Mercy Financial Assistance Program

National Health Service Clinic Balances ONLY

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 who are truly unable to fulfill their financial obligations to us for medical services provided. In order to comply with government regulations, patients requesting Financial Assistance for services received at a ***National Health Service Clinic*** must 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
3. ☐ Copy of your current year federal and state tax returns (if not available, must provide as 4506_T)
4. ☐ Copy of unemployment letter/report showing weekly and maximum benefits
5. ☐ Copies of pay stubs from the last 60 days for each household member that is 18 or older
6. ☐ Proof of eligibility with State Agencies (SSI, SSD, VA, Worker's Compensation, etc)
7. ☐ Copy of Insurance Card (s) and/or Medicaid application made or rejection letter
8. ☐ Other: _____

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

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 allow ten (10) business days for us to review your submitted information. Mercy will explore any other payer sources that may be available to the patient, prior to approving a discount.

You will be notified by letter of the financial assistance discount we are able to provide. 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.

If you have both NHSC Clinic and Mercy Hospital balances please call us at the number above and request the **non-NHSC** Financial Assistance application (do not submit this application).

Mercy

National Health Service Clinic Financial Assistance Application

Please provide your Primary Physician and Location	
Primary Physician	**Primary Physician Location**

Guarantor Last Name	**First Name**	**Middle**	Marital Status
			Single, Married, Divorced or Widowed:
Social Security Number*	Date of Birth		
Home Phone Number	Cell Phone Number	Work Phone Number	

Employer	Occupation	Length of Employment

Employers Address: Address/P.O. Box	City	State	Zip Code

Spouse/Co-Applicant Last Name	**First Name**	**Middle**	Marital Status
			Single, Married, Divorced or Widowed:
Social Security Number*	Date of Birth		
Home Phone Number	Cell Phone Number	Work Phone Number	

Employer	Occupation	Length of Employment

Employers Address: Address/P.O. Box	City	State	Zip Code

Social security number not required to process application

Please list all household members including yourself & complete information for each				
Name	**Social Security Number***	**Date of Birth**	**Relationship**	**School Attending**

Please provide Gross Income details (prior to deductions) for head of household, spouse and dependents under 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. 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.)

Social security number not required to process application

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

I, as payor and signer of this form; represent that the information provided is true and accurate to the best of my knowledge.

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

I, as payor and signer of this form; represent that the information provided is true and accurate to the best of my knowledge.

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

Social security number not required to process application