RESCU Medical Aid Request Form

Whether active or retired, any pass holding participant of a themed show is eligible for medical relief from RESCU. Simply fill in this entire form and fax or mail with the requested documentation. For quick proof of eligibility, a new option is to include a snapshot of your festival pass! As always, if you need any help completing this aid form, leave a message at 1.800.374.9215 for prompt assistance.

This medical case is:
☐ Before any treatment ☐ Currently undergoing treatment ☐ Treatment completed ☐ Long-term or lifelong ☐ Needing Advocacy

Prospective Client

Legal Name_____ *Also known as* _____

Phone_____ May we text? ☐Yes ☐No

_____
Email

DOB_____ Age_____

SSN (*last 4 digits only*)_____ Gender_____

# of dependents_____

Check all that apply

☐ Current Participant ☐ Returning Client
☐ Past Participant or Retired ☐ Dependent
☐ Student ☐ Minor under 12
☐ Single ☐ Senior over 65
☐ Married ☐ Veteran
☐ Partnered ☐ Head of Household

Client Insurance Status & Basic Financial Information

☐ Client has health coverage

Clients Monthly health coverage payment $_____.00

Any Deductible? $_____.00

☐ Workers' Comp ☐ Medicare ☐ Medicaid

Starting Date _____

☐ Client had no health coverage

Client Annual Income $_____.00

Household Annual Income $_____.00

Average Household Monthly Expenses $_____.00

Billing Address & Alternative Disbursement Address

Street_____ City, State, Zip _____

If a financial amount is approved:
☐ please send the disbursement check to the billing address above
☐ please send the disbursement check to the alternative disbursement address below

If on the road, temporary or alternative disbursement mailing address:

c/o _____

Street_____ City, State, Zip _____

Alternate Contact Information

I authorize RESCU to discuss any aspect of my case with this alternate contact ☐ Yes ☐ No

Name_____

Phone_____

Email_____

Relationship_____

Is the Alternate Contact the…

Parent or Legal Guardian of Client ☐ Yes ☐ No

Financially Responsible for Client ☐ Yes ☐ No

Only If "YES" to either of the two above, provide the Alt. Contact's Annual income $_____.00

Client Health Issue

Provide a **one-sentence** summary of the health issue or diagnosis:

_____

Now give the details of your medical situation here. Use additional paper if necessary. (*What/Where/When/How*)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Which of the following were/are/will be required as a result of the Health Issue?

☐ Ambulance
☐ Surgery
☐ Medical Equipment
☐ Hospitalization *# of days* _____

☐ Rehabilitation
☐ Counseling
☐ Caregiver

☐ Long-Term Treatment
☐ Short Term Prescription *Total Cost* $_____.00
☐ Long Term Prescription *Cost/month* $_____.00
☐ Other _____

Advocacy

Advocacy is lowering your bills through negotiation. We can provide training and/or assistance with this.

Have you attempted to negotiate down any of your bills? ☐ Yes ☐ No

Are you willing or able to be guided on how to advocate for yourself? ☐ Yes ☐ No ☐ Possibly

Do you have any other pending charity applications? ☐ Yes ☐ No

Show Involvement

Can you provide a copy of a Show Pass? ☐ Yes ☐ No

Check all Pass(es) previously held: (even if you cannot provide a copy)

☐ Employee ☐ Grounds Crew ☐ Entertainment
☐ Volunteer ☐ Security ☐ Guild
☐ Manager ☐ Food Services ☐ Game/Rides
☐ Owner ☐ Crafters ☐ Other

How many seasons have you worked Shows? _____ years

What was your ANNUAL Income from Shows the last year you worked? $_____.00

We need to know the list of shows from your last year of participation. *Please name all of the shows for that year here:*

_____

_____

Now provide more detailed information about your two most recent Show arrangements

	Show #1	Show #2
Company Name		
Job Title		
Supervisor Name		
Supervisor Phone #		
Name of Show Worked		
# of Years Worked		
The last Year Worked		
Still There?	☐ Yes ☐ No	☐ Yes ☐ No

Was there loss of Show work? ☐ Yes ☐ No *(if No, skip to next section)*

Start date of Show work loss _____ until **Current Date**. How long of time for work loss? _____ weeks

Current Show Related Lost Wages: $ _____.00

Anticipated Show work loss: From Current Date until _____ Anticipated how long? _____ weeks

Anticipated Show Related Lost Wages: $ _____.00

Non-Show Employment

Annual income from Non-Show Employment: $_____.00 Job title _____

Do you get any other monthly check? (pension, disability, etc.) ☐ Yes ☐ No

If yes to the above question, how much? $_____.00 from who? _____

Keep going! You are almost finished!

