial assistance, please ask your Admissions Representative for an application. The application can also be requested:

By phone: Patient Financial Services at (501) 202-3900

In writing: Patient Financial Aid Office, 904 Autumn Road, Suite 400, Little Rock, AR 72211

The Baptist Health/Arkansas Health Group financial assistance policy, plain language summary and application are available to the public at all facilities and on the web at https://www.baptist-health.com/patients-visitors/insurance-financial-assistance/.

FOR HOSPITAL USE

Baptist Org#_____ Dept._____ Case#_____ User ID#_____

A member of the VHA alliance

APPLICATION FOR ASSISTANCE

Before this application can be considered, we must have a copy of your most recent tax return.

Patient Name _____ Social Security # _____

Address_____ Phone _____

City_____ State_____ Zip _____

HOUSEHOLD MEMBERS:

	Name	Age	Employer	Relationship to Patient
1.				
2.				
3.				
4.				
5.				

INCOME: List Gross Income of Total Household for:	**Last Twelve Months**
Wages	
Farm/Self Employed	
Public Assistance	
Social Security	
Unemployment	
Workers' Compensation	
Strike Benefits	
Alimony	
Child Support	
Military Family Allotments	
Pensions	
Income From Dividends, Interest, Rent, Etc	
Other	

EXPENSES: List All Expenses as Requested Below:	**Average Cost**	**Monthly Payment**
Medical and Dental		
Childcare		
Rent or Mortgage		
Property Taxes (if not included in mortgage)		
Telephone		
Electricity		
Gas		
Water		
Food		

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OTHER EXPENSES:

_____

_____

_____

_____

MAIL TO: **Baptist Health/Arkansas Health Group Customer Service**
904 Autumn Road, Suite 400
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LIST ALL CARS, TRUCKS, BOATS, MOBILE HOMES, CAMPERS, MOTORCYCLES OR OTHER VEHICLES:

	Make	Model	Year	Monthly Payments	Loan Balance
1.					
2.					
3.					
4.					

Do you or any member of your household own real estate or other property, including house property, land, or buildings? YES _____ NO _____

If YES, please provide information regarding the value of the property, any amount owed, and how the property is used.

VALUE _____ AMOUNT OWED _____

	YES	NO
Is this rental property?		
Do you have health insurance?		
Do you have disability income insurance?		

If yes to health insurance or disability income insurance, please list:

PAYER NAME _____

POLICY NUMBER _____

I AFFIRM THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I AUTHORIZE BAPTIST HEALTH/ARKANSAS HEALTH GROUP TO OBTAIN A COPY OF MY CREDIT REPORT IF DEEMED NECESSARY TO AID IN DETERMINING MY ELIGIBILITY FOR FINANCIAL ASSISTANCE.

_____ _____
Signature of Person Making Request for Assistance Date

FOR HOSPITAL USE

APPROVED ❑ DENIED ❑

_____ _____
Signature Date

Account 1_____ Account 3_____ Account 5_____
Account 2_____ Account 4_____ Account 6_____