



Mail to:  
**R.E.S.C.U. 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 to the best of your ability and submit to the above address.

**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             |
| Age   | DOB | Married/Single/Head of Household |                   | # Dependents              |
| Patient's Name (if different from above)                                    |     | Relationship                     |                   | Date of Birth             |
| Alternate contact name ( <b>required</b> )                                  |     | Relationship                     |                   | Phone ( <b>required</b> ) |
| Insurance Coverage Y/N _____. If yes, clarify your coverage and deductible: |     |                                  |                   |                           |
|   |     |                                  |                   |                           |
|   |     |                                  |                   |                           |

**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: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**II. Medical (cont)**

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 |
|----------------|---------------|---------------|------------|------------|----------|
|                |               |               |            |            |          |
|                |               |               |            |            |          |
|                |               |               |            |            |          |
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|                |               |               |            |            |          |
|                |               |               |            |            |          |
|                |               |               |            |            |          |
| <b>Totals</b>  |               |               |            |            |          |

**III. 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? \_\_\_\_\_ Is your work loss still occurring? \_\_\_\_\_  
 Estimated Return Date: \_\_\_\_\_ Annual Income: \_\_\_\_\_ Estimated Lost Wages: \_\_\_\_\_  
 Have you attempted to negotiate any of the above bills? (Y/N) \_\_\_\_ If yes, briefly provide details:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Other Needs:  
 I would like help from a RESCU advocate\* \_\_\_\_\_ I would like info on how to negotiate bills \_\_\_\_\_  
 \*An advocate will negotiate and speak on your behalf with medical billing centers.  
 Please provide any other pertinent information that would assist us in determining the extent of your need:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_



