APPLICATION FOR FINANCIAL ASSISTANCE

PATIENT INFORMATION

Patient Name	DOB	Telephone No.	Patient No.
Home Address		Rent ☐ Own ☐	Live with parents? No ☐ Yes ☐
SSN	Marital Status		
Name & Address of employer		Employer Telephone No.	How long employed?
Position/Title		Supervisor's Name	
If unemployed, last date & place of employment		Position/Title	

RESPONSIBLE PARTY INFORMATION

Name	Relationship to patient	DOB	Telephone No.
Street address, if different from patient			
SSN	Marital Status	Family Size	Names & DOB
Name & Address of Employer		How long employed?	Employer Telephone No.
Position/Title		Supervisor's Name	
If unemployed, last date & place of employment		Position/Title	
Name of Nearest Relative		Relationship	
Address		Telephone No.	

SPOUSE INFORMATION

Name	DOB	SSN	Name of Employer
Employer Address		How long employed?	Employer Telephone No.
Position/Title		Supervisor's Name	
If unemployed, last date & place of employment			Position/Title

HAVE YOU APPLIED FOR MEDICAID OR ANY OTHER COUNTY ASSISTANCE? ☐ NO ☐ YES (DATE/STATE_______________________________)	DID YOU HAVE HEALTH INSURANCE ON THE DATE OF SERVICE? ☐ NO ☐ YES (PROVIDE COPY OF CARD WITH THIS APPLICATION)

MONTHLY INCOME				ASSETS	
ITEM	☐ Patient ☐ Spouse ☐Father ☐ Mother	☐ Patient ☐ Spouse ☐Father ☐ Mother	☐ Patient ☐ Spouse ☐Father ☐ Mother	Checking Account(s) – bank & account number	Balance
Base Income					
Overtime				Savings Account(s) – bank & account number	Balance
Social Security					
Interest/Dividends				Other (bank & account number, money market, CD, IRA)	Balance
Rental Income					
Alimony/Child Support				Life Insurance (company & policy number)	Value
Unemployment					
State Assistance				Stocks, Bonds & Mutual Funds (company)	Value
Food Stamps					
Pension				Automobiles/Trucks (make, model & year)	Value
Disability					
Worker's Compensation					
Other				Other Assets (personal, livestock, machinery, motorcycles, RVs)	Value
				Real Estate (list and describe)	Present Value
TOTAL				**TOTAL ASSETS**	

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PLEASE COMPLETE THE INFORMATION AS THOROUGHLY AS POSSIBLE SO THAT AN ACCURATE ASSESSMENT OF YOUR CURRENT FINANCIAL SITUATION CAN BE DETERMINED. ALONG WITH THE FINANCIAL STATEMENT, AT LEAST TWO OF THE FOLLOWING ITEMS ARE REQUIRED FOR REVIEW. PLEASE PROVIDE THE FOLLOWING ITEMS:

1. **MOST RECENTLY FILED FEDERAL AND STATE INCOME TAX RETURN.**
2. **BANK ACCOUNT STATEMENT (CHECKING AND SAVINGS; LAST THREE MONTHS)**
3. **VERIFICATION OF INCOME (PAYCHECK STUBS, UNEMPLOYMENT CHECK, SOCIAL SECURITY CHECKS, ETC.).**

MONTHLY EXPENSES		OTHER EXPENSES	MONTHLY PAYMENT	BALANCE	PAYMENT CURRENT?
ITEM	MONTHLY PAYMENT	Charge Accounts			☐ No ☐ Yes
Rent					☐ No ☐ Yes
Mortgage					☐ No ☐ Yes
Electricity					☐ No ☐ Yes
Gas/Propane					☐ No ☐ Yes
Water					☐ No ☐ Yes
Refuse		Personal Loan (name & purpose)			☐ No ☐ Yes
Telephone					☐ No ☐ Yes
Cable TV		Automobile Loan (name)			☐ No ☐ Yes
Food					☐ No ☐ Yes
Clothing		Real Estate Loan (name)			☐ No ☐ Yes
Medicine					☐ No ☐ Yes
Baby Sitter		Cellular Phones/Pager			☐ No ☐ Yes
Transportation					☐ No ☐ Yes
Alimony/Child Support		Miscellaneous (name & purpose)			☐ No ☐ Yes
Auto Insurance					☐ No ☐ Yes
Home Insurance					☐ No ☐ Yes
Life Insurance		**TOTALS**	**TOTAL MONTHLY PAYMENTS**	**TOTAL BALANCE**	
Health Insurance					
Personal Property Tax					
Real Estate Tax		**SUMMARY**			
Sub-total					

Total Monthly Income $____________________

Total Monthly Expenses $____________________

Discretionary Income $____________________

Monthly Payment Arrangements $____________________

OTHER EXPENSES

Will the patient be unable to work or go to school due to physical impairment? ☐ No ☐ Yes
If yes, what is the disabling condition or diagnosis? ____________________
How long will the patient be disabled? ____________________ (Please attach a statement from the doctor.)

COMMENTS

PATIENT AGREEMENT

The undersigned applies for financial assistance indicated in this application and represents that all statements made in this application are true and are made for the purpose of obtaining financial assistance. The original or a copy of this application will be retained by the creditor, even if financial assistance is not granted. The undersigned also agrees to allow this facility to contact any or all of the above references for credit verification, including credit bureaus.

Patient Signature **Responsible Party or Spouse Signature**

Date **Facility Representative** **Department**

Please Mail Completed Application & Support to:
Mercy Health Rehabilitation Hospital
Attn: Finance
3180 Belmont Ave
Youngstown, OH 44505