CARTI FINANCIAL ASSISTANCE APPLICATION

CARTI is a not-for-profit, tax-exempt entity with a mission to provide world-class cancer treatment and compassionate care and to improve our knowledge through education and research. Consistent with this mission, the organization recognizes its obligation to provide financial assistance to those in need within the communities it serves.

Patients without insurance, who do not qualify for any third party or government health benefits, will receive an automatic discount off their billed charges as outlined in the CARTI Self-Pay Policy prior to generation of the patient statement / invoice. For insured or non-insured patients, additional financial assistance discounts up to 100% of billed charges may be provided to applicants based on the terms of this policy and the discretion of the organization.

CARTI will take into account the overall financial circumstances of the applicant and apply this policy consistently. If approved, CARTI may elect, at its sole discretion, to reduce or waive certain amounts which are due from uninsured or under-insured patients who can successfully demonstrate that paying medical expenses would cause significant hardship.

Return Completed Application To:

ATTN: REVENUE INTEGRITY
CARTI
8901 CARTI WAY
Little Rock, AR 72205-6523

Questions or Need Assistance?

Call CARTI Financial Counseling: 501-537-8641

Disclaimers

- Financial Assistance is based solely on patient's need and qualifications, CARTI offers discounts of 60%, 75% or 100%. The discount is applicable only to services received at CARTI. Certain limitations do exist, including: pathology, physician dispensing, DME, etc are not included
- Eligibility Term, if approved
    - **Charity care is not retrospective**. If approved, the term starts on the day the application is received, as recorded by CARTI.
    - If charges are incurred after submitting the application, and charity care is approved, those charges will be adjusted, so the patient does not have to delay their care waiting for a decision.
    - **The Eligibility Term is up to six months.**
    - Prior to the end of the term, **applicant must proactively re-apply** if they wish to continue to receive assistance.
- All original paperwork submitted during the application process will be returned to the patient along with the eligibility decision.
- Charity Care provided by CARTI is applied on an as needed basis and subject to a thorough review. If applicant attempts to attain assistance by withholding financial information or any form of deceit, they can be prohibited for receiving assistance in the future.
- Approved discounts are not applicable to co-pays, and these must still be paid upon check-in.

Financial Counseling:
Phone: 501-537-8641
Email: PAFC@CARTI.com

CARTI Toll-Free: 1-855-552-2784

MRN: _____
Patient Name: _____
Date of Birth: _____

Patient Financial Assistance Application

Para asistencia en español, por favor solicite un intérprete.

Completion of this application will allow CARTI to review your eligibility for receiving assistance from the Patient Financial Assistance / Charity Care program. It is important that you complete this application and return it with all required documentation within ten (10) business days. If you have difficulty completing this application or you have additional questions, please contact a CARTI Financial Counselor. Submission of a completed application and required documentation does not guarantee approval for financial assistance, and you remain responsible for your account balance. Please complete all sections and submit all required documents. We may request additional documents if necessary to review and validate your application.

Patient Information

Patient's Name:

Telephone Number:

Date of Birth:

Sex:
☐ Male ☐ Female

Arkansas Driver's License Number / State ID Number:

Social Security Number:

Primary Residence Address Line 1:

Address Line 2:

City:

State:

Zip Code

Home Phone Number:

Mobile Phone Number:

Marital Status:
☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Marital Status Year:

Authorized Representative

Authorized Representative / Guardian

☐ Same as Patient ☐ Completed by Representative/Guardian Denoted Below

Authorized Representative Name:

Telephone Number:

Date of Birth:

Sex:

☐ Male ☐ Female

Arkansas Driver's License Number / State ID Number:

Social Security Number:

Primary Residence Address Line 1:

Address Line 2:

City:

State:

Zip Code

Home Phone Number:

Mobile Phone Number:

Marital Status:

☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Marital Status Year:

Household Income Sources

List All Household Members:

