Russell Medical
MEMBER OF UAB HEALTH SYSTEM

Pt Name:_____
Date:_____

RM Charity Care Checklist

Patient Name: _____
(Last) (First) (MI)

DOB: _____ SS#: _____ MR:_____

ALL Documents REQUIRED for Charity Care Review

_____ **Completed Charity Care Application**
_____ **Proof of Income-**
- _____ Proof of Social Security Income
- _____ Pay Stubs (2 copies)
- _____ Letter from Employer – If unable to provide Pay Stubs
- _____ Proof of Unemployment
- _____ Notarized letter if supported by relatives/friends or are unemployed

_____ **Insurance –**
- _____ Insurance card(s)
- _____ Proof of non-eligibility of Medicaid

_____ **Other Income Documentation –**
- _____ Food Stamps Verification or Denial
- _____ Child Support documentation – if receiving
- _____ Alimony, Unemployment and/or Pension documentation
- _____ Income Tax Form Signed 1099 or W-2(s)
- _____ Last 2 complete bank statements *Must be current*

_____**Signed statement from physician stating reason for inability to work–page 5**
_____**Pharmacy print out of prescriptions purchased in the last six (6) months**

_____Other: _____
_____Other: _____

OFFICE USE ONLY:

Verifications Received By: _____ Date: _____
Documentation Complete: _____ Date: _____

Documentation missing:_____
_____
_____

RM Charity Care Documentation Requirements

In order for Russell Medical Center to evaluate your financial situation, we **must** receive all required information. Please return the information within thirty (30) days so that we may process your application.

1) The completed Charity Care Application attached to this letter. 2) Proof of your income, spouse's income, and proof of income of anyone living with you of working age.

- **a.** Most recently signed income tax form, complete with a copy of W-2(s), 1099, etc. If you did not file taxes, verification of non-filing from the IRS is **required**. IRS phone number (IRS – 1-800- 829-1040)
- **b.** Proof of Social Security income, if applicable.
- **c.** Copies of two (2) or more of your most recent pay stubs (or a letter from your employer that has been notarized or is on company letterhead verifying gross income.)
- **d.** Proof of alimony, child support, unemployment, pension, etc.
- **e.** Two most recent bank statements.

3) If you are unable to work due to illness, a letter from your Primary Care Physician confirming your inability to work is **required**. If you are living with a spouse, parent, friend or family
4) member, their income has to be included unless you are paying that person for specific living arrangements. If so, a **notarized** letter explaining these arrangements is required.
5) If you receive no income, and are being supported by relatives or friends, a **notarized** letter explaining these arragnements is required. The letter must be signed by person(s) lending assistance.
6) If you, your spouse, or anyone of working age living with you is unemployed, a **notarized** letter is also required stating length of unemployment, along with the name and relationship to you.
7) If you or anyone in your household receives food stamps, a verification letter is required.
8) Proof of non-eligibility of Medicaid, if a Medicaid application was submitted to the state.
9) Pharmacy printout of prescription medications purchased in the past six months.

Once you have completed or need help filling out the enclosed application and collected **all** of the items listed, please mail the information to P.O. Box 939 Alexander City AL, 35011 or call (256) 329-7136 to schedule an appointment with our patient accounting supervisor for review.

Failure to return the requested information within thirty (30) days **will result in the denial of this application.** The falsifying of any information on the Charity Care Application or discount care renewals will result in financial assistance becoming null and void.

My signature below verifies that I have read and understand the list and statements above.

Signature of Patient: _____

Date Signed: _____

Russell Medical
MEMBER OF UAB HEALTH SYSTEM

RM Charity Care Application

Patient Information

MR#: _____ SS#: _____

Name: _____ D/O/B: _____/_____/_____
Last First MI (MM) (DD) (YY)

Current Address: _____
Street/AptNumber City State Zip

Previous Address: _____
Street/AptNumber City State Zip

Telephone Numbers: Home (_____) _____
Work (_____) _____
Cell (_____) _____

Responsible Party Information

Name: _____ D/O/B: _____/_____/_____
Last First MI (MM) (DD) (YY)

Relationship to Patient: _____ SS #: _____

Current Address: _____
Street/AptNumber City State Zip

Previous Address: _____
Street/Apt Number City State Zip

Telephone Numbers: Home (_____) _____
Work (_____) _____
Cell (_____) _____

List all persons residing in household

	Name	Age	Disabled?	Annual Income
Head of House	_____	_____	Y/N	_____
Spouse	_____	_____	Y/N	_____
Child	_____	_____	Y/N	_____
Child	_____	_____	Y/N	_____
Child	_____	_____	Y/N	_____
Child	_____	_____	Y/N	_____

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RM Charity Care Application
Income, Expenses & Assets

You must list any and all income from any of these sources as well as provide proof of said income.

