



# Mercy Financial Assistance Application

## OFFICE USE ONLY

<b>MED REC # / FACILITY</b>	<b>PROGRAM</b>	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: _____
_____ CLINIC	_____ 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:**

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## 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**
<b>TOTAL HHS</b> _____		<b>TOTAL INCOME</b>	\$ _____	\$ _____	\$ _____	

\*\*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.

**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 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