Business Office
1730 E Portland St
Springfield, MO 65804

DATE

Patient Name
Mailing Address
City, State, Zip

RE: Financial Assistance Guarantor Account # *********

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 insurance 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 insurance screening service at 1-844-764-6850 to see if you may be eligible for insurance coverage. 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.

The items check marked below are needed:

☒ Financial Assistance Application

☒ Complete COPY of your most **Current Year Income Tax Return with schedules**

- Everyone in household income tax return
- 4506-T (if you do not file Income Taxes) 1-800-908-9946

☒ COPIES of **60 days pay stubs** for each employed family member in household and those included on your tax return.

- **Income sources include:**

  Interest, Salary, Rent, Alimony, Pensions, Disability, Dividends, Social Security, Unemployment, Child Support, Student Grants, Workers Compensation, Public Assistance, Other written documentation from income source

☒ Copy of last **2 months of mortgage/rent payments**

☒ Complete 3 months of bank statements from checking and saving accounts

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 both Hospital and Clinic balances, two separate letters will be sent, as discount amounts may differ between the two. In order to keep your account in good standing with Mercy Hospital & Mercy Clinic, please continue monthly payments towards any outstanding balances as we process your application. If you have any questions or concerns, please contact us at 855-420-7900.

Mercy Financial Assistance Application

Guarantor Information			
Last Name	First Name	MI	Marital Status
			Single, Married, Divorced or Widowed
Home Address	City, State, Zip	Phone Number	
Employer	Occupation	Length of Employment	

Spouse/Co-Applicant Information			
Last Name	First Name	MI	Marital Status
			Single, Married, Divorced or Widowed
Home Address	City, State, Zip	Phone Number	
Employer	Occupation	Length of Employment	

Please list all household members *including yourself* & complete information for each				
Full Name	**Social Security Number**	**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**	**Yearly Total**
Self-Employment				Weekly Bi-Weekly Monthly	
Investment Property				Weekly Bi-Weekly Monthly	
Social Security/ Disability				Weekly Bi-Weekly Monthly	
Pension				Weekly Bi-Weekly Monthly	
Unemployment				Weekly Bi-Weekly Monthly	
Child Support/Alimony				Weekly Bi-Weekly Monthly	

Workers Compensation				Weekly Bi-Weekly Monthly	
VA Benefits				Weekly Bi-Weekly Monthly	
Other				Weekly Bi-Weekly Monthly	

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).

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**

_______________________________ _______________________ ______________

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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