



## RESCU Foundation Medical Aid Request Form

I submitted the Aid Form to RESCU on \_\_\_\_\_ (date).

I was contacted by \_\_\_\_\_ (name) of RESCU, on \_\_\_\_\_ (date).

### **Instructions:**

- Please keep a copy of this document for your records.
- Fill out the Aid Form *completely*. Incomplete forms and blanks will delay our ability to assist you.
- Sign the last 2 pages.
- Attach copies of all of the following that you have (if applicable).
  - Unpaid medical bills
  - Paid medical bills
  - Receipts from out of pocket expenses (prescriptions, office visits, etc)
  - Estimates of any upcoming procedures.
  - Documentation of insurance, disability, diagnosis or letters from doctors.
  - Lists of prescription assistance needs.
- Fax or mail the Aid Form using the contact info at the top of the Aid Form as soon as possible.

Please read the details below for more information on the entire process and what you can expect from RESCU. Thank you.

### **Additional Information:**

#### **What can I expect from RESCU?**

-The RESCU Foundation is a 501(c)(3) non-profit organization that provides assistance when an eligible applicant has a medical need. RESCU does not provide complete financial assistance, and RESCU is not insurance. RESCU is able to provide limited financial assistance in some situations; RESCU **does not pay in full** the bills submitted by an applicant. RESCU is able to provide advocates who may be able to negotiate with providers to reduce a bill amount or to set-up a payment plan. While the Advocacy Program has much success, RESCU **does not guarantee any particular result** for an applicant's specific situation, or that a case will conclude within a particular length of time.

#### **When should I fill out and send in my Aid Form?**

-As soon as possible. Time is of the essence.

-Immediately following any procedure, hospital stay or office visit. Even if you have not received all of your bills to date, please submit what you have with your completed application, and forward other medical bills *as soon* as they arrive.

-Notice of an upcoming procedure allows us to find and negotiate with a facility.

***RESCU has the most success with bills received within the first 30-60 days after your discharge.***

*-Negotiating medical bills that have gone into collections is far more challenging and much less successful. Don't ignore the bills or the process. We know it can be overwhelming but we are here to help.*

### **How do I complete the Aid Form?**

- It is crucial that you complete *every* section of the Aid Form. Write “N/A” (not applicable) if it doesn’t apply to you. Do not leave blanks. Skipping a section will delay our ability to assist you.
- Send us copies of each medical bill as they arrive. Usually the very first bill is your most detailed. This bill has the most valuable information for us and is sometimes hard to track down if not supplied by you.

### **What happens once my Aid Form has been received?**

- RESCU will contact you within a few days of receiving your Aid Form and will ask any necessary follow up questions on your submission.
- Your case will be submitted to the Disbursement Department for determination of eligibility and one or more of the following:
  - \*financial aid directly to the patient
  - \*assignment of an advocate (if requested)
  - \*payments directly to a facility
  - \*assistance with aid through outside programs
- Soon after the Disbursement Department meets, we will contact you and let you know the recommended plan of action for your case.

### **What is the benefit of having an advocate?**

- An advocate will work with you to help you understand all the options related to your medical bills and find one that works best for your individual situation.
- An advocate can make calls directly to the billing facilities for you to set up payment plans, negotiate your bills or even attempt to stop bill collector’s phone calls.
- An advocate is trained to see if you qualify for financial assistance from the hospital or from local, state or federal programs, and to negotiate with hospitals and other medical facilities to obtain a more favorable monetary result for your situation.
- An advocate can help determine if you qualify for prescription assistance or other assistance programs.
- An advocate can negotiate directly with collection agencies and other facilities, hopefully reducing your bills and resulting in a payment plan that is within your budget.

### **Why does RESCU ask for my gross income?**

Knowing your income level allows RESCU to quickly determine which financial and/or prescription assistance programs you may be qualified to receive. RESCU does not require proof of income, however, hospital programs do. Submitting verification such as tax returns, pay stubs, or bank statements may qualify you for a reduced or eliminated bill.

### **Why does RESCU need to know my social security number?**

The medical billing facilities regularly use your social security number for a security layer on your account. When an advocate calls a billing facility, privacy laws require the advocate know your social security number.

### **When should I follow up with RESCU?**

If you have a question, or are worried that your Aid Form has not been received, or haven’t heard any news in a while, contact us! You may email us at [Assistance@RESCUfoundation.org](mailto:Assistance@RESCUfoundation.org); call or text the Advocacy Program Director at (937) 479-0711; visit us at [www.RESCUfoundation.org](http://www.RESCUfoundation.org); leave us a voicemail at (800) 374-9215.



