APPLICATION FOR FINANCIAL ASSISTANCE

Dear Patient:

In order for Roosevelt General Hospital to complete your application for assistance, the following application and supporting documents must be returned to the Financial Counselors in person, by fax at 575-356-9200, or by mail to RGH attn: Financial Counselor 42121 US Hwy 70 Portales, NM 88130

SECTION I. APPLICANT INFORMATION

Name (Last, First, Middle)	Best Phone # to reach you (H, C, W)	Alternate phone # (H, C, W, O)

Address Where You Live (Street)	City	State	Zip/ County
Mailing Address (Street or P.O. Box)	**City**	**State**	**Zip/ County**

E-mail Address	Preferred Language (mark one)	Marital Status (circle one)
	○ English ○ Spanish ○ Other_________________	Married (legal or common law) Single Separated Divorced Widowed
Have you received Financial Assistance before?____________		

PLEASE ANSWER ALL QUESTIONS BELOW

Residency:

1. Are you sponsored by, or the dependent of someone else?___ yes ___no; who?__________________
2. If you are not a US Citizen, do you have eligible immigration status?____ yes _____no
   If yes a)Immigration document type______________________ b) Visa/A #______________________
   c) Code /Status_________________________ d) Expiration date ________________________

Living Arrangements: (check one)

☐ Own or paying a mortgage ☐ Living in a house provided by someone else ☐ Living with someone else

☐ Homeless- no permanent home ☐ Shelter:________________________ ☐ Rent house/apt./room

☐ Visitor ☐ Other: ____

Other Health Coverage: (check all that apply)

1. Do you or anyone in your household have health care coverage through any of the following?

☐ Medicare ____ A ____ B ☐ Medicaid: ________________ ☐ Marketplace (Obamacare)

☐ VA/ Tricare: ________________ ☐ CHIP ☐ Cobra ☐ Private or Employer

Third Party: type____________________________ date of injury/accident: ________________________

2. In the past 60 days, did health coverage end for anyone in your household? ______ yes ______ no
   If yes what kind of coverage and when did it end? ____
3. In the last 30 days did you or anyone in your household apply for Medicaid? ______ yes ______ no
4. Is anyone in your household unable to work because of a disability or illness? ______ yes ______ no
   If yes who?____
5. Has anyone in the household ever applied for SSI or disability? ______ yes _______ no
   If yes who?__________________________________ when? _________________________________
   Current status of application:____
6. Is anyone in the household waiting for an insurance settlement because of an accident? ______ yes
   ______ no. Who_________________________ when____________________ type__________________

SECTION II. FAMILY SIZE AND INCOME

Family Size

(Fill in the spaces below with information about yourself and everyone else who lives in your household and are considered dependents)

Name (last, first, middle initial)	SSN (if applicable)	Sex	DOB (mm/dd/yyyy)	Relation to you	US Citizen	Pregnant	Person requesting assistance
				Self	Yes No	Yes No	Yes No
					Yes No	Yes No	Yes No
					Yes No	Yes No	Yes No
					Yes No	Yes No	Yes No
					Yes No	Yes No	Yes No
					Yes No	Yes No	Yes No
					Yes No	Yes No	Yes No
					Yes No	Yes No	Yes No

Income

(List all income received from all sources for everyone in your household… you will need to provide current proof of all sources of income)

Name of person receiving money	Source of Income	Gross amount	How often received

Copyright ©2009 The Academy of Healthcare Revenue LLC. All rights reserved.

SECTION III. RIGHTS AND RESPONSIBILITIES

IMPORTANT------READ CAREFULLY AND THOROUGHLY

I hereby submit the above statement for the purpose of allowing Roosevelt General Hospital to evaluate my financial status and determine my eligibility for various financial assistance programs.

I hereby attest that the information that I have provided herein is true and correct. The statements I have made, including my answers to all questions, are true and correct to the best of my knowledge.

I understand that this application is a legal document and that if this information is determined to be false and deceptive, I will be denied assistance and liable for payment of charges of all services rendered.

I understand that this request for financial assistance does not apply to other healthcare providers outside of RGH Clinics and Hospital or for services that are not deemed medically necessary.

I agree to report any changes within 14 days from the date of change such as: income, address (home or mailing), people that live with me, health coverage, e-mail address, phone number. If you provide us with your e-mail address, you are agreeing to receive correspondence from RGH about your household's financial assistance and eligibility.

If you do not have the required documentation, please inform us as we may be able to accept an alternate form of documentation to satisfy the requirement. Patients who fail to follow through with the application process, or who refuse to apply for outside programs, that they may potentially be eligible for, may be denied financial assistance (i.e. Medicaid)

I have been told and understand that this application will be considered without regard to race, color, religion, creed, national origin, age, sex, disability, or political belief; that I may request a review of the decision made on my application or recertification for assistance; and that I may request orally or in writing, a fair decision about actions affecting receipt or termination of the financial assistance program.

By applying for Financial Assistance, I also agree to accept payment responsibility for any amount due from me as a result of any partial grant, which may be awarded.

My signature below authorizes the release of information to RGH, RGH vendors and contractors, state and federal agencies, or patient assistance programs and to review records.

____________________________________ ________________________

(Patient's/Guarantor's Signature) *(Date)*

____________________________________ ________________________

(Spouse's/Significant Other's Signature) *(Date)*

For Internal Use Only:

Account Number	*Facility*	*Amount of W/O*	*Account Number*	*Facility*	*Amount of W/O*

Approved: ________ yes ________ no ___________% date of approval: ________________________________

HH members approved:____

Denied: ________ yes ________ no date of denial: ________________________________

Reason for denial: ____

Copyright ©2009 The Academy of Healthcare Revenue LLC. All rights reserved.