Jefferson Regional Medical Center
1600 W 40th Avenue
Pine Bluff, AR 71603

Financial Assistance Application

ACCOUNT NO: _____

TOTAL BALANCE: _____

SERVICE DATES: _____

DATE: _____

NAME: _____

ADDRESS: _____

_____

(CITY) (STATE) (ZIP)

YOU MAY BE ELIGIBLE FOR HELP WITH YOUR HOSPITAL BILL

In order to help, 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. Bring us your last two (2) paycheck stubs. Every person who lives in your house and works should provide them.
2. If you work for yourself (self–employed), we will need your most recent income tax return.
3. If you have no income, we will need two (2) letters from friends or neighbors explaining how your bills are being paid.

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

For more information on the JRMC Financial Assistance Policy go to www.jrmc.org.

You may also contact the Business Office at 870–541–7964.

JRMC Financial Assistance Application

DATE: _____

PATIENT NAME: _____
(FIRST) (MIDDLE) (LAST) (MAIDEN)

SOCIAL SECURITY #: _____ DATE OF BIRTH: _____

HOME PHONE #: _____ CELL PHONE #: _____

ADDRESS: _____

_____
(CITY) (STATE) (ZIP)

PRESENT EMPLOYER: _____

EMPLOYMENT DATE: _____ EMPLOYER'S PHONE #: _____

ACCOUNT #: _____ ACCOUNT #: _____ ACCOUNT #: _____

ACCOUNT #: _____ ACCOUNT #: _____ ACCOUNT #: _____

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

FULL NAME	RELATIONSHIP	AGE

APPLICANT'S SIGNATURE: _____

DATE SIGNED: _____

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