+rmc
Regional Medical Center

DECO

Financial Assistance Application

Please provide the following information to be considered for financial assistance:

Applicant's Full Name:_____ SSN:_____

Applicant's Address:_____ City:_____

State:_____ Zip:_____ Phone:_____

Family Size:_____(Include Self, Spouse, and dependents living in the home.) Please list the information below:

Name of Spouse:_____ SSN:_____

Please list the names and SSNs of all children or dependents in your household:

Name_____SSN_____ Name_____SSN_____

Name_____SSN_____ Name_____SSN_____

Name_____SSN_____ Name_____SSN_____

Does South Carolina Medicaid cover your dependents? Please check one: Yes_____ No_____

Household Income: **Must provide proof of this income:**

List ALL income, earned and unearned. (Use the "before deductions: amount.)

1. **Total income** in the last month $_____
   (Last 3 Check Stubs showing gross income and deductions; AND recent Bank Statements showing deposits)
2. **Gross income** listed on your federal income tax return $_____
   (Provide a copy of your Federal Tax Form 1040.)

Failure to provide all documents will delay the processing of your application

1. You MUST attach proof of ALL income as requested:
   a. Last three Check Stubs
   b. Most recent Bank Statements showing deposits; Social Security Award Letter (if applicable)
   c. Copy of your Federal Tax Form 1040
   d. Valid Drivers License
   e. Food Stamps Award Letter (if applicable)
2. If you listed ZERO income, attach the written DECLARATION STATEMENT as to who provides your room and board and please provide above information from the family members.

Approvals are for a period of 1 year retroactively & 6 months from the date of the application. RMC's Financial Assistance covers residents of Orangeburg and Calhoun County Residents ONLY.

CERTIFICATION: I certify that the above information is true and accurate to the best of my knowledge. Furthermore, I will make application for any assistance (Medicaid, Medicare, Medical Insurance, Auto Insurance, etc.) that may be available for payment of my hospital charges, and I will take any action reasonable necessary to obtain such assistance and will assign or pay to the hospital the amount recovered for hospital charges. If any information that I have given process to be untrue, I understand that the hospital may reevaluate my financial status and take whatever action becomes appropriate.

Applicant's Signature_____ Date of Request_____

DECLARATION STATEMENT

NAME: _____

You are being evaluated for RMC's Charity Assistance Program. If you do not have any income, you must provide information about your provider of room and board.

If no income – Who provides you with room and board?

_____

_____

_____

_____

I certify that the information given is true and complete to the best of my knowledge. If any information that I have given proves to be untrue, I understand that the hospital may re-evaluate my financial status and take whatever action becomes appropriate.

_____ _____

SIGNATURE DATE

Memorandum of Understanding
between Deco Recovery Management acting as
Authorized Representative on behalf of Client

Authorized Representative Organization Name and Address:
DECO Recovery Management Inc., 3000 St. Matthews Road, Orangeburg, SC 29118

I,_____, give my informed Consent and Agreement to DECO to create, collect, disclose, access, maintain, use, and/or store my personally identifiable information (PII) to perform the following duties on my behalf.

- Inform me and/or my authorized representative about the full range of Medicaid, Social Security Disability (SSD), and other health coverage program options for which I am eligible.
- Help me complete my application/enroll in Medicaid, SSD, or other health coverage programs.
- To use electronic records and signatures as applicable, and in compliance with the HIPAA Privacy Rule; The Electronic Signatures in Global and National Commerce Act (E-SIGN); and The Uniform Electronic Transactions Act (UETA).

Disclosures:

- ❖ DECO will inform me of any possible conflicts of interest they might have; is required to act in my best interest; will follow privacy and information security standards when creating, collecting, disclosing, accessing, maintaining, storing, and/or using my PII.
- ❖ DECO is not required to maintain or store any of my PII other than this authorization form, but if DECO does maintain or store my PII, they will follow privacy and information security standards.
- ❖ I am not required to provide subsequent information, but by signing this authorization, I give my informed consent for DECO to follow-up with me on applying and/or enrolling in Medicaid, SSD, or other health coverage programs; monitor and respond accordingly to notices from DHHS, SSA, and/or any other health coverage program agencies on my behalf for the purpose of helping to facilitate completion of the application and enrollment process, including signing applications and supplemental documents where applicable.
- ❖ I understand that DECO will not charge me and/or my authorized representative a fee for any assistance provided.
- ❖ I understand that I may revoke this authorization at any time and will notify DECO if I choose to revoke my authorization.

DECO has informed and acknowledged that any, and all information obtained concerning me/my family will be confidential; will only be used to help determine me and/or my family's eligibility for governmental assistance programs.

I hereby release and forever hold harmless, DECO Recovery Management and its authorized representatives, from any, and all Legal Responsibility/Liability which may arise from this assistance.

_____ _____
Signature of Client/Guardian Date

Authorization to Represent

I, the undersigned, hereby authorize the release/disclosure of the following information, which will be considered confidential, to a representative of DECO Recovery Management who is acting as my authorized representative in my effort to obtain Medical Assistance, Supplemental Security Income (SSI) and/or Disability Benefits.

Further, the undersigned does hereby authorize_____, as a representative of DECO Recovery Management, to represent me in the matter being appealed in the notice of appeal filed_____ and raising the issue noted in the said notice. DECO Recovery Management and its said representative shall represent me throughout the appeal process, including any future appeals filed in the regard to the Medical Assistance application submitted on or about_____.