**Fax to: 888-299-9513  
OR**

**Mail to:  
RESCU Foundation  
2206 N. Main St. #223  
Wheaton, IL 60187**

## Medical Aid Request Form

*For RESCU 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# \_\_\_\_\_  
 Advocacy Amount: \_\_\_\_\_  
 Other Notes: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Please completely fill out this form.**

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

*Applicant's Name			Primary Phone #	Alternate Phone #
Billing Address			Email Address	
City, State, Zip			Age	Married, Single, Head of Household
			# Dependents	
Date of Birth	Social Security #	Annual Income	Preferred means of communication: <input type="checkbox"/> CALL <input type="checkbox"/> TEXT <input type="checkbox"/> EMAIL	
Patient's Name (if different from applicant)			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: _____ _____				

I authorize my RESCU representative to discuss any and all aspects of my case, including medical bills, with the following persons:

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_  
 Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

I understand that if I decide that I no longer want RESCU to speak with a person named above, I must send a signed statement to the RESCU Foundation of this decision. This release is null and void in three (3) years on the date signed in Part V.

\*\*\*Applicant's Initials: \_\_\_\_\_

**\*\*\*RESCU Assistance\*\*\***

RESCU assistance may be in one or more of the following areas. **Rank them (1-5) 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 need financial assistance for upcoming medical expenses.
- \_\_\_ I would like information on possible prescription assistance from other agencies, foundations or manufacturers.
- \_\_\_ I need financial assistance due to major loss of work in relation to my medical condition.

**II. Medical** (Attach a copy of each medical bill or, if you have Medicaid or VA Assistance, provide a statement of treatment or diagnosis.)

**Date/length of accident/illness:** \_\_\_\_\_

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

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Did accident/illness require: Ambulance \_\_\_\_ Surgery \_\_\_\_ Rehab Facility \_\_\_\_ Hospital Stay (# Days) \_\_\_\_\_  
 List all of your medical bills below. (**Attach a copy of the bill or estimate.**)

Treatment Date	Facility Name	Facility Type	Treated by	Total Bill	Amt Paid
<b>TOTALS</b>					

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

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

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**III. Additional Information**

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:

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**WAIVER OF LIABILITY**

This Waiver of Liability (“Waiver”) executed on this \_\_\_\_\_ day of \_\_\_\_\_, 201\_\_\_\_\_, by \_\_\_\_\_ (“Client”) in favor of the RESCU FOUNDATION, INC. (“RESCU”).

In this document, RESCU means RESCU Foundation, Inc., a Wisconsin non-profit corporation, its officers, directors, employees and agents and any volunteers acting for RESCU Foundation, Inc.

I understand that RESCU is a non-profit organization seeking to assist participants of Renaissance faires and other historical enactments in medical need. I am aware that RESCU does its best to insure that my personal information is kept private and protected. I am aware that RESCU does its best to obtain a more favorable result for my situation, and that RESCU is not assuming responsibility for payment on submitted medical bills.

In consideration thereof, I, and my personal representative, heirs, guardian, and next of kin hereby waive and release all claims of any nature I may have, including but not limited to any liability or claims of injury to my body or property or of my right to privacy, resulting from my application for assistance from RESCU.

I have read and clearly understand that this Waiver discharges RESCU from any liability or claim that I, the Client, may have any against RESCU with respect to personal and property damage or right to privacy. I also understand that RESCU does not assume any financial responsibility.

I am signing this waiver voluntarily, without duress. I realize that I am not required to sign this Waiver, and I understand that if I choose not to sign this Waiver, RESCU may limit or deny assistance. I know that I have given up substantial rights by signing this document.

\_\_\_\_\_  
Signature of Client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent or Guardian (if under 18)

\_\_\_\_\_  
Date



## THIRD PARTY RELEASE OF INFORMATION

If, on your application, you have checked that you would like assistance from a RESCU Foundation advocate, please read and sign the following release form. If an advocate was not requested, disregard this form.

I, \_\_\_\_\_, hereby authorize my  
Print Applicant's Name  
**RESCU Foundation Advocate to speak on my behalf and to represent my interests when dealing with the financial burdens associated with my medical bills. I give permission to medical facilities, collection agencies and any other businesses to fax or mail any requested information or statements to my RESCU Advocate as requested by my Advocate.**

**I authorize my RESCU Advocate to make any corrections to my contact information, including updates to my address and phone, and to advise medical or collections facilities of these changes. My advocate also has permission to add me to a "no call" list.**

**This release is null and void in three (3) years from the date signed below.**

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date

**For your privacy and protection, this information will be kept confidential in strict accordance with the HIPAA guidelines.**