Mercy Financial Assistance Program

Date:

Guarantor Name:
Address:
City & State:

Account Number (s):

Mercy strives to meet the medical needs of our patients in a manner consistent with our Mission, Vision, and Core Values. As such, we attempt to provide financial assistance to patients and families are truly unable to fulfill their financial obligations to us for medical services provided. Please submit the below items so that we may assess your financial situation and determine if you qualify for a financial assistance discount:

1. ☐ Completed Financial Assistance Application (attached)
2. ☐ Copy of a valid driver's license, state identification, or other form of valid identification with photo verification included

Should either item be missing, the application will be returned to you. If supporting documentation is not provided within 7 days, Mercy will proceed with our normal collections process.

Please mail above items to: **Mercy Customer Assistance**
1730 E Portland St
Springfield, MO 65804

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 any time 855-420-7900.

Revised 7/6/15

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**