



<input type="checkbox"/> New Patient
<input type="checkbox"/> Renewal
MRN # _____
Guarantor Acct # _____
See Documents From:
E #: _____
<i>For office use only</i>

Dear Patient/Applicant:

You are receiving this Patient Financial Assistance Application because you wish to apply for medical care at Mercy Hospital JFK Clinic. **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.**

Please provide **all** the following documents in the checklist below:

- Financial Assistance Application (following page of this document)
- If any household member included on the financial assistance application is uninsured and requesting financial assistance, we ask that they contact our Medicaid screening service at 1-844-764-6850 to determine Medicaid eligibility. If eligible, we will help you apply. It is required that all uninsured patients call the screening line before submitting this application.
- A complete copy of the most current years required filing of Federal Income Tax return, including **all** forms and schedules, for **all** household member(s) included on the financial assistance application.
 - If you do not file Federal Income Tax, please complete the 4506-T (Proof of non-filing) form attached to this application.
 - a. Complete the top portion of the form
 - b. Check box #7
 - c. Sign at the bottom of the form and return with application
 This form provides proof that you do not file income taxes and is required to process your financial assistance application.
- Copies of proof of income for **all** household member(s) included on the financial assistance application.
 - Income sources including Interest, Salary (**60 days of pay stubs needed**), Rent, Alimony, Pensions, Disability, Dividends, Social Security (need most recent benefit letter), Unemployment Benefit Letter, Child Support, Student Grants, Workers Compensation, Public Assistance
 - If you do not have income – please provide a Statement of Support signed by whomever is providing your support. You may provide a handwritten letter or use the attached form.
 - If you are Self-employed and have business income, we will need a **year-to-date profit and loss** spreadsheet/statement for the current year.

Specific medical care needed:

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

List the reasons you are seeking medical care: _____

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

ALL fields **must** be completed for application to be processed; indicate n/a on all fields that do not apply.

Responsible Party Information				
Responsible Party Name:		DOB:	Phone number:	Account number:
Current Mailing Address			City, State, Zip	Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Legally Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed
				Family size: *Complete Household section below
Employer Name:		Self Employed:		Email Address:
Years Employed:		Years Employed:		

Household Information
Please attach a separate sheet for additional household members, including all required documents

First & Last Name	Relationship	DOB & SSN/ ITIN	Employed	Full time student	Gross monthly income if 18 or over – Check all applicable forms of income and indicate total amount received from all sources. (Documents for each income source required)
	Self	<input type="checkbox"/> No SSN/ ITIN	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Wages <input type="checkbox"/> Unemployment <input type="checkbox"/> Workers Compensation <input type="checkbox"/> Disability <input type="checkbox"/> Pension(s) <input type="checkbox"/> Social Security <input type="checkbox"/> Alimony <input type="checkbox"/> Child Support <input type="checkbox"/> Government Assistance <input type="checkbox"/> Other
		<input type="checkbox"/> No SSN/ ITIN	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Wages <input type="checkbox"/> Unemployment <input type="checkbox"/> Workers Compensation <input type="checkbox"/> Disability <input type="checkbox"/> Pension(s) <input type="checkbox"/> Social Security <input type="checkbox"/> Alimony <input type="checkbox"/> Child Support <input type="checkbox"/> Government Assistance <input type="checkbox"/> Other
		<input type="checkbox"/> No SSN/ ITIN	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Wages <input type="checkbox"/> Unemployment <input type="checkbox"/> Workers Compensation <input type="checkbox"/> Disability <input type="checkbox"/> Pension(s) <input type="checkbox"/> Social Security <input type="checkbox"/> Alimony <input type="checkbox"/> Child Support <input type="checkbox"/> Government Assistance <input type="checkbox"/> Other
		<input type="checkbox"/> No SSN/ ITIN	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Wages <input type="checkbox"/> Unemployment <input type="checkbox"/> Workers Compensation <input type="checkbox"/> Disability <input type="checkbox"/> Pension(s) <input type="checkbox"/> Social Security <input type="checkbox"/> Alimony <input type="checkbox"/> Child Support <input type="checkbox"/> Government Assistance <input type="checkbox"/> Other
		<input type="checkbox"/> No SSN/ ITIN	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Wages <input type="checkbox"/> Unemployment <input type="checkbox"/> Workers Compensation <input type="checkbox"/> Disability <input type="checkbox"/> Pension(s) <input type="checkbox"/> Social Security <input type="checkbox"/> Alimony <input type="checkbox"/> Child Support <input type="checkbox"/> Government Assistance <input type="checkbox"/> Other
		<input type="checkbox"/> No SSN/ ITIN	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Wages <input type="checkbox"/> Unemployment <input type="checkbox"/> Workers Compensation <input type="checkbox"/> Disability <input type="checkbox"/> Pension(s) <input type="checkbox"/> Social Security <input type="checkbox"/> Alimony <input type="checkbox"/> Child Support <input type="checkbox"/> Government Assistance <input type="checkbox"/> Other

If your financial situation has changed within the last 12 months, please explain below.

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.
- 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, you may lose your clinic status.

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 or ITIN number provided to be my legally assigned individual number.

- 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.

