McGehee Hospital

Financial Assistance Application

McGehee Hospital will provide financial assistance to patients and their families who meet certain criteria set forth. This program is intended to assist those in need of degrees of financial assistance. Anyone can apply for assistance; however, every applicant will be evaluated on a case by case basis. It is the intent of our program to assist those in need, and by doing so it may be necessary from time to time to contact you or your family for updates on your financial situation. Financial assistance does not apply to services that are provided outside of our hospital. Thank you for your cooperation and we look forward to serving you.

Patients who exceed the income guidelines may be reconsidered when special circumstances apply. See chart below for Income Requirements. The Financial Guidelines are as follows.

McGehee Hospital

2025 POVERTY GUIDELINES FOR THE 48 CONTIGUOUS STATES AND THE DISTRICT	
Persons in family/household	**Poverty guideline**
1	$15,650
2	$21,150
3	$26,650
4	$32,150
5	$37,650
6	$43,650
7	$48,650
8	$54,150
For families/households with more than 8 persons, add $5,500 for each additional person.	

All Financial Assistance Applications must be turned in to the Front/Business Office.

McGehee Hospital

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(Note: This application must be filled out completely to be considered)

Section 1

Applicants Name: _____

SS# _____ DOB: _____ Phone: _____

Address (Physical): _____

Address (Mailing): _____

City: _____ State: _____ County: _____Zip: _____

Current Occupation: _____

Employer: _____

Previous Employer: _____

Section 2

Income: List income from all sources in the family or household.

Source of Income	**Monthly Total**	**Quarterly Total (last 3 months)**
Wages	$	$
Farm or Self-Employment	$	$
Public Assistance	$	$
Social Security	$	$
Unemployment Compensation	$	$
Worker's Compensation	$	$
Alimony / Child Support	$	$
Pensions	$	$
Dividends, Interest, Rent	$	$
Other Sources of Income	$	$

Section 3

Other Information: List all information for members of the family or household.

Other Information	**Monthly Balance**	**Quarterly Balance (last 3 Months)**
List Bank (Checking / Savings Account) and Balance	$	$
List Credit Cards including the Amount	$	$

Section 4

Family / Household Size:

Name	**Relationship / Age**

Section 5

1. Do you own your home or rent? _____ Lessor: _____
2. Have you applied for Medicaid or AR Kids? _____
    a. If Yes, when did you apply? _____
    b. Why were you denied? _____
3. What steps are you taking in order to improve your current financial situation?

    _____

Section 6

I hereby request that McGehee Hospital make a determination of my eligibility for financial assistance in order to cover services incurred. I affirm that the above information is true and correct to the best of my knowledge. I have not made any false statements, errors, or omissions. If any information I have given proves to be untrue, I understand that this constitutes fraud and that the Hospital may seek legal action as deemed necessary.

NOTICE: COPIES OF THE ORIGINAL DOCUMENTATION FOR ALL INFORMATION MUST BE PROVIDED WITH THE FINANCIAL ASSISTANCE APPLICATION. YOU MUST ALSO PROVIDE A COMPLETE COPY OF YOUR CURRENT TAX RETURN INCLUDING COPIES OF ALL W-2 AND 1099 FORMS.

Signature: _____

Date: _____

McGehee Hospital is under no legal obligation to provide this financial assistance. It does so in order to help members of the community who are actively trying to help themselves. McGehee Hospital reserves the right to deny financial assistance to any person depending upon the particular facts and circumstances of each case.

Approval of financial assistance eligibility remains in effect for one year after initial determination