William Bee Ririe Hospital and Rural Health Clinic
Charity Care Financial Assistance Application Form Instructions

William Bee Ririe Hospital and Rural Health Clinic WBRH/RHC provides Charity Care Financial Assistance to **Nevada residents** who meet certain income requirements when they are; uninsured, underinsured, ineligible for any government program, who are unable to pay for their care when they.

A request for Charity Care Financial Assistance will be considered for emergent and inpatient services provided within the last 6 months. Charity Care Financial assistance does not cover clinic visits, elective surgery or procedures.

<u>In order for your application to be processed, the following documents are required, if applicable:</u>

☐ **Completed Financial Application Form –do not leave any blanks. It must be signed and dated.**

☐ **A copy (do not submit original) of your prior year tax return.**

☐ **2 months checking and saving account bank statements (All accounts including Chime, Virtual Wallet, Sofi,**

☐ **etc.). You must provide current bank statements. Provide documentation representing all sources of current income. 4 bi-weekly and 8 weekly current paycheck stubs.**

☐ **Retirement plan (pension, 401K, IRA, etc.). 2 months**

☐ **Copy of social security, disability, or unemployment check award letter**

☐ **State of Nevada Medicaid decision/denial notice.** You may obtain this by contracting the State office in the area in which you live. All potentially eligible patients must provide an official letter of determination letter with the reason for acceptance or denial. Any determination letter stating a failure to provide information or failure to participate in the interview will note be accepted in consideration of this application for financial assistance.

If all areas are not complete and / or the required documents are not attached, the application will be rejected and returned to the applicant.

<u>If you have questions or need help completing this application:</u> Please contact Patient Financial Services at 775-289-3001 ext. 614.

Mail your completed application with all documentation to:

William Bee Ririe Hospital and Rural Health Clinic.
1500 Avenue H Ely, Nevada 89301

Be sure to keep a copy for yourself.

To submit your completed application in person: Bring it to our Patient Financial Service office located inside the hospital at 1500 Avenue H Ely, NV 89301

By submitting a Charity Care Financial Assistance application, you give your consent for us to make necessary inquiries to confirm financial obligations and information.

Please be advised that this is not a guarantee that financial assistance will be awarded. WBRHCAH/RHC reserves the right to deny charity care financial assistance to patients for any reason deemed appropriate (e.g. failure to cooperate, providing false information, refusal to apply for Medicaid, etc.). Payments should continue on a regular basis until a determination has been made. Your application and information provided will be reviewed and a decision will be provide to you in writing.

Thank you.

William Bee Ririe Hospital and Rural Health Clinic

Charity Care Financial Assistance Application Form

PURPOSE

The purpose of the Charity Care Financial Assistance Program is to provide financial assistance to individuals who are uninsured, underinsured, ineligible for any government program, and who are unable to pay for their care.

REQUIREMENTS

Please answer all questions completely and to the best of your knowledge in order to prevent any delays to the application review process. All required documentation must be submitted with this signed and dated application or the application will be considered incomplete. . **If all areas are not complete and / or the required documents are not attached, the application will be rejected and returned to the applicant.**

Please fill out all information completely. If it does not apply, write "NA." Attach additional pages if needed.

PATIENT AND APPLICANT INFORMATION

Patient first name	Patient middle name		Patient last name
Marital Status:	Birth Date		Patient Social Security Number
Guarantor (Person Responsible for Paying Bill)	Relationship to Patient	Birth Date	Social Security Number

Mailing Address

____

____

City State Zip Code

Main contact number(s)

( ) __________________

( ) __________________

Email Address:

____

Employment status of person responsible for paying bill

□ **Employed** (date of hire: ______________________) □ **Unemployed** (how long unemployed:________________________)

□ **Self-Employed** □ **Student** □ **Disabled** □ **Retired** □ **Other** (______________________)

FAMILY INFORMATION

List all family members in your household, including you. Do not include extended family (grandparents, aunt, uncle, etc.) Income must be provided for all household members.

FAMILY SIZE ___________

Name	Date of Birth	Relationship to Patient	Employer(s) name or source of income	Total gross monthly income (before taxes):	Also applying for financial assistance?
					Yes / No
					Yes / No
					Yes / No
					Yes / No
					Yes / No
					Yes / No

All adult family members' income must be disclosed. Examples of sources of income include:

- Wages - Unemployment - Self-employment - Worker's compensation - Disability - SSI - Child/spousal support
- Work study programs (students) - Pension - Retirement account distributions - Other (*please explain_____________*)

REQUIRED DOCUMENTS

Completed Financial Assistance Application

A copy of the prior year tax return

Documentation representative of all current sources income.

- **4 bi-weekly and 8 weekly current paycheck stubs.**
- **Retirement plan (pension, 401K, IRA, etc.).**
- **Copy of social security, disability, or unemployment check award letter**

Checking and Savings accounts bank statements **(All accounts including Chime, Virtual Wallet, Sofi, etc.).**

A copy of official State Medicaid program determination letter

EXPENSE INFORMATION

We use this information to get a more complete picture of your financial situation.

Monthly Household Expenses:	To whom owed	Present Balance	Monthly payment
Rent/mortgage	___________________________________	$___________________	$______________
Utilities	___________________________________	$___________________	$______________
Food	___________________________________	$___________________	$______________
Auto Loan	___________________________________	$___________________	$______________
Insurance Premiums	___________________________________	$___________________	$______________
Credit Cards	___________________________________	$___________________	$______________
Medical expenses	___________________________________	$___________________	$______________
Cost of Prescription Medication(s)	___________________________________	$___________________	$______________
Other Debt/Expenses (*child support, loans, medications, other*)	___________________________________	$___________________	$______________

Additional information- use the back of this page

ASSET INFORMATION

This information may be used to determine your available assets.

Current checking account balance

$____________________________

Current savings account balance

$____________________________

Other account balance (e.g. Direct deposit debt accounts, SoFi, etc.)

$____________________________

Does your family have these other assets?

Please check all that apply

Asset	Bank Number & Account Number	Account Balance
□ Stocks	_____________________________	$______________
□ Bonds	_____________________________	$______________
□ 401K	_____________________________	$______________
□ IRA	_____________________________	$______________
□ Trust(s)	_____________________________	$______________
□ Auto (Year and Make)	_____________________________	$______________
□ Auto (Year and Make)	_____________________________	$______________
□ Residence Market Value	_____________________________	$______________
□ Insurance Cash Value	_____________________________	$______________
□ Other(e.g. second home)	_____________________________	

Please provide a copy of your retirement plan. You may be asked to provide proof of your assets.

PATIENT AGREEMENT

I understand that WBRH/RHC may verify information by reviewing credit information and obtaining information from other sources to assist in determining eligibility for financial assistance or payment plans. You are hereby authorized to check my credit history in order to evaluate this application for financial assistance consideration.

I certify that all statements made in this application are true and correct. I understand if the financial information I give is determined to be false, the result may be denial of financial assistance, and I may be responsible for and expected to pay for services provided.

____ ______________________________________

Signature of Person Applying Date

Accounts to be Consider

Patient Name	Date	Account Number	Amount
Total Financial Assistance Requested			