Dear Applicant:

Mercyhealth is proud to partner with patients who are experiencing financial difficulty. You may be eligible for Mercyhealth's Community Care Program if you are unable to pay your bill in full. Please complete the application below and send the required information within the next 30 days. You may also apply for this assistance through your Mercyhealth MyChart App. When the fully completed application is received, we will evaluate your qualifications for partial or full assistance.

You may be required to meet with a Mercyhealth Patient Financial Counselor (PFC), or a Customer Service Representative (CSR) to complete this process. Mercyhealth will help determine your eligibility for any government, or other financial resources. You also may be required to apply for Medicaid or other Health Insurance through the Marketplace at www.healthcare.gov or by calling (800) 318-2596. We can assist in completing the application and answer any questions you may have.

Mercyhealth's Community Care Program will assist with medically necessary services provided by Mercyhealth only.

Community Care approval decisions are based upon your household's annual gross income. In order to assess your situation, you must complete the application in its entirety, including signature(s). You must also provide Income documentation for all members of the household that shall include any one of the following:

- ☐ Copy of W-2 forms and/or Federal Income Tax Return (1040 or 1099 forms) for the most recent tax year, including all schedules filed with the original return.
- ☐ Copies of the two most recent payroll voucher/check stubs from all jobs held in the current year, showing your year to date income.
- ☐ Documentation of fixed income (Social Security, Veterans, Pensions, Unemployment Compensation, Child Support/Alimony, W2 payments, Disability).
- ☐ Written income verification from an employer if paid in cash.

Failure to provide the above listed items, could delay the processing of your application. If you have any questions, please contact Mercyhealth's Customer Service at (866) 269-7115 or (800) 987-4170. We look forward to assisting you.

Mercyhealth respects the confidentiality and dignity of its patients and understands that applying for Financial Assistance may be a sensitive issue. All application information is subject to Mercyhealth's privacy practices.

FINANCIAL ASSISTANCE APPLICATION

General Information					
PATIENT LAST NAME	PATIENT FIRST NAME	MI	(optional) Race, Ethnicity, preferred language (will not have any impact on outcome)		SOCIAL SECURITY NUMBER (not required if uninsured in Illinois)
STREET ADDRESS			CITY STATE ZIP		E-MAIL ADDRESS
DATE OF BIRTH	Sex	TELEPHONE – HOME	TELEPHONE – WORK		TELEPHONE - CELL
SPOUSE'S NAME					DATE OF BIRTH

Employment Information	
APPLICANT	**SPOUSE/PARTNER**
EMPLOYMENT STATUS: (CHECK BOX) ☐ FULL TIME ☐ PART TIME ☐ SELF-EMPLOYED ☐ UNEMPLOYED ☐ RETIRED ☐ OTHER: _____ **IF EMPLOYED**: EMPLOYER NAME: _____ EMPLOYER ADDRESS: _____ EMPLOYER PHONE #: _____ OCCUPATION: _____ DATE HIRED: _____ SALARY $_____	**EMPLOYMENT STATUS: (CHECK BOX)** ☐ FULL TIME ☐ PART TIME ☐ SELF-EMPLOYED ☐ UNEMPLOYED ☐ RETIRED ☐ OTHER: _____ **IF EMPLOYED**: EMPLOYER NAME: _____ EMPLOYER ADDRESS: _____ EMPLOYER PHONE #: _____ OCCUPATION: _____ DATE HIRED: _____ SALARY $_____
IF UNEMPLOYED: UNEMPLOYMENT BENEFITS $_____/WEEK DATE UNEMPLOYED: _____ REASON FOR UNEMPLOYMENT:	**IF UNEMPLOYED:** UNEMPLOYMENT BENEFITS $_____/WEEK DATE UNEMPLOYED: _____ REASON FOR UNEMPLOYMENT:

Household Information- Please list all people living at your address (even if they are not applying for assistance)
***Illinois residents only list dependents shown on your tax return**

