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# Mercy Medical Center

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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 in the envelope provided. 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 completed, signed and returned with the required documents listed below within 14 days of the date of this letter.

**You must continue to make payments on the account while this application is being reviewed.**

### REQUIRED DOCUMENTS:

- MOST RECENT COPY OF ALL INCOME FOR ONE MONTH INCLUDING PAY STUBS, SSI, PENSIONS, UNEMPLOYMENT, CHILD SUPPORT, SPOUSAL SUPPORT, ETC. IF SELF-EMPLOYED, A YEAR TO DATE PROFIT AND LOSS STATEMENT.
- MOST RECENT BANK STATEMENT FOR EACH BANK ACCOUNT.
- A COPY OF YOUR MOST RECENT *FEDERAL 1040 TAX RETURN (ALL FORMS FILED INCLUDING W-2'S AND / OR ALL SCHEDULES)*. CALL 1-800-829-1040 OR 1-800-829-0922 IF YOU NEED TO OBTAIN A COPY.
- 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 ACCOUNT, MANLEY, OR FLEX ACCOUNT (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.

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If you have recently lost your insurance coverage, are you eligible for COBRA? \_\_\_\_\_

Are you scheduled for?

- Repetitive treatments - how often and for how long \_\_\_\_\_
- Surgery - date \_\_\_\_\_
- Other - date \_\_\_\_\_

Have you received or expect to receive services from any of the following:

- Centennial Medical Group (Dr. Feldman, Dr. Bronstein, Dr. Mani)
- Roseburg Urology (Dr. Chiou)
- Umpqua Valley Surgery (Dr. DeWing)
- Mercy Home Health and Hospice

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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
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

SSI / 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.) \_\_\_\_\_  
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y 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 \_\_\_\_\_