

Financial Assistance Program



701 10th Street SE
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319 398-6121
www.mercycare.org

In recognition of Mercy Medical Center's mission to provide quality health care to all persons in need, regardless of their financial status, Mercy has developed this financial application in an effort to assist those who need assistance in a fair non-discriminatory manor.

INSTRUCTIONS:

1. A financial application must be completed for assistance.
2. Request for assistance must be made within 60 days of discharge, or payment or rejection by a third party carrier.
3. A completed application must be returned within 14 days of the date issued.
4. To be eligible for assistance, each applicant must first meet the minimum Gross Income requirements as is established in the United States Federal Register under the heading Income Poverty Guidelines.
5. Mercy Medical Center will verify income and other financial information via financial statements, tax returns, other documents and phone verifications. Refusal of an applicant to provide necessary information will result in denial of financial assistance.
6. Mercy Medical Center will submit a response to the applicant within 7 working days of receipt of a completed application.
7. Only one financial application will be made per account.
8. **ASSISTANCE WILL NOT BE GRANTED IN ANY OF THE FOLLOWING CIRCUMSTANCES:**
 - A. Fraudulent information at the time of registration or on an application for assistance.
 - B. Hospital stays or portions of stays not meeting the Medical Necessity guidelines for hospitalization.
 - C. Any portion of an account balance payable or expected to be payable by any third party.

THE FOLLOWING ITEMS ARE NEEDED FOR INCOME AND ASSETS:

- 1) Copy of _____ income tax and w-2's
- 2) Copy of pay stubs or wage statement from employer(s) showing earnings from last three (3) months
- 3) Computer printout from Job Service of Iowa showing all unemployment benefits received during the last four (4) quarters
- 4) Copy of most recent bank statement for checking and savings accounts
- 5) Notice of decision from the Department of Human Services.

I have read and understand the above conditions to receive financial assistance. I also understand that all information on this application will be verified by Mercy Medical Center staff, and that this will serve as a release for income verification and as a release to investigate my credit history. I swear all statements in this application are true and correct and if any information submitted is false it shall be cause for denial of this application.

Signature of Applicant _____ Date _____

PATIENT FINANCIAL REPORT

Applicant Name _____

Address: Number and Street _____ City _____ State _____ Zip _____

Telephone Number: Area Code (_____) _____

Please check appropriate box:

Buying home Buying mobile home Renting Apartment Living with relatives Other

How long have you lived at this address? _____ Years _____ Months

Patient Name _____

Patient Date of Birth _____ Social Security Number _____

Date of Service _____ Type of Service _____

Family Size: Number of Adults: _____ Number of Children: _____ Total: _____

EMPLOYMENT HISTORY

Employee Name	Employer Name	Dates of Employment	Gross Income Last 12 Months
Applicant			
Applicant: If employed less than 3 years, previous employer			
Spouse			
Spouse: If employed less than 3 years, previous employer			

OTHER SOURCES OF INCOME

Social Security Monthly Benefit: \$ _____ Child Support/Alimony Monthly Benefit: \$ _____

Public Assistance Monthly Benefit: \$ _____ Investments Income Monthly Benefit: \$ _____

Cash from Relatives Monthly Benefit: \$ _____ Total Monthly Income: \$ _____

Savings Account Amount: _____ Institution: _____ Account No.: _____

Checking Account Amount: _____ Institution: _____ Account No.: _____

Other Assets: Stocks: _____ Company: _____

Life Insurance Cash Value: _____ Company: _____

Other \$ _____ Explain: _____

OTHER SOURCES OF INCOME continued

Real Property:

Auto: Make _____ Model _____ Year _____ Value \$ _____ Amount owed \$ _____

Auto: Make _____ Model _____ Year _____ Value \$ _____ Amount owed \$ _____

Auto: Make _____ Model _____ Year _____ Value \$ _____ Amount owed \$ _____

Boats, Trailers, Livestock, Farm Land, Residential Property:

Describe: _____ Value \$ _____

_____ Value \$ _____

_____ Value \$ _____

Loans:

Name of Institution: _____ Monthly payment \$ _____ Balance \$ _____

Purpose: _____

Name of Institution: _____ Monthly payment \$ _____ Balance \$ _____

Purpose: _____

Name of Institution: _____ Monthly payment \$ _____ Balance \$ _____

Purpose: _____

Charge Card: _____ Monthly payment \$ _____ Balance \$ _____ Credit Limit \$ _____

Charge Card: _____ Monthly payment \$ _____ Balance \$ _____ Credit Limit \$ _____

Charge Card: _____ Monthly payment \$ _____ Balance \$ _____ Credit Limit \$ _____

FOR OFFICE USE ONLY

Monthly Income: \$ _____ **Monthly Payments:** \$ _____ **Debt Ratio:** _____ %

Information Verified by: _____ **Approval** **Denial**

Supervisor Signature: _____ **Department:** _____

Notes: _____
