Application for Financial Assistance / Charity Care

Mena Regional Health System

For assistance in completing application, contact the Patient Financial Counselor at (479) 243-2333

Financial Assistance Application

Mena Regional Health System will grant financial assistance to qualified patients on the self-pay portions of their accounts.

To qualify for Charity Care the application must meet the following eligibility requirements:

1. Care rendered must not be experimental or cosmetic, and considered reasonable and necessary for the diagnosis/treatment of illness or injury.
2. The applicant's financial situation is consistent with the provision of charity care.
3. The applicant is **not** eligible for federal or state assistance (Medicaid) based on income guidelines or denied application.
4. There is no other source of payment for the patient's self-pay portion of the medical bill.
5. Bad Debt Accounts are **not** eligible for (Charity Care).

ATTACHMENTS:

All applicants must attach the copies of the following:

Incomplete applications will be denied.

1. Federal or State tax returns for most recent tax year.
2. Copy of most recent social security related income amount, if applicable.
3. Pay stubs for three (3) month for all household members who are employed.
4. Proof of any other source of income.
5. Copies of all bank statements for three (3) months.
6. Copy of denial letter from Medicaid if applicable.
7. Any other information deemed necessary by MRHS.

Mena Regional Health System
Attention: Patient Financial Services

FINANCIAL ASSISTANCE APPLICATION Date:_____

Please answer all questions completely and to the best of your knowledge in order to prevent delay of this application. Copies of required documents **MUST** be attached or application will be rejected as incomplete.

IF ALL AREAS ARE NOT COMPLETED, THE APPLICATION WILL BE REJECTED.

Patient Name:_____Phone#:_____

Address:

_____

_____

Age: _____ Marital Status: _____ County of residency: _____

Do you have or have you had in the most recent 3 months medical insurance? _____

Hospital Account Number Amount

1. _____$_____
2. _____$_____
3. _____$_____

Clinic Account Number Amount

1. _____$_____
2. _____$_____
3. _____$_____

Section 1 – Household & Employment Information
List all persons living in household:

NAME_____ **RELATIONSHIP** _____**AGE**____

NAME_____ **RELATIONSHIP** _____**AGE**____

NAME_____ **RELATIONSHIP** _____**AGE**____

NAME_____ **RELATIONSHIP** _____**AGE**____

NAME_____ **RELATIONSHIP** _____**AGE**____

NAME_____ **RELATIONSHIP** _____**AGE**____

Was this visit to the hospital in any way related to an on-the-job injury or occupational disease? _____
If yes, please
explain_____

_____

Are you presently employed:

Patient:_____ Part Time:_____ Full Time:_____

Spouse:_____ Part Time:_____ Full Time:_____

Current employer: _____

Employer Address : _____

Phone: _____Length of employment_____

Spouse's current employer:

_____

Employer Address :

_____

Phone: _____Length of employment_____

If unemployed, list past employment:

Employer: _____ _____

Address: _____ _____

_____ _____

Phone: _____ _____

Date last employed: _____ _____

Section 2 – Monthly Household Income & Expenses
Household Monthly Income

SUPPLY COPIES OF SUPPORTING DOCUMENTS
Wages: $ _____ Food Stamps: $_____

Tips: $_____ Retirement: $_____

Alimony/Child Support:$_____

Unemployment: $_____

Social Security: $ _____

Pensions: $ _____

Military Family Allotments: $_____

Income from Dividends:$_____

Income from Interest: $_____

Income from Rent: $_____

Income Other: (explain) $_____

Total Income: $_____

Household Monthly Expenses

SUPPLY COPIES OF SUPORTING DOCUMENTS

House Rental / Payment $_____

Food $_____

Car Payment $_____

Car Operating Expenses $_____

Phone /Gas / Electric $_____

Other Utility $_____

Insurance $_____Describe _____

Medical Expenses $_____

Child Care $_____

Other (Specify) $_____

Total Expenses **$_____**

Section 3 – Assets & Liabilities

Assets (Value) Liabilities (Balance Owed)

Name and Address of Bank _____

_____

Savings Account Amount $ _____

Checking Account Amount $_____

Stocks/Bonds/CDs/IRAs $_____

(copies of statements required)

Other Assets (Specify) $ _____

_____ _____

Patient/Applicant Signature Date

Received MRHS by _____

Date: _____