

Mercy – Des Moines

Standardized Financial Assistance Application (Page 1 of 4)

Household Information

Patient Name	Social Security #	Date of Birth	Account #
Guarantor's Name	Relationship to Patient	Date of Birth	Social Security #
Guarantor's Address	County of Residence	Home Phone #	Length of Residence
City	State	Zip Code	
Previous Address (if less than 2 years at current address)	City, State, Zip	Marital Status	# of Dependents in Household

List Names and Ages of Dependents in Household:

Employment/Income Information

Employer (Guarantor/Patient)	Previous Employer (Guarantor/Patient)	Spouse Employer
Address	Address	Address
Job Title/Length of Employment	Job Title/Length of Employment	Job Title/Length of Employment
Business Telephone #	Business Telephone #	Business Telephone #
Hourly Rate \$	Hourly Rate \$	Hourly Rate \$
Monthly Income (Gross) \$	Monthly Income (Gross) \$	Monthly Income (Gross) \$
Monthly Income (Net) \$	Monthly Income (Net) \$	Monthly Income (Net) \$
Other Income Source/Amount \$	Total Family Monthly Income \$	Total Family Income last 12 months \$

Have you applied for Medicaid or any other State/County Assistance? (check one)

Yes No

Assistance

Date of Application	Caseworker Name/Phone #		
Have you filed Bankruptcy? <input type="checkbox"/> Yes <input type="checkbox"/> No	Chapter 7	Chapter 13	Date Filed
Are you a Homeowner? <input type="checkbox"/> Yes <input type="checkbox"/> No	Approximate Dollar Value \$	Approximate Balance on Loan \$	Years left on Loan
Bank Name	Avg. Checking Balance \$	Avg. Savings Balance	

Assets

AUTOMOBILE(S)				
1. Make:	Model:	Year:	Payment Amount:\$	Balance Due:\$
2. Make:	Model:	Year:	Payment Amount:\$	Balance Due:\$
Other Assets (Stocks Bonds, Property, Business, Boat etc.)				

Expenses

Expense Description	Monthly Payment	Payment To	Balance Due	Limit
Rent/Mortgage	\$			
Credit Cards	\$		\$	\$
	\$		\$	\$
	\$		\$	\$
Bank Loans	\$		\$	
	\$		\$	
School Loans	\$		\$	
Other Expenses	Monthly Payment	Other Expenses	Monthly Payment	Other Expenses
Food	\$	Medication	\$	Auto Insurance
Utilities	\$	Life Insurance	\$	Other
Gas/Auto	\$	Medical Bills	\$	OTHER
TOTAL MONTHLY EXPENSES:\$				

NOTE: You may attach additional sheets of paper, if necessary.

IMPORTANT: Income verification must be attached (two most recent pay stubs and income tax return)

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Payment To	Date of Service	Monthly Payment	Balance Due
		\$	\$
		\$	\$
		\$	\$
		\$	\$
		\$	\$
		\$	\$
		\$	\$
		\$	\$
TOTAL MEDICAL BILLS OWED TO OTHERS THAN MERCY MEDICAL CENTER:\$			

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 the information submitted is subject to verification. I authorize Mercy-Des Moines to perform a credit check for both guarantor/patient and spouse.

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

DIRECTIONS FOR COMPLETING FINANCIAL ASSISTANCE APPLICATION

Household Information Section

- Complete the patient name, patient’s Social Security number, patient’s date of birth, and patient’s hospital account number(s) if known.
- Complete the guarantor name, relationship to patient, guarantor’s date of birth, and guarantor’s Social Security number. If the guarantor is the same as the patient, write “Same” in these fields.
- Complete the guarantor’s address, home telephone number and length of residence at this address.
- Complete the guarantor’s previous address (if length of residence at current address is less than 2 years), guarantor’s marital status and number of dependents living in the household (if there are no dependents, please write ‘0’ in this field).
- List the names and ages of all dependents living in the household.

Employment/Income Section

- Complete the employer information for the guarantor or patient, depending upon who has responsibility for the balance due. Please complete the name of the employer, the employer’s address, the guarantor/patient’s job title and length of employment and a business telephone number. Please also note the guarantor/patient’s hourly rate, gross monthly income (before taxes/deductions) and net monthly income (after taxes/deductions). If the guarantor/patient is unemployed, please indicate how expenses are being met.
- Complete the previous employer information for the guarantor or patient. Include the name of the employer, the employer’s address, the guarantor/patient’s job title and length of employment and a business telephone number. Please also note the guarantor/patient’s hourly rate, gross monthly income (before taxes/deductions) and net monthly income (after taxes/deductions). If there is no prior employment, please write “N/A” in the first field.
- Complete the employment information for the guarantor/patient’s spouse. Include the name of the employer, the employer’s address, the spouse’s job title and length of employment and a business telephone number. Please also note the spouse’s hourly rate, gross monthly income (before taxes/deductions) and net monthly income (after taxes/deductions). If there is no spouse or the spouse is unemployed, please write “N/A” in the first field.
- List any additional sources of income and the amount of income. This would include child support, Social Security, bonuses from employers, rental income, alimony, pension income, welfare or VA benefits.

