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. For under-insured or uninsured patients, additional financial assistance discounts up to 100% of the applicable patient responsibility 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: PATIENT FINANCIAL ADVOCATES
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% of the applicable Patient Responsibility. The discount is applicable only to services received at CARTI.
- Certain limitations do exist, including: pathology, pharmacy, and DME services.
- Eligibility Term will be effective from the first date of service and will end twelve (12) months following the application date.
- If Charity Care is approved, the discount will be applied to the patient's current balance as well as all charges incurred after the date of application through the end of the term, allowing the patient to proceed with treatment while the decision is being made.
- Charity Care will be approved for a term of twelve (12) months. At the end of the twelve (12) month period, if the patient wishes to continue to receive Charity Care, the applicant must re-apply
- 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. Any applicant who attempts to attain assistance by withholding financial information or any form of deceit, will be denied and can be prohibited from receiving assistance in the future.
- Approved discounts are not applicable to co-pays. Co-pays must be paid and collected at check-in.

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Patient Financial Assistance Application

Para asistencia en español, por favor solicite un intérprete.

Completion of this application will allow CARTI to review and determine 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 your CARTI Financial Advocate at 501-537-8641. 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.

Before this application can be considered, we must have a copy of your most recent tax return OR 30 days of paystubs.

Application Date: _____ First Date of Service: _____

Charity Care End Date: _____

Patient Name:_____ Last 4 of SSN: _____

Address:_____

City:_____ State:_____ Zip:_____

Telephone Number:_____ Date of Birth:_____ Sex: Female / Male

HOUSEHOLD MEMBERS

Name	Age	Employer	Relationship to Patient
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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FINANCIAL ASSISTANCE APPLICATION

LIST TOTAL GROSS HOUSEHOLD INCOME:

Wages/Income (must include most recent tax return): $_____

Do you receive government assistance? No / Yes If yes what type? _____

Have there been any significant changes to your income since your last tax return was filed? Yes / No
If yes, please explain: _____

_____

HOUSING:

Rent or Mortgage: _____ Do you own your home? Yes / No

Taxes: _____

Telephone: _____

Electricity: _____

Gas: _____

Water: _____

Food: _____

Car/Truck/Boats: _____

Additional real estate: _____

Other: _____

Income: List Gross Income of Total Household: _____

Wages/Income (proof must be attached): _____

Do you receive government assistance? No / Yes

If yes what type? _____

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 the death of a family member within the past six (6) months which effected your income.
- ☐ 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 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.

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FINANCIAL ASSISTANCE APPLICATION

Attestation:

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 this application or on accompanying submitted documentation is found to be materially false, fabricated, altered, or a misrepresentation of the truth.
Furthermore, I agree to notify Carti of any change in my insurance and eligibility status if approved for financial assistance.

Signature of Patient or Authorized Legal Representative Date

Signature of Patient's Financial Advocate Date