WBRCAH/RHC

Financial Assistance Program

In keeping with our mission to provide quality care and support to our patients and their families, we at William Bee Ririe Critical Access Hospital and Rural Health Clinic (WBRCAH/RHC), offer financial assistance to persons who are unable to carry the financial burden of their medical care.

Upon completion of the enclosed Financial Assistance Application form, and the submission of the required documents, you may be eligible for financial assistance as defined by WBRCAH/RHC.

If you feel that you are a candidate for this provision, please make an appointment to discuss your individual needs with an admitting representative or billing associate.

To arrange a meeting, you may call 1-775-289-3467 and select extension 148 or 233.

Date

Re: Financial Assistance Program

To Whom It May Concern:

In an effort to resolve your account in a timely manner, we at William Bee Ririe Critical Access Hospital and Rural Health Clinic (WBRCAH/RHC) would like to provide information about our Financial Assistance Program.

Enclosed with the Financial Assistance Application form, you will find a description of the required documentation, which must accompany the completed application. Without all appropriate information, your application cannot be considered.

As in all other aspects of your family's medical care, be assured that the information you provide is completely confidential and your privacy will be treated with the greatest respect.

As a representative of WBRCAH/RHC, I will be happy to assist you in the application process. Allow approximately 14 business days for full review and consideration. *(Please be advised that we will consider charges incurred prior to your application date; charges for services rendered after that date will not be included.)*

You may contact me during regular business hours at (775) 289-3467 extension 148. In the event that you are unable to reach me at this number, please leave a detailed message referencing the Financial Assistance Program, along with the patient's name, and a telephone number where you can be reached. This will enable me to serve you as quickly as possible.

Thank you for your cooperation in this matter.

Sincerely,

Cassie J. Henriod
Patient Financial Services Manager
WBRCAH/RHC

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WBRCAHRH

Account #_____

Patient Name: _____

FINANCIAL ASSISTANCE APPLICATION

LAST NAME (PATIENT)	FIRST	MIDDLE	SOCIAL SECURITY #	BIRTHDATE
RESIDENCE ADDRESS (FACILITY ADDRESS IF HOMELESS)			HOW LONG	PHONE
CITY		STATE		ZIP
LAST NAME (GUARANTOR IF DIFFERENCE FROM ABOVE)			SOCIAL SECURITY #	BIRTH DATE
EMPLOYER OF GUARANTOR (NAME AND FULL ADDRESS				
	PHONE			MONTHLY GROSS PAY $
OTHER EMPLOYER (NAME AND FULL ADDRESS				
	PHONE			MONTHLY GROSS PAY $
IF UNEMPLOYED, NAME OF LAST EMPLOYER AND FULL ADDRESS				
				LAST EMPLOYMENT DATE

FAMILY MEMBERS (IF MORE SPACE IS NEEDED, PLEASE ATTACH AN ADDITIONAL SHEET OF PAPER)	BIRTH DATE	RELATIONSHIP	EMPLOYED BY	EMPLOYER PHONE
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

☐ RENT HOME ☐ OWN HOME	OTHER MONTHLY INCOME	$	SPECIFY SOURCE

OWED TO OTHERS	TO WHOM OWED	PRESENT BALANCE	MONTHLY PAYMENT	ASSETS	BANK NUMBER &ACCOUNT NUMBER	ACCOUNT BALANCE
RENT/MORTGAGE				CHECKING		
UTILITIES				SAVINGS OR CERTIFICATE		
FOOD				403(B) OR 401(K)		
AUTO LOAN				STOCKS & BONDS		
CREDIT CARDS				IRA		
				AUTO (YEAR & MAKE)		
				AUTO (YEAR & MAKE)		
OTHER OBLIGATIONS (CHILD SUPPORT, ALIMONY, INSURANCE PAYMENTS)				RESIDENCE MARKET VALUE		
ADDITIONAL INFORMATION (SEE BACK)				INSURANCE CASH VALUE		
BILLS OWED TO OTHER MEDICAL PROVIDERS				OTHER ASSETS (DESCRIBE E.G., SECOND HOME)		
COST OF PRESCRIPTION MEDICATION (S)						
TOTAL DEBTS				TOTAL ASSETS		

I CERTIFY THAT ALL STATEMENTS MADE IN THIS APPLICATION ARE TRUE AND COMPLETE. YOU ARE HEREBY AUTHORIZED TO CHECK MY CREDIT HISTORY IN ORDER TO EVALUATE THIS APPLICATION FOR FINANCIAL ASSISTANCE CONSIDERATION.

SIGNATURE	DATE

In order for this application to be considered for Financial Assistance, the following documents are required, if applicable

Completed Financial Assistance Application Form

A copy of the prior year tax return

Documentation representative of current income

Copies of social security, disability, or unemployment check or award letter.

A copy of a state AHCCCS/Medicaid Decision/Denial Notice. You can obtain this by contacting the AHCCCS/Medicaid office in the area in which you live. All potentially eligible patients must provide a valid "Notice of Action" from AHCCCS/Medicaid stating completion of the application and the reason for acceptance or denial. Any Notice of Action stating a failure to provide information or failure to participate in the interview will not be accepted in consideration of this application for financial assistance.

Please return your completed application with all requested forms within 10 days. Contact the Business Office at (775) 289-3467 EXTENSION 148 if you have any questions.

Please be advised that this is not a guarantee that financial assistance will be awarded; and payments should continue on a regular basis until a determination has been made. Your application and the information provided will be reviewed and verified and a decision will be provided to you in writing.

Thank you for your cooperation. We look forward to being of assistance to you to resolve your account.

Return by this Date: _____

Account Number: _____

Account Balance: _____