RESCU Aid Request Form - Medical

*The Medical Aid Panel wants to make an informed and timely decision for you! Any pass-holding participant of a Renaissance Festival or similar event is eligible for medical relief from the RESCU Foundation whether active or retired. Complete a **separate** form for **EACH issue**, then sign and return it to us with copies of the bills or estimates. If you are having trouble filling out this aid form, leave us a message at **800.374.9215** and we will be happy to help you finish!*

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

Prospective Client

Legal Name: _____ Preferred Name: _____

May we text?

Phone: _____ ☐ Yes ☐ No

Email: _____

DOB: _____ Age: _____

SSN (*last 4 digits only*): _____

# of Dependents: _____

☐ Male ☐ Female ☐ Non-Binary

Your Correct Pronoun: _____

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

Billing Address and 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: _____

REQUIRED 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 …

A Parent or Legal Guardian of Client? ☐ Yes ☐ No

Financially Responsible for Client? ☐ Yes ☐ No

If "YES" to either of the two above, provide Alternate Contact's annual income: $ _____ .00

Client Health Issue

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

Please 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?

- ☐ **NONE of these**
- ☐ Ambulance
- ☐ Medical Equipment
- ☐ Hospitalization # *of days* _____
- ☐ Surgery
- ☐ Rehabilitation
- ☐ Counseling
- ☐ Caregiver
- ☐ Long-Term Treatment
- ☐ Short Term Prescription *Total Cost* $ _____ .00
- ☐ Long-Term Prescription *Cost/month* $ _____ .00
- ☐ Other: _____

Advocacy

RESCU provides training and/or assistance with finding resources to reduce your medical bills.

Have you received or asked for a reduction on your bills? ☐ Yes ☐ No

Have you applied for any other charity? ☐ Yes ☐ No

Any social media fundraising campaign to help? ☐ Yes ☐ No

Client Insurance Status

☐ Client HAS health coverage ☐ Client does NOT have health coverage for this issue ☐ Client does NOT have health coverage

Client's Monthly health coverage payment: $ _____ .00 with a Deductible of: $ _____ .00

☐ Workers' Comp ☐ Medicare ☐ Medicaid ☐ N/A Starting Date: _____

Basic Financial Information

Client Annual Net Income: $ _____ .00 **Annual Income from Shows:** $ _____ .00

Contributing Household Member Income: $ _____ .00 Average Monthly Expenses: $ _____ .00

NON-Show Employment

☐ ***Check if Not Applicable***

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

Employer: _____

Do you get any other monthly check (e.g., pension, disability, child support)? ☐ Yes ☐ No

If yes to the above question, how much? $ _____ .00 From whom? _____

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 ☐ Volunteer ☐ Manager ☐ Owner
☐ Ground Crew ☐ Security ☐ Food Services ☐ Crafters
☐ Entertainment ☐ Guild ☐ Games/Rides ☐ Other

When was the last year you worked at a show? _____

Show Name	Company Name	Job Title	Supervisor	Income	Years	Returning?
						☐ Yes
						☐ Yes
						☐ Yes
						☐ Yes
						☐ Yes
						☐ Yes
						☐ Yes
						☐ Yes
						☐ Yes
						☐ Yes

Was there loss of **weekend** Show work? (Do not include loss of production.) ☐ Yes ☐ No

Start date of Show work loss: _____ End date of Show work loss: _____

How many work weekends were lost during this time? _____ How much average per week was lost? $ _____ .00

Have you experienced **loss of production**? ☐ Yes ☐ No

Which Shows will be affected by the loss of production? _____

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) >>>				$	$	$

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's 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 andEstimates *Quantity:* _____
- ☐ Out-of-Pocket Expense Receipts *Quantity:* _____
- ☐ *Helpful:* 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, please contact us because something is amiss.
Leave a message at 800.374.9215 or email **Contact@RESCUfoundation.org** for further assistance.

THIRD PARTY RELEASE OF INFORMATION

I, _____ ,
Print Client Name

hereby authorize 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 the RESCU Advocacy Program 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 two (2) years from the date signed below.

_____
Date

_____
Printed Client Name

_____
Client Signature

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

*Call 1.800.374.9215 for further help * * Fax completed forms to 888.299.9513*