Full Legal Name	Date of Birth	Employer / School	Relationship
			☐ Patient ☐ Spouse ☐ Dependent ☐ Responsible Party
			☐ Patient ☐ Spouse ☐ Dependent ☐ Responsible Party
			☐ Patient ☐ Spouse ☐ Dependent ☐ Responsible Party
			☐ Patient ☐ Spouse ☐ Dependent ☐ Responsible Party
			☐ Patient ☐ Spouse ☐ Dependent ☐ Responsible Party

Household Income Financial Breakdown

List Combined **GROSS (Pre-Tax/Pre-Deductions) ANNUALIZED (YEARLY)** Income for each Member of the Household Category:

Income Source	Patient	Spouse	Dependents	Resp. Parties
Gross Salary / Wages				
Self-Employment				
Rental				
Self-Employment / Contract				
Dividends / Interest				
Stocks / Bonds / Investment Distributions				
Trust Distributions				
Public Assistance				
Social Security				
Unemployment				
Workers' Compensation				
Alimony				
Annuity Distributions				
Child Support				
Military Family Allotments				
Retirement / IRA / Pension				
Strike Benefits				
Disability				
Food Stamps				
Insurance Distributions (i.e. Life)				
Lottery / Gambling Winnings				
Other:				
Other:				
Other:				

Household Expenses

List Combined **ANNUALIZED (YEARLY)** Expenses for each Member of the Household Category:

Expense Source	Patient	Spouse	Dependents	Resp. Parties
Vision/Dental				
Medication Out of Pocket				
Child/Elderly Care				
Primary Residence Rent / Mortgage				
Other Loans Payments				
Property Taxes				
Utilities - Telephone				
Utilities - Electricity				
Utilities - Gas				
Utilities - Water				
Food				
Clothes				
Car Payment / Transportation				
Credit Cards				
Health Insurance Premiums				
Life Insurance Premiums				
Other Insurance Premiums				
Other:				
Other:				
Other:				

Non-CARTI Outstanding Medical Bill Balances:

Source / Facility	Current Balance	Medical Service	Owner
			☐ Patient ☐ Spouse ☐ Dependent ☐ Responsible Party
			☐ Patient ☐ Spouse ☐ Dependent ☐ Responsible Party
			☐ Patient ☐ Spouse ☐ Dependent ☐ Responsible Party
			☐ Patient ☐ Spouse ☐ Dependent ☐ Responsible Party

Household Assets - Vehicles

List Vehicles for Household:

Year	Make	Model	Purchase Price	Owner
				☐ Patient ☐ Spouse ☐ Dependent ☐ Responsible Party
				☐ Patient ☐ Spouse ☐ Dependent ☐ Responsible Party
				☐ Patient ☐ Spouse ☐ Dependent ☐ Responsible Party
				☐ Patient ☐ Spouse ☐ Dependent ☐ Responsible Party

Household Assets – Depository & Cash Bearing Accounts

List Bank / Depository / Investment Accounts for Household. Include any cash on-hand or reserves over $500 held (such as in a deposit box or safe).

Bank / Depository Name	Current Balance	Owner
		☐ Patient ☐ Spouse ☐ Dependent ☐ Responsible Party
		☐ Patient ☐ Spouse ☐ Dependent ☐ Responsible Party
		☐ Patient ☐ Spouse ☐ Dependent ☐ Responsible Party
		☐ Patient ☐ Spouse ☐ Dependent ☐ Responsible Party
		☐ Patient ☐ Spouse ☐ Dependent ☐ Responsible Party

Household Assets - Property

List Property Assets for Household (Home, Trailer, Land, Boat, Camper, Non-Primary Residence):

Property Description	Purchase Price	Purchase Year	Owner
			☐ Patient ☐ Spouse ☐ Dependent ☐ Responsible Party
			☐ Patient ☐ Spouse ☐ Dependent ☐ Responsible Party
			☐ Patient ☐ Spouse ☐ Dependent ☐ Responsible Party
			☐ Patient ☐ Spouse ☐ Dependent ☐ Responsible Party
			☐ Patient ☐ Spouse ☐ Dependent ☐ Responsible Party

