WEST RIVER HEALTH SERVICES
1000 Highway 12 ■ Hettinger, ND 58639-7530 ■ 701-567-4561

Financial Assistance Document Requirements

Thank you for considering our Financial Assistance Program. In addition to the application, **please submit the following required documentation**:

- **Copy of my/our last year tax return (signed Form 4506-T if no tax returns) OR copies of my/our last three month's pay stubs and verification of Social Security Benefits**
- **Copies of my/our last three month bank statements (all pages)**
- **Child support Government Payments (Stimulus or PPP Grant), or any other financial gifts**
- **Release of information**
- **Copy of my/our letter of acceptance/denial from Medicaid.**

Once we have the requested information, we will be able to determine if you are eligible and/or what kind of plan we can offer you. Please be sure to submit your application within **two weeks** of receiving this packet. If you are unable to complete the application in **two weeks**, give us a call to discuss your options. You can fax, e-mail or mail the information to us. If you have any questions, please do not hesitate to contact us.

Thank you,

Financial Counselors
West River Health Services
Direct: (701) 567-6156
Tracy.finck@wrhs.com
Fax: (701) 567-6369

Please send all application information back to this address:

West River Health Services
Attn: Financial Counselors
1000 Highway 12
Hettinger, ND 58639

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APPLICATION FOR FINANCIAL ASSISTANCE

Applicant's Name: _____

Co-Applicant's Name: _____

Address: _____
Street **City** **State** **Zip**

Applicant's Social Security Number: _____

Co-Applicant's Social Security Number: _____

Home Phone Number: _____

Cell/Alternative Phone Number(s): _____

Number of Members in Household: _____

Applicant's Employer (Name and Phone Number): _____

Co-Applicant's Employer (Name and Phone Number): _____

I/We certify that the above information is **true and accurate** to the best of my/our knowledge. Further, I/We will make application for any assistance, which may be available for payment of my hospital/clinic charges, and I/We will take any action reasonably necessary to obtain such assistance and will assign or pay the hospital/clinic the amount recovered.

I/We understand that this application is made so that West River Health Services can judge my eligibility for charity care based on the established criteria on file at the hospital/clinic.

I/We have enclosed the following required documentation:

- **Copy of my/our last year tax return (signed Form 4506-T if no tax returns) OR copies of my/our last three month's pay stubs and verification of Social Security Benefits**
- **Copies of my/our last three month bank statements (all pages)**
- **Child Support, Government Payments (Stimulus or PPP Grant), or any other financial gifts**
- **Release of information**
- **Copy of my/our letter of acceptance/denial from Medicaid.**

I/We affirm that the information listed in this application is true and correct to the best of my/our knowledge. I/We hereby authorize West River Health Services to investigate any information provided and I/We authorize the release of any information pertaining to income that West River Health Services deems necessary in making an eligibility determination.

Applicant's Signature: _____ **Date**_____

Co-Applicant's Signature: _____ **Date**_____

Updated 01/19/2024

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RELEASE OF INFORMATION

I/We, _____, hereby authorize you to release employment, insurance, income and bank statements to West River Health Services. This information will help me/us to apply for financial assistance with my/our hospital bills.

I/We understand that West River Health Services is required to keep all information confidential and that further disclosure of information is prohibited without my/our written consent.

I/We am/are aware that this authorization will expire one year from my/our dated signature(s).

Applicant Signature _____Date _____

Co-Applicant's Signature _____ Date_____