Financial Assistance Application
Rock Regional Hospital, LLC.

Is this application for future or past services? ☐ Future Services ☐ Past Dates of Service

Where were/are services being performed?_____Acct#_____

Patient's Information:

Last Name First Name Middle Initial Social Security Number Date of Birth

Street Address City State Zip

Mailing Address City State Zip

Please check appropriate box: ☐Single ☐Married ☐Common Law ☐Separated ☐Divorced ☐Widowed

Gender: ☐Male ☐Female Language: ☐English ☐Spanish ☐Other

Home Phone Number_____ Work Phone Number _____

Person Responsible for Paying the Bill:

Last Name First Name Middle Initial Relationship to Patient Social Security Number

Name of Insurance Company (VA, Medicare, Commercial, AFLAC, etc.) Effective Date

Please indicate ALL people living in the household, including applicant. Indicate who you are claiming on your tax return: (Use additional sheet of paper if needed)

NAME	RELATIONSHIP TO PATIENT	DATE OF BIRTH	SOCIAL SECURITY NUMBER	TAX DEPENDENT(Y/N)
1.	Self			
2.				
3.				
4.				
5.				
6.				

Are services related to a workers' compensation or motor vehicle accident claim? ☐ Yes ☐ No

Is anyone in your household: (Check all that apply)

☐ Pregnant Who? _____

☐ A victim of a crime that caused injury Who?_____

☐ Disabled Who? _____

☐ Not a U.S. citizen Who? _____

If LPR how many years?_____Immigration status: _____

☐ Eligible for COBRA insurance Who? _____

Do you have or plan to file a personal injury claim ☐ Yes ☐ No to compensate for injuries received?

Do you receive subsidized Housing, Food Stamps or Women's Infants and Children's Program (WIC) ☐Yes ☐No

Monthly Household Income Information:

	Patient	Spouse/Co-Applicant
Gross Income (before deductions)		
Self Employment Income		
Unemployment		
Social Security/SSI (please specify):		
Retirement (Pension, Annuity)		
Alimony or Child Support		
Interest and Dividends from Investment Accounts		
Real Estate Rental Income		
Other Income		
Total Income		

Total Household Income

Monthly Household Expense Information:

	Total		Total
Mortgage/Rent		Groceries	
Electricity		Car Payment (s)	
Household Gas		Day Care	
Water/Sewer		Child Support/Alimony	
Phone/Cell Phone		Student Loans	
Cable/Internet		Medical Expenses	

Total Household Expense

If you have no monthly income, please attach an explanation of how you are meeting your monthly living expenses.

INFORMATION OBTAINED FROM:_____RELATIONSHIP TO PATIENT: _____

I am applying for financial assistance with Rock Regional Hospital Health, Inc. (Rock Regional Hospital) as billing/collection agent for the affiliated healthcare providers indicated above. I understand that it is the expectation of Rock Regional Hospital that patients use all of their available financial resources to pay their medical bills before financial assistance will be considered or granted. The information I have provided in this Application and supporting documents are true and complete. By signing this form, I agree to allow Rock Regional Hospital to verify my employment and credit history for the purpose of determining eligibility for financial assistance. I also authorize all organizations and facilities to release information concerning my credit or financial status to Rock Regional Hospital for this same purpose. I understand that Rock Regional Hospital may require more specific proof of any information on this FAA and supporting documents will be provided upon request. If any information in this FAA and supporting documents is found to be false, misleading, or incomplete, my application for assistance will be denied. Rock Regional Hospital reserves the right to re-evaluate and/or reverse any charitable service designation if material information is not disclosed, or information was misrepresented or deliberately withheld , or if I (or my heirs) make demand for or file a civil action against a third party for personal injuries or damages (including medical charges/expenses). I understand and agree that any financial assistance granted by Rock Regional Hospital may not be used by me or my legal representatives in any negotiations, settlements or lawsuit for the purpose of enhancing an award of monetary damages. Should this occur, I agree that Rock Regional Hospital has the right to reverse any charitable service designation and pursue full charges. The undersigned agrees that any hospital that rendered medical services to the patient named above may file and maintain a hospital lien before or after financial assistance is granted on all potential recovery sources.

_____ _____

Applicant's Signature Date Co-Applicant's Signature Date

Financial counselors are available Monday through Friday 9:00am to 4:00pm. Phone: 316-425-2400