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10. Complete the total family monthly income (add together the guarantor/patient net income, the spouse net income and additional sources of income). If there is no income, explain how expenses are being met.
11. Complete the total family income for the past 12 months (add together the guarantor/patient net income, the spouse net income and additional sources of income). If there has been no income, explain how expenses are being met.

Assistance Section

12. Indicate whether you have applied for Medicaid or other state/county assistance. Please list the date you applied for assistance and provide the assigned caseworker's name and telephone number. Use additional paper, if needed, to completely explain this field.
13. Indicate whether you have ever filed for bankruptcy. If so, check the type of bankruptcy and list the date that you filed and the date of discharge. Use additional paper, if needed, to completely explain this field.

Assets Section

14. Indicate whether you are a homeowner. If you are, please note the approximate dollar value of your home, the approximate balance on your home loan and the number of years you have left on the loan.
15. Please list your bank's name and average checking account balance. If you have a savings account, list your average savings account balance. If there is no savings account, write "N/A" in this field.
16. List the make, model and year of each automobile. Indicate the monthly payment and the balance left on your auto loan.
17. List any additional assets you may have. This includes stocks, bonds, property, businesses, boats, etc., that you may own. Use additional paper, if needed, to completely explain this field. If there are no other assets, please write "N/A" in this field.

Expenses Section

18. Please list your monthly rent or mortgage payment and indicate to whom the payment is made. If you do not pay rent or mortgage, please note why you have no payment or indicate if you live with relatives or others. Use additional paper, if needed, to completely explain this field.
19. Please indicate any credit card balances you currently have. List the monthly payment amount, to whom the payment is made and the total balance due. Please indicate the credit limit for each card. Use additional paper, if needed, to list all the credit cards you have. If you have no credit cards, write "N/A" in these fields.
20. Indicate any bank loans you have. List the monthly payment amount, to whom the payment is made and the total balance due. Use additional paper, if needed, to completely explain this field. If you have no bank loans, write "N/A" in these fields.
21. Indicate any educational loans you have. These may include, but are not limited to, college loans, private school loans (or tuition), daycare expenses or any other loans that apply to education. Please specify the type of school loan you are paying (i.e., college, tuition, daycare, etc.). List the monthly payment amount, to whom the payment is made and the total balance due. Use additional paper, if needed, to completely explain this field. If you have no school loans, write "N/A" in these fields.
22. List other monthly expenses.
 - Food: list the amount paid for food on monthly bases.
 - Utilities: list the total amount paid on a monthly basis for all utilities (i.e. electricity, gas, water, sewer, trash, etc.). If there are no utility bills paid, please write "N/A" in this section and explain.
 - Gas/Auto: list the amount paid on a monthly basis for gas or transportation needs. If you do not pay for gas or transportation, please write "N/A" in this field.
 - Medication: please list the total amount paid on a monthly basis for medication/prescriptions. If there are no medication payments, write "N/A" in this field.
 - Life Insurance: list the monthly premium you pay for your life insurance policy. If you do not make a life insurance payment, write "N/A" in this field.
 - Medical Bills: add together the monthly payments of all of your medical bills (i.e. physician bills, insurance co-pays, insurance deductibles, hospital bills, radiology bills, ambulance bills). If you are not making any payments on medical bills, please write "N/A" in this field.

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- Auto Insurance: list the total amount you pay on a monthly basis for auto insurance. If you pay on a quarterly basis, please divide your quarterly payment by three and write in that amount; if you pay every six months, please divide the total amount you pay by six and write in that amount. If you do not pay auto insurance, write “N/A” in this field.
- Other: list any other monthly payments that you make that do not fall under one of the previous categories. Please specify what the payment is for and the amount of the monthly payment. If there are no other payments, write “N/A” in this field.

23. Please total your monthly expenses and write in this amount.

Additional Description of Medical Bills Section

24. Please list details about all of your medical bills other than those that are owed to Mercy Medical Center. These may include physician bills, insurance co-pays or deductibles, radiology bills, etc. Please indicate to whom the bill is owed, the date of service, your monthly payment and the balance due. Add the balance due column and write in the total amount.

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.

BY SUBMITTING THIS APPLICATION, YOU ARE STATING THAT THE GUARANTOR/PATIENT HAS COMPLETED THIS FORM ACCURATELY AND TO THE BEST OF HIS/HER KNOWLEDGE.

TO SUBMIT THIS APPLICATION, PLEASE INCLUDE THE FOLLOWING:

- Completed, signed and dated application
- Two recent pay stubs for all household members who are 18 years old or above
- Current income tax return

MAIL YOUR APPLICATION PACKAGE TO:

Mercy Medical Center
Patient Accounts Department - FA
1111 6th Avenue
Des Moines, IA 50314

If you have questions, please call (515) 643-8200