ATTACHMENT A

Unity Health

Application for Financial Assistance

Patient Name:_____

Patient Number:_____

Dear Patient or Guarantor:

You may qualify for the Financial Assistance Program at Unity Health!

Please fill out this application and submit it back to Unity Health as soon as possible to see if you qualify for a discount on your healthcare costs.

*Application must be complete to be considered for financial assistance.
Please submit this information within 14 days.

☑ TOTAL HOUSE HOLD INCOME TO DATE-_____
☑ COPY OF _____ INCOME TAX RETURN

If you have any questions about the financial assistance program, please call or come by the Business Office at Unity Health.

Sincerely,

Financial Counselor
(501) 380-1022

ATTACHMENT A

APPLICATION FOR FINANCIAL ASSISTANCE

Name of Head of Household:_____
(LAST) (FIRST) (MIDDLE)

Current Mailing Address: _____
(Street / PO Box) (CITY) (STATE) (ZIP)

Home Telephone:_____ Mobile/Cell Phone: _____

Employer: _____ Employer's Phone: _____

Employer's Address:_____
(Street / PO Box) (CITY) (STATE) (ZIP)

Social Security Number (Head of Household):_____

Spouse's Name: _____
(LAST) (FIRST) (MIDDLE)

Spouse's SS#: _____Employer:_____

Employer's Address: _____
(Street / PO Box) (CITY) (STATE) (ZIP)

Employer's Phone Number: _____

Do you have any Insurance Coverage? ___ Yes ___ No

If Yes, what kind? _____

PLEASE LIST ALL FAMILY MEMBERS THAT LIVE IN YOUR HOUSEHOLD INCLUDING YOURSELF AND SPOUSE:

	Name: (Last, First, Middle)	Date of Birth	Relationship
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____

ATTACHMENT A

Patient Number

Total Household Income for the last 12 months

INCOME: List all GROSS INCOME including CASH for all members listed on Page 1:

EMPLOYMENT EARNINGS:
(Including Self Employment)

Head of Household: $_____

Spouse: $_____

Other working family members: $_____

Farm Income: $_____

SOCIAL SECURITY Income: $_____
(Any family members)

Child Support / Alimony: $_____

Military Family Allotments: $_____

Retirement / Pension: $_____

Other Income not listed: $_____
(Any family members)

TOTAL INCOME: $_____

THIS INFORMATION ON INCOME MUST BE COMPLETE

I certify that the above information is true and accurate to the best of my knowledge. As part of the application process, Unity Health may verify information contained on my application and in other documents required in connection with the program. Furthermore, I will make any assistance (Medicaid, State Funds, other charitable funds) for payment of my hospital charges known to the hospital and take reasonable action necessary to notify the hospital of such assistance. If any information I have given proves to be false, I understand that the hospital may re-evaluate my financial status and take whatever action necessary including, but not limited to, re-instatement of hospital charges and suspension from the hospitals financial assistance program.

ALL INFORMATION PROVIDED TO THE FINANCIAL ASSISTANCE PROGRAM IS KEPT CONFIDENTIAL AND IS USED FOR THE SOLE PURPOSE OF ASSESSING AN APPLICANTS FINANCIAL NEED FOR PROGRAM SERVICES

********* Applicant's Signature:** _____ **Date:** _____

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Application for Financial Assistance

EXPENSES WORKSHEET

		Monthly	Annual
Electric Bill		$_____	$_____
Water Bill		$_____	$_____
Telephone Bill		$_____	$_____
Automobile Expenses		$_____	$_____
Clothing		$_____	$_____
Entertainment		$_____	$_____
Food (do not include food stamps)		$_____	$_____
Insurance:	Automobile	$_____	$_____
	Home	$_____	$_____
	Life & Health	$_____	$_____
Installment Payments:	House	$_____	$_____
	Car	$_____	$_____
	Other	$_____	$_____
Other Payments:	Hospital	$_____	$_____
	Doctor	$_____	$_____
	Other	$_____	$_____
TOTAL EXPENSES:		$_____	$_____

I certify that the above information is true and accurate to the best of my knowledge. As part of the application process, Unity Health may verify information contained in my application and in other documents required in connection with the application, either before the application is approved or as a part of its quality control program. Further, I will make application for any assistance (Medicaid, Medicare, insurance, etc.) which may be available for payment of my medical charges, and I will take action reasonably necessary to obtain such assistance and will assign or pay to Unity Health the amount recovered for medical charges. If any information I have given proves to be untrue, I understand that Unity Health may reevaluate my financial status and take whatever action becomes appropriate.

_____ _____

Applicant's Signature Date of Request