CHI Mercy Health

Mercy Medical Center

2700 Stewart Parkway
Roseburg, OR 97471

_____/_____/_____
Date

Dear Patient:

The mission of Mercy Medical Center and Catholic Health Initiatives is to nurture the healing ministry of the Church by bringing it new life and viability in the 21st century. Fidelity to the Gospel urges us to emphasize human dignity and social justice as we move toward the creation of healthier communities. Mercy Medical Center provides care without regard to ability to pay.

In light of this mission, Mercy Medical Center offers a variety of opportunities to assist with non-elective medical treatment, whether it be absorbing part of the cost based on need or helping to identify community or governmental programs to fit your needs. This program does not cover elective medical services, services received at Parkway Medical Supply, or any providers that are independent contractors – including but not limited to radiologists, anesthesiologists, and emergency room physicians.

If you wish to apply for financial assistance for your account, please complete the attached application and return it to 2700 Stewart Pkwy, Roseburg OR 97471, Attn: MECS. Your situation will be evaluated based on the **national criteria for poverty level income**. We will gladly consider you for financial assistance provided the application is complete, signed and returned with the required documents listed below within 14 days of the date of this letter. We will make every effort to process your application within 30 days of receipt but you must continue to make payments on the account while this application is being reviewed. **INCOMPLETE APPLICATIONS CANNOT BE PROCESSED**

REQUIRED DOCUMENTS

- Most recent copy of all income for one month including: paystubs, social security benefit letter, pension benefit letter, unemployment benefit letter, child support, spousal support, school account summary by term (for college students), a year-to-date profit/loss statement (if self-employed), etc. Verification must show GROSS income.

- A copy of your most recent US Individual 1040 tax return (all forms filed including W-2 and all schedules). If you need to obtain a copy, please call 1-800-908-9946 for a free transcript.

- Most recent bank statement for each bank account.

- If you are receiving assistance from DHS, disability services, or any other financial assistance, please include documentation of your current benefits.

- A copy of your medical savings, Manley, or flex account balance (if you have one).

- Please apply for the Oregon Health Plan (OHP) and attach a copy of the acceptance/denial letter. If you have not received the OHP letter yet, please return this application and send the OHP letter once it is received.

In order to help us identify your account(s) you wish to have considered for financial assistance, please mark below if you have received or expect to receive services from any of the following:

☐ HOSPITAL INPATIENT
☐ HOSPITAL OUTPATIENT
☐ COMMUNITY EDUCATION
☐ MERCY HOME HEALTH OR HOSPICE
☐ SURGERY - date _____
☐ OTHER - _____

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Please note – Mercy Medical Center may access external validation resources to assist in determining whether a full application for assistance is required.

1) Patient or Responsible Party if patient is minor	**Social Security #**	**Date of Birth**	**Account #**
2) Spouse's Name	**Social Security #**	**Date of Birth**	**Mobile Phone #**
3) Mailing Address	**County of Residence**	**Home Phone #**	**Mobile Phone #**
City	**State**	**Zip Code**	**Length of Residence**
4) Previous Address (if less than 2 years at above)	**City, State, Zip**	**Marital Status**	**# of Dependents in Household**

5) Have you applied for Medicaid or any other State/County Assistance? (Circle One)	**Yes**	**No**

Application Date & Facility Applied At	**Caseworker Name/Telephone Number/Status of Application**

6) List Names, dates of births, and relationships of Dependents in Household:

7) Responsible Party's Employment Status	**8) Spouse's Employment Status**	**9) Other (name): Employment Status**
(Circle One)	**(Circle One)**	**(Circle One)**
Employed Self-employed Unemployed	Employed Self-employed Unemployed	Employed Self-employed Unemployed
Student Disabled Retired	Student Disabled Retired	Student Disabled Retired
Name of Employer	**Name of Employer**	**Name of Employer**
Job Title/Length of Employment	**Job Title/Length of Employment**	**Job Title/Length of Employment**
Employer Address / Telephone #	**Employer Address / Telephone #**	**Employer Address / Telephone #**
Pay Cycle: (Circle One)	**Pay Cycle: (Circle One)**	**Pay Cycle: (Circle One)**
Weekly Bi-Weekly Monthly	**Weekly Bi-Weekly Monthly**	**Weekly Bi-Weekly Monthly**
Previous Employer:	**Previous Employer:**	**Previous Employer:**
Last Date of Employment	**Last Date of Employment:**	**Last date of Employment:**
Monthly Income Gross	**Monthly Income Gross**	**Monthly Income Gross**
Monthly Income Net	**Monthly Income Net**	**Monthly Income Net**
Other Income Source (Alimony / Child Support / Unemployment/ Gambling / 1099):	**Other Income Source (Alimony / Child Support / Unemployment/ Gambling / 1099):**	**Other Income Source (Alimony / Child Support / Unemployment/ Gambling / 1099):**
Amount: $	**Amount: $**	**Amount: $**

