

# 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 or services received at Parkway Medical Supply.

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: FAR. 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 1-800-829-1040 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

MERCY HOME HEALTH OR HOSPICE

HOSPITAL OUTPATIENT

SURGERY - Date \_\_\_\_\_

COMMUNITY EDUCATION

OTHER - \_\_\_\_\_

# Mercy Medical Center

2700 Stewart Parkway Roseburg, OR 97471

Patient Account Services (541) 677-2307

## Financial Disclosure (Please print legibly)

Responsible Party: \_\_\_\_\_ Age: \_\_\_\_\_ Birth date: \_\_\_\_\_ SS# \_\_\_\_\_  
 Spouse: \_\_\_\_\_ Age: \_\_\_\_\_ Birth date: \_\_\_\_\_ SS# \_\_\_\_\_  
 Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Marital Status  Single  Married  Legally Separated  Divorced  Widowed Number in household \_\_\_\_\_  
 (provide copy)

**Dependents** (as listed on your taxes):

Name	Date of Birth	Relation	Name	Date of Birth	Relation
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

## Income and Financial Data

Status (employed / unemployed / student / disabled / retired)	Employer Name	Job Title	Hire Date (mm/yy)	Pay Cycle (ex: weekly, monthly)	Monthly Gross Wages
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

**If Unemployed:**

Previous Employer	How long Unemployed	If you expect to return, when?	Unemployment Remaining	Monthly Compensation
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Social Security / Disability monthly amount \_\_\_\_\_  
 Pension / IRA monthly amount \_\_\_\_\_  
 TANF grant monthly amount \_\_\_\_\_  
 Child Support monthly amount \_\_\_\_\_  
 School loans or grants \_\_\_\_\_  
 Other income - list source: \_\_\_\_\_ amount \_\_\_\_\_  
**Total Monthly Income** \_\_\_\_\_

If no income, how are you meeting your basic living needs? Basic living needs are things like food, shelter, clothing. \_\_\_\_\_

Do you currently file taxes?  Yes  No If not, please explain why? \_\_\_\_\_

Have you filed bankruptcy?  Yes  No  Chapter 7  Chapter 13 Date filed: \_\_\_\_\_ Date discharged: \_\_\_\_\_

## Assets

Checking Account Bank Name \_\_\_\_\_ Amount \_\_\_\_\_  
 Savings Account Bank Name \_\_\_\_\_ Amount \_\_\_\_\_

Vehicles:	Year	Make	Model	Value
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Other Assets: (recreational vehicles, CD's, stocks, bonds, second home, rentals, land, etc.) \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Household Monthly Expenses**

**Home:**

Own    Property address: \_\_\_\_\_ Mortgage \$ \_\_\_\_\_  
 Lender: \_\_\_\_\_ Property taxes \$ \_\_\_\_\_  
 Homeowners insurance \$ \_\_\_\_\_

Rent    Rent paid to (if no rent paid, who you live with): \_\_\_\_\_ Rent \$ \_\_\_\_\_

**Utilities:** Gas \$ \_\_\_\_\_ Electricity \$ \_\_\_\_\_ Water/Sewer \$ \_\_\_\_\_ Garbage \$ \_\_\_\_\_  
 Phone \$ \_\_\_\_\_ Cell phone \$ \_\_\_\_\_ Cable/Satellite \$ \_\_\_\_\_ Internet \$ \_\_\_\_\_

**Food & Household Items:** Groceries \$ \_\_\_\_\_ or Clothing \$ \_\_\_\_\_ Household \$ \_\_\_\_\_  
 Food Stamps \$ \_\_\_\_\_

**Auto:** Loan payment(s) \$ \_\_\_\_\_ \$ \_\_\_\_\_ Insurance \$ \_\_\_\_\_ Gas & oil \$ \_\_\_\_\_

**Insurance Premiums:** Dental/Vision \$ \_\_\_\_\_ Accident/Life \$ \_\_\_\_\_ Health \$ \_\_\_\_\_

**Drugs & Medical Supplies** (your expense): \$ \_\_\_\_\_ **Medical Savings Account:** \$ \_\_\_\_\_

**Misc.** (child care, etc): Type \_\_\_\_\_ \$ \_\_\_\_\_ Type \_\_\_\_\_ \$ \_\_\_\_\_

**Credit Cards:**

Name	Credit Limit	Current Balance	Monthly Payment

**Medical Bills:**

Name of Doctor / Hospital / Clinic	Balance Owing	Monthly Payment

**Other Creditors Not Already Listed:**

Name	Type (school loan, etc.)	Balance Owing	Monthly Payment

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

**If your monthly expenses exceed your monthly income, please explain how you are meeting your expenses?**

**Checklist**

Have you answered all questions? Do not leave anything blank. Attach additional sheets if necessary.

Have you attached the following:

- Most recent verification of ALL income for one month (paystubs or benefit letters)
- Year to date profit and loss statement for self employed persons
- Most recent Federal tax return (all pages filed including W-2)
- Copy of Medical Savings Account / Flex Account balance
- Most recent bank statement(s)
- Food Stamp acceptance letter
- OHP acceptance / denial letter
- Statement explaining any special circumstances

- 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 the information submitted is subject to verification; therefore, I grant permission and authorize Department of Human Services, any bank, insurance company, real estate firm, 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.

**Date:** \_\_\_\_\_ **Signature of Applicant: X** \_\_\_\_\_

**Date:** \_\_\_\_\_ **Signature of Spouse: X** \_\_\_\_\_