PFFIN

Patient Name: _____ DOB: _____ Date: _____

Permanent Address: _____ City: _____ ZIP: _____

State: _____ Hm Phone: _____ Wk Phone: _____

Mailing Address if Different:

Address: _____ City: _____

State: _____ ZIP: _____

Employer Name: _____ Employer Ph: _____

Employer Address: _____

1	Have you applied for financial aid or completed this form in the last 90 days?	☐ Yes	☐ No
2	Do you currently have any type of health insurance?	☐ Yes	☐ No
3	Was your provider visit a result of an accident at work?	☐ Yes	☐ No
4	Was your provider visit a result of an auto accident?	☐ Yes	☐ No
5	Is your primary residence outside of the US?	☐ Yes	☐ No

If you answered YES to ANY of the questions above, STOP. Contact the Business Office of the Baptist facility where services were received to discuss your account.

For the following table, please list the patient and all family members living in the same household as the patient. Family members are persons related by birth, marriage, or adoption. Include the relationship and age of all family members. Then, list the amount and source of each person's income. Income includes gross (pre-tax) wages, rental income, unemployment compensation, social security, retirement, disability benefits, public assistance, etc. Documentation supporting the income calculations must be submitted with this signed application.

Family Member (Name)	Relationship to Patient	Age	Source of Income or Employer Name	Last Three Months Pay Stubs	Income for 12 Months Tax Return
Total Family Members			Total Income		

Your application cannot be processed unless you provide <u>one</u> of the following documents to support <u>each source of</u> income listed above.

Pay stubs for the last three months
Income Tax return for the previous year
W2 Form for the previous year
Federal & State Assistance Documents
Legal documents/Child Support
Pension/retirement statements
Bank Statements (for SSA/Retirement deposits only)

Please return this application and the requested information to the Business Office of the Baptist facility where services were received.

I certify that the information provided is true and accurate to the best of my knowledge.

_____ _____

Signature of Patient, or Person Authorized to Sign for Patient **Relationship to Patient**

_____ **Place of Service** _____ **Hospital or** _____ **Physician**

Date

FOR PROVIDER USE ONLY

Account Number _____ Date of Service _____

BMHCC Provider _____

NEA BAPTIST

NEA Baptist Jonesboro Business Office
4800 East Johnson, Jonesboro, AR 72405
FAX #: 870-936-1062
Email Address: fap@bmhcc.org

FINANCIAL APPLICATION

▼ Patient Label ▼