DECO Recovery Management is representing me and at my request is assisting me with my Medical Assistance, Supplemental Security Income (SSI) and/or Disability Benefits case at the Department of Social Services, Human Services or Social Security Administration. Please arrange to have all correspondence and information sent to me by any person, agency or organization listed below sent also to DECO Recovery Management at the above address. They are as follows:

1. Present and/or former employers.
2. Rental agencies, mortgage lenders, utility companies, landlords and residence managers
3. Schools, (Public or Private).
4. Official Government records including, but not limited to, motor vehicle records, wage earnings, unemployment benefits, State and Federal tax returns.
5. Financial Institutions to include savings accounts, checking accounts and lending firms
6. Hospitals, Clinics, Private Doctors to determine any physical or medical condition affecting eligibility.
7. Social Service Agencies
8. Out-of-town inquiries, including certification of Birth, Death, Marriage, etc.
9. Other persons and/or agencies, as necessary, to determine resources, household composition, etc.
10. Other, as specified: _____
11. Other, as specified: _____

All persons, firms, corporations, commissions, agencies, and organizations of any kind, whether public or private, having knowledge of my financial, medical or other circumstances, are hereby authorized to answer, in full, any questions, which may be asked by the representative of DECO Recovery Management on my behalf.

I understand that the information received pursuant to this authorization may be disclosed by the recipient and might lose its protected status.

I understand that I may revoke this authorization at any time by giving written notice to DECO Recovery Management. If I do revoke this authorization, however, my revocation will not affect any prior actions taken in reliance on my authorization.

If I have any questions about this authorization, I may contact a DECO Eligibility Representative at (803) - 395-2539 , who will provide me with more information about this authorization, or about DECO Recovery Management's privacy practices in accordance with a current Business Associate Agreement with **REGIONAL MEDICAL CENTER**, in compliance with the Health Insurance Portability and Accountability Act (HIPAA).

The term of this release is not to exceed two years from the date of signing written below.

Signed in_____this the_____day of_____, 20____
(City or County and State)

_____
Witness (if Marked with an "X")

_____
Signature of Applicant or Recipient

_____
Applicant Social Security Number

_____
Applicant Address

_____
City, State, Zip

_____
Applicant Phone Number

Authorization for Release of Information

I, the undersigned, hereby authorize the release/disclosure of the following information, which will be considered confidential, to a representative of DECO Recovery Management who is aiding me in my effort to obtain Medical Assistance, Supplemental Security Income (SSI) and/or Disability Benefits.

DECO Recovery Management is a representative for **REGIONAL MEDICAL CENTER** and at my request is assisting me with my Medical Assistance, Supplemental Security Income (SSI) and/or Disability Benefits case at the Department of Social Services, Human Services or Social Security Administration. Please arrange to have all correspondence and information sent to me by any person, agency or organization listed below sent also to DECO Recovery Management at the above address. They are as follows:

1. Present and/or former employers.
2. Rental agencies, mortgage lenders, utility companies, landlords and residence managers
3. Schools, (Public or Private).
4. Official Government records including, but not limited to, motor vehicle records, wage earnings, unemployment benefits, State and Federal tax returns.
5. Financial Institutions to include savings accounts, checking accounts and lending firms
6. Hospitals, Clinics, Private Doctors to determine any physical or medical condition affecting eligibility.
7. Social Service Agencies
8. Out-of-town inquiries, including certification of Birth, Death, Marriage, etc.
9. Other persons and/or agencies, as necessary, to determine resources, household composition, etc.
10. Other, as specified: _____
11. Other, as specified: _____

All persons, firms, corporations, commissions, agencies, and organizations of any kind, whether public or private, having knowledge of my financial, medical or other circumstances, are hereby authorized to answer, in full, any questions, which may be asked by the representative of DECO Recovery Management on my behalf.

I understand that the information received pursuant to this authorization may be disclosed by the recipient and might lose its protected status.

I understand that I may revoke this authorization at any time by giving written notice to DECO Recovery Management. If I do revoke this authorization, however, my revocation will not affect any prior actions taken in reliance on my authorization.

If I have any questions about this authorization, I may contact a DECO Eligibility Representative at (803) - 395-2539 who will provide me with more information about this authorization, or about DECO Recovery Management's privacy practices in accordance with a current Business Associate Agreement with **REGIONAL MEDICAL CENTER**, in compliance with the Health Insurance Portability and Accountability Act (HIPAA).

The term of this release is not to exceed two year from the date of signing written below.

Signed in_____this the_____day of_____, 20____
(City or County and State)

_____
Witness (if Marked with an "X")

_____
Signature of Applicant or Recipient

_____
Applicant Social Security Number

_____
Applicant Address

_____
City, State, Zip

+rmc
Regional Medical Center

DECO is assisting you with **Medical Financial Assistance** to help pay for your medical services or treatments incurred during your Emergency Room visit or your stay to the Regional Medical Center. In order to complete the enrollment process we need the following information.

You will be screened for the following programs before your application is forwarded for the last resort of Medical Financial Assistance:

- ☐ Medicaid and/or Social Security Disability Benefits/SSI
- ☐ COBRA
- ☐ Crime Victims Compensation

The following is required information to process your application:

- ☐ Copy of the last 3 employment check stubs
- ☐ Copy of Federal Tax Form 1040
- ☐ Most recent Bank Statement
- ☐ Social Security Award letter
- ☐ Valid Driver's License (If you do not have a valid ID, a Mortgage/Rent or Utility Bill will be acceptable)

DECO Benefits Advisors are located onsite to assist you in determining eligibility and in qualifying for medical financial assistance from federal or state resources.

DECO Recovery Management
Regional Medical Center
3000 St. Matthews Road
Orangeburg, SC 29118
(Located across from the Chapel)

(803) 395-2079 (803) 395-2539
FAX: 803-395-2952