

# Arkansas Children's Hospital FINANCIAL ASSISTANCE FORM



Arkansas Children's Hospital (ACH) offers a financial assistance program for patients not eligible for other assistance programs. If it is determined that eligibility exists for other programs, those applications must be completed before an ACH Financial Assistance discount can be approved. All services for Arkansas residents, that are medically necessary, are eligible for financial assistance discounts. Cosmetic services are not eligible. Only emergency services for non residents are eligible. Services for international patients are not eligible under this policy. If you have questions or need help completing this application, please call

the Admissions Office at 501-364-1230 or toll free 1-800-280-1230. Please return the form and the required information to Arkansas Children's Hospital, P.O. Box 34114, Little Rock, AR 72203.

<b>GUARANTOR NAME</b> (Responsible Party)
Guarantor Street Address
Guarantor City, State, Zip
Guarantor Home Phone Number

## HOUSEHOLD MEMBERS (List persons living in household who are immediate family members of guarantor. Include yourself.)

Name	SSN	Employer	Work Phone	Member has Outstanding ACH Bills?	Age	Relationship to Guarantor	List ALL Insurance Medicaid or Other Coverage	Arkansas Resident?	U.S. Citizen? If no, attach green card.
				YES NO				YES NO	YES NO
				YES NO				YES NO	YES NO
				YES NO				YES NO	YES NO
				YES NO				YES NO	YES NO
				YES NO				YES NO	YES NO
				YES NO				YES NO	YES NO
				YES NO				YES NO	YES NO
				YES NO				YES NO	YES NO
				YES NO				YES NO	YES NO
				YES NO				YES NO	YES NO

## HOUSEHOLD INCOME (List persons living in household who are immediate family members of guarantor. Include yourself.)

Total Income for Past Three Months (Proof of Income Required)	Head of Household	Other Wage Earner	Other Wage Earner
Name of person			
Total gross pay			
Tips			
Farming or self-employment (tax forms required)			
Social Security, SSI or other disability			
VA, retirement, unemployment & Workers' Comp			
Income from dividends, interest, rent, etc.			
Public Assistance			
Monthly child support or spousal support received			
Contributions			
Other			
Number of months worked during period reported			
<b>Income from Last Year's Tax Return (Tax Return Required)</b>			
Did you file taxes for last year?	YES NO	YES NO	YES NO
Gross income from Total Income line on tax return			
Number of months worked during last tax year			
Number of months worked in current tax year			
If self-employed, depreciation claimed on tax return			

Please record all income and resources in the space provided. Income verification is required for all discounts. Tax forms, pay stubs, employee earning statements from employers, SSA statements, business account records, etc. may be submitted as verification of earnings.

## HOUSEHOLD RESOURCES

Type	Owner(s)	Average beginning balance for past three months
Savings		
Checking account		
Christmas Club or Credit Union		
Cash on hand		
Stocks, bonds & other investment accounts		

## SIGNATURE(S) REQUIRED

Date \_\_\_\_\_

I certify that the above information is true and accurate to the best of my knowledge. I understand that this application is made so that the hospital can determine my eligibility for financial assistance. If any information I have given proves to be inaccurate or incomplete, I understand that the hospital may reinstate any balances discounted in error. My/our signature(s) on this form gives permission to verify the information on this form including permission to contact employers and to check my/our credit history.

Guarantor Signature \_\_\_\_\_

Other Wage Earner Signature \_\_\_\_\_

Other Wage Earner Signature \_\_\_\_\_

Please retain a copy of the application and the income verification for your records. The information you submit will not be returned to you.