

**Mercy – Des Moines**  
**Standardized Financial Assistance Application (Page 1 of 2)**

**Patient Information**

Account # \_\_\_\_\_  
 Name \_\_\_\_\_  
 Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_\_

**Did you file taxes last year?**  Yes  No

**Patient/Guarantor (Person responsible for bill) Information**

Name \_\_\_\_\_  
 Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Martial Status:  Married  Single  Divorced  Separated

Street Address \_\_\_\_\_  
 City \_\_\_\_\_  
 State \_\_\_\_\_ Zip Code \_\_\_\_\_

County of Residence \_\_\_\_\_ Length of Residence \_\_\_\_\_  
 Home Phone # \_\_\_\_\_ Cell Phone# \_\_\_\_\_

Previous Address (if less than 2 years at current address)  
 Street Address \_\_\_\_\_  
 City \_\_\_\_\_  
 State \_\_\_\_\_ Zip Code \_\_\_\_\_

**Employer**

Business Phone # \_\_\_\_\_  
 Job Title \_\_\_\_\_ Length of Employment \_\_\_\_\_  
 Rate of Pay \_\_\_\_\_ Are you paid:  Hourly

Weekly  Bi-weekly  Monthly  Other  
 Monthly Income (Gross-Before Taxes) \_\_\_\_\_

**Other Income:** (Indicate Source, monthly amount and attach supporting documentation)  **Food Stamps** \$ \_\_\_\_\_

**Social Security** \$ \_\_\_\_\_  **Pension** \$ \_\_\_\_\_

**Unemployment** \$ \_\_\_\_\_  **Child Support** \$ \_\_\_\_\_

**Alimony** \$ \_\_\_\_\_  **Other** \$ \_\_\_\_\_

**Spouse's Information (Spouse MUST sign application)**

Name \_\_\_\_\_  
 Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_\_  
**Employer**

Business Phone # \_\_\_\_\_  
 Job Title \_\_\_\_\_ Length of Employment \_\_\_\_\_  
 Rate of Pay \_\_\_\_\_ Are you paid:  Hourly

Weekly  Bi-weekly  Monthly  Other  
 Monthly Income (Gross-Before Taxes) \_\_\_\_\_

**Other Income:** (Indicate Source, monthly amount and attach supporting documentation)  **Food Stamps** \$ \_\_\_\_\_

**Social Security** \$ \_\_\_\_\_  **Pension** \$ \_\_\_\_\_

**Unemployment** \$ \_\_\_\_\_  **Child Support** \$ \_\_\_\_\_

**Alimony** \$ \_\_\_\_\_  **Other** \$ \_\_\_\_\_

**Total Monthly Gross Income for Household** \$ \_\_\_\_\_

**Total Annual Gross Income for Household** \$ \_\_\_\_\_

**CERTIFICATION:**

- I, the undersigned, certify that the completed information in this document is true and accurate to the best of my knowledge.
- I will apply for any and all assistance that may be available to help pay this bill.
- I understand that the information submitted is subject to verification. I authorize Mercy – Des Moines to verify the above information for both guarantor/patient and spouse.

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

**Household Members:** (if additional space needed attach info to app)

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

**Assistance**

Have you applied for Medicaid/Title XIX or any other State or County assistance?  Yes  No

Date of Application \_\_\_\_\_

Case Worker Name & Phone # \_\_\_\_\_

Have you filed for bankruptcy?  Yes  No

If yes, date filed \_\_\_\_\_

Chapter 7  Chapter 13 Date of Discharge \_\_\_\_\_

**Assets/Resources**

Are you a homeowner?  Yes  No

Estimated Market Value of home \_\_\_\_\_

Approximate balance due on loan \_\_\_\_\_

Years left on loan \_\_\_\_\_

Do you have a checking account?  Yes  No

Bank Name \_\_\_\_\_ Average balance \_\_\_\_\_

Do you have a savings account?  Yes  No

Bank Name \_\_\_\_\_ Average balance \_\_\_\_\_

**Automobiles:**

Make	Model	Year	Payment Amount	Balance Due
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Other Assets/Resources (stocks, bonds, property, business, boat, motorcycle etc.) \_\_\_\_\_

