Forrest City Medical Center

1601 Newcastle Rd. Forrest City AR. 72335

Indigent Care Program

Thank you for selecting our facility for your healthcare needs. We trust your experience with us met your expectations. We would like to introduce our Indigent Care Program. This program is designed to assist our St. Francis County residents with outstanding balances that may have accumulated within the past year. If you are a St. Francis County Arkansas resident and would like to apply for Indigent assistance, please contact our Financial Counselors @ 870-261-0493 or 870-261-0495.

FORREST CITY MEDICAL CENTER
1601 Newcastle Road
FORREST CITY, AR 72335
870-261-0000

Account Number: _____

Service Date: _____

Account Balance: $_____

Dear Mr./Mrs./Ms. _____:

Enclosed you will find an Indigent Care application. You **must** fill the application out as completely as soon as possible and sign and date it on the back page. Send or bring the application back to us with in **15 days** along with **most recent tax return as well as proof of three months prior income, three months bank statement on all accounts checking, savings, etc. and copies of your monthly bills. Example of monthly bills Gas Bill, Water Bill, Phone, Cable Bill, Insurance House Payment, Rent Receipt, Car Payment, ETC.**

If you meet the guidelines, the Indigent Care Board may pay your account in full.

IF YOU DO NOT SEND ALL OF THE REQUESTED INFORMATION YOUR APPLICATION WILL NOT BE CONSIDERED. ALL 8 PAGE'S OF THIS FORM MUST BE TURNED IN.

Please contact me for an appointment time.

If you have any questions I can be reached at **870-261-0172.**

Sincerely,

Wanda Armstrong
Financial Counselor

FORREST CITY MEDICAL CENTER
1601 Newcastle RD
FORREST CITY AR 72335
(870) 261-0000

APPLICATION FOR INDIGENT CARE ASSISTANCE

Please answer all questions as completely and as accurately as possible. If you do not understand a question the caseworker you speak with will help you. If you do not have enough space for your answer, attach another sheet of paper to this application.

Social Security Number	Last Name	First Name	MI	Birthdate	Sex	Marital Status

Account Number	Date of Service	Account Balance	Telephone number where you can be reached

Present Address	City	State	Zip code

Mailing Address (If Different)	City	State	Zip Code

Previous Address	City	State	Zip Code

Number of Years at Present Address			

Please list everyone in your home (including yourself) and complete each space by their name:

SOCIAL SECURITY NUMBER	NAME LAST	NAME FIRST	BIRTHDATE	SEX	RELATIONSHIP TO YOU

INCOME: DOES ANYONE IN YOUR HOUSEHOLD HAVE INCOME FROM THE FOLLOWING?

SOURCE OF INCOME			AMOUNT BEFORE ANY DEDUCTIONS	HOW OFTEN RECEIVED	NAME OF PERSON(S) RECEIVING	MEDICAL BENEFITS INSURANCE	
Place of employment	YES [ ]	NO [ ]				YES [ ]	NO [ ]
Place of employment	YES [ ]	NO [ ]				YES [ ]	NO [ ]
Farming	YES [ ]	NO [ ]				YES [ ]	NO [ ]
Self-employment	YES [ ]	NO [ ]				YES [ ]	NO [ ]
Rental of Property	YES [ ]	NO [ ]				YES [ ]	NO [ ]
Retirement Benefits	YES [ ]	NO [ ]				YES [ ]	NO [ ]
Social Security	YES [ ]	NO [ ]				YES [ ]	NO [ ]
Supplemental Security Income (SSI)	YES [ ]	NO [ ]				YES [ ]	NO [ ]
Veteran's Benefit or Other Pensions	YES [ ]	NO [ ]				YES [ ]	NO [ ]
Child Support/Alimony	YES [ ]	NO [ ]				YES [ ]	NO [ ]
Contributions from Friends or Relatives	YES [ ]	NO [ ]				YES [ ]	NO [ ]
Unemployment Benefits	YES [ ]	NO [ ]				YES [ ]	NO [ ]
Insurance	YES [ ]	NO [ ]				YES [ ]	NO [ ]
Other (Such as Part-time work, babysitting, etc.)	YES [ ]	NO [ ]				YES [ ]	NO [ ]

What income did you have 30 days before hospitalization? _____

What is your anticipated income? _____

How have you been meeting your expenses for the past 6 months? _____

RESOURCES:DOES ANYONE IN YOUR HOME HAVE, OR IS THEIR NAME ON ANY OF THE FOLLOWING?

