North Arkansas
Regional Medical Center

620 N. Main ⁜ Harrison, Arkansas 72601 ⁜ (870) 365-2000 "We're Here For Life"

These are the application instuctions for the NARMC Subsidy Program. The Subsidy Program is based on family size and net income. You must meet eligibility guidelines to qualify.

The Subsidy application is not a guarantee of payment, **so you must continue to make payments on your NARMC account/s throughout this process.** Please make payment arrangements on your account/s with the Patient Representative at (870) 414-4007.

Please complete the application and Financial Statement. Mail or deliver the forms with the items listed below to NARMC c/o Subsidy Program 620 N. Main, Harrison, AR 72601.

1. Proof of your household's take home (net) income for the past three months.

Proof of income includes any ONE OF THE FOLLOWING:

- Last 3 months of pay check stubs
- Verification letter from employer stating your net income
- Print-out from Social Security or copy of check
- Last 3 months of bank statement if your paychecks are direct deposited
- Most recent tax document if you are self-employed

If you have no income, you must present:

- Notarized statement stating how long you have been without an income
- A separate notarized statement stating how you are obtaining food and housing signed by the person who is supplying your food and housing.

2. You must send a letter of denial from Medicaid, unless:

- You are already on Medicaid
- Your NARMC bills are more than 90 days old.

To obtain a letter of denial from Medicaid, you must apply for Medicaid through your County Office of the Arkansas Department of Health and Human Services.

- In Boone County, call 870-741-6107
- In Newton County, call 870-446-2237
- In Carroll County, call 870-423-3351
- In Marion County, call 870-449-4058
- In Searcy County, call 870-448-3153

If we can be of further assistance please call (870) 365-2498 and leave a message.

North Arkansas
Regional Medical Center

620 N. Main ✱ Harrison, Arkansas 72601 ✱ (870) 365-2000 "We're Here For Life"

What About My Bill?
Important Facts

- **You will receive a separate bill from each physician who provides care to you.** This includes your Primary Care Physician, any consulting Physician, the Radiologist (Radiology Associates), Anesthesiologist (Boone County Anesthesia Group), Pathologist.
- **Call 870-414-4007 to talk to a Patient Accounts Respresentative about your hospital bill.**
  - Set-up a 6 month payment plan on your account;
  - Request an itemized bill;
  - Discuss concerns about your bill;
  - Request information about possible help with your bill through the NARMC Subsidy Program (see below).
- **Prompt payment in full of an unpaid balance is eligible for a discount.** Please inquire at the Business Office by calling 870-414-4007.
- **You can use your Visa, Mastercard or Discover Care to pay your bill.**
- **Every time you receive hospital services, both inpatient and outpatient, you need to renegotiate your payment plan.** Your bills are not automatically combined.
- **To apply for Medicaid you can contact your hospital Medicaid Worker at 870-414-4043**

NARMC Subsidy Program Information

Below are the financial guidelines for the Subsidy Program. The amount of assistance you qualify for is based on your family's net monthly income. Call 870-365-2498 to request an application.

Family Size	1	2	3	4	5	6	7	8
Net yearly income	$21,840 or below	$29,400 or below	$36,960 or below	$44,520 or below	$52,080 or below	$59,640 or below	$67,200 or below	$74,760 or below

North Arkansas
Regional Medical Center

620 N. Main ※ Harrison, Arkansas 72601 ※ (870) 365-2000 "We're Here For Life"

SUBSIDY PROGRAM FINANCIAL STATEMENT

Name of Applicant or Responsible Party:	
Account Number:	Social Security Number:
PLEASE ATTACH PROOF OF MONTHLY INCOME	
Your Net Income Per Month:	Spouse's Net Income Per Month:
Income from Cattle or Other Farm Activities:	Food Stamps Per Month:
Child Support Income Per Month:	Other Income:

The information I have provided on this financial statement is correct to the best of my knowledge. I understand it will be used by NARMC to evaluate my ability to pay for hospital services.

_______________________________ _______________________

Signature of Applicant or Responsible Party Date

North Arkansas
Regional Medical Center

620 N. Main ※ Harrison, Arkansas 72601 ※ (870) 365-2000 "We're Here For Life"

SUBSIDY PROGRAM APPLICATION

Name of Patient or Responsible Party:		
Social Security Number:	**Date of Birth:**	**Phone Number:**
Address:		
Spouse's Name:	**Family Size:**	**Medicaid Application Date**
Employer:		
Spouse's Employer:		

I certify that the above information is true and accurate to the best of my knowledge. I understand that a new application must be submitted every 90 days or as requested. I understand that the information, which I submit for verification by NARMC is subject to review by Federal and /or State regulatory agencies and others as required. I understand that NARMC my re-evaluate my financial status and take whatever action may be appropriate at any time.

_______________ _______________________________

Date Signature of Applicant/Responsible Party

Eligibility Determination (For Office Use Only)

Proof-of-income (Y)___(N)___MCD Denial Required (Y)___(N)___ Provided (Y)___(N)___

Financial Statement (Y)___(N)___ Net Annual Income ___________

Approved Subsidy Assistance % ____________

Denied Funds: Reason: ____________________ Notified: __________

Approved by: __________________________ Date: ____________