

Mercy Medical Center – New Hampton Financial Assistance

We are required by law to keep information about you confidential. The information below will only be used for the purpose of confirming your need for financial assistance. Financial assistance is based on Federal Poverty Income Levels. **Incomplete forms will not be processed. Income verification such as previous Income Tax Return or three month's of paycheck stubs must be submitted for this form to be considered complete.**

Applicant:	Spouse:												
SSN: _____ DOB: _____	SSN: _____ DOB: _____												
Address: _____	Address: _____												
Phone/Cell Phone: _____													
1. Household Gross Monthly Income: (include all taxable income, wages, salary, tips, child support, etc.) \$ _____ Other Income: \$ _____ List: _____ If income is \$0.00 (zero) explain:													
2. Resources: Checking Account Balance: _____ Savings Account Balance: _____	IRA: _____ Stocks/Bonds: _____ Other Property: _____												
3. Dependents: <table style="width: 100%; border: none;"> <thead> <tr> <th style="width: 25%;">Name</th> <th style="width: 25%;">Date of Birth</th> <th style="width: 25%;">Name</th> <th style="width: 25%;">Date of Birth</th> </tr> </thead> <tbody> <tr> <td>1. _____</td> <td>_____</td> <td>3. _____</td> <td>_____</td> </tr> <tr> <td>2. _____</td> <td>_____</td> <td>4. _____</td> <td>_____</td> </tr> </tbody> </table>		Name	Date of Birth	Name	Date of Birth	1. _____	_____	3. _____	_____	2. _____	_____	4. _____	_____
Name	Date of Birth	Name	Date of Birth										
1. _____	_____	3. _____	_____										
2. _____	_____	4. _____	_____										
4. Housing Expense: Renting Own/Buying Payment: \$ _____ Property Value: \$ _____ Balance Owing: \$ _____													
5. Auto Expenses: (List year, make, model and payment amount for all cars, trucks)													
1. RV/Boat/ATVs: (List type, year and payment)													
7. Support Payments; (Any support payments ordered by the court and made by the person)													
8. Monthly Expenses (Medication expenses require documentation from your pharmacy.)													
9. Please indicate other financial assistance programs applied for within the last year (social security disability, Medicaid, etc.)													
Please provide or attach any information you feel would be helpful in understanding your current situation.													
Client Affirmation: I affirm that the statements made herein are true and correct to the best of my knowledge. I understand that any false statements or misstatements of material fact could result in disqualification for financial assistance. I understand that I must provide verification of income, expenses, dependents, bank statements, pay vouchers and tax statements. I understand that a credit report may be used as part of the assistance determination process.													
Patient Signature: _____	Date: _____												