Baxter Regional Medical Center

Applicant Name: _____

Date: _____

FINANCIAL ASSISTANCE: Baxter Regional Medical Center 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 allow the Hospital to determine your eligibility for financial assistance, you must complete the attached Financial Statement in its entirety, and return it with copies of the following information attached.

- **Copy of Most Current Tax Return** (complete with all attachments)
- **Copy of Most Current Tax Assessment** (personal and real property taxes)
- **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 worker's compensation benefits, statement of gross wages from employer, alimony & child support income (divorce decree), etc.)
- **Complete Copies of Your Last Two Bank Statements, on *ALL* Bank Accounts.**
- **Medicaid Denial** - You must apply for Medicaid to be eligible for financial assistance.
  - For assistance or to be screened for eligibility, please call (870) 508-7058
- **Verification of Out of Pocket expenses paid over the past 12 months, for medications & medical care.** Print outs from your pharmacy and you're your physician's office are required for verification.
  - Please Do Not Send Monthly Statements or Prescriptions Receipts!

If you have any questions or need assistance, please call (870) 508-1080 and ask to speak with a Financial Counselor, they will be happy to assist you.

FINANCIAL STATEMENT

RESPONSIBLE PARTY

NAME

ADDRESS

CITY STATE ZIP

PHONE NO. SOCIAL SECURITY

DATE OF BIRTH: _____

EMPLOYER

EMPLOYER PHONE NO.

OCCUPATION / POSITION / TITLE

NO. OF YEARS SUPERVISOR

SPOUSE

NAME

DATE OF BIRTH SOCIAL SECURITY

SPOUSE'S EMPLOYER

TOTAL NUMBER OF DEPENDENTS _____
(# claimed on tax return)

HOME: RENT ____ \ OWN _____\ BUYING _____

HOME VALUE: $_____

Have you filed bankruptcy in the past 14 years?
Yes \ No

INCOME - LIST GROSS INCOME FOR *ENTIRE* FAMILY:	**LAST 12 MONTHS**
WAGES - SOCIAL SECURITY - PENSIONS	
PUBLIC ASSISTANCE (FOOD STAMPS / DISABILITY)	
UNEMPLOYMENT - WORKERS COMPENSATION	
ALIMONY - CHILD SUPPORT - MILITARY FAMILY ALLOTMENTS	
TRUSTS, DIVIDENDS, INTEREST, RENT, ETC.	
TOTAL INCOME	

To verify income attach a copy of your last year's income tax returns, current tax assessment (personal, real property), verification of YOUR TOTAL INCOME stated above, and copies of your last two bank statements on all bank accounts. (i.e., copies of paycheck stubs, monthly social security or public aid checks, unemployment or worker's compensation, statement of gross wages from your employer, bank account statements, etc.)

Medicaid Denial - You must apply for Medicaid to qualify for financial assistance.

- For assistance, please (870) 508-7058

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

All information provided in this application is correct to the best of my knowledge, and I have been given opportunity to ask questions regarding financial assistance. I understand that by signing below I am giving authorization for BRMC 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 that is found to be materially false or cannot be confirmed may result in denial of this application for financial assistance.

Signature of Applicant Date

Signature of Spouse if Applicable Date