EUREKA SPRINGS HOSPITAL

Phone: (479) 253-7400
Fax: (479)363-8023

Date: _____

Enclosed you will find the application for financial assistance.

We must receive the completed application with the requested documentation within 45 working days from your date of discharge or your application can be denied. You must include copies of the following with your application to be accepted for review.

- Previous year's tax returns
- Last 2 paycheck stubs, including social security and/or disability **(Required)**
- Previous 2 months checking accounts and bank statements **(Required)**
- Copies of each bill that you are responsible for in a given month and will claim on this application
- Any denied/approved applications for assistance from the State Agency to qualify for assistance, such as Medicare, Medicaid, Insurance, etc.

Eureka Springs Hospital Commission is under no legal obligation to provide financial assistance but may do so as a community service.

If you have questions, please contact the Business Office at (479)253-7400 Ext. 2226

Patient MRN #: _____ Encounter(s) #: _____

_____

_____

_____

EUREKA SPRINGS HOSPITAL

Phone: (479) 253-7400
Fax: (479)363-8023

Date: _____

Patient Name: _____

Patient DOB: _____

Medicare #: _____

Medicaid #: _____

As provided for in Federal Law, I hereby request that **Eureka Springs Hospital Commission** (Facility) make written determination of my eligibility for waiver of any Medicare deductible or co-insurance that would normally be due for services received at this facility.

In determining eligibility, the undersigned and Facility understand the following:

1. If the patient's income is equal to or less than the attached schedule of per capita income or if the patient has a current Medicaid card, he/she will qualify for waiver of Medicare deductible and co-insurance.

   Patient's family size _____ and annual income level $ _____.

2. It is the facility's responsibility to obtain sufficient documentation and verify the stated income level. (Copies of the most recent income tax return and/or copies of monthly social security check should be attached. Any other documentation verifying the patient's income should also be attached).

We the undersigned certify that the above statement of annual income, and all attached supporting documentation is true and correct to the best of our knowledge.

_____ _____
Facility Representative Date

_____ _____
Patient/Responsible Party Date

EUREKA SPRINGS HOSPITAL

Phone: (479) 253-7400
Fax: (479)363-8023

I hereby Request that Eureka Springs Hospital Commission make a determination of my eligibility for Eureka Springs Hospital's Financial Assistance, in order to cover services incurred on _____.
Date

1. Patients Name: _____ DOB: _____
   Social Security #: _____ Phone #: _____
2. Physical Address: _____ City: _____
   County: _____ State: _____ Zip Code: _____
3. Current Employer: _____
   Previous Employer: _____
4. Income: List income from all sources in the family or household.

	Monthly Total for Patient	**Monthly Total for Spouse/Other**
Wages	$	$
Farm/Self Employment	$	$
Public Assistance	$	$
Social Security	$	$
Unemployment Compensation	$	$
Workers Compensation	$	$
Alimony/Child Support	$	$
Pensions	$	$
Dividends/Interest/Rental	$	$

EUREKA SPRINGS HOSPITAL

Phone: (479) 253-7400
Fax: (479)363-8023

5. Please list below any bank accounts and credit cards that you or anyone else in your household have

   (If needed, please attach additional information on a separate sheet)

Bank	**Account #**
Credit Card	**Balance**

6. Family/Household Size:

Name	Age	Relationship

7. Do you own or rent your own home? _____.

   Landlord Name and Phone #: _____.

EUREKA SPRINGS HOSPITAL

Phone: (479) 253-7400
Fax: (479)363-8023

8. Monthly Expenses (**Must include copies of Bills or Cancelled Checks**):

Rent/Mortgage	$	Car Payment	$
Gas/Propane	$	Auto Fuel	$
Electric	$	Auto Insurance	$
Water	$	Home Telephone	$
Medications	$	Cell Phone	$
Child Care	$	Internet	$
Groceries	$	Cable/Satellite	$

9. What steps are you taking in order to improve your current financial situation?

_____

_____

_____

_____

_____

_____

_____.

EUREKA SPRINGS HOSPITAL

Phone: (479) 253-7400
Fax: (479)363-8023

I affirm that the information listed in the financial/charity application is true and correct to the best of my knowledge. I have not made any false statements, errors or omissions. If any information that I have given proves to be untrue, I understand that this constitutes fraud, and the hospital will seek legal action as deemed necessary.

Signature: _____ Date: _____

Eureka Springs Hospital Commission is under no legal obligation to provide financial assistance. It does so to help community members actively trying to help themselves. If the application is not completed in its entirety and the required documentation is not provided this application will be null and void.

_____ _____
Recommended by/ (Business Office Manager) Recommended by (Social Worker)

Date: _____ Date: _____

_____
Approved by (Hospital Administrator)

$_____
Approved amount

_____
Date