Hardships

Please check all conditions that apply and for which you can substantiate the appropriate documentation:

☐ You are currently homeless or were homeless within the past six (6) months.
☐ You were evicted or facing eviction or foreclosure within the past six (6) months.
☐ You received a shut-off notice from a utility company within the past one (1) month.
☐ You experienced domestic violence within the past one (1) year.
☐ You experienced the death of a family member within the past six (6) months.
☐ You experienced a fire, flood, or other natural or human-caused disaster that caused substantial damage to your primary residence within the past one (1) year.
☐ You filed for bankruptcy within the past six (6) months.
☐ You experienced unexpected increases in necessary expenses due to caring for an ill, disabled, or aging family member within the past six (6) months.
☐ You claim a child as a tax dependent who's been denied coverage for Medicaid and CHIP within the past one (1) year.
☐ You lost your job or became unemployed within the past three (3) months and have not received any unemployment benefits or supplemental government assistance as of today.
☐ You suffered irreparable harm from a catastrophic event not otherwise covered by any insurance policy, such as total shutdown of your business from a pandemic or force of nature in the past (3) months.

Questionnaire

Latest Tax Returns Filed:

☐ Federal ☐ State

Latest Federal Adjusted Gross Income (AGI):

Latest Arkansas Medicaid Application Decision Date:

Arkansas Medicaid Application Decision:

- ☐ Did not Apply / Refuse to Apply
- ☐ Approved, Full
- ☐ Approved, QMB ☐ Approved, SMB ☐ Approved, Spend-Down
- ☐ Approved, Other: _____
- ☐ Denied Due Incomplete Application / Missing Documentation
- ☐ Denied Due to Income
- ☐ Denied Due to Assets
- ☐ Denied Due to Look-Back Penalty / Disqualifying Transfers
- ☐ Denied, Other: _____

Marketplace Insurance Application Decision:

- ☐ Did not Apply / Refuse to Apply
- ☐ Approved & Enrolled
- ☐ Approved, but Could not Afford
- ☐ Denied, Reason: _____

PRIMARY HEALTH INSURANCE POLICY

Company / Carrier Name:

Member ID:

Policy Name / Type:

Group ID:

SECONDARY HEALTH INSURANCE POLICY

Company / Carrier Name:

Member ID:

Policy Name / Type:

Group ID:

SUPPLEMENTAL COVERAGE (Health Ministry, Cancer Policy, Etc)

Company / Carrier Name:

Member ID:

Policy Name / Type:

Group ID:

CERTIFICATION

I UNDERSTAND THAT THIS APPLICATION MAY NOT BE PROCESSED UNTIL ALL REQUIRED INFORMATION IS SUBMITTED. I UNDERSTAND THAT ADDITIONAL INFORMATION MAY BE REQUIRED TO PROCESS MY APPLICATION.

I AFFIRM THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I AUTHORIZE CARTI TO OBTAIN A COPY OF MY CREDIT REPORT IF DEEMED NECESSARY TO AID IN DETERMINING MY ELIGIBILITY FOR FINANCIAL ASSISTANCE. I ALSO HEREBY AUTHORIZE CARTI THE RIGHTS TO CONTACT ANY OF THE ABOVE LISTED EMPLOYERS, CREDITORS, BANKS, OR LISTED THIRD PARTIES FOR THE PURPOSE OF CONFIRMING MY INCOME, ASSETS, EXPENSES, AND FINANCIAL STATUS. I UNDERSTAND THAT I WILL BE DISQUALIFIED FROM APPLYING FOR CARTI FINANCIAL ASSISTANCE IN THE FUTURE IF ANY OF THE INFORMATION ON THIS APPLICATION OR ON ACCOMPANYING SUBMITTED DOCUMENTATION IS FOUND TO BE MATERIALLY FALSE, FABRICATED, ALTERED, OR A MISREPRESENTATION OF THE TRUTH.

