RCA
RESOURCE CORPORATION OF AMERICA

Does patient have primary insurance? ☐ N ☐ Y ______________ Room # __________

Account Number: ______________ **SS#** ______________

Patient Email Address: ______________ **DOB:** ______________

Patient Demographic

☐ Same as Demo

Last, First: ______________

Maiden Name: ______________

Street: ______________

City, State: ______________

County & Zip: ______________

Mailing Address ______________
(if different from above ______________

Phone: ______________

Cell: ______________

Citizenship Status

☐ US
☐ Legal Resident Entry Mo/Yr ______
☐ Work Permit
☐ VISA (Student/Tourist/Business)
☐ Foreign Citizen (72 hour Pass)
☐ Undocumented
☐ Refugee/Asylee From__________

Place of Birth: ______________

Patient Primary Language: ______________

Mother's Maiden Name: ______________

Father's Name: ______________

Difficulty Reading/writing? ☐ Y ☐ N

Guarantor

☐ Same as Patient

Guarantor: ______________

DOB: ______________

SS#: ______________

Street: ______________

City, State: ______________

County & Zip: ______________

Phone: ______________

Cell: ______________

If PO Box need physical ______________

Household Composition

Patient's Marital Status

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated (how long) ________

Spouse Information

Spouse Name: ______________ DOB: ______________

SS#: ______________ ☐ US Citizen ☐ Legal Resident Yr ☐ Undocumented

Tax Calculations

Did applicant file taxes in prior year? ☐ Y ☐ N Will they file? ☐ Y ☐ N

Under what status? ☐ Single ☐ Married/ Jointly ☐ Married/ Separate

Adj Gross Income ________ # Dependents Claimed? ________

Were you claimed as a tax dependent by someone? ☐ Y ☐ N

Relationship to Tax Filer who claimed you? ______________

Child 1: ☐ Dir Related ☐ Step Child
☐ Dependent Claimed
Name: ______________
DOB: ______________
SS# ______________
US Citizen: ☐ Yes ☐ No
Sex: ☐ M ☐ F
Coverage? ☐ MCD ☐ Ins ☐ None

Child 2: ☐ Dir Related ☐ Step Child
☐ Dependent Claimed
Name: ______________
DOB: ______________
SS# ______________
US Citizen: ☐ Yes ☐ No
Sex: ☐ M ☐ F
Coverage? ☐ MCD ☐ Ins ☐ None

Child 3: ☐ Dir Related ☐ Step Child
☐ Dependent Claimed
Name: ______________
DOB: ______________
SS# ______________
US Citizen: ☐ Yes ☐ No
Sex: ☐ M ☐ F
Coverage? ☐ MCD ☐ Ins ☐ None

Child 4: ☐ Dir Related ☐ Step Child
☐ Dependent Claimed
Name: ______________
DOB: ______________
SS# ______________
US Citizen: ☐ Yes ☐ No
Sex: ☐ M ☐ F
Coverage? ☐ MCD ☐ Ins ☐ None

Patient Income

☐ Employed ☐ Self-Employed ☐ Cash/Day Work ☐ Unemployed (Since ________)

Employer: ______________

☐ Hourly $_______ Hrs/PP:_________ ☐ Salary Rate $_________

Employer Phone: ______________

Frequency Paid: ☐ Weekly (x 4.33) ☐ Bi-Weekly (x 2.17) ☐ Semi-Monthly (x 2.00) ☐ Monthly

Length of Employment: ______________ ☐ Mo ☐ Yrs

Est. Mo. Income $ __________ Last check received $ __________ Income DOS Month $ __________

Spouse Income

☐ Employed ☐ Self-Employed ☐ Cash/Day Work ☐ Unemployed (Since ________)

Employer: ______________

☐ Hourly $_______ Hrs/PP:_________ ☐ Salary Rate $_________

Employer Phone: ______________

Frequency Paid: ☐ Weekly (x 4.33) ☐ Bi-Weekly (x 2.17) ☐ Semi-Monthly (x 2.00) ☐ Monthly

Length of Employment: ______________ ☐ Mo ☐ Yrs

Est. Mo. Income $ __________ Last check received $ __________ Income DOS Month $ __________

Does patient or spouse have insurance available thru employer but declined coverage due to cost? ☐ Y ☐ N If yes, what was monthly premium? ______________

Has patient or spouse lost health coverage from an employer in the last 60 days? ☐ Y ☐ N SEP Eligible? ☐ Y ☐ N COBRA Eligible? ☐ Y ☐ N Cost for COBRA? __________

