Arkansas Methodist
Medical Center

900 WEST KINGSHIGHWAY
P O BOX 339
PARAGOULD AR 72450

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. Your application will not be considered unless all required documentation is provided.

APPLICATION MUST BE COMPLETE AND RETURNED WITHIN TEN DAYS. APPLICATIONS LACKING INFORMATION WILL BE DENIED.

_____ **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.

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

_____ **Proof of Medicaid denial or exemption from the ACA Marketplace.**

Please return this application with requested information to:

Arkansas Methodist Hospital

Adult Patient Arkansas Marketplace Eligibility Questionnaire

Have you applied for Medicaid or insurance coverage through the Arkansas Marketplace? __________________

The deadline to sign up for insurance through the Arkansas Marketplace Exchange is March 31st. You must sign up for coverage if you are an Arkansas resident or face a penalty. We here at AMMC will be happy to guide you through the process if you do not have access to a computer with internet service. If you are low income you may qualify for Medicaid or insurance coverage at no cost to you. There is no set enrollment period for Medicaid; you can apply at any time if you qualify.
You are welcome to complete the process on your own at www.healthcare.gov
You can also call the healthcare hotline at 1-800-318-2596 There are operators to answer questions and/or help you sign up for coverage 24/7. Please feel free to contact me by phone if you have any questions:

Aubrey Stromire- FINS Financial Solutions Inc. / Arkansas Methodist Medical Center 900 W. Kingshighway, Paragould, AR. 72450
Phone: (870) 239-8018 | Fax: (870) 239-7283
Aubrey.Stromire@arkansasmethodist.org

FINANCIAL ASSISTANCE APPLICATION

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? ___Food Stamps ___AR Kids ___HUD ___Medicaid ___**Other**

(Please explain)

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 _______________

____

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	
MONTLYLY 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 set up payment arrangements.

●I understand that assistance is contingent upon exhausting all other avenues of medical coverage including Medicaid and/or insurance coverage through the Marketplace 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. If Marketplace coverage is beyond your financial means and you are exempt from the ACA mandate, you may still qualify for financial assistance.

SIGNED: ________________________________ DATE: __________________

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

APPROVED: ___________________ DISAPPROVED: _________________________

SIGNATURE: ______________________________ DATE: ___________________