

**Mercy – Des Moines
Standardized Financial Assistance Application (Page 1 of 2)**

Patient Information

Account # _____
 Name _____
 Social Security # _____ Date of Birth _____

Did you file taxes last year? Yes No

Patient/Guarantor (Person responsible for bill) Information

Name _____
 Social Security # _____ Date of Birth _____
 Martial Status: Married Single Divorced Separated

Street Address _____
 City _____
 State _____ Zip Code _____

County of Residence _____ Length of Residence _____
 Home Phone # _____ Cell Phone# _____

Previous Address (if less than 2 years at current address)
 Street Address _____
 City _____
 State _____ Zip Code _____

Employer

Business Phone # _____
 Job Title _____ Length of Employment _____

Rate of Pay _____ Are you paid: Hourly
 Weekly Bi-weekly Monthly Other

Monthly Income (Gross-Before Taxes) _____

Other Income: (Indicate Source, monthly amount and attach supporting documentation) Food Stamps \$ _____

Social Security \$ _____ Pension \$ _____

Unemployment \$ _____ Child Support \$ _____

Alimony \$ _____ Other \$ _____

Spouse's Information (Spouse MUST sign application)

Name _____
 Social Security # _____ Date of Birth _____

Employer

Business Phone # _____
 Job Title _____ Length of Employment _____

Rate of Pay _____ Are you paid: Hourly
 Weekly Bi-weekly Monthly Other

Monthly Income (Gross-Before Taxes) _____

Other Income: (Indicate Source, monthly amount and attach supporting documentation) Food Stamps \$ _____

Social Security \$ _____ Pension \$ _____

Unemployment \$ _____ Child Support \$ _____

Alimony \$ _____ Other \$ _____

Total Monthly Gross Income for Household \$ _____

Total Annual Gross Income for Household \$ _____

CERTIFICATION:

- I, the undersigned, certify that the completed information in this document is true and accurate to the best of my knowledge.
- I will apply for any and all assistance that may be available to help pay this bill.
- I understand that the information submitted is subject to verification. I authorize Mercy – Des Moines to verify the above information for both guarantor/patient and spouse.

Household Members: (if additional space needed attach info to app)

Name _____ Date of Birth _____
 Name _____ Date of Birth _____
 Name _____ Date of Birth _____

Assistance

Have you applied for Medicaid/Title XIX or any other State or County assistance? Yes No

Date of Application _____

Case Worker Name & Phone # _____

Have you filed for bankruptcy? Yes No

If yes, date filed _____

Chapter 7 Chapter 13 Date of Discharge _____

Assets/Resources

Are you a homeowner? Yes No

Estimated Market Value of home _____

Approximate balance due on loan _____

Years left on loan _____

Do you have a checking account? Yes No

Bank Name _____ Average balance _____

Do you have a savings account? Yes No

Bank Name _____ Average balance _____

Automobiles:

Make	Model	Year	Payment Amount	Balance Due
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Other Assets/Resources (stocks, bonds, property, business, boat, motorcycle etc.) _____

Monthly Expenses

Rent/Mortgage Amount \$ _____

Utility Costs (heat, air, water etc) \$ _____

Groceries \$ _____ Gas for Auto \$ _____

Auto Insurance \$ _____ Life Insurance \$ _____

Medication \$ _____ Other \$ _____

Monthly Payment: Payment To: Balance Due:

Bank Loans: \$ _____ \$ _____

Credit Cards: \$ _____ \$ _____

School Loans: \$ _____ \$ _____

Other Expenses: \$ _____ \$ _____

Total Monthly Expenses \$ _____

Proof of Income: a copy of the following documentation **must** accompany your application in order to be processed:

- Most recent year Federal and State Tax Returns with all required schedules and W2s.
- Two Current Pay Stubs (Guarantor and Spouse)
- Other income documentation such as but not limited to:

Social Security Food Stamps Pension Alimony
 Child Support Unemployment Other

*****Your application will not be considered without the above documentation and may be returned to you along with a letter detailing the documentation missing*****

Important: Guarantor and Spouse (if applicable) **must** sign the back of the application in order to be processed.

Signature _____ (Patient/Guarantor)	_____ Date
Signature _____ (Spouse)	_____ Date

OVER

Mercy – Des Moines Standardized Financial Assistance Application (Page 2 of 2)
Additional Descriptions of Medical Bills (other than those owed to Mercy Medical Center):

Payment To	Date of Service	Monthly Payment	Balance Due
		\$ _____	\$ _____
		\$ _____	\$ _____
		\$ _____	\$ _____
		\$ _____	\$ _____
		\$ _____	\$ _____

TOTAL MEDICAL BILLS OWED TO OTHERS THAN MERCY MEDICAL CENTER: \$ _____

CERTIFICATION:

1. I, the undersigned, certify that the completed information in this document is true and accurate to the best of my knowledge.
2. I will apply for any and all assistance that may be available to help pay this bill.
3. I understand that the information submitted is subject to verification. I authorize Mercy – Des Moines to verify the above information for both guarantor/patient and spouse.

Signature (Guarantor/Patient) _____	Date _____
Signature (Spouse) _____	Date _____

ADDITIONAL DOCUMENTATION:

Please note that by signing the application, you have agreed to attach forms of income verification (pay stubs and income tax returns, etc.). In addition, you may attach bank statements, copies of Social Security checks/letters or other documentation. If there is no income, please verify how expenses are being met. It is important to fully explain a lack of income so that full consideration of your application can be made. If the guarantor/patient or the spouse is self-employed, please attach bank statements from the past 2-3 months. All required documentation must be attached for your application to be considered. If the application is incomplete, it will be returned. Mercy-Des Moines will not be responsible for follow-up on incomplete applications.

TO SUBMIT THIS APPLICATION, PLEASE INCLUDE THE FOLLOWING:

- **Completed, signed and dated application by Guarantor and Spouse**
- **Proof of Income:** a copy of the following documentation **must** accompany your application in order to be processed:
 - Most recent year Federal and State Tax Returns with **all** required schedules and W2s.
 - Two Current Pay Stubs (Guarantor and Spouse)
 - Other income documentation such as but not limited to:
 - Social Security Food Stamps Pension Alimony
 - Child Support Unemployment Other

*****Your application can not be considered without the above documentation and may be returned to you along with a letter detailing the documentation needed*****

PLEASE MAIL OR HANDDELIVER YOUR APPLICATION PACKAGE TO:

Mercy Physician Billing Office
Financial Assistance
1200 University Ave., Suite 200
Des Moines, IA 50314

If you have questions, please call (515) 643-2519.