Mercy Financial Assistance Program

Date:

Guarantor Name:
Address:
City & State:

Account Number (s):

Mercy strives to provide assistance to patients and families who are truly unable to fulfill their financial obligations to us for medical services provided. We offer Medicaid screenings, a Financial Assistance Program and discounted fees for uninsured patients who do not qualify for the Financial Assistance Program. Interest free loans and long-term payment plan options are also available.

If you are ***uninsured*** and needing assistance, we ask that you call our Medicaid screening service at **1-844-764-6850** to see if you may be eligible for Medicaid. If you are, we'll help you apply. It is required that uninsured patients call the screening line before submitting this application.

If you are ***insured*** or **have already been screened**, please return all required items on the list below so that we may review your account for possible qualification into our Financial Assistance program. **Please send all items below to 1730 E Portland St. Springfield, MO 65804:**

- Financial Assistance **Application**(following page of this document)
- Complete COPY of your most Current Year **Income Tax Return, for all members of your household**. OR a 4506-T form (if you do not file income taxes) call 1-800-908-9946 for questions regarding this form.
- COPIES of **pay stubs/income** for last 60 days for each employed family member in the household and those included in your tax return.
    - **Income sources include**: Interest, Salary, Rent, Alimony, Pensions, Disability, Dividends, Public Assistance, and Other written documentation from income source.
- If your total income has changed significantly from your last tax return, please provide written documentation of the changes.

<u>If any of the above documents are not submitted within 15 days, we will be unable to consider you for assistance</u> and will proceed with our normal collections process.

Please allow ten (10) business days for us to review your submitted information. You will be notified by letter of the financial assistance discount we are able to provide. If you have any questions, please contact us at: **855-420-7900.**

Guarantor and Spouse/Co-Applicant Information

Full Name	Address City, Zip and State	Phone #	Marital Status (Single, Married, Divorced or Widowed)	Employer	Length of Employment

Please list all household members including yourself & complete information for each

Full Name	Social Security #	Date of Birth	Relationship to Guarantor	School Attending

Please provide Gross Income details (prior to deductions) for head of household, spouse, and dependents over age 18 and attach supporting documentation.

Source of Income	Patient	Spouse	Other	Pay Periods (Weekly Bi-weekly or Monthly)	Yearly Total
Self-Employment					
Investment Property					
Social Security/Disability					
Pension					
Unemployment					
Child Support/Alimony					
Workers Comp					
VA					
Other					

Please explain why you are requesting financial assistance and provide documentation, if possible (e.g. loss of job, death in the family, divorce, extraordinary medical bills). This should be attached to the charity application

Please sign and date below, as application must be signed and dated by all applicable parties in order to complete processing.

I represent that the information provided is true and accurate to the best of my knowledge. I, as payor and signer of this form; certify to the social security number provided to be my legally assigned, individual social security number.

Signature of Patient/Guarantor **Social Security Number** **Date**

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I represent that the information provided is true and accurate to the best of my knowledge. I, as payor and signer of this form; certify to the social security number provided to be my legally assigned, individual social security number.

Signature of Spouse/Co-Applicant **Social Security Number** **Date**

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