Signature of Patient/Responsible Party	Social Security/ITIN Number	Date
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_____	_____	_____
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Signature of Spouse/Co-Applicant	Social Security/ITIN Number	Date
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_____	_____	_____
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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) days 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 documents 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

Request for Transcript of Tax Return

▶ Do not sign this form unless all applicable lines have been completed.
▶ Request may be rejected if the form is incomplete or illegible.
▶ For more information about Form 4506-T, visit www.irs.gov/form4506t.

OMB No. 1545-1872

Tip: Get faster service: Online at www.irs.gov, **Get Your Tax Record** (Get Transcript) or by calling **1-800-908-9946** for specialized assistance. We have teams available to assist. **Note:** Taxpayers may register to use [Get Transcript](#) to view, print, or download the following transcript types: **Tax Return Transcript** (shows most line items including Adjusted Gross Income (AGI) from your original Form 1040-series tax return as filed, along with any forms and schedules), **Tax Account Transcript** (shows basic data such as return type, marital status, AGI, taxable income and all payment types), **Record of Account Transcript** (combines the tax return and tax account transcripts into one complete transcript), **Wage and Income Transcript** (shows data from information returns we receive such as Forms W-2, 1099, 1098 and Form 5498), and **Verification of Non-filing Letter** (provides proof that the IRS has no record of a filed Form 1040-series tax return for the year you request).

1a Name shown on tax return. If a joint return, enter the name shown first.	1b First social security number on tax return, individual taxpayer identification number, or employer identification number (see instructions)
2a If a joint return, enter spouse's name shown on tax return.	2b Second social security number or individual taxpayer identification number if joint tax return
3 Current name, address (including apt., room, or suite no.), city, state, and ZIP code (see instructions)	
4 Previous address shown on the last return filed if different from line 3 (see instructions)	
5 Customer file number (if applicable) (see instructions)	

Note: Effective July 2019, the IRS will mail tax transcript requests only to your address of record. See **What's New** under **Future Developments** on Page 2 for additional information.

6 **Transcript requested.** Enter the tax form number here (1040, 1065, 1120, etc.) and check the appropriate box below. Enter only one tax form number per request. ▶ _____

a **Return Transcript**, which includes most of the line items of a tax return as filed with the IRS. A tax return transcript does not reflect changes made to the account after the return is processed. Transcripts are only available for the following returns: Form 1040 series, Form 1065, Form 1120, Form 1120-A, Form 1120-H, Form 1120-L, and Form 1120S. Return transcripts are available for the current year and returns processed during the prior 3 processing years. Most requests will be processed within 10 business days

b **Account Transcript**, which contains information on the financial status of the account, such as payments made on the account, penalty assessments, and adjustments made by you or the IRS after the return was filed. Return information is limited to items such as tax liability and estimated tax payments. Account transcripts are available for most returns. Most requests will be processed within 10 business days

c **Record of Account**, which provides the most detailed information as it is a combination of the Return Transcript and the Account Transcript. Available for current year and 3 prior tax years. Most requests will be processed within 10 business days

7 **Verification of Nonfiling**, which is proof from the IRS that you **did not** file a return for the year. Current year requests are only available after June 15th. There are no availability restrictions on prior year requests. Most requests will be processed within 10 business days

8 **Form W-2, Form 1099 series, Form 1098 series, or Form 5498 series transcript.** The IRS can provide a transcript that includes data from these information returns. State or local information is not included with the Form W-2 information. The IRS may be able to provide this transcript information for up to 10 years. Information for the current year is generally not available until the year after it is filed with the IRS. For example, W-2 information for 2016, filed in 2017, will likely not be available from the IRS until 2018. If you need W-2 information for retirement purposes, you should contact the Social Security Administration at 1-800-772-1213. Most requests will be processed within 10 business days

Caution: If you need a copy of Form W-2 or Form 1099, you should first contact the payer. To get a copy of the Form W-2 or Form 1099 filed with your return, you must use Form 4506 and request a copy of your return, which includes all attachments.

9 **Year or period requested.** Enter the end date of the tax year or period requested in mm/dd/yyyy format. This may be a calendar year, fiscal year or quarter. Enter each quarter requested for quarterly returns. Example: Enter 12/31/2018 for a calendar year 2018 Form 1040 transcript.

____ / ____ / ____ | ____ / ____ / ____ | ____ / ____ / ____ | ____ / ____ / ____

Caution: Do not sign this form unless all applicable lines have been completed.

Signature of taxpayer(s). I declare that I am either the taxpayer whose name is shown on line 1a or 2a, or a person authorized to obtain the tax information requested. If the request applies to a joint return, at least one spouse must sign. If signed by a corporate officer, 1 percent or more shareholder, partner, managing member, guardian, tax matters partner, executor, receiver, administrator, trustee, or party other than the taxpayer, I certify that I have the authority to execute Form 4506-T on behalf of the taxpayer. **Note:** This form must be received by IRS within 120 days of the signature date.

<input type="checkbox"/> Signatory attests that he/she has read the attestation clause and upon so reading declares that he/she has the authority to sign the Form 4506-T. See instructions.	Phone number of taxpayer on line 1a or 2a
▶ Signature (see instructions)	Date
▶ Title (if line 1a above is a corporation, partnership, estate, or trust)	
▶ Spouse's signature	Date