Other Income

Count
for MAGI Programs

☐ Unemployment $________ ☐ Widow's/Survivor's Benefits $________

☐ SSD $ ________ How Long Until MCR ________ ☐ Other $ ________

☐ Retirement / Pension $ ________ ☐ Cash Assistance $________

Cash Assistance Received from: ______________

Do Not Count
for MAGI Programs

☐ Child Support $ __________ ☐ Court-Ordered ☐ Voluntary

☐ SSI $ ________ MCD Benefits ☐ Y ☐ N ☐ Food Stamps $ __________

☐ VA Benefits $ ________ ☐ Workers Comp $ __________ ☐ GI Bill $________

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Patient Resources

(Do Not Count for MAGI Programs)

☐ Checking $ Institution:_______ ☐ Savings $ Institution:_______

Auto 1

☐ Own ☐ Financed Pymt $_______ ☐ Leased

Yr: _____ Make: _______ Model: _______

Auto 2

☐ Own ☐ Financed Pymt $_______ ☐ Leased

Yr: _____ Make: _______ Model: _______

Auto 3

☐ Own ☐ Financed Pymt $_______ ☐ Leased

Yr: _____ Make: _______ Model: _______

Any Additional Assets: ☐ **Stocks $** _______ ☐ **Bonds $** _______ ☐ **Retirement / 401(k) $** _______ ☐ **IRA $** _______

☐ **Burial Plot $** _______ ☐ **Life Ins $** _______ ☐ **Real Property $** _______ ☐ **Boat / RV / ATV $** _______ ☐ **Other** _______

Patient Expenses

Home: ☐ Own ☐ Rent Mortgage / Lease Amt $ _______

☐ Staying with_______

Food: Avg. Mo. Exp. $ _______

Gas: Avg. Mo. Exp. $ _______

Medications: Avg. Mo. Exp. $ _______

Electricity: Avg. Mo. Exp. $ _______

Water: Avg. Mo. Exp. $ _______

Phone

☐ Home $ _______

☐ Cell $ _______

Patient Deductions

☐ Alimony Paid $ _______

☐ Student Loan Interest $ _______

☐ Educator Expenses $ _______

☐ Health Savings Account (HSA) $ _______

☐ IRA Deductions $ _______

☐ Self-Employment Business Exp $ _______

Young Adult

Is Patient under age of 26? ☐ Y ☐ N

Does patient have a parent with employer sponsored health insurance? ☐ Y ☐ N

Date of parent's open enrollment period?

____

Is patient a former foster care child and now between the ages of 18 and 26? ☐ Y ☐ N

Hospitalization

Admitting Diagnosis: _______ Treating Diagnosis: _______

If diagnosis is Breast or Cervical Cancer, is this initial diagnosis/treatment? ☐ Y ☐ N

Other Medical Conditions: _______

Is Patient Pregnant ☐ Y ☐ N

Due Date: _______

Related to Work? ☐ Y ☐ N

Related to Accident ☐ Y ☐ N *(If Y was pt at Fault)* ☐ Y ☐ N Date of Accident: _______ ☐ MVA ☐ TPL

Ins. Name: _______ Ins. Phone: _______ Claim # _______ Policy # _______

At Fault Party Information

Ins. Name: _______ Ins. Phone: _______ Claim # _______ Policy # _______

Related to a crime ☐ Y ☐ N Police report filed ☐ Y ☐ N Agency Reported to: _______ Report/Incident # _______

Date of Incident _______ Brief Description of Crime _______

Applied for disability ☐ Y ☐ N ☐ RSDI ☐ SSI

Stage: ☐ Initial ☐ Recon ☐ Hearing *Original File Date:* _______ *Alleged onset date:* _______

Disability Attorney/Rep: ☐ Y ☐ N Name of Representative: _______ Phone: _______

Does patient claim to be disabled? ☐ Y ☐ N Is patient able to work? ☐ Y ☐ N Usual Occupation? _______ Yrs of Exp? _______

Does patient plan on returning to work? ☐ Y ☐ N

Highest Level of Education Completed: ☐ Elementary ☐ Middle School ☐ High School ☐ GED ☐ Tech Cert. Degree ☐ College/Grad

Patient must answer yes to all four questions in order to qualify for Mill Bill Reimbursement

Is the patient a veteran? ☐ N ☐ Y

Is the patient reg. in the VA Health Care System? ☐ N ☐ Y

Has patient recvd services through the VA in last 24 mo's? ☐ N ☐ Y

Did patient receive Emergency Service at your facility? ☐ N ☐ Y

Have you applied for MCD before? ☐ Y ☐ N If yes, when? _______

Case Worker Name: _______

Does anyone in your household, including yourself, smoke tobacco? How many? ☐ Y ☐ N

# of people_______?

Regional Questions

Are you on CHIP Perinatal? ☐ N ☐ Y CHIP ID # _______ ☐ Below 185% ☐ Above 185%

Are you currently on a county program? ☐ N ☐ Y Name of County Program: _______

Example: Gold Card/MAP/Ector County

Patient Signature: _______ Date: _______ Witness: _______ Date: _______

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