

# Jefferson Regional

## Jefferson Regional Financial Assistance Plain Language Summary

Jefferson Regional recognizes there are many uninsured and /or underinsured people in the community and we are committed to providing programs by which those people can receive medical care and be billed fairly according to their means and ability to pay.

- A. Treat all patients equitably, with dignity, respect and compassion.
- B. Provide emergency services regardless of a patient's ability to pay.
- C. Assist patients who cannot pay for all or part of their care.
- D. Recognize patients and their families have a responsibility to help qualify them for financial assistance.
- E. Develop and administer financial assistance policies fairly.
- F. Utilize multiple communication approaches to inform patients of the financial assistance available and provided.

## Federal Poverty Guidelines

At Jefferson Regional we use the Federal Poverty Guidelines to define our financial assistance policy. If your total household income is under the Federal poverty amount, you pay nothing. For those with insurance, financial assistance may be granted to balances remaining after insurance pays (underinsured) if the Federal Poverty Guidelines are met. Proof of income is required.

## Amounts Generally Billed

Amounts Generally Billed means the amounts generally billed for care to individuals who have third party coverage for such care. Jefferson Regional defines and calculates the AGB using the following method.

- A. Retrospective look back including Medicare and commercial payer percentages combined. Any patient who qualifies for Financial Assistance through Jefferson Regional's Financial Assistance Policy will not be billed for more than the amounts generally billed described above.

## Financial Assistance Application

To inquire about a financial assistance application, you may call the Jefferson Regional Business Office Patient Representatives Monday through Friday 8 a.m. to 4:30 p.m. at (870)541-7644 to begin the process or request an application at no cost to you by mail. You may also download a copy of the application in PDF form on our website at [www.jrmc.org/patients-visitors/billing](http://www.jrmc.org/patients-visitors/billing) insurance/financial assistance or pick up an application at 1600 W 40<sup>th</sup> Street, Pine Bluff Arkansas.

The completed application should be accompanied by the following supporting documents or their equivalent:

1. Last two pay stubs for each employed member of the household.
2. Proof of residency such as driver's license, State ID, or utility bill in your name.
3. Household members 18 or older with no income will need to provide two letters from a friend or neighbor containing an explanation of how the patient's basic financial needs are being met.

# Financial Assistance Application

Date \_\_\_\_\_

Account # \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

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(City)

(State)

(zip)

## YOU MAY BE ELIGIBLE FOR HELP WITH YOUR HOSPITAL BILL

In order to assist you, we need you to fill out the enclosed form. Please sign, date, and return it with required documentation (see application) to JRMC for processing. You will receive a written notice of your application approval or denial.

### Instructions:

1. We will need a copy of your Driver's License
2. Bring us a copy of your last 2 paycheck stubs. Every person who lives in your house and works will need to provide them. (This includes SSI, Disability, and Retirement)
3. If you are self-employed, we will need your most recent income tax returns.
4. If you have no income, we will need (2) letters from friends or neighbors explaining how your bills are being paid.

We cannot provide assistance for dental, cosmetic surgery, accidents, or other situations where other coverage may apply.

For more information, please contact our Business Office at 870-541-7644.

DATE: \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_  
(FIRST) MIDDLE (LAST)

SOCIAL SECURITY # \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

HOME PHONE # \_\_\_\_\_ CELL PHONE# \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
\_\_\_\_\_  
(CITY) (STATE) (ZIP)

PRESENT EMPLOYER: \_\_\_\_\_

EMPLOYER'S PHONE #: \_\_\_\_\_

Please list all household members, their relationship to you, and their age

FULL NAME	RELATIONSHIP	AGE

APPLICANT'S SIGNATURE: \_\_\_\_\_

DATE SIGNED: \_\_\_\_\_