PATIENT FINANCIAL ASSISTANCE

You are receiving this letter and Patient Financial Assistance Application because you have requested financial assistance related to the services you have received from Howard Memorial Hospital. In order to accurately assess your financial situation and provide you with possible assistance, the following information is required:

1. Complete and sign the attached **Patient Financial Assistance Application** form.
2. Attach a copy of your most current **Federal Income Tax Return.** Include all schedules and pages. If you do not file a tax return, please explain why. If you need a copy of your tax return, you can call the Internal Revenue Service (IRS) at 1-800-829-1040.
3. Attach a copy of the most recent three (3) months of **pay check stubs** for all members of your household.
4. Attach a copy of the most recent **bank statement** for all accounts.

If these documents are not available, please explain why in the section of the Patient Financial Statement provided for documentation

For the Patient Financial Statement, Members of Household are defined as follows:

- If the patient is an adult include the patient, the patient's spouse and any dependents.
- If the patient is a minor, include the patient, the patient's father, dependents of the father, the patient's mother and dependents of the mother.
- "Dependents" is defined in accordance with IRS guidelines.

For the Patient Financial Statement, income represents cash receipts before taxes and include but is not limited to, wages, salaries, tips; interest; dividends; taxable refunds, credits or offsets of state and local income taxes; alimony received; business income/loss; capital gains/loss; IRA distributions, pensions, and annuities; income from rental real estate, royalties, partnership, S corporation, and trusts; farm income/loss, unemployment compensation; social security benefits, VA benefits, workman's compensation, and disability.

The responsible party and spouse (if applicable) should sign the Patient Financial Statement form in order to consider it complete. Upon receipt of your completed Patient Financial Statement and supporting documentation, we will review the information and make a determination as to the eligibility for assistance. If you choose not to complete the Financial Statement or not to provide the required supporting documentation, we will proceed with normal collection processes.

Please return all of the above information within thirty (30) days to be considered for assistance and allow thirty (30) days for the review process. You will be notified of the determination via letter. Please send all requested information to: Howard Memorial Hospital c/o Patient Financial Counselor 130 Medical Circle Nashville, AR 71852.The information can also be faxed to 870-845-8027 attn: Financial Counselor, or emailed to the email address below.

If you have any questions, concerns or need assistance completing the form, please feel free to contact Amanda Manlove our Patient Financial Counselor at (870) 845-8018 or email her any questions or documentation to: amandakm@howardmemorial.com

Thank you for taking the time to complete this request for information. Please return your completed Patient Financial Statement form and documentation:

HOWARD MEMORIAL HOSPITAL
PATIENT FINANCIAL ASSISTANCE APPLICATION

Guarantor/Responsible Party Name (full legal name)	
Patient Name (if other than responsible party)	Patient Account Number
Address (street, city, state, zip code)	Phone Number(s)
Spouse Name	Spouse Phone Number(s)

Employer Information

☐ Guarantor ☐ Patient ☐ Spouse	☐ Guarantor ☐ Patient ☐ Spouse
Employer: Name	Employer: Name
Address	Address
Phone #	Phone #
Job Title	Job Title
Length of Employment Years - _____ Months - _____	Length of Employment Years - _____ Months - _____

Members of Household: Please refer to cover letter to determine member of household

Name	Date of Birth	Relationship to you

Income: Please refer to cover letter to determine income.

Source of Income	Household Member	Amount Received (gross)	Weekly = W Biweekly = B Monthly = M Annually = A

Banking and Investment: Include all bank accounts, savings accounts, retirement accounts (IRA, Pension Fund, 401k, 403b, etc.), money market, mutual funds, etc.

Banking/Investments	**Amount**	**Comments**

Other Assets: Include real or personal property EXCEPT patient home (primary residence) and personal vehicles. Examples of assets to include are rental property, vacant lots, farm acreage, business property, vacation property, boats, motor homes, all terrain vehicles, etc.

Property:	Estimated Value	Amount Owed on Property	Net Value

Please explain why you are requesting financial assistance. If you are not able to provide requested documentation please explain why.
(continued from page 3)

If your income/lifestyle has changed, please explain and provide documentation; i.e. loss of job, death in the family, divorce, extraordinary medical bills or other expenses, etc.

This Patient Financial Statement should be signed and dated by all applicable parties in order to process your application.

I represent that the information provided is true and accurate to the best of my knowledge. Howard Memorial Hospital is hereby authorized to obtain a credit report in connection with the social security number which I, as payer and signer of this form, certify to be my legally assigned and individual social security number.

Signature of Patient or Responsible Party **Social Security Number** **Date**

I represent that the information provided is true and accurate to the best of my knowledge. Howard Memorial Hospital is hereby authorized to obtain a credit report in connection with the social security number which I, as payer and signer of this form, certify to be my legally assigned and individual social security number.

Signature of Spouse **Social Security Number** **Date**