Total Monthly Household Income: $_____

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10) Other Assets (Stocks, Bonds, Property, Boat, Business, 401k etc.)				
11) Have you filed Bankruptcy? **Yes No**	**Chapter 7**	**Chapter 13**	**Date Filed**	**Date of Discharge**
12) Are you a Homeowner? **Yes No**	**Approximate $ Value**	**Approximate Balance on Loan**		**Years left on Loan**
13) Bank Name – Checking Account	**Avg. Checking Balance**	**Bank Name - Savings Account**		**Avg. Savings Balance**
14) If you do not have any income, please state what your current situation is below. If you have someone assisting you with your living expenses, please provide a letter from the person supporting you, and attach it to your application.				

15) AUTOMOBILE(S) **1. Make:**	**Model:**	**Year:**	**Payment Amount:**	**Balance Due:**
2. Make:	**Model:**	**Year:**	**Payment Amount:**	**Balance Due:**

MONTHLY EXPENSES			
Description	**Monthly Payment**	**Description**	**Monthly Payment**
Rent/Mortgage	**$**	**Life Insurance**	**$**
Charge Cards	**$**	**Auto Insurance**	**$**
Bank Loans	**$**	**Health Insurance**	**$**
Food	**$**	**Medical Bills**	**$**
Utilities	**$**	**School Loans**	**$**
Gas (car)	**$**	**Other:**	**$**
Medication	**$**	**Other:**	**$**
TOTAL MONTHLY EXPENSES	**$**		

Note: Attach additional sheet if necessary. Important: income verification must be attached – W2, Pay Stub, Tax Return with schedules, etc.

PLEASE READ THE FOLLOWING BEFORE SIGNING AND DATING THE APPLICATION

Please be advised that your signature indicates you have agreed to attach all income verification. If there is no income, please verify how expenses are being met. It is important to explain a lack of income completely so that full consideration of your application can be made. If the guarantor/patient or the spouse is self-employed, please attach the last 2-3 months of bank statements. Additional information may be requested by the financial counselor. All documentation must be attached for full consideration. If the application is incomplete, it will be returned. We will not be responsible for follow-up on incomplete applications.

CERTIFICATION

1. **I, the undersigned, certify that the completed information in this document is true and accurate to the best of my knowledge.**
2. **I will apply for any and all assistance that may be available to help pay this bill.**
3. **I understand the information submitted is subject to verification; therefore, I grant permission and authorize local welfare agencies, any bank, insurance co., real estate co., financial institution and credit grantors of any kind to disclose to any authorized agent of Mercy Medical Center information as to my past and present accounts, policies, experiences and all pertinent information related thereto. I authorize Mercy Medical Center to perform a credit check for both guarantor/patient and spouse.**

Signature (Guarantor/Patient)	**Date**
Signature (Spouse)	**Date**

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DIRECTIONS FOR COMPLETING FINANCIAL ASSISTANCE APPLICATION

1: Complete the name, social security number, date of birth, and the hospital account number(s) if known of the responsible party.

2: Complete the spouse's name, date of birth, and social security number.

3: Complete the responsible party's address, home telephone number and length of residence at this address.

4: Complete the responsible party's previous address (if current residence is less than two years), guarantor's marital status, and number of dependents living in household. If there are no dependents, please mark "-0-"in the dependent field.

5: Complete the questions regarding Medicaid and other State/County assistance. Please advise if you have applied for assistance (and on what date). Provide the assigned Caseworker's name, telephone number and the status of the application. You may attach a separate sheet if needed.

6: List the names and birthdates, and relationship of each dependent residing in the household.

7 – 9: Complete the employment information for the responsible party in the left column Circle the employment status (employed, self-employed, unemployed, retired, or disabled. Next complete the name of the employer, job title, length of employment, the employer's address and telephone number. Circle the payment frequency (such as weekly or monthly). If you are currently unemployed, list your previous employer and the date of separation. You must also list the monthly income from the employer as well as any other income received such as alimony, social security, rental income, pension income, welfare, VA benefits, child support, gambling, or unemployment compensation. Complete the information for your spouse in the center column, and any other household member in the column on the right.

