Community Care Program

APPLICATION PATIENT FINANCIAL SERVICES

Thank you for your interest in the Jamestown Regional Medical Center (JRMC) Community Care Program. We are committed to treating patients who have financial needs with the same dignity and consideration that is extended to all patients. JRMC considers each individual's ability to pay for medical care and extends Community Care or Partial Community Care to eligible patients, unable to pay for their care. Please complete and submit an application.

Please read through the guidelines for Community Care and Partial Community Care. Full Community Care is total bill coverage. Partial Community Care is a percentage of bill coverage. Community Care or Partial Community Care is granted to patients who meet the American Hospital Association and Jamestown Regional Medical Center guidelines. The guidelines include but are not limited to a patient's ability to pay. All other sources of financial assistance must be exhausted and the charges incurred must be a medical necessity.

To apply, an application will need to be completed and submitted, along with all necessary paperwork. The information provided is used to help verify income and expenses and determine eligibility. Please initial "Part Two" if you have not filed taxes in the last two years.

See the instruction and checklist of required documentation on page 2.

Today's Date: _____

Your application will need to be submitted as soon as possible. Time limits for Community Care do exist.

Please make every effort to return your application within two weeks using email, mail or by dropping off at any JRMC registration desk. Online applications can also be completed by scanning the QR code found below.

CommunityCare@jrmcnd.com

Jamestown Regional Medical Center
2422 20th Street SW
Jamestown, ND 58401

After submission of your application and all necessary paperwork, JRMC will review the documents provided. You will be notified by mail. Payments on account should be continued through this process.

For more information, please contact the JRMC patient financial counselor at (701) 952-1050 or (800) 281-8888.

We appreciate your time to complete this application.
Jamestown Regional Medical Center

INSTRUCTIONS

1) Complete and Sign Application

Your application may be denied and returned if not completed properly.

2) Gather and Copy Documents

By presenting proof, your eligibility can better be assessed.

These materials include:

- income taxes for the past two years*
- additional documentation of income needed for verification if you are:
  - receiving income from another source such as Social Security, retirement, alimony, child support, VA or welfare
  - making payments to another source such as alimony or child support
- three recent bank statements
- six recent pay stubs
- Notification of Benefit Decision from the ND Department of Health and Human Services (if applicable)

*If you did not file income taxes, please provide your two most recent W-2 forms or the last six pay stubs from your employer, along with an **initialed PART TWO: INCOME TAXES** included in this packet (page 4) to verify that they were not filed.

3) Send application and all necessary documents to Jamestown Regional Medical Center.

Please review the checklist to make sure you have all the documents.

CHECKLIST

◯ I filled out and signed the application fully and to the best of my knowledge.

◯ All the required proper documentation listed is included:

- income taxes for the past two years
- additional documentation of income
- three recent bank statements
- six recent pay stubs

◯ You may need to bring:

- Notification of Benefit Decision
- proof of expenses

Community Care Program

APPLICATION PATIENT FINANCIAL SERVICES

APPLICANT INFORMATION

First Name:		M.I.:		Last Name:			
Address:							
City:			State:			Zip:	
Home Phone:			Cell:				
Date of Birth:			Social Security:				
Employment:			Job Title:				
Work Address:							
City:			State:			Zip:	
Work Phone:							

OPTIONAL

This may aid in qualifying you for a federal or state assistance program such as Medicaid or Disability.

Are you pregnant? ☐ YES ☐ NO

Are you disabled? ☐ YES ☐ NO

Dependent 1: _____ Dependent on applicant? ☐ YES ☐ NO

Name Age

Dependent 2: _____ Dependent on applicant? ☐ YES ☐ NO

Name Age

Dependent 3: _____ Dependent on applicant? ☐ YES ☐ NO

Name Age

Dependent 4: _____ Dependent on applicant? ☐ YES ☐ NO

Name Age

CO-APPLICANT INFORMATION

First Name:		M.I.:		Last Name:			
Address:							
City:			State:			Zip:	
Home Phone:			Cell:				
Date of Birth:			Social Security:				
Employment:			Job Title:				
Work Address:							
City:			State:			Zip:	
Work Phone:							

PART 1: INCOME & OTHER ASSETS

Must provide proof of pay stubs, tax returns and bank statements.

Monthly Net Income		**Assets**	
Self (monthly net)	$	Life Insurance (cash value)	$
Spouse (monthly net)	$	Stocks/Bonds/Mutual Funds	$
Rental Income	$	Retirement Plans	$
Other	$	Savings Accounts	$
		Real Estate (net cash value)	$
		Other	$
TOTAL MONTHLY INCOME	**$**	**TOTAL ASSETS**	**$**

PART 2: INCOME TAXES

☐ I have not filed for income taxes in the past two years due to a low-income status. _____ INITIAL

☐ I am up to date on filing for income taxes and will provide income tax statements for the past two years.

PART 3: PARTIAL COMMUNITY CARE AGREEMENT

Payment plans arranged with partial Community Care Application awardees are considered reasonable by the Patient Accounts Coordinator.

I promise to pay Jamestown Regional Medical Center (JRMC) the remainder of my bill, if I receive Partial Community care to cover a portion of my current bill. I have been informed of JRMC's payment plan and have reviewed it above. If I default on this plan, I know that the hospital can take action to see that they are paid for the services that were offered including, but not limited to, sending my account to a collection agency.

The information stated in this application is correct to the best of my knowledge. You are authorized to check my credit and employment history and to answer questions about your credit experience with me.

You are further authorized to disclose any information contained herein and other information obtained by you with regard to my credit and employment history to third parties, solely for the purpose of obtaining financing for payment of any indebtedness that I might owe you.

By signing this agreement I am promising to cooperate with the hospital staff and provide adequate information, in a timely manner, to get my bill resolved. I understand that my signing this form gives JRMC the right to verify this information and deny me of Community Care if I am fraudulent.

_____ _____

Applicant Signature Date

_____ _____

Co-applicant Signature Date