

Mercy Medical Center – New Hampton
Financial Assistance

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. **Income verification such as Income Tax Return or check stubs need to be included for this form to be considered complete. ***INCOMPLETE FORMS WILL NOT BE PROCESSED*****

PLEASE RETURN to Mercy Medical Center-North Iowa, PFS-NH, 1000 4th St SW, Mason City, IA 50401

Applicant Name:	Marital Status: S M Male Female	Spouse Name:	Male Female
Address:		Address:	
City/State/Zip:		City/State/Zip:	
SSN:	DOB:	SSN:	DOB:
Contact Phone # / Cell Phone # :			
1. Gross Monthly Income: (Self) \$ _____ (Spouse) \$ _____ Child Support Received: \$ _____ Employer _____ Spouse Employer _____ Circle those that apply: Wages/Salary Unemployment Veteran Benefits Pension/Retirement Alimony/Child Support Social Security SSI (If yes, date you applied) _____ ** Income documentation required – Income tax return/pay stubs ** If unemployed, please note how you are meeting your monthly expenses _____ _____			
2. Resources: Checking Account Balance: _____ IRA: _____ Stocks/Bonds: _____ Savings Account Balance: _____ Other: _____			
3. Name of dependents living with you: Date of Birth Date of Birth 1. _____ _____ 3. _____ _____ 2. _____ _____ 4. _____ _____			
4. Housing Expense: Rent - Own/Buy Property Value: \$ _____ Balance Owing: \$ _____ Payment: \$ _____ Other Property: Own/Buy Property Value: \$ _____ Balance Owing: \$ _____ Payment: \$ _____			
5. Autos: Year _____ Make _____ Value _____ Balance _____ Payment _____ Year _____ Make _____ Value _____ Balance _____ Payment _____			
6. RV/Boat/ATVs: (List type, year and payment):			
7. Support Payments: (Any support payments ordered by the court and made by the person)			
8. Do you have health insurance? Yes No If yes, who in your family is insured: _____ Circle those that apply: Medicare Medicaid IowaCare Blue Cross Other insurance name: _____ Health Insurance Premium (amount you pay monthly): \$ _____ Drug Coverage: Yes No VA Drug Assistance: Yes No Monthly Prescription Expense: \$ _____ (Requires documentation from pharmacy)			
9. Have you applied for other financial assistance programs (Social Security Disability, Medicaid, IowaCare, Food Stamps, etc.) Yes No Are you eligible: Yes No Have you received benefits: Yes No			
** 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, Neurosurgery of North Iowa, and applicable Pharmaceutical Manufacturing Companies for their determination of financial assistance.			
Signature: _____		Date: _____	