

Mercy Hospital, Inc.  
 P.O. BOX 180  
 218 East Pack  
 Moundridge, Kansas 67107  
 620-345-6391  
 Financial Assistance Application

Applicant's Name \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_  
 Telephone # \_\_\_\_\_ SS # \_\_\_\_\_ DOB \_\_\_\_\_  
 Patient's Name \_\_\_\_\_ Patient Account # (s) \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_  
 Telephone # \_\_\_\_\_ SS # \_\_\_\_\_ DOB \_\_\_\_\_  
 Employer \_\_\_\_\_ Position \_\_\_\_\_ How Long? \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_  
 Telephone # \_\_\_\_\_  
 Spouse's Name \_\_\_\_\_ SS # \_\_\_\_\_ DOB \_\_\_\_\_  
 Spouse's Employer \_\_\_\_\_ Position \_\_\_\_\_ How Long? \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_  
 Telephone # \_\_\_\_\_

Number of family members \_\_\_\_\_ (Including you, your spouse, your children and any one residing with you that you support. Also students, regardless of their residence, who are supported by their parents or others related by birth, marriage or adoption are considered to be residing with those who support them).

**INCOME: LIST INCOME FOR YOUR FAMILY FROM:**

	