John and Jane Doe
123 Main Street
Wynne, AR 72396

You and/or your family may qualify for discounts up to 100% on **accounts** here at our facility, through our Financial Assistance Program. You may feel that you do not qualify. However the Federal Guidelines have changed. A family of (4) can have an income up to $50,000.00 and still be eligible for partial discounts. I have enclosed a Financial Assistance Application if you are interested in applying for this program.

If you have any questions, please call 888-339-2904

Also, if you are having trouble buying your medicines, we have a new **Medicine Assistance Program** here at our hospital that may help you. For more information on the medicine assistance program, please call Carolyn Hirons @ 208-2135.

**** **Please note – in order to qualify for the financial assistance program referenced above, you must have a Medicaid denial or have proof that you have met with an "affordable Healthcare" advocate.**

We are anxious to hear from you, so please consider applying for these programs. It may help you settle your outstanding bills here at CrossRidge Community Hospital.

Thank you,

CrossRidge Community Hospital
PO Box 590
Wynne, AR 72396

**You must apply for Medicaid before this application can be processed.**
If denied. Please atach a copy of denial.
If approved, please send Medicaid number.

## Application for Financial Assistance

PATIENT NAME: ______________________________ DATE: ______________

MEDICAL RECORD NUMBER: ______________________________

Please answer all question as completely and as accurately as possible. If you do not have enough space for your answer, attach another sheet of paper to this application.

Please list everyone in your home including the patient and complete each space by their name:

| Social Security Number | Last Name | First Name | Birth Date | Relationship to you | Employer |
|---|---|---|---|---|---|
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| | | | | | |
| | | | | | |

INCOME: DOES ANYONE IN YOUR HOME INCLUDING THE PATIENT HAVE INCOME FROM THE FOLLOWING?:

| Monthly Income<br>Please Circle Yes or No | | | Name of Person's Receiving | How Often received | Amount After Deductions |
|---|---|---|---|---|---|
| Employment/Work | Yes | No | | | |
| Farming/Self-Employment | Yes | No | | | |
| Rental of Property | Yes | No | | | |
| Retirement Benefits | Yes | No | | | |
| Social Security Benefits | Yes | No | | | |
| Supplement Security SSI | Yes | No | | | |
| Veteran's/Other Pensions | Yes | No | | | |
| Serviceman's Allotments | Yes | No | | | |
| Job Corps Allotments | Yes | No | | | |
| Child Support/Alimony | Yes | No | | | |
| Contributions/Family, Friends | Yes | No | | | |
| Unemployment Benefits | Yes | No | | | |
| Worker's Compensation | Yes | No | | | |
| Roomers or Boarders | Yes | No | | | |
| Insurance | Yes | No | | | |
| Savings or Dividends | Yes | No | | | |
| Other (Babysitting,Part-time Work) | Yes | No | | | |

**TOTAL MONTHLY INCOME $** ______________

**PROOF OF TOTAL HOUSEHOLD MONTHLY INCOME**
**AND CURRENT BANK STATEMENTS REQUIRED**
Paycheck stubs, copy of monthly benefit checks, award letters, employer wage letters, etc.

File Income Tax _________(Yes) Attach a copy of your current 1040 Federal Income Tax Documents.
File Income Tax _________(No) Explain: ____________________________________
If you work ________(Yes) and do not make enough to file Income Tax, attach a copy of your W-2 Forms.
Have Checking account______(Yes)______(No) If you marked (Yes), attach a current copy of your Bank Statement.
Have Savings account____(Yes)______(No) If you marked (Yes), attach a current copy of your Savings Statement
Receive Public Assistance _____(Yes)_____(No), If (Yes), attach proof of Food Stamps & HUD.

HUD $___________________Per Month Food Stamps $___________________Per Month

Has anyone in your home worked in the last 6 months who is not working now? If yes, list their name, the last month/year in which the person worked, and the place they worked____________________________________

How have you been meeting your expenses for the past 6 months ?____________________________________

MONTHLY EXPENSES

| | |
|---|---|
| Monthly House or Rent Payment………… ………… ………… ………… ………… | $ |
| Monthly Car or Truck Payments ………… ………… ………… ………… ………… | $ |
| Monthly Bank Loan Payments ………… ………… ………… ………… ………… | $ |
| Monthly Credit Card Payments (List minimum amount payable per month)….. ………… | $ |
| Monthly Doctor, Dentist, or Hospital Payments……….. ………… ………… ………… | $ |
| Monthly Utilities(Electric, Gas, Water, Telephone, Cable, Etc……. ………….. ………… | $ |
| Monthly Food, Clothing, Car Fuel, Donations………………………… ………… ………… | $ |
| Monthly Student Loan Payments……………………..………… ………… ………… | $ |
| Monthly Child Day Care Payment……………………….. ………… ………… ………… | $ |
| Monthly Child Support Payment……………………….. ………… ………… ………… | $ |
| Monthly Medicine (Amount not paid by Heath Insurance Plans)….. ………… ………….. | $ |
| Insurance Premiums paid every month (Not paid through check deductions)……………. | $ |
| Insurance Paid every 3 months……….$____________ ………… ………… ………… | $ |
| Insurance Paid every 6 months……….$____________ ………… ………… ………….. | $ |
| Insurance Paid every 12 months……...$____________ ………… ………… ………… | $ |
| Personal & Real EstateTax per year.. $_____________ ………… ………… ………… | $ |
| **TOTAL MONTHLY EXPENSES ………… ………… ………… ………… …………** | **$** |

**Please Read Before Signing**

The information on this form is for the purpose of considering charity care. I certify that the information furnished is true and accurate to the best of my knowledge, I authorize CrossRidge Community Hospital, its agent or any Credit Bureau or other Investigative Agency employed by CrossRidge Community Hotpial to investigate the references herein listed, statements made, or other data obtained from me pertaining to my credit and financial responsibility. CrossRidge Community Hospital reserves the right to request verifircation or to adjust monthly living expenses for reasonableness. Applications cannot be processed without proof of income documents and will be returned to you.

Signed: ____________________________________ Date: ____________________

Telephone Number (Where you can be reached)…. Area Code____________Number ________________________

Mailing Address:____________________________________________________________
(Street or Post Office) (City) (State) (Zip)

PLEASE MAIL APPLICATION TO:
CrossRidge Community Hospital P. O. Box 1713 Jonesboro, AR 72403

In order to process application - Patient Must:

Complete application -
    Estimate expenses (do not need copies of bills)

Proof of lasts month's total household income
    Example:
        Paid every two weeks - need last 2 pay check stubs
        Social Security - either copy of SS stating how much you should
            receive or proof on bank statement
        Proof of monthly retirement/pension income

Copy of last month's bank statement ---- checking and/or savings

Copy of last years Federal Income Tax Return - not W2
    If self -employed: attach schedule C

Proof of any other household income
    HUD
    Food Stamps
    Child Support
    Unemployment Award Letter

**IF you do not have any insurance: you MUST contact the Business Office to set up an appointment to meet with our affordable Healthcare Insurance Representative Candis Colllins, before this application can be processed. Call: 888-238-2904 for appointment**

AUTO ACCIDENT ACCOUNTS ARE NOT ELIGIBLE FOR ASSISTANCE without documentation from auto insurance showing no litigation or no payment has been or will be made to the patient!

Send or bring application and all documentation to:

CrossRidge Community Hospital
P O BOX 1713
Jonesboro, AR 72403