FUTHERMORE, I AGREE TO NOTIFY CARTI OF ANY CHANGE IN MY INSURANCE AND ELIGIBILITY STATUS IF APPROVED FOR FINANCIAL ASSISTANCE.

Patient or Authorized Legal Representative Signature	Print Patient or Authorized Legal Representative Name	Relationship to Patient	Date

Application Information - Completed by Financial Counselor ONLY

Medical Record Number:

Application Submission Date:

Financial Counselor Name:

Application Review Date:

Previous Approved Enrollment Period:

Patient Financial Assistance Documents Checklist

Government Medical Assistance Determination

One (1) or more document required, dated within 6 months of Application Submission Date:

- ☐ Arkansas Medicaid Determination Letter
- ☐ Marketplace Determination Letter
- ☐ Medicare Determination Letter
- ☐ Other Government Healthcare Coverage/Assistance Determination Letter

Proof of Insurance Coverage

One (1) or more document required per Healthcare Insurance or Policy denoted on the application:

- ☐ Health Savings Account or Flexible Spending Account Statement
- ☐ Marketplace Coverage Determination Letter(s)
- ☐ Supplementary (Health Ministry, Cancer Policy, etc) Coverage Policy Letter(s)
- ☐ Medical Insurance Card(s) or Policy Coverage Letter(s) from Company

Income

Two (2) or more document required per Member of Household and/or Responsible Party, dated within 12 months of Application Submission Date:

- ☐ Most Recent Federal Income Tax Return(s) and/or State Income Tax Return(s)
- ☐ Most Recent W-2s and 1099s
- ☐ Last 6 Pay Statement(s) from All Employers
- ☐ Social Security and Supplemental Security Income Statements or Award Letter(s)
- ☐ Unemployment Statement(s)
- ☐ Workers Compensation Statement(s) or Award Letter(s)
- ☐ Rental / Farm / Business Income Document(s)
- ☐ Retirement Income Statement(s) (i.e. IRA, Pension, 401lk, 403b, etc)

Assets

First Item Listed Below **AND** One (1) or more document required per Listed Asset, dated within 12 months of Application Submission Date:

- ☐ **(Always Required) Account Summary Statement(s) from All Bank, Investment, and Other Depository Accounts Listed with Last 3 months of Transactions Present**

- ☐ Account Statement(s) from All Loan Accounts with Last 3 Months of Transactions Present
- ☐ Investment / Security Account Statement(s)
- ☐ Retirement Account Statement(s)
- ☐ Trust Account Statement(s)
- ☐ Mortgage Statement(s) for non-primary residence(s)

Expenses

Two (2) or more document required:

- ☐ Medical Bills Received within Last 3 Months
- ☐ Credit Card Statement(s) or Summary Document(s)
- ☐ Bills for Rent, Electric, Gas, Telephone, or Water Received within Last 3 Months
- ☐ Bills from Other Living Expenses to Patient Received within Last 3 Months

Residency

One (1) or more document required:

- ☐ Mortgage Statement(s)
- ☐ State / County Tax Bill(s)
- ☐ Utility Bill(s)
- ☐ Rent / Lease Agreement(s) or Statement(s)
- ☐ Deed / Title

Identity

One (1) or more document required for the Patient and/or Authorized Representative:

- ☐ Driver's License or State ID (Not Expired)
- ☐ Social Security Card
- ☐ Birth Certificate
- ☐ Passports or Passport Card(s)
- ☐ U.S. Citizenship Identification Card(s)
- ☐ Department of Homeland Security & U.S. Citizenship & Immigration Services Issued Forms, such as Permanent Resident/Resident Alien Card, Certificate of Naturalization, Certificate of Citizenship, Employment Authorization
- ☐ Marriage Certificate
- ☐ Military ID
- ☐ Armed Forces Discharge Papers