



Mercy Health Partners Financial Assistance Application

OFFICE USE ONLY

MED REC # / FACILITY	PROGRAM	CONTROL NUMBER: _____
_____ SVMMC	_____ HCAP	WRITE OFF DATE: _____
_____ SCMH	_____ HFA 200%	NUMBER OF PIECES IMAGED: _____
_____ SAMH	_____ HFA 300%	PATIENT NUMBER: _____ DOS: _____
_____ DMH	_____ HFA 400%	PATIENT NUMBER: _____ DOS: _____
_____ MHT	_____ SELF PAY	PATIENT NUMBER: _____ DOS: _____
_____ MHW	_____ CARENET	PATIENT NUMBER: _____ DOS: _____
_____ NWOIL	_____ DA	PATIENT NUMBER: _____ DOS: _____
_____ CRMC	_____ CATASTROPHIC	SEE ATTACHED FOR ADDITIONAL PATIENT NUMBERS: _____
_____ AMC		

PATIENT INFORMATION

PATIENT OR APPLICANT'S NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

SOCIAL SECURITY NUMBER: _____ PHONE NUMBER: _____

EMPLOYMENT INFORMATION

NAME OF EMPLOYER (PATIENT/GUARANTOR): _____

DATE HIRED: _____ DATE EMPLOYMENT ENDED: _____

NAME OF EMPLOYER (SPOUSE): _____

DATE HIRED: _____ DATE EMPLOYMENT ENDED: _____

IF ZERO INCOME IS REPORTED PROVIDE EXPLANATION OF HOW PATIENT IS SUPPORTING SELF:

HOUSEHOLD INFORMATION

*FAMILY INCLUDES IMMEDIATE FAMILY WHO LIVE IN YOUR HOME SUCH AS PATIENT, PATIENT'S SPOUSE, ALL OF PATIENT'S CHILDREN UNDER 18 (NATURAL OR ADOPTIVE) WHO LIVE IN PATIENT'S HOME. PATIENTS UNDER 18 INCLUDE PARENTAL INCOME.

ADDITIONAL FAMILY MEMBERS MAY BE INCLUDED ON A SEPARATE SHEET AND ATTACHED TO APPLICATION.

NAME	AGE	RELATIONSHIP TO PATIENT*	GROSS INCOME 3 MONTHS PRIOR TO DATE OF SERVICE	GROSS INCOME 12 MONTHS PRIOR TO DATE OF SERVICE	CURRENT GROSS INCOME	TYPE OF INCOME**
TOTAL HHS		TOTAL INCOME	\$	\$	\$	

**TYPES OF INCOME INCLUDED BUT NOT LIMITED TO: WAGES, SELF EMPLOYMENT, SOCIAL SECURITY, UNEMPLOYMENT, CHILD SUPPORT, ALIMONY, WORKERS COMP, PENSION, VA BENEFITS.

PLEASE PROVIDE INCOME VERIFICATION WITH THIS APPLICATION: PAY STUBS, W-2'S, SELF-EMPLOYMENT RECORDS, AWARD LETTER, BANK STATEMENT SHOWING DIRECT DEPOSIT, OR ANY DOCUMENT CONTAINING INCOME INFORMATION.

Revised 8/7/2008-WEB

PROGRAM ELIGIBILITY

HAVE YOU APPLIED FOR MEDICAID OR DISABILITY ASSISTANCE? YES _____ NO _____
IF YES, WHAT WERE THE RESULTS? _____ BILLING NUMBER: _____
WERE YOU AN OHIO RESIDENT AT THE TIME SERVICES WERE PROVIDED? YES _____ NO _____
DO YOU HAVE ASSETS OVER \$10,000 SUCH AS SAVINGS, CHECKING, STOCKS, BONDS, CD'S, OR OTHER? YES _____ NO _____
IF YES, PLEASE LIST TYPE AND AMOUNT: TYPE _____ AMT _____

INSURANCE INFORMATION

DID YOU HAVE HEALTH INSURANCE AT THE TIME SERVICES WERE PROVIDED? YES _____ NO _____
INSURANCE NAME: _____
INSURANCE BILLING ADDRESS: _____
POLICY NUMBER: _____ GROUP NUMBER: _____
POLICY HOLDER NAME: _____
POLICY HOLDER DATE OF BIRTH: _____ POLICY HOLDER SOCIAL SECURITY #: _____

MOTOR VEHICLE ACCIDENT INFORMATION

ARE ANY MEDICAL BILLS DUE TO A MOTOR VEHICLE ACCIDENT? YES _____ NO _____
NAME OF AUTO INSURANCE: _____
AUTO INSURANCE BILLING ADDRESS: _____
POLICY NUMBER: _____
NAME OF PERSON LIABLE FOR ACCIDENT: _____
LOCATION OF ACCIDENT: _____
NAME OF RESPONDING LAW ENFORCEMENT: _____
AGENT NAME: _____ PHONE NUMBER: _____
ATTORNEY NAME: _____ PHONE NUMBER: _____

WORKER'S COMP INFORMATION

IS THIS A WORK RELATED INJURY? YES _____ NO _____
IF YES HAVE YOU FILED A WORKERS COMP CLAIM? YES _____ NO _____
WHAT IS THE CLAIM NUMBER? _____

ESTATE INFORMATION

IS THERE AN ESTATE PENDING? YES _____ NO _____
EXECUTOR NAME: _____ PHONE NUMBER: _____
ATTORNEY NAME: _____ PHONE NUMBER: _____

PLEASE ATTACH COPY OF COURT APPOINTED PAPERS

SIGNATURE

I UNDERSTAND ANY FINANCIAL ASSISTANCE PROVIDED BY MERCY HEALTH PARTNERS MAY BE REVERSED IF IT IS DETERMINED THIS INFORMATION IS NOT CORRECT. "PROVIDING FALSE INFORMATION TO INDUCE ANOTHER TO EXTEND CREDIT OR TO BESTOW ANY OTHER VALUABLE BENEFIT MAY BE A VIOLATION OF THE OHIO REVISED CODE SECTION 2921.13".

BY MY SIGNATURE BELOW I AFFIRM THE INFORMATION ON THIS APPLICATION IS TRUE TO THE BEST OF MY KNOWLEDGE.

SIGNATURE OF PATIENT OR GUARANTOR DATE SIGNATURE OF SPOUSE DATE