BAXTER HEALTH

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 ACCOUNT 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. Please **do not fax or email documents**, as it may delay or prevent you from being considered for financial assistance.

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 and 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, including checking, savings, Christmas Club, etc.
   - EVERY PAGE of bank statements, 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 and medical care. Printouts 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 a Financial Counselor at 870-508-1080.

PLEASE MAIL APPLICATION AND REQUESTED DOCUMENTS IN ONE ENVELOPE 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 # of dependents (# CLAIMED ON TAX RETURN) _____

Home value: _____

____ RENT ____ OWN ____ BUYING

Have you filed bankruptcy in the past 14 years?

____ YES ____ NO

HOUSEHOLD PARTNER / SPOUSE INFO

If you have a spouse/partner, they MUST complete this section and sign and date below.

NAME

DATE OF BIRTH SOCIAL SECURITY #

EMPLOYER YEARS OF EMPLOYMENT

MONTHLY GROSS INCOME FOR ENTIRE FAMILY (HOUSEHOLD APPLICATION: ALL INCOME MUST BE DISCLOSED)

NAME:	*SOURCE:	AMOUNT:	DEPOSITED WHERE: Bank and Last 4 of Account #
NAME:	*SOURCE:	AMOUNT:	DEPOSITED WHERE: Bank and Last 4 of Account #
NAME:	*SOURCE:	AMOUNT:	DEPOSITED WHERE: Bank and Last 4 of Account #
NAME:	*SOURCE:	AMOUNT:	DEPOSITED WHERE: 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 CHECKLIST TO ENSURE EVERYTHING IS ENCLOSED/COMPLETE

- ☐ LAST FEDERAL (IRS) TAX RETURN
- ☐ LAST TWO BANK STATEMENTS
- ☐ HOUSEHOLD INCOME VERIFICATION
- ☐ 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.

WITH QUESTIONS, PLEASE CALL 870-508-1080 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 the opportunity to ask questions that I might have regarding this document. I understand that by signing below I am giving authorization for Baxter Health 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 COMPLETE ABOVE SECTION AND SIGN / DATE APPLICATION.