Recovery Mobile Clinic Patient Recovery Fund Program Form

What does the Patient Recovery Fund program cover?

The PRF, if approved, will cover determined on the need of the patient, the office visit copay, full cost of office visit, urine drug screen processing and equipment, copay of medication cost or full cost of the medication. However, depending on available resources, the PRF may not be able to cover full costs of treatment. The patient may still be responsible for a portion of the cost, even if the application is accepted.

If you have questions or need help completing this application:

Visit the Patient Recovery Fund website page, or forward questions to the Recovery Mobile Clinic.

In order for your application to be processed, you must provide us with:

- Information about your family – *fill in the number of family members in your household*

  (Family includes people related by birth, marriage, or adoption who live together)

- Provide us information about your family's gross monthly income *(income before taxes and deductions).*
- Provide documentation for family income
- Attach additional information if needed
- Sign and date the form

Note: You do not have to provide a Social Security number to apply for financial assistance.

If you provide us with your Social Security number, it will help speed up processing of your application. Social Security numbers are used to verify information provided to us. If you do not have a Social Security number please mark, "not applicable", "NA".

Email or mail a completed application with all documentation to the address below. *Make sure to keep a copy for yourself.*

Recovery Mobile clinic

7111 Dixie Highway #142

Clarkston Mi, 483

Phone: 248-567-2334

info@recoverymobileclinic.com

To submit your completed application in person:

Visit the Recovery Mobile Clinic schedule to find the practice location for the week to submit the forms or contact us at 248-567-2334.

We will notify you of the final determination of eligibility and appeal rights, if applicable, within 14 calendar days of receiving a complete financial assistance application, including documentation of income.

By submitting a financial assistance application, you give us consent for us to make necessary inquiries to confirm financial obligations and information.

!!!We want to help!!!

Please submit your application promptly, preferably at least 14 days before your next injection is due to allow time for processing and to avoid any lapse in treatment. Please contact the Recovery Mobile Clinic if you think that you will not have the paperwork completed on time for other treatment options that are available!!!

Recovery Mobile Clinic
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Patient Recovery Fund Application

Please fill out all information completely. If it does not apply, write "NA". Attach additional pages as needed.

Screening Information			
Do you need an interpreter? Yes No *if yes, list preferred language:*			
Has the patient applied for Medicaid? Yes No *Required before applying for financial assistance*			
Does the patient receive state public services such as TANF, Basic Food, or WIC? Yes No			
Is the patient currently homeless Yes No			
Please Note			
Please note we cannot guarantee that you will qualify for financial assistance, even if you apply. Once you send in your application, we may check all the information and may ask for additional information of proof of income. Within 14 calendar days, after we receive your completed application and documentation, we will notify you if you qualify for assistance.			
Patient and Applicant Information.			
Patient First Name	Patient Middle Name	Patient Last Name	
Male _____ Female _____ Other _____	Date of Birth	Social Security Number *(optional* buy may help with securing assistance)*	
Responsible Party for Paying Balance	Relationship to Patient	Date of Birth	Responsible Party's Social Security Number *(optional* buy may help with securing assistance)*
Mailing Address City State Zip Code		Main Contact(s) Number ( ) _____ ( ) _____ Email Address: _____ _____ _____	
Employment status of a person responsible for paying bill: Employed (Date of Hire_____) Unemployed (How long unemployed:_____) (Full-Time) (Part-Time) (Self- employed) (Student) (Disabled) (Retired) (Other _____)			

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Family Information

List family members in you household, including you. "Family" includes people related by birth, marriage, or adoption who live together. FAMILY SIZE _____					
Name	Date of Birth	Relationship to patient	If 18 years old or older: Employers(s) name or source of income	If 18 years old or older: Total gross monthly income (before taxes):	Also applying for Financial Assistance?
					Yes/No
					Yes/No
					Yes/No
					Yes/No

Income Information

We use this information to get a more complete picture of your financial situation.

Monthly Household Expenses:

Rent/Mortgage $_____ Medical Expenses $_____

Insurance Premiums $_____ Utilities $_____

Other Debt/Expenses $_____ (Child Support, Loans, Medications, other)

List other Expenses _____

Additional Information

Please attach an additional page if there is other information about your current financial situation that you would like us to know, such as financial hardship, excessive medical expenses, seasonal or temporary income or personal loss.

PATIENT AGREEMENT

I understand that the Recovery Mobile Clinic (RMC) may verify information by reviewing credit information and obtaining information from other sources to assist in determining eligibility and financial assistance or payment plans.

I affirm that the above information is true and correct to the best of my knowledge. I understand if the financial information I give is determined to be false, the result may be denial of financial assistance and I may be responsible for and expected to pay for services provided.

_____ _____

Signature of Patient applying Date

_____ _____

Signature of Responsible Party applying Date