South Arkansas Regional Hospital
Patient Financial Assistance
700 West Grove Street
El Dorado, AR 71730
www.sarhcare.org

South Arkansas Regional Hospital
in collaboration with UAMS Health

Dear Mr./Ms.

Enclosed is an application for the SARH Health Financial Assistance Program. This program is available to Arkansas residents and others who meet certain income requirements. To apply for this program, please complete the enclosed application and provide the following documentation:

- Proof of income from all sources for all adult members in your household for the past 2 months, including either pay stubs or verification of self-employment income.
- Proof of Arkansas residency.
- Medicaid approval letter, denial letter or the validation ID from the Medicaid application

If you have any questions about the application or need help completing the application, you can contact us at one of the telephone numbers below. We will notify you when the application is received by our office. You will also receive notification indicating approval or denial of financial assistance within 30 days of receipt.

If the application packet is not complete, we will notify you in writing of the items missing. You will have 15 days to provide the necessary information. Failure to provide the required information may result in a denial for financial assistance.

If any of the provided information is found to be false or untrue, the application will be denied and any discount received will be withdrawn. The application will also be denied if you fail to cooperate with the Medicaid application process.

The application can be mailed to the address at the top of this letter or delivered to the hospital. The date the application is returned will be used to determine the effective date of the discount if assistance is approved.

Sincerely,

Financial Assistance
South Arkansas Regional
Hospital
(870) 863-2000 (local)

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FINANCIAL ASSISTANCE CHECKLIST

1. **Application**
   (__) Answer all the questions completely
   (__) Sign and date the application

2. **Complete Medicaid application at www.access.arkansas.gov**
   (__) Proof of application by providing application T number
   Or
   (__) Approval letter from Medicaid
   Or
   (__) Denial letter from Medicaid

3. **Proof of income for all adults that live in your house (18 years old and older).** Please include all sources of income.
   (__) A copy of your completed signed Federal Tax Return with all schedules for the latest filed year.
   (__) Pay stubs from the last 2 months. (Wages, tips and salaries before deduction)
   (__) Social Security benefit letter
   (__) Other proof of income
   (__) Assets: bank account statements for the past 3 months or other asset documentation
   (__) If no income, complete the Patient/Provider Statement.

4. **Proof of your identity and where you live with one of the following:**
   (__) A copy of your Arkansas driver's license or photo ID card
   Or
   (__) A copy of your visa, passport, or other photo ID card (proof of identity) **and** a lease agreement, a utility bill or completed Arkansas Residency Application Declaration form (proof of where you live).

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FINANCIAL ASSISTANCE APPLICATION

Patient Name _____ Social Security # _____

Address _____

City _____ State _____ Zip Code _____

HOUSEHOLD MEMBERS:

Name	Age	Employer	Relationship to Patient
1.			
2.			
3.			
4.			
5.			
6.			
7.			

INCOME: List Gross Income for Household — Last 12 months

Wages	$ _____
Farm/Self Employed	$ _____
Social Security	$ _____
Pensions	$ _____
Unemployment	$ _____
Child Support	$ _____
Alimony	$ _____
Workers' Compensation	$ _____
Public Assistance	$ _____
Other (describe)_____	$ _____

ASSETS: Bank accounts, real estate, rental property, stocks etc.

Savings (provide statements for the last 3 months)	$ _____
Checking (provide statements for the last 3 months)	$ _____
Other (describe): _____	$ _____

Do you have health insurance or disability income insurance? Yes ☐ No ☐

If yes, please list: Payor Name _____ Policy # _____

Have you applied for Arkansas Medicaid? Yes ☐ No ☐

I certify that this information is true and complete. I authorize any credit investigation deemed necessary to verify this information.

Signature _____ Date _____

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PATIENT / PROVIDER STATEMENT

(Only complete if the patient has no income)

PATIENT STATEMENT

I am not employed and receive no household income from any source.

Print Patient Name: _____

Patient Signature: _____ Date: _____

PROVIDER STATEMENT

I provide basic monthly living expenses for the person above. These expenses may include food, shelter, medication, utilities, and transportation.

Print Provider Name: _____

Telephone Number: _____

Address: _____

City/State/Zip Code: _____

Provider Signature: _____ Date: _____

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ARKANSAS RESIDENCY APPLICATION DECLARATION

(Only complete if you have no document to prove residency)

I cannot provide Arkansas state residency verification documentation.

I hereby declare that the above information is true and accurate. I understand that this declaration form is used to help verify that I meet Arkansas state residency requirements for the SARH Charity. I understand that a false or misleading declaration by me may result in Charity adjustments for which I would not otherwise have qualified, and may subject me to civil and criminal penalties.

Print Name: _____

Telephone Number: _____

Address: _____

City/State/Zip Code: _____

Signature: _____ Date: _____

It is South Arkansas Regional Hospital's policy to provide Emergency Medical Services to all individuals regardless of their ability to pay. Moreover, SARH will provide such services to all patients without discrimination (within the meaning of section 1867 of the Social Security Act (42 U.S.C. § 1395dd)) regardless of their eligibility under this Financial Assistance Policy.