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Searcy County Circuit Court
Debbie Loggins, Circuit/County Clerk
2022-Mar-13 15:13:45
65CV-21-20
C20D01 : 6 Pages

IN THE CIRCUIT COURT OF SEARCY COUNTY, ARKANSAS

CIVIL DIVISION

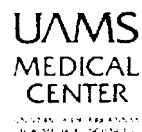
CASE No. 65CV-21-20

MICHEAL PIETRCZAK	**PLAINTIFF**
v.	
RURAL REVIVAL LIVING TRUST; AND LAURA LYNN	**DEFENDANTS**
LAURA LYNN HAMMETT	**COUNTER-CLAIMANT**
v.	
MICHEAL PIETRCZAK	**COUNTER-DEFENDANT**

EXHIBIT G

Fraudulent UAMS Financial Application

07/12/2016



Micheal Pietrczak
903 Lincoln St
MALVERN, AR 72104

RE: Patient Name: Micheal Pietrczak
Account Number: [illegible]4271

Dear Micheal Pietrczak:

Your application or renewal application for the UAMS discount program was received in our business office on 07/12/2016.

Please allow forty-five (45) days for completion of our review and determination. If additional information is required to complete our process you will be contacted to provide the information.

You will be notified by mail when the application is approved or denied. If you have any questions, please contact our customer service department at 1-855-841-8307 or 501-686-7400.

Sincerely,

Office of Financial Clearance
UAMS Medical Center

(501) 686-7400 (local)
(855) 841-8307 (toll-free)

UAMS Medical Center Financial Assistance Application

FOR IN OFFICE USE ONLY: CPI: CC3013623
[X] new [ ] renewal [ ] logged in QMS

Please mail your completed application with proof of total household income and proof of Medicaid determination, and proof of Medical debt.

This Financial Assistance Application will be automatically denied if any of the requested information is not receive of if the information is not received in its entirety.

Date: July 12, 2016

SS#: [redacted]0372 Date of Birth: [redacted]72

Patient's Name: Pietrczak, Micheal Alexander
last first middle

Address: 903 Lincoln ST.
Street
malvern, AR 72104
City State Zip

Patient's Employer: N/A

Address:

Gross income per month: $

LIST HOUSEHOLD MEMBERS:

	Name	Relationship	Age
1.	Walter Pietrczak	my Dad	69
2.	Micheal Pietrczak	self	43
3.			
4.			

I certify that this information is true and complete. I authorize any credit investigation deemed necessary to verify this information.

Signature: [signature]

Date/Time: July 12, 2016 @ 10:04 AM

Return to:
UAMS Office of Financial Clearance
4301 West Markham, Slot 729
Little Rock, AR

SPOUSE OR OTHER RESPONSIBLE CO-APPLICANT:
Name: N/A

Employer:

Address:

Gross income per month: $

Other income: (SSI, pensions, child support, etc) $

Total monthly income: $ 0

ASSESTS: Bank accounts, real estate, rental property, stocks, etc

Savings: $

Checking: $ 12.79

Other (describe): $

RECEIVED
JUL
BY: [signature]

STATEMENT OF INCOME/UNEMPLOYMENT

UAMS MEDICAL CENTER
UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES

PROVIDER STATEMENT

[redacted] 362

Account# [crossed out]

I verify that [crossed out] Pietrczak is not employed and receives no income from any source. I currently provide basic monthly y expenses . Iestimate the monthly expenses amount to be $ 500, mo . *THIS* LINE CANNOT BE BLANK.
(Best Guess)

Date July 12, 2016

Walter Pietrzak
Signature of Provider

Phone# 501 4626707
Address 903 Lincoln St
Malvern AR
72104

Briefly explain how Basic monthly expenses are being provided. I live with my Dad.

Examples of Basic Monthly Expenses:
Food —
Shelter(rent) —
Medications —
Transportation —
Utilities —

RECEIVED
Jul
BY: [illegible]

DRIVER'S LICENSE **DL**

CLASS: D

DLN [redacted]3321 DOB [redacted]-1972

6501

PIETRCZAK
MICHEAL
ALEXANDER
998[illegible] LICK FORK RD
W[illegible] SPRINGS, AR 72686 0000

Issued 02 11 201[illegible] Expires 10 17 201[illegible]

Sex M Height 6-01 Eyes BLU

Endors Restr B

RECEIVED

BY:

Motor Vehicle Auto Accident Liability
Verification Form

N/A

1. Is any of your treatment at the University Hospital due to an accident? (✓) Yes - Proceed to question# 2
( ) No - Stop, this form is complete. Please sign at the bottom.

2. Please indicate tile type of accident: ( ) Auto ( ) Boating ( ) Motorcycle (✓) Other - Please Explain Briefly
An ATV 4 Wheeler

3. What is lhe date olthe accident? (mm/dd/yy) May 26, 2016

4. Were you the (✓) Driver ( ) Passenger

5. Who was at fault? (✓) Driver of the vehide the patient was in ( ) Driver of other car

6. Who is the auto Insurance responsible for your medical clamis?
Insurance Company's Name: N/A
Agent's Name:
Address:
City, State: Zip Code:
Phone Number:

7. If the insurance company listed in# 6 is not your personal Auto insurance please provide your Automobile Insurance information:

Insurance Company's Name: N/A
Agent's Name:
Address:
City, State: Zip Code:
Phone Number:

8. Have you consulted an attorney for the accident? ( )Yes (✓) No

9. Please provide the following information on your attorney: Name: N/A
Address:
City:
State:
Zip Code:
Phone Number:

10. If you have an attorney,please sign the attached authorization for Release of Information: N/A

Patient Signature: [signature] Date: July 12, 2016 Time: 10:45AM

RECEIVED
J 14
BY: [signature]