Mercy

☐ New Patient
☐ Renewal
MRN# _____

Guaranter Account# _____
See Documents from:
E# _____

For office use only

Dear Patient/Applicant:

You are receiving this Patient Financial Assistance Application because you wish to apply for medical care at Mercy Hospital JFK Clinic. **In order to accurately assess your financial situation and to determine your eligibility, the following information is required and must be filled out in its entirety or it will be returned.**

Patient Name: _____ Date of Birth: _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Specific medical care needed:

☐ Medical ☐ Pediatrics ☐ Gynecology ☐ Obstetrics: If pregnant, how many weeks? _____

☐ Other: _____

List medical problems/diagnoses:

_____

_____

_____

_____

_____

Are you transferring your care to us? ☐ Yes ☐ No If yes, from where: _____

New patients applying for Mercy Hospital JFK Clinic services should allow ten (10) days for the review process. Current patients updating/renewing their application for Mercy Hospital JFK Clinic services should apply thirty (30) days prior to the expiration date and allow ten (10) for the review process. New and renewing applicants will be notified of the determination via letter. If you have any questions, concerns, or need assistance completing the forms, please feel free to contact us at 314-251-6382.

Please return the Patient Financial Assistance Application form and supporting financial documentation to:

Mercy Hospital JFK Clinic
Attn: Application Coordinator
615 S. New Ballas Rd. | St. Louis, MO 63141
or
Email to: MercySt.LouisJFKClinic@mercy.net
or
Fax to: 314-251-4454

1. Complete and **sign** the enclosed **Patient Financial Assistance Application*** form.
2. Attach a **copy** of your or responsible parties most recent **Federal and State Income Tax Returns and W-2s*** for all members of your household. Include all schedules and pages. If you do not file a tax return, please include a letter of non-filing from the Internal Revenue Service (IRS). They can be reached at 1-800-908-9946 or www.irs.gov.
3. Attach a **copy** of the last two **Pay Check Stubs*** for **all members** of your household. If paid by cash, please submit verification of employment and salary on company letterhead.
4. Attach a **copy** of the last two **Bank Statements** and/or **Debit Card Statements*** for **all accounts** for **all members** of your household.
5. Attach a **copy** of the most recent **SSD/SSI Award Letter*** for **all members** of your household.
6. Attach a **copy** of the most recent **Proof of Child Support, Pension, and/or Unemployment Benefits*** for **all members** of your household.
7. Attach a **copy** of **Insurance Card/Medicare/Medicaid Card*** for **all members** of your household.

** *Please only include **one copy per family**.*

If these documents are not available, please explain why in the **Additional Information** section on page 4.

PATIENT FINANCIAL ASSISTANCE APPLICATION

Guarantor/Responsible Party Name (full legal name)	
Patient Name (if other than responsible party)	Patient Phone Number (home or cell)
Address	City, State, Zip Code
Spouse	Spouse Phone Number (home or cell)
Emergency Contact	Emergency Contact Phone Number (home or cell)

Employer Information

☐ **Guarantor** ☐ **Patient** ☐ **Spouse/Significant Other** **Employer:** Name	☐ **Guarantor** ☐ **Patient** ☐ **Spouse/Significant Other** **Employer:** Name
Address	Address
City, State, Zip Code	City, State, Zip Code
Phone	Phone
Job Title/Length of Employment	Job Title/Length of Employment

Members of Household:

Members of Household are defined as follows:

- If the patient is an adult include the patient, the patient's spouse/significant other and any dependents living in the home (all members of household).
- If the patient is a minor, include the patient, the patient's father, dependents of the father, the patient's mother, and dependents of the patient's mother (all members of household).
- Dependents are defined in accordance with IRS guidelines.

Name	Medicaid #	Date of Birth	Relationship to you

Income:

- Income is defined as cash receipts before taxes and includes but is not limited to:
  - Wages, salaries, tips; child support, alimony; Social Security and disability benefits; unemployment compensation; VA benefits, workman's compensation; business income/loss; pension; income from rental real estate.

Source of Income	Household Member	Amount Received	W - Weekly B - Biweekly M - Monthly A - Annually

Banking and Investments:

- Include all bank accounts, savings accounts, retirement accounts (IRA, Pension Fund, 401k, 403b, etc), money markets, mutual funds, etc.

Banking/Investments	Amount	Comments

Additional Information:

- List below any current or previous local, state or federal assistance program applications including but not limited to:
  - Any Social Security benefit, Medicaid, Medicare. Examples of Social Security benefit include Supplemental Income, Disability, Survivor benefit.

Assistance Program	Application Date	Determination

If your income/lifestyle has changed, please explain and provide documentation (i.e., loss of job, death in the family, divorce, extraordinary medical bills or other expenses, etc.)

If you are not able to provide requested documentation, please explain why.

Financial Information:

- Once accepted as a Mercy Hospital JFK Clinic patient, **you are required to renew your Clinic charity rate with us, every 6 months.** This charity rate is also your rate for services at Mercy Hospital St. Louis; therefore, there is **no need to apply for the Hospital charity.**
- An up-to-date Patient Financial Assistance Application is required to remain eligible for Clinic services and will be reviewed according to hospital policy.
- Any changes in the patient's family financial status or in their registration information must be reported to the **Patient Benefit Advisor or the Application Coordinator.**
- Patients are required to apply for any available medical assistance such as Medicaid, Medicare part B or D or any other insurance coverage when eligible. If such assistance programs are not pursued or maintained, the clinic sliding scale discount may be revoked, and patients may be responsible for all incurred fees for services provided.

Payment Information:

- Office co-pays or balances are collected at check-in.
- Patients must bring their ID and insurance cards to each visit.
- Pharmacy co-pays will range from $.50 to $5.00 for each prescription filled.

The Patient Financial Assistance Application **must be signed and dated** by the responsible party **and** spouse/significant other in order for the application to be considered complete. By signing below, I understand that, should I be medically and financially eligible.

- If I receive an acceptance letter indicating my Clinic rate and Office co-pay, I agree to pay the rate and co-pay for all services provided.
- If I am a new patient, I will receive a Clinic brochure and will review it in its entirety.
- I will adhere to the Clinic's financial, payment and appointment policies/guidelines.
- I understand that if I am in violation of any of these policies/guidelines, my clinic privileges will be terminated.

Billing Information:

- If you have any questions regarding your Hospital or Physician billing statements, please **bring them to our billing department** and we will review them for you.

I represent that the information provided is true and accurate to the best of my knowledge. Mercy is hereby authorized to obtain a credit report in connection with the Social Security or ITIN number which I, as payor and signer of this form, certify to be my legally assigned individual number.

_____	_____	_____
Signature of Patient or Responsible Party	Social Security/ITIN Number	Date

I represent that the information provided is true and accurate to the best of my knowledge. Mercy is hereby authorized to obtain a credit report in connection with the Social Security or ITIN number which I, as payor and signer of this form, certify to be my legally assigned individual number.

_____	_____	_____
Signature of Spouse/Significant Other or Responsible Party	Social Security/ITIN Number	Date