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
900 W. Kingshighway
PO Box 339
Paragould, AR 72451
Phone: (870) 239-7129

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, 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.

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I hereby request Arkansas Methodist Medical Center Business Office to make a determination of my eligibility for the AMMC Financial Assistance Program.

Patient Name_____
Guarantor on Account_____

Patient Information:
Address_____ Telephone #_____
_____ Date of Birth_____
_____ SSN_____

Do you currently receive any type of Public assistance? YES / NO
If yes, what type? ___SNAP ___ArKids ___HUD ___Medicaid ___**Other (please explain)**
Are you Medicaid eligible? YES / NO ***Complete Questionnaire**

Are you employed? _____ (If YES, attach copies of recent check stubs)

If unemployed, please explain _____

Total Household Income for prior three (3) months _____

How have you been meeting your expenses for the past six (6) months _____
_____

Please list each member in your household, their date of birth and their relation to you.

Household Member Name	DOB / Relation

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.

SIGNED: _____ DATE: _____

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

APPROVED: _____DISAPPROVED: _____

SIGNATURE: _____
DATE:_____