Roosevelt General Hospital and Clinics

APPLICATION FOR FINANCIAL ASSISTANCE

*For Roosevelt General Hospital (RGH) to complete the process for financial assistance, this form must be completed and returned with supporting documents. Submit form and documents by **visiting** RGH Financial Counselors at 42121 US Hwy 70, Portales; or **fax** to (575) 356-9200; or **mail** to RGH, Attn: Financial Counselors, PO Box 868, Portales, NM 88130.*

SECTION I. APPLICANT INFORMATION

Name (Last, First, Middle)	Best Phone # to reach you (H, C, W)		Alternate phone # (H, C, W, O)
Address Where You Live (Street)	City	State	Zip/ County
Mailing Address (Street or P.O. Box)	City	State	Zip/ County
E-mail Address	Preferred Language (mark one)		
	English	Spanish	Other:
Have you received financial assistance before?	Yes	No	

SECTION II. FAMILY SIZE AND INCOME

Family Size

(Fill in the spaces below with information about yourself and everyone else who lives in your household and are considered dependents)

Name (last, first, middle initial)	DOB (mm/dd/yyyy)	Relation to you	Pregnant	Person requesting assistance
		Self	Yes No	Yes No
			Yes No	Yes No
			Yes No	Yes No
			Yes No	Yes No
			Yes No	Yes No
			Yes No	Yes No

Income

(List all income received from all sources for everyone in your household… you will need to provide current proof of all sources of income)

Name of person receiving money	Source of Income	Gross amount	How often received

SECTION III. RIGHTS AND RESPONSIBILITIES

IMPORTANT------READ CAREFULLY AND THOROUGHLY

- I hereby submit the above statement for the purpose of allowing Roosevelt General Hospital to evaluate my financial status and determine my eligibility for various financial assistance programs.
- I hereby attest that the information that I have provided herein is true and correct. The statements I have made, including my answers to all questions, are true and correct to the best of my knowledge.
- I understand that this application is a legal document and that if this information is determined to be false and deceptive, I will be denied assistance and liable for payment of charges of all services rendered.
- I understand that this request for financial assistance does not apply to other healthcare providers outside of RGH Clinics and Hospital or for services that are not deemed medically necessary.
- I agree to report any changes within 14 days from the date of change such as: income, address (home or mailing), people that live with me, health coverage, e-mail address, phone number. If you provide us with your e-mail address, you are agreeing to receive correspondence from RGH about your household's financial assistance and eligibility.
- If you do not have the required documentation, please inform us as we may be able to accept an alternate form of documentation to satisfy the requirement.
- I have been told and understand that this application will be considered without regard to race, color, religion, sex, sexual orientation, gender identity, national origin, age, disability, political belief, insurance status, marital status, or immigration status; that I may request a review of the decision made on my application or recertification for assistance; and that I may request orally or in writing, a fair decision about actions affecting receipt or termination of the financial assistance program.
- By applying for Financial Assistance, I also agree to accept payment responsibility for any amount due from me as a result of any partial grant, which may be awarded.
- My signature below authorizes the release of information to RGH, RGH vendors and contractors, state and federal agencies, or patient assistance programs and to review records.

_____ _____

(Patient's/Guarantor's Signature) *(Date)*

_____ _____

(Spouse's/Significant Other's Signature) *(Date)*

For Internal Use Only:

Account Number	*Facility*	*Amount of W/O*	*Account Number*	*Facility*	*Amount of W/O*

Approved: _____ yes _____ no _____% date of approval: _____

HH members approved:_____

Denied: _____ yes _____ no date of denial: _____
Reason for denial: _____