

GOOD NEIGHBOR PROJECT



Application for Insurance Assistance

Name: _____ Telephone: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Length of Time at Present Address: _____
 Previous Address: _____
 Birthdate: _____ SSN: _____ Marital Status: M S
 Source(s) of Income: _____

List name, birthdate and relationship of all people in your household (attach additional sheet if necessary).

Name	Birthdate	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Name of Present Health Insurance Carrier: _____
 Address: _____ Phone # _____
 _____ Policy # _____
 Maximum Ins. Co-Pay: _____ Deductible _____

Are you currently receiving or eligible to receive any type of medical assistance?

	Yes	No		Yes	No
Social Security Disability	<input type="checkbox"/>	<input type="checkbox"/>	Helping Hands	<input type="checkbox"/>	<input type="checkbox"/>
Medicaid	<input type="checkbox"/>	<input type="checkbox"/>	Other (specify) _____	<input type="checkbox"/>	<input type="checkbox"/>
CHIPS	<input type="checkbox"/>	<input type="checkbox"/>			

Present Employer _____ Phone # _____
 Spouse's Employer _____ Phone # _____

Please submit a copy of your current Federal income tax return and a current balance sheet/financial statement. If you do not file tax returns, please submit copies of your six(6) most recent bank statements.

I hereby certify that the information given by me on this form is correct and complete to the best of my knowledge, and grant permission to West River Health Services to obtain additional information concerning my eligibility, including copies of my credit history. I agree to contact the Patient Financial Services Manager if circumstances change my need(s) prior to action on this application. I understand any medical services outside the West River Health Services system will not be eligible for reimbursement. I understand the aid received from the Good Neighbor Project is contingent on fund availability, and application approval is not a guarantee of assistance.

Applicant Signature _____ Date _____
 Co-Applicant Signature _____ Date _____

*Return completed application to:
 Patient Financial Services Manager, West River Health Services
 1000 Highway 12, Hettinger, ND 58639
 (701) 567-6152*