10: Please complete the section listing other assets you may have. This includes stocks, bonds, property, boats and businesses you may own. Use additional paper if needed to give complete details. If there are no additional assets, please mark "N/A".

11: Please indicate if you have ever filed bankruptcy. If you have not filed bankruptcy, please mark "No". Please verify that all questions have been completed. Attach additional paper if needed for any explanations.

12: Please complete the homeowner information. If you are a homeowner, please note the approximate dollar value, the approximate balance on the loan, and the number of years left on the loan. If you are not a homeowner, please mark "No".

13: Please complete the banking information as requested and list the bank name. Complete the checking account number and provide the average checking account balance. Please do the same for the savings account field. If there is no savings account, please place "N/A" in the savings field.

14. If you have no source of income, please use this section to provide details of your current situation. If someone is assisting you with living expenses, please provide a letter from the person supporting you. It must be attached to the application.

15: For automobile information, please list the make, model and year of your vehicle. Please list the monthly payment amount and the current balance. Attach additional documentation for more than four autos.

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HOW TO COMPLETE THE MONTHLY EXPENSE SECTION (copies of monthly bills/statements may be requested**):**

RENT/MORTGAGE: Please verify the amount you are paying in rent or by mortgage. Indicate to whom the payment is made, the account number and the current balance due. If you do not pay rent or mortgage, please note why you have no payment or if you live with relatives or others. Use additional paper if needed.

CHARGE CARDS: Please indicate any charge card payments you are currently making. Please indicate the monthly payment amount, to whom the payment is made, the account number and the current balance due. Please indicate the credit limit for each card. Use additional paper if you needed to complete this field. If you have no charge cards please note "N/A".

BANK LOANS: Please indicate any bank loans you may be paying. Indicate the monthly payment amount, to whom the payment is made, the account number and the current balance due. Use additional paper if needed to completely explain this field. If you have no bank loans, please mark "N/A".

SCHOOL LOANS: Please list any educational loans you may be paying. This can include, but not be limited to, college loans, private school loans (or tuition), day-care expenses or any other loans that apply to education. Please use additional paper if needed. Please specify if you are paying school loans, etc. If this does not apply to you, please mark "N/A".

LIST OTHER MONTHLY EXPENSES:

FOOD: Please list the amount paid for food on a monthly basis.

UTILITIES: Please list the amount paid on a monthly basis for electricity, gas, water, trash and any other utility you may pay. Please add these and place the total (for all of them) in the utilities section. If there are no monthly utilities paid, please mark "N/A" in this section and explain. Use a separate sheet of paper if needed.

GAS (CAR): Please list the amount paid on a monthly basis for transportation needs related to your vehicle. If there is no payment made on a monthly basis for gas, please mark the field "N/A".

MEDICATION: Please add the amounts you pay on a monthly basis for medication needs. If there are several prescriptions or medications you take, please add them together and place the total amount in this section. If there are no monthly medication payments, please place "NA" in this section.

LIFE INSURANCE: If you have a life insurance policy, please indicate the monthly amount you pay. If there is no payment, please place "N/A" in this section.

HEALTH INSURANCE: If you have health insurance, please indicate the monthly amount you pay for premiums. If there is no payment, please place "N/A" in this section.

MEDICAL BILLS: Please add any medical bills you may be paying on a monthly basis. This may include, but not be limited to, physician bills, insurance co-pays, insurance deductibles, other hospital bills, radiology bills, ambulance bills, etc. Please use a separate sheet of paper to list these amounts. Add them together and place the total amount paid on a monthly basis for these accounts in this section. If there are no monthly medical payments being made, please place "N/A" in this section.

AUTO INSURANCE: Please place the total amount you pay on a monthly basis for auto insurance. If you pay on a quarterly basis, please divide the quarterly payment by three and place the amount in this section. If you pay every six months, please divide the total amount you pay by six and place the amount in this section. If there is no monthly payment being made, please mark N/A in this section.

OTHER: This includes any monthly payments you currently are making that are not listed in the previous sections. Please provide details of what you are paying, to whom, and the balances due. Please use a separate sheet of paper if needed. If this section does not apply to you, mark "N/A".

TOTAL MONTHLY EXPENSES: Please estimate your monthly expenses and place this amount in this section.

RETURN COMPLETED APPLICATIONS TO:

Mercy Medical Center
ATTN: MECS/TEG
2700 Stewart Pkwy
Roseburg OR 97471
541-677-2217