		AMOUNT	WHERE	NAME OF PERSON(S)
Cash on hand	YES [ ] NO [ ]			
Checking Account	YES [ ] NO [ ]			
Savings Account	YES [ ] NO [ ]			
Money in a Christmas Club	YES [ ] NO [ ]			
Money in a Credit Union	YES [ ] NO [ ]			
Property other than your home	YES [ ] NO [ ]			
Mortgages	YES [ ] NO [ ]			
Stocks	YES [ ] NO [ ]			
Bonds	YES [ ] NO [ ]			
Other (Trust Fund, C.D., IRA, Promissory Note, Mutual Fund, etc.)	YES [ ] NO [ ]			

Health Insurance

Does anyone in your household now have health insurance of any kind? [ ] Yes [ ] No

If yes, please name household member(s) and insurance company: _____

_____

Has anyone in your household had health insurance, or Medicaid, in the last 12 months? [ ] Yes[ ] No

If yes, please name household member(s) and insurance company, and state why this insurance is no longer available:

_____

_____

READ THIS PAGE CAREFULLY BEFORE YOU SIGN THIS APPLICATION.

I understand that I must help establish my eligibility by providing as much information as I can about my circumstances.

I authorize FCMC to obtain information from other state agencies and other sources to confirm the accuracy of my statements.

Due to my financial situation, I certifiy that I am unable to meet my financial obligation in the amount of $_____ to Forrest City Medical Center. To the best of my knowledge, the information provided above is accurate and complete and includes all pertinent details regarding my financial status.

I understand that the information which I submit is subject to verification by Forrest City Medical Center and subject to review by the Indigent Care Board as required. I also understand that the information I put on this form and any documents I attach may be presented to the Trustees for the Trust Fund for the Medically Indigent Residents of St. Francis County. I understand that the information on this application will then be subject to release to any person requesting it under the Freedom of Information Laws. I certify that the above information is true and correct.

I understand Social Security Numbers (SSNs) will be used in a computer match to detect and prevent duplicate participation- SSNs are also used in a match through the State Income and Eligibility Verification System to secure wage, unearned income and benefit information from the Social Security Administration, Employment Security Division, and Internal Revenue Service. Information received may be verified through collateral contact when discrepancies are found bv Indigent Care Program and may affect eligibility or level of benefits.

I understand that no person may be denied Indigent Care assistance on the grounds of race, color, sex, age, handicap, religion, national origin, or political belief

ASSIGNMENT OF MEDICAL SUPPORT. I authorize any holder of medical or other information about me to release information needed for a hospital claim to the Indigent Care Program. I further authorize release of any information to other parties who may be liable for my medical expenses. As an eligibility condition I automatically assign my right to any settlement, judgment, or award which may be obtained against any third party to FCMC to the full extent of any amount which is paid by Indigent Care Program for my behalf. I authorize and request that funds, settlement or other payments made by or on behalf of third parties, including tortfeasors or insurers arising out of a Medicaid claim, be paid directly to FCMC. My application for Indigent Care benefits shall in itself constitute an assignment by operation of law and shall be considered a statutory lien of any settlement, judgment, or award received by me from a third party. A third party is any person, entity, institution, organization or other source which may be liable for injury, disease, disability or death sustained by me or others named herein, including estates of said individuals. I also assign all rights in any settlement made by me or on my behalf arising out of any claim to the extent of medical expenses paid by Indigent Care Program, whether or not a portion of such settlement is designated for medical expenses. Any such funds received by me shall be paid to FCMC. A copy of this authorization may be used in place of the original.

I DECLARE UNDER PENALTY OF PERJURY THAT THE ABOVE IS TRUE AND CORRECT. If I receive benefits to which I am not entitled because I withheld information or provided inaccurate information, such assistance will be subject to recovery by Indigent Care Board, any assistance I receive in the future may be reduced to recover this overpayment, and I may be subject to prosecution for fraud and fined and/or imprisoned.

Signature of Applicant

Date Signed

Witness, if signed by mark

Address of Witness

This application has been reviewed and it has been determined that there is no other available source of payment through standard collection/litigation procedures and/or other charity program.

Signed: _____

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.

Exhibit B
Charity Care/ Financial Assistance Program Application

Forrest City 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 **870-261-0493**

Thank you for your cooperation!

Patient Financial Advocate / Business Office

R1 RCM Inc | Forrest City Medical Center |1601 New Castle Rd | Forrest City AR .72335
Office: 870-261-0493 Fax: 870-261-0280

Exhibit A
Example of "Availability of Charity Care" – English Version

Patient Account Number: _____ **Date of Application:** _____

PATIENT INFORMATION

Name_____

Address_____

City_____

State/ZIP_____

SS#_____

Employer_____

Address_____

City_____

State/Zip_____

Work Phone_____

Length of Employment_____

Supervisor_____

PARENT/GUARANTOR/SPOUSE

Name_____

Address_____

City_____

State/Zip_____

SS#_____

Employer_____

Address_____

City_____

State/Zip_____

Work Phone_____

Length of Employment_____

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 sell 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

$_____

BOM_____

Amount Approved:

CEO_____

CFO_____