



Arkansas Methodist
MEDICAL CENTER

**FINANCIAL ASSISTANCE APPLICATION
ARKANSAS METHODIST MEDICAL CENTER
900 W. KINGSHIGHWAY
P. O. BOX 339
PARAGOULD, AR. 72451-0339
870-239-7129**

The following documentation is required to process your Financial Assistance Application. If you are unable to provide any of the information, you must note an explanation. Please return the following information with your completed application.

_____ **Copy of most recent Income Tax Return.**_____ Please check if you are exempt from filing taxes and explain why you are exempt or your application will be denied. _____.

_____ **Proof of Current Income.**
You may provide check stubs (minimum one month) or an official statement on letterhead from Employer. If you receive Social Security only, you may obtain a printout from the Social Security Office.

_____ **Completed Adult Patient Medicaid Eligibility Questionnaire** (attached)

_____ **Current bank statements** (past TWO months)_____ Check here if you do not have a bank account.

Please return this application with requested information to:

Arkansas Methodist Hospital
Business Office
c/o Crysty Henry
900 West Kingshighway
PO Box 339
Paragould, AR 72450
Phone: (870) 239-7129
Email: Crystyl.Henry@arkansasmethodist.org

Adult Patient Medicaid Eligibility Questionnaire

1. Are you over 65 years of age or blind? _____
(*If yes, you may qualify for Medicaid)

2. Are you pregnant? _____
(*If yes, you may qualify for Medicaid)

3. Are you disabled? _____
(If no, skip to question 4)

If yes, are you receiving disability payments from Social Security? _____
(*If yes, you may qualify for Medicaid) Answer question 5

If no, are you currently in the appeal process with Social Security? _____

4. Do you have minor children (under age 18) living in your household that are in your **legal custody**? _____

If yes, are both biological parents of these children living in the household?

If no, is child support received? _____

If no, are you willing to pursue child support? _____

If yes, are one or both parents employed? _____

If no, are one or both parents disabled? _____

(*If there is deprivation such as a missing, unemployed or disabled parent to minor children in the household, you may be eligible for Medicaid) Answer question 5

5. Do you have three times the amount of your monthly household income in unpaid medical bills? _____

This assistance program is contingent upon the patient exhausting all other avenues of medical coverage including Medicaid. You must be ineligible for Medicaid assistance or be denied by the Department of Human Services Office in your county of residence to receive financial assistance.

Please list your expenses.

Monthly House or Rent payment	\$
Monthly Car or Truck payment	\$
Monthly Bank Loan payment(s)	\$
Monthly Credit Card payments (minimum)	\$
Monthly Doctor or Hospital payments	\$
Monthly Utilities (Electric, Gas, Water, phone, etc.)	\$
Monthly Food, Clothing, Auto Fuel	\$
Monthly Student Loan payment	\$
Monthly Child Day Care payment	\$
Monthly Child Support payment	\$
Monthly Medicine (your out-of-pocket expense)	\$
Insurance premiums	\$
OTHER (please specify)	\$
TOTAL MONTHLY EXPENSES	\$

Personal Property & Real Estate Paid Yearly \$ _____

DECLARATION

- I affirm that the above information I have supplied to Arkansas Methodist Medical Center is true and correct to the best of my knowledge.
- I understand that I may be asked to prove my statements, and that my eligibility will be Subject to verification by contact of my employer, bank, etc...
- I understand that my application cannot be processed without the proof of income documents.
- I understand that if I do not qualify for AMMC Financial Assistance program, that I may qualify for reduced payments on a Sliding scale payment program.
- **I understand that assistance is contingent upon exhausting all other avenues of medical coverage including Medicaid and that I must be ineligible or denied Medicaid by the Dept. of Human Services for reasons outside of my control in the county where I reside.**

SIGNED: _____ **DATE:** _____

****FOR BUSINESS OFFICE ONLY****

APPROVED: _____ **DISAPPROVED:** _____

SIGNATURE: _____

DATE: _____