



Mail to:
RESCU Foundation
 707 State Rte 725 #123
 Dayton, OH 45459 OR
 Fax to: 888-299-9513

For R.E.S.C.U. Use Only

Date Rec'd _____ Case # _____
 Advocate _____
 One Time _____ On Going _____
 Amount(s):
 Decided _____ Disb. _____ Date _____ Ck# _____
 Decided _____ Disb. _____ Date _____ Ck# _____
 Decided _____ Disb. _____ Date _____ Ck# _____
 Decided _____ Disb. _____ Date _____ Ck# _____
 Advocacy Amount: _____
 Other Notes: _____

**Medical Financial Aid
 Request Form**

Please completely fill out this form and submit by mail or fax to the above.

Copies of all pertinent medical bills or statement of treatment or diagnosis must be attached.

I. Patient Info (*Applicant is the party responsible for payment of medical bills. Ex. Parent for minor)

*Applicant's Name		Home Address			
City/State/Zip		Primary Phone #	Alternate Phone #	Email Address	
Annual Income	Soc. Sec #	Age	DOB	Married/Single/Head of Household	# Dependents
Patient's Name (if different from above)		Relationship		Date of Birth	
Alternate contact name (required)		Relationship		Phone (required)	
Insurance Coverage Y/N _____ If yes, clarify your coverage and deductible:					

*****RESCU Assistance*****

- RESCU assistance may be in one or more of the following areas. Rank them (1-4) in order of importance to you.
- ____ I want to have an advocate negotiate for me to reduce bill amounts and/or set up patient payment plans.
 - ____ I need financial assistance to help alleviate out-of-pocket medical and prescription expenses already incurred.
 - ____ I have an upcoming appointment or procedure where I will need financial assistance or help with negotiation.
 - ____ I would like information on possible assistance from other agencies, foundations or manufacturers for prescription assistance.

Please provide any other pertinent information that would assist us in determining the extent of your need:

II. Medical (Attach a copy of each medical bill, or provide a statement of treatment from your medical professional for Medicare, VA or State Assistance.)

Fully describe accident/illness: (Attach add'l sheet if necessary.) Date/length of accident/illness: _____

Did accident/illness require: Ambulance ____ Surgery ____ Rehab Facility ____ Hospital Stay (# Days) _____
 List the medical bills for which you would like assistance: (A **copy of the bill must be attached** to be considered)

Treatment Date	Facility Name	Facility Type	Treated by	Total Bill	Amt Paid
TOTALS					

II. Additional Info

List all related out-of-pocket expenses such as prescriptions, excessive driving to treatment, deductibles, etc:

Are more bills expected? (Y/N) ____ List additional or upcoming procedures & estimated amounts:

How much work loss has occurred? _____ Still occurring? ____ Est. Return Date: _____ Est. Lost Wages: _____
 Have you attempted to negotiate any of your bills? (Y/N) ____ If yes, provide brief details:
