MAGNOLIA REGIONAL MEDICAL CENTER
FINANCIAL ASSISTANCE REQUIREMENT LETTER

Dear Patient and/or Guarantor,

In keeping with the Core Values of Magnolia Regional Medical Center, it is our desire to provide financial assistance in a manner that respects the dignity of our patients and their families. We understand financial and medical hardships, and based upon your qualifications, you may be able to receive financial assistance. Thank you for choosing Magnolia Regional Medical Center!

Please complete the financial application and attach the required documents listed below that are applicable to you:

All applicants:

- **Previous calendar year tax return (1040, 1040A, or 1040EZ).**
- **Last three (3) bank statements.**

If you are employed:

- **Three most recent check stub copies or company letterhead indicating hourly rate and base pay (annual salary).**

If you receive any of the following benefits we need a copy of your annual benefit letter, or the check, or a bank statement that lists the direct deposit:

- **Social Security/SSI.**
- **VA retirement benefits.**
- **Unemployment benefits.**

Other sources of financial support:

- **If someone else is providing you money for rent, food or utilities, we need that person's income per guidelines above.**
- **You may submit 3 letters from friends or neighbors stating how your basic needs are being met. Family members cannot provide this information.**
- **Pensions, alimony, child support, workers' compensation, survivor benefits, interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony and other miscellaneous sources will need documentation of amounts received.**

Additional information may be required for further review. Falsifying information on the application could result in the denial of financial assistance.

Please return the application completed and signed to the Business Office within (10) days for processing, or

Mail to: Magnolia Regional Medical Center
Attn: FAP Application
PO BOX 629
Magnolia, AR 71754-0629

If you have an additional questions and/or concerns, please contact our Financial Counselor at 870-235-3006.

All information received is personal and confidential.

MAGNOLIA REGIONAL MEDICAL CENTER
FINANCIAL STATEMENT

Date: _____

PATIENT/RESPONSIBLE PARTY INFORMATION

Account #: _____

Patient Name: _____ SSN: _____ DOB: _____

Address: _____ City/State/Zip: _____ Phone: _____

Employer: _____ Employer's Address_____

City/State/Zip#_____

Employer's Phone: _____ Length of Employment: _____ Monthly Income: $_____

Other Income: $_____

SPOUSE/PARTNER INFORMATION

Patient Name: _____ SSN: _____ DOB: _____

Address: _____ City/State/Zip: _____ Phone: _____

Employer: _____ Employer's Address_____

City/State/Zip#_____

Employer's Phone: _____ Length of Employment: _____ Monthly Income: $_____

Other Income: $_____

DEPENDENTS **

Full Name	Relationship	Birth Date (MM/DD/YYYY)
1) _____	_____	_____
2) _____	_____	_____
3) _____	_____	_____
4) _____	_____	_____
5) _____	_____	_____
6) _____	_____	_____
7) _____	_____	_____
8) _____	_____	_____

**** If more than 8 dependents please use separate page**

Are you currently enrolled in Government Assistance or Medicaid Program? Yes ___ No___ How many adults _____ children _____ are in the family?

Do you receive health or Medical Insurance through your Employer? Yes ____ No _____ Spouse's Employer? _____

Are there any other possible insurance sources? Yes ____ No _____ Explain (Other Source): _____

Is the illness related to a Motor Vehicle Accident? Yes ____ No ____ If yes, who is the Insurance Agent? _____

Phone: _____

OUTSTANDING MEDICAL ACCOUNTS

Do you owe any other Hospitals? Yes ____ No _____ **If yes, how much? _____**

Do you owe any Doctor's Offices/Clinics? Yes___ No ___ **If yes, how much? _____**

Would you like to apply for State Assistance? Yes ____ No _____

PERSONAL REFERENCES

Name: _____ **Phone: _____**

Address: _____ **City/State/Zip_____**

Name: _____ **Phone: _____**

Address: _____ **City/State/Zip_____**

SIGNATURE DISCLAIMER

I certify that the information I have provided is true and correct. I understand that false or misleading information will result in my request for Financial Assistance to be denied.

Print Name: _____

Signature: _____

Date: _____

Received by: _____

Date: _____