

**Mercy Medical Center – North Iowa
Financial Assistance**

****Please Return By: _____

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 check stubs need be included for this form to be considered complete.**

Applicant: _____		Spouse: _____	
Address: _____		Address: _____	
SSN: _____	DOB: _____	SSN: _____	DOB: _____
Phone/Cell Phone: _____			
1. Employer: _____ Household Gross Monthly Income: (Include all taxable income, wages, salary, tips, etc.) \$ _____ Child Support: \$ _____ Other Income: \$ _____ (Describe) _____			
2. Resources: _____		IRA: _____	
Checking Account Balance: _____		Stocks/Bonds: _____	
Savings Account Balance: _____		Other: _____	
3. Dependents:	Name	Date of Birth	Name Date of Birth
1.	_____	_____	3. _____
2.	_____	_____	4. _____
4. Housing Expense: Renting Own/Buying Property Value: \$ _____ Balance Owing: \$ _____ Payment: \$ _____ Other property Owned/Buying: Property Value: \$ _____ Balance Owing: \$ _____			
5. Autos: Year _____ Make _____ Value _____ Balance _____ Payment _____ Year _____ Make _____ Value _____ Balance _____ Payment _____			
6. RV/Boat/ATVs: (List type, year, value 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 a true and correct listing of my assets. I understand that any false statements or misstatements of material fact could result in disqualification for financial assistance. I authorize release of this application and the results to the following providers: Mason City Clinic, Radiologists of North Iowa, North Iowa Anesthesia Associates, Pathology Associates, Mason City Surgery Center, Radiation Oncology and Neurosurgery of North Iowa for their determination of financial assistance.			
Patient Signature: _____		Date: _____	