HOUSEHOLD MEMBERS	AGE	RELATIONSHIP TO APPLICANT	SOURCE OF INCOME (SSI, SSDI, WORKERS COMPENSATION, CHILD/FAMILY SUPPORT, VETERANS BENEFITS, RENTAL, SUPPORT FROM FRIENDS/FAMILY, OTHER)	MONTHLY AMOUNT

Assets (Attach other if necessary)	Monthly Expenses (Attach other if necessary)	
CHECKING ACCOUNT BALANCE $	MORTGAGE/RENT $	MORTGAGE LOAN BALANCE $
SAVINGS ACCOUNT BALANCE $	AUTO LOAN $	AUTO LOAN BALANCE $
CASH ON HAND (NOT IN BANK) $	GAS $	ELECTRIC $
VALUE OF HOME $	PHONE $	CABLE/SATELLITE $
OTHER REAL ESTATE $	CREDIT CARD (S) $	OTHER LOAN $
STOCKS, BONDS, CDs $	CHILD CARE $	OTHER $
VEHICLE MAKE/TYPE/YEAR	CHILD SUPPORT $	INSURANCE PREMIUM $
OTHER ASSETS $	OTHER COURT ORDERED $	MONTHLY FOOD $

Reason for Application (include any special circumstances, e.g. extraordinary medical expenses that Mercyhealth should consider. If you have no income, please explain your living arrangements. (Attach additional pages if necessary)

If you are **uninsured,** presumptive eligibility criteria may be used to determine if a patient is eligible for hospital financial assistance without further review by the hospital. Please check any of the items listed below that apply to you:

____Homeless

____Medicaid eligible

____Patient is deceased with no estate

____Supplemental Nutrition Assistance Program (SNAP or LINK)

____Temporary Assistance for Needy Families (TANF)

____Patient has a mental incapacitation with no one to act on patient's behalf

____Women, Infants, and Children Nutrition Program (WIC)

____Illinois Free Lunch and Breakfast Program

____Low Income Home Energy Assistance Program

____IDHA Rental Housing Support Program

____Receipt of grant assistance for medical services

By signing below, I certify that the information is true and correct to the best of my knowledge. I will apply for any state, federal, or local assistance for which I may be eligible to help pay for this hospital bill. I authorize the Mercyhealth Community Care Program to obtain any financial information held by the Social Security Administration, County Social Services, Credit Bureaus, lending institutions, other financial institutions and/or insurance companies on myself and my family, for the purpose of determining eligibility for Mercyhealth Community Care funding. This authorization is valid for one (1) year from my dated signature. I can revoke it at any time in writing, except to the extent that Mercyhealth has already acted in reliance on it. I understand that a photocopy of this consent is as valid as the original. I understand that if I knowingly provide untrue information in this application, I will be ineligible for financial assistance, any financial assistance granted to me may be reversed, and I will be responsible for the payment of the hospital bill.

Signature of Applicant: _____ Date: _____

If signed by a person other than the applicant, complete the following and provide documentation, if necessary.

Signature of legally authorized person: _____ Date: _____
Applicant is: ☐ Minor ☐ Disabled ☐ Legal Guardian

Complaints or concerns with the uninsured patient discount application process or hospital financial assistance process may be reported to the Health Care Bureau of the Illinois Attorney General. The Office of the Attorney General may be reached at https://www.illinoisattorneygeneral.gov/index.html or by calling (800) 243-0618.

You may receive a copy of Mercyhealth's Financial Assistance Policy. You may also receive help with an application Monday through Friday 8 am to 4:30 pm or return a completed application and supporting documents to:

MercyCare Building
580 N. Washington Street-Customer Service Department
PO BOX 5003
Janesville, WI 53547
(608) 741-7630 or toll free (866) 269-7115
E-mail: custserv@mhemail.org
Or upload documents to your MyChart Financial Assistance Application
Or meet with a Patient Financial Counselor at any of our Mercyhealth locations.

You may also e-mail completed applications and documents to:
mercycommunitycare@mhemail.org

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