Declaratory Statement

APPLICATION FOR UNCOMPENSATED SERVICES

Rapides Regional Medical Center

Account Number(s):_____

Patient Name:_____ Social Security Number:_____

Responsible Party Name:_____ Social Security Number:_____

Address:_____

Dependents in Household

(This includes spouse, children under 18, and all others claimed on your tax return)

Name (First, Middle and Last Name if different than Patient)	**Age**
_____	_____
_____	_____
_____	_____
_____	_____

Employment (Patient/Responsible Party)

Employer Name _____ Hourly Rate_____ Hours worked Per week_____

Current Gross Weekly, Monthly, or yearly income **(Before Taxes**)_____

If Unemployed, date last worked_____

Employment (Spouse) if applicable

Employer Name _____ Hourly Rate_____ Hours worked Per week_____

Current Gross Weekly, Monthly, or yearly income **(Before Taxes**)_____

If Unemployed, date last worked_____

***Did you file a tax return? If yes, please supply the most current tax return. If not, please supply the most current Social Security Benefit Statement. W-2, or 1099's.**

THIS INFORMATION MUST ACCOMPANY THE APPLICATION FOR ASSISTANCE OR THE APPLICATION WILL NOT BEPROCESSED***Other Income**

	PATIENT	**SPOUSE**
Social Security		
Pension		
Unemployment		
Worker's Compensation		
VA Benefits		
Rental Income		
Stocks, Bonds, 401K		
Dividend/Interest		
Child Support		
Alimony		
Other		

Have you ever applied for Medicaid? _____ Were you approved? _____ I, the undersigned, certify that the above information is true and accurate to the best of my knowledge. I understand that the information submitted is subject to verification. In the review process, a credit report may be requested to verify the information provided in this application. I understand that falsification of information submitted may jeopardize my consideration for the program. Furthermore, to qualify for this program, I understand I must apply for any and all assistance that may be available to help pay this hospital bill bill prior to completing this application.

Signature_____Date_____

ELIGIBILITY DETERMINATION (For Office Use Only) Eligible_____ Ineligible_____

Date & Signature_____

Please mail to: **RRMC, PATIENT ACCOUNTS, 211 4th Street, Alexandria, LA 71301**

Uninsured Patient Information Document

This document is intended to help provide uninsured patients with an understanding of the financial aspects of their healthcare. Patients covered by automobile, third-party liability or other reimbursement that may be billed for these services will not qualify for the uninsured discount.

This document also provides options available to assist you in resolving your account. To assist uninsured patients, RRMC will apply a discount to your account and then will work with you to resolve your remaining account balance.

The following information is an outline of how an uninured account will be processed and the discount that may be available to you. if you have received an elective cosmetic or flat-rate procedure, these discounts do not apply. Otherwise, RRMC discounts all uninsured bills. The discounted balance due on the account is expected to be paid in full at time of service.

- Total charges for services provided are applied to the account
- Uninsured discount is applied to total charges, thereby reducing the account balance.
- If you are unable to pay the discounted account balance in full, we will work with you to establish monthly payment arrangements.
- If you cannot establish monthly payment arrangements we will assist you with applying for Medicaid assistance.
- If you obtain Medicaid we will bill them and you will only be responsible for any non-covered charges.
- If you do not qualify for Medicaid, you may complete the Financial Assistance Application and provide supporting documentation as needed and have the visit reviewed for a potential Charity discount.
- If you qualify for a Charity discount, based upon Federal Poverty Guidelines, your account will be considered paid in full.
- If you do not meet the Federal Poverty Guidelines, you will need to make arrangements to resolve your bill immediately.

RRMC provides a 100% discount on approved charity accounts. All other uninured accounts will receive a partial discount.

_____ _____

Patient /Responsible Party Signature **Date**

_____ _____

Witness Signature **Date**

ELIGIBILITY DETERMINATION (For Office Use Only) Eligible_____ Ineligible_____
Date & Signature_____
Please mail to: **RRMC, PATIENT ACCOUNTS, 211 4th Street, Alexandria, LA 71301**

ELIGIBILITY DETERMINATION (For Office Use Only) Eligible_____ Ineligible_____
Date & Signature_____
Please mail to: **RRMC, PATIENT ACCOUNTS, 211 4th Street, Alexandria, LA 71301**