INCOME

DESCRIPTION	MONTHLY INCOME
A. Gross Salary for You	$_____
Net Salary for You	$_____
B. Gross Salary Spouse/SO	$_____
Net Salary for Spouse/SO	$_____
C. Social Security Benefits	$_____
D. Rental Income	$_____
E. Pension Income	$_____
F. Child Support-Income	$_____
G. Alimony-Income	$_____
H. Additional Income	$_____
I. Dividend & Interest	$_____
J. VA Benefits	$_____
K. Welfare	$_____
L. Other– List	$_____
Total Income	**$_____**

EXPENSES

DESCRIPTION	EXPENSE
A. Rent / Mortgage	$_____
B. Food	$_____
C. Utilities-Power/Water	$_____
D. Repairs-Car/Home	$_____
E. Personal Loans-List	$_____
F. _____	$_____
G. Car Payment	$_____
H. Charge Accounts	$_____
I. Credit Card	$_____
J. Cell Phone	$_____
K. CABLE TV	$_____
L. Medication(s)	$_____
M. Alimony – Paid out	$_____
N. Child Care	$_____
O. Medical Transportation	$_____
P. Education-Students	$_____
Total Expenses	**$_____**

ASSETS

DESCRIPTION	VALUE AMOUNT	DESCRIPTION	VALUE AMOUNT
A. Checking Account	$_____	E. IRA Investment	$_____
B. Savings Account C.	$_____	F. Retirement 401K	$_____
Insurance Policy D.	$_____	G. CD / Other H.	$_____
Other	$_____	_____	$_____

Total Assets Value for Both Columns; $ _____

Checking/Savings – Financial Institution Name:_____

Russell Medical
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RM Charity Care Consent

Name: _____ DOB: _____
(Last) (First) (MI)

_____ I understand that the information I submit is subject to verification by Russell Medical Center and subject to review by state and/or federal enforcement agencies and others as required.

_____ I am consenting charity care administrative services for Russell Medical Center. I certify under the statutes of perjury that the information on these pages is true and correct, and that I do not have the financial means to pay for medical care rendered to the above patient.

_____ I will report if my financial situation changes in the upcoming calendar year to Russell Medical Center immediately.

_____ I understand that I am responsible for any remaining balance after applicable discounts have been applied.

***My signature on this application verifies that if I am entitled to any other medical benefits, including, but not limited to a supplemental insurance carrier, my application for assistance may be denied, and I may be responsible for the total amount of the bills accrued at Russell Medical Center.**

Signature of Responsible Party: _____ Date: _____

Russell Medical
MEMBER OF UAB HEALTH SYSTEM

Name: _____

Patient Care Confirmation

Please answer the following questions in order for us to properly evaluate your charity care application. Once completed you, the applicant, will need to return this form along with your application. If you or your physician has any questions regarding this form, please call (256) 329-7308 or (256) 329-7136.

1. Are you pending disability benefits? YES / NO
2. Are you unable to work due to an illness or injury? YES / NO

3. **Please list the reason for your need for RM Charity Care assistance:**

_____
_____
_____

Physician Treatment Confirmation

Please have your physician answer the following questions in order for us to properly evaluate your charity care application based on your medical condition. We will need specific information about each of the illnesses, injuries or medical conditions that keep you from working. Once completed you, the applicant, will need to return this form along with your application. If you or your physician has any questions regarding this form, please call (256)329-7308 or (256) 329-7136.

Physician Information:

_____ _____
NAME OF PHYSICIAN PHYSICIAN SIGNATURE & TODAY'S DATE

_____ _____
TELEPHONE NUMBER INCLUDING AREA CODE FAX NUMBER INCLUDING AREA CODE

1. What is the major illness, injury, or condition that keeps the patient from working?

2. What is the estimated time frame that you expect the patient to be unable to work? (i.e., 1 month, 3 months, 6 months, etc.)

RM Charity Care Non-Covered Procedures

***Charity Care does not cover physician office visits or the physician's professional fees if surgery is performed. Charity Care or discounted care also does not cover the following services or services not normally covered by health insurance:**

- Reconstructive surgery
- Cosmetic surgery
- Breast implants
- Breast reduction
- Treatment for infertility
- Addiction related diagnosis
- Medications
- Durable medical equipment

This is an example of services not covered under the Charity Care or Discount Care Program. This list does not include all exclusions to the program. Should you have any questions regarding your particular plan of care, please feel free to call our office. We reserve the right to change or update covered or non-covered services without notice.

Charity Care also does not apply to physician office visits or any other bills from outside agencies such as thrid party billing for ER Physicians or any testing that is read by an outside agency.

My signature below verifies that I have read and understand the list and statements above.

Signature: _____ Date: _____