

FINANCIAL ASSISTANCE CHECKLIST

To be eligible for assistance, the following Financial Assistance form requirements must be completed:

- Attach the required copy of your most recent complete tax return.
 - or a Social Security benefit letter
 - or other proof of income
- Provide three (3) months' worth of Current Bank Statements.
- Answer all questions completely.
- Sign and date the Application for Assistance on page 2.
- Return the Application for Assistance with current tax return in the self-addressed envelope.

MAIL TO: Baptist Health/Arkansas Health Group Customer Service
11001 Executive Center Drive, Suite 100
Little Rock, AR 72211

This application is also available in Spanish on the Baptist Health/Arkansas Health Group website, www.baptist-health.com, or by calling (501) 202-3900.

Esta Solicitud esta disponible en Español, en la página de internet del hospital Baptist Health/Arkansas Health Group. La dirección de internet es: www.baptist-health.com
O llámenos a: (501) 202-3900.

PLEASE RETURN THE APPLICATION INFORMATION PROMPTLY TO AVOID ADDITIONAL STATEMENTS.

FINANCIAL ASSISTANCE GUIDELINES PLAIN LANGUAGE SUMMARY

Since 1920, BAPTIST HEALTH has provided patient-centered services with Christian compassion and personal concern. Consistent with our mission, BAPTIST HEALTH offers financial assistance to eligible patients. Baptist Health will provide emergency or medically necessary care to individuals regardless of their ability to pay.

Patients without insurance (who do not qualify for any third party or government health benefits) will receive an automatic discount of 75% off their billed hospital charges. Baptist Health uses a look-back method based on claims allowed by Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period. The discount will be taken before a patient's billing statement is sent. Questions about the uninsured discount should be directed to Patient Financial Services at (501) 202-3900.

For insured or non-insured, additional financial assistance discounts are available on a sliding scale based upon income levels of the current Federal Income Poverty Guidelines. Up to 100% of billed charges may be provided based on completion and evaluation of an Application for Financial Assistance, with required supporting documentation. Financial need does not consider age, gender, race, social or immigrant status, sexual orientation, or religious affiliation. Patients who are eligible for Financial Assistance cannot be charged more than the amounts generally billed for emergency or other medically necessary care.

ELIGIBILITY CRITERIA

Baptist Health will perform an assessment of medical necessity and financial ability, and based on the assessment results, may provide free or discounted care to patients who qualify for financial assistance under this policy. Baptist Health does not delay care for patients who have a past due financial balance. Standard procedures will be followed in determining eligibility.

To be eligible for financial assistance, the following steps must be completed:

1. Answer all questions completely
2. Sign and date the Application for Financial Assistance
3. Attach a copy of all required documentation (see below)
4. Return the Application for Financial Assistance with required documentation

Application should be returned to:

Baptist Health Customer Service, Patient Financial Aid Office, 11001 Executive Center Drive, Suite 100, Little Rock, AR 72211

For questions, please call 501-202-3900.

Required Documentation (as applicable):

- Signed Application for Financial Assistance;
- If applicable: Complete copy of most recent Tax Return with attachments;
- If patient does not file taxes: proof of earnings (check stub, payroll record, or letter from employer);
- If applicable: Proof of disability (Social Security Administration Benefits letter)
- In some cases, additional documentation may be required to determine eligibility

Patients who do not provide the requested information may not be eligible for financial assistance. In addition, patients seeking financial assistance are expected to cooperate with any efforts to secure other healthcare coverage prior to financial assistance determination. Applicants of all ages are eligible for financial assistance. Baptist Health also has software which uses publicly available demographic information to determine presumptive eligibility for patients who do not respond to offers of financial assistance. The hospital verbally attempts to contact patients to inform them of financial assistance.

This policy applies to most charges, but will not apply to Radiology Consultants, Pathology Labs of Arkansas, or any other outside services.

If you believe you may be eligible for financial assistance, please ask your Admissions Representative for an application. The application can also be requested:

By phone: Patient Financial Services at (501) 202-3900

In writing: Patient Financial Aid Office, 11001 Executive Center Drive, Suite 100, Little Rock, AR 72211

This Plain Language Summary of the Financial Assistance Guidelines is also available in Spanish up on request, or at the below link to our website.

The BAPTIST HEALTH financial assistance policy, plain language summary and application are available to the public at all facilities and on the web at <https://www.baptist-health.com/patients-visitors/insurance-financial-assistance/>.

FOR HOSPITAL USE

Baptist Org# _____ Dept. _____ Case# _____ User ID# _____

APPLICATION FOR ASSISTANCE

Before this application can be considered, we must have a copy of your most recent tax return.

Patient Name _____ Social Security # _____

Address _____ Phone _____

City _____ State _____ Zip _____

HOUSEHOLD MEMBERS:

Name	Age	Employer	Relationship to Patient
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____

INCOME: List Gross Income of Total Household for:

Last Twelve Months

Wages	_____
Farm/Self Employed	_____
Public Assistance	_____
Social Security	_____
Unemployment	_____
Workers' Compensation	_____
Strike Benefits	_____
Alimony	_____
Child Support	_____
Military Family Allotments	_____
Pensions	_____
Income From Dividends, Interest, Rent, Etc	_____
Other	_____

EXPENSES: List All Expenses as Requested Below:

Average Cost

Monthly Payment

Medical and Dental	_____	_____
Childcare	_____	_____
Rent or Mortgage	_____	_____
Property Taxes (if not included in mortgage)	_____	_____
Telephone	_____	_____
Electricity	_____	_____
Gas	_____	_____
Water	_____	_____
Food	_____	_____

OTHER EXPENSES:



LIST ALL CARS, TRUCKS, BOATS, MOBILE HOMES, CAMPERS, MOTORCYCLES OR OTHER VEHICLES:

	Make	Model	Year	Monthly Payments	Loan Balance
1.	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____
4.	_____	_____	_____	_____	_____

Do you or any member of your household own real estate or other property, including house property, land, or buildings? YES _____ NO _____

If YES, please provide information regarding the value of the property, any amount owed, and how the property is used.

VALUE _____ AMOUNT OWED _____

	YES	NO
Is this rental property?	_____	_____
Do you have health insurance?	_____	_____
Do you have disability income insurance?	_____	_____

If yes to health insurance or disability income insurance, please list:

PAYER NAME _____

POLICY NUMBER _____

I AFFIRM THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I AUTHORIZE BAPTIST HEALTH/ARKANSAS HEALTH GROUP TO OBTAIN A COPY OF MY CREDIT REPORT IF DEEMED NECESSARY TO AID IN DETERMINING MY ELIGIBILITY FOR FINANCIAL ASSISTANCE.

Signature of Person Making Request for Assistance _____

Date _____

FOR HOSPITAL USE

APPROVED

DENIED

Signature _____

Date _____

Account 1 _____

Account 3 _____

Account 5 _____

Account 2 _____

Account 4 _____

Account 6 _____