

Helena Regional Medical Center

To process your application for financial assistance, we request copies of the following:

- Checking account statements for the last 3 months
- Savings account statements for the current month
- Proof of any other cash assets, such as CD's, IRA's, etc...
- Pay stubs for the last 3 months or the 3 most recent months
- Proof of any government benefits you receive, such as Social Security, Disability/SSI, TANF, etc...
- Proof of retirement income
- Proof of General Assistance
- Proof of LINK or SNAP (food stamps)
- Proof of additional income, such child support or family support
- Proof of unemployment benefits or denial letter
- Denial letter from Medicaid
- Tax return and W-2's from previous year
- Copies of all monthly bills
- Copies of all related medical bills
- Letter of assistance from family or friends (**Please try to have the person include specific services they provide assistance with and how often**)

*It is absolutely of highest importance to bring these documents in as soon as possible. **If these documents are not returned to the hospital, your application will be automatically denied, and you will be responsible for paying the balance on the account.** Once again, simply filling out the application is not enough; we must have all documents to begin processing the application. Upon completion of the application and return of necessary documents, the application will be submitted for review and you will be notified of the hospital's decision. **Please note, there is no guarantee of acceptance, and if approved, there may still be a balance that you are responsible for paying.** If you have any questions or concerns or would like to make an appointment to return documents, please call **870-338-5800**

Thank you for your cooperation!

Patient Financial Advocate / Business Office

R1 RCM Inc | Helena Regional medical Center | 1801 Martin Luther King Jr DR | Helena Ar 72342
Office: 870-338-5800 Fax: 870-816-3824

Charity Care Policy

***This hospital will provide care to persons who are unable to pay for their care.**

To be eligible for charity care, you must:

- **Have no other source of payment such as: insurance, governmental assistance, or savings; or**
- **Have hospital bills beyond your financial resources; and**
- **Provide proof of income and income resources; and**
- **Complete an application and provide information required by the hospital.**

***Forms and information about applying for charity care are available upon request.**

Patient Account Number: _____

Date of Application: _____

PATIENT INFORMATION

PARENT/GUARANTOR/SPOUSE

Name _____

Name _____

Address _____

Address _____

City _____

City _____

State/ZIP _____

State/Zip _____

SS# _____

SS# _____

Employer _____

Employer _____

Address _____

Address _____

City _____

City _____

State/Zip _____

State/Zip _____

Work Phone _____

Work Phone _____

Length of Employment _____

Length of Employment _____

Supervisor _____

Supervisor _____

RESOURCES

Checking: YES NO

Savings: YES NO

Cash on hand: \$ _____

Vehicle 1: Yr _____ Make _____ Model _____

Vehicle 2: Yr _____ Make _____ Model _____

Vehicle 3: Yr _____ Make _____ Model _____

INCOME

Patient/ Guarantor:
Wages (monthly): _____

Spouse/ Second Parent:
Wages (monthly): _____

OTHER INCOME

Child Support: \$ _____
VA Benefits: \$ _____
Workers' Comp: \$ _____
SSI: \$ _____
Other: \$ _____

OTHER INCOME

Child Support: \$ _____
VA Benefits: \$ _____
Workers' Comp: \$ _____
SSI: \$ _____
Other: \$ _____

LIVING ARRANGEMENTS

Rent: _____ Own: _____ Other (explain) _____

Landlord/Mortgage Holder: _____

Phone Number _____ Monthly payment \$ _____

REQUIRED DOCUMENTS

The following documents must be attached to process your application for Charity Care/Financial Assistance:
Proof of Income: Prior year income tax return, last 3 months bank statements, last 4 check stubs (if applicable), or a letter from employer, or letter from Social Security, etc...
Other documents as requested.

- Proof of Expenses: Copy of mortgage payment or rental agreement, copies of all monthly bills (including credit cards, bank loans, car loans, insurance payments, utilities, cable and cell phones.)
- Other documents as requested.

*The information provided in this application is subject to verification by the hospital and has been provided to determine my ability to pay my debt. I understand that any false information provided by me will result in denial of any financial assistance by the hospital.

**The hospital reserves the right to pull a copy of your credit report.*

Signature of Applicant _____

Hospital Representative Completing Application _____

***The below signatures are an indication of your review of the application and supporting documentation and that you find the information to meet policy requirements.**

Approval/ Authorization of Charity Write-Off
\$ _____

Amount Approved:
CEO _____

BOM _____

CFO _____