**Monthly Expenses**

Rent/Mortgage Amount \$ \_\_\_\_\_

Utility Costs (heat, air, water etc) \$ \_\_\_\_\_

Groceries \$ \_\_\_\_\_ Gas for Auto \$ \_\_\_\_\_

Auto Insurance \$ \_\_\_\_\_ Life Insurance \$ \_\_\_\_\_

Medication \$ \_\_\_\_\_ Other \$ \_\_\_\_\_

	Monthly Payment:	Payment To:	Balance Due:
Bank Loans:	\$ _____	_____	\$ _____
Credit Cards:	\$ _____	_____	\$ _____
School Loans:	\$ _____	_____	\$ _____
Other Expenses:	\$ _____	_____	\$ _____

**Total Monthly Expenses** \$ \_\_\_\_\_

**Proof of Income:** a copy of the following documentation must accompany your application in order to be processed:

- Most recent year Federal and State Tax Returns with all required schedules and W2s.
- Two Current Pay Stubs (Guarantor and Spouse)
- Other income documentation such as but not limited to:

Social Security  Food Stamps  Pension  Alimony  
 Child Support  Unemployment  Other

**\*\*\*Your application will not be considered without the above documentation and may be returned to you along with a letter detailing the documentation missing\*\*\***

**Important:** Guarantor and Spouse (if applicable) must sign the back of the application in order to be processed.

**OVER**

**Mercy – Des Moines Standardized Financial Assistance Application (Page 2 of 2)**  
**Additional Descriptions of Medical Bills (other than those owed to Mercy Medical Center):**

Payment To	Date of Service	Monthly Payment	Balance Due
		\$ _____	\$ _____
		\$ _____	\$ _____
		\$ _____	\$ _____
		\$ _____	\$ _____
		\$ _____	\$ _____

TOTAL MEDICAL BILLS OWED TO OTHERS THAN MERCY MEDICAL CENTER: \$ \_\_\_\_\_

**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 that the information submitted is subject to verification. I authorize Mercy – Des Moines to verify the above information for both guarantor/patient and spouse.

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

**ADDITIONAL DOCUMENTATION:**

Please note that by signing the application, you have agreed to attach forms of income verification (pay stubs and income tax returns, etc.). In addition, you may attach bank statements, copies of Social Security checks/letters or other documentation. If there is no income, please verify how expenses are being met. It is important to fully explain a lack of income so that full consideration of your application can be made. If the guarantor/patient or the spouse is self-employed, please attach bank statements from the past 2-3 months. All required documentation must be attached for your application to be considered. If the application is incomplete, it will be returned. Mercy-Des Moines will not be responsible for follow-up on incomplete applications.

**TO SUBMIT THIS APPLICATION, PLEASE INCLUDE THE FOLLOWING:**

- **Completed, signed and dated application by Guarantor and Spouse**
- **Proof of Income:** a copy of the following documentation **must** accompany your application in order to be processed:
  - Most recent year Federal and State Tax Returns with **all** required schedules and **W2s**.
  - Two Current Pay Stubs (Guarantor and Spouse)
  - Other income documentation such as but not limited to:
 

<input type="checkbox"/> Social Security	<input type="checkbox"/> Food Stamps	<input type="checkbox"/> Pension	<input type="checkbox"/> Alimony
<input type="checkbox"/> Child Support	<input type="checkbox"/> Unemployment	<input type="checkbox"/> Other	

**\*\*\*Your application can not be considered without the above documentation and may be returned to you along with a letter detailing the documentation missing\*\*\***

**PLEASE MAIL OR HANDELIVER YOUR APPLICATION PACKAGE TO:**

Mercy Medical Center  
Patient Accounts Department - FA  
1055 6th Avenue  
Des Moines, IA 50314

If you have questions, please call (515) 247-4199.