An Easy Bill Spreadsheet with *You Can Do It!* Instructions

① Charity and financial aid reduction has covered: $_____.00 ② Insurance has covered: $_____.00

Now for what is left:

Please list all expenses and include all pages of the bills. Copy this sheet if more lines are needed.

③ Who is billing you?	④ In Collections?	⑤ Service Date	⑥ Date of Statement	⑦ Client Total	⑧ Client Payments	⑨ Owe Currently
	☐					
	☐					
	☐					
	☐					
	☐					
	☐					
	☐					
	☐					
	☐					
Total each column *(including amounts listed on any additional pages)* >>>				$	$	$

Bill Spreadsheet Instructions

① **Charity or Financial Aid reduction**: Enter how much your bills were reduced by a self-pay discount, financial aid or another charity, without including insurance.

② **Insurance reduction**: Enter how much your bills were reduced by insurance.

③ **Who is billing you**: Enter the name of the facilities that provided the medical service for each bill (examples: Carnillion Clinic, Tomball Hospital, Dr. Smith, Aadams Dental, Urgent Care, LabTec, etc). Also list here any additional medical expense receipts that are related to your medical needs (examples: prescriptions, bandages, hotel, air fare, gas, medical equipment, etc)

④ **In collections:** Check this box if your bill has been turned over to a collections/debt recovery agency.

⑤ **Service Date**: Enter the date you received the medical service and incurred the expense.

⑥ **Date of statement**: Enter the date the service provider sent the statement, typically located at the top of your bill. It is essential that we are given current statements. If your **statement is older than 3 months**, please have them issue a current statement/bill. This does not apply to paid receipts, as there is no statement involved.

⑦ **Client total**: Enter the amount YOU owe after all insurance payments or charitable deductions have been posted but INCLUDING any payments you have already made. For medical cash receipts: Enter the total of the receipt you spent on a medical need.

⑧ **Client payments**: List the amount of your personal payments. This can be a receipt, or the amount in the body of an itemized bill. For medical cash receipts, "Client Total" and "Client Payments" are the same amount.

⑨ **Owe Currently**: How much do you still owe? For your bills this is the amount after all forms of payments are deducted. For receipts this amount will always be zero.

Signature and Liability Release

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 holds my personal information in strict confidence in accordance with HIPAA guidelines.** I am aware that RESCU does its best to obtain a more favorable result for my situation, but there is no guarantee for success and that RESCU is not assuming responsibility for payment on submitted medical bills. In consideration thereof, I hereby waive and release RESCU of any and all claims of any nature I and all other persons who may have a right to be involved on my behalf, 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 also understand that RESCU does not assume any financial responsibility for any claims submitted through my submission of this form. I hereby certify that I have completed this form to the best of my abilities and that the statements provided are true. I understand that any material misrepresentation of statements in this application and in any other past or future communication about my situation with RESCU may disqualify me from assistance, and I understand that I may be required to pay back any financial assistance provided by RESCU before the misrepresentation was identified. I am signing voluntarily and without duress.

Client's Signature	Client's Printed Name	Date
Responsible Party' Signature *(if different)*	Responsible Party's Printed Name	Date

Documentation Checklist

Please provide all documentation listed here. For bills and receipts, indicate the # of items (pieces of paper) you are including. A photocopy or scan is acceptable for all items, but PDF format is preferred.

- ☐ Completed RESCU Medical Aid Form
- ☐ Medical Bills & Estimates *Quantity:* _____
- ☐ Out-of-Pocket Expense Receipts *Quantity:* _____
- ☐ *Optional:* Image of at least one of Client's Faire Participant Passes

Submitting Your Aid Form

Submit all requested documentation via fax, mail, or other mail carrier. To protect your privacy, HIPAA discourages emailing your case information. RESCU encourages you to choose the option that will not cause more financial hardship.

Fax	**888-299-9513** Faxing from an office store can be expensive Look online first for reasonable faxing options
USPS ~ UPS ~ FedEx	**RESCU Foundation, Inc.** 2206 N Main St #223 Wheaton, IL 60187

RESCU is proud of our speedy response to clients.
If you do not hear from us within 14 days

Leave a message at 800-374-9215 or email **Contact@RESCUfoundation.org** for further assistance.

THIRD PARTY RELEASE OF INFORMATION

I, _____, hereby authorize

Print Client Name

The RESCU Advocacy Program to speak on my behalf and to represent my interests when dealing with the financial burdens associated with my medical bills.

I authorize medical facilities, collection agencies, and any other businesses to fax, mail, or email any requested information or statements to RESCU Advocate(s) as requested.

I authorize RESCU Advocacy 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.

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

_____

Date

_____

Printed Client Name

_____

Client Signature

The RESCU Foundation treats our client information in strict accordance with the HIPAA guidelines. www.RESCUfoundation.org