Name of Applicant_____
D.O.B. _____
Issue Date _____
Office Received Date: _____

Financial Assistance Program

Mercy Medical Center
701 10th Street SE
Cedar Rapids, IA 52403
Direct Line 319 369-4505
Fax Line 319-369-4677
www.mercycare.org

In recognition of Mercy'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 manner.

Instructions:

1. A financial application must be completed for assistance.
2. A completed application must be returned within 30 days of the date issued.
3. 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.
4. Mercy 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.
5. Mercy will submit a response to the applicant within 30 working days of receipt of a completed application.

6. **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 guideline for hospitalization.
    c. Any portion of an account balance payable or expected to be payable by any third party.
    d. If an account is in excess of 240 days from the date of the first statement.

THE FOLLOWING ITEMS ARE NEEDED FOR INCOME AND ASSETS:

If you cannot produce these items, please explain why or we must deny your application.

Current Copies:

1. Copy of _____ income tax and w-2's
2. Copy of most recent paystub, with a year to date amount listed
3. Social Security Benefits letter
4. If you are self-employed: balance sheet and income statement
5. Computer printout from Work Force of Iowa showing all unemployment benefits received during the last four (4) quarters – only if you are not currently working. **Phone 319-365-9474**
6. Copy of most recent bank statement for checking and savings accounts.

HOSPITAL

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 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. This determination is applicable to all past Mercy Medical Center self-pay balances as well as all future Mercy Medical Center self-pay balances for one year from the date the determination is made.

CLINIC

PATIENT CONSENT

I am making application for financial hardship for dates of *services from*_____ *to* _____ *in the amount of $*_____. ***I understand that*** **this determination will NOT apply to future Services provided by MercyCare Community Physicians after this date. I understand that I will be financially responsible for any new charges incurred with Mercycare Community Physicians.**

Signature of Applicant_____**Date**_____

PATIENT FINANCIAL REPORT

Applicant Name _____

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

Telephone Number (_____) _____

US Citizen ( ) Yes ( ) No

Have you been an Iowa resident for more than thirty (30) days? ( ) Yes ( ) No

Please check the appropriate box:
( ) Home Owner ( ) Mobile Home Owner ( ) Renting ( ) Apartment ( ) Living with relatives ( ) Other

If other, please explain_____

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

Patient Name _____

Patient Date of Birth _____

Number of Adults in Family _____ Number of Children under 18 _____

Please list your spouse, minor children, and their dates of birth if applicable_____

_____

EMPLOYMENT HISTORY

Employee Name	Employer Name	Dates of Employment	Gross Income last 12 months
Applicant			
Spouse / Significant Other			

ASSETS

Equity of Residence: _____
If you cannot provide any of the required documents, please explain below:_____

_____

_____

For additional assistance please contact:
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701 10th Street SE
Cedar Rapids, IA 52403
319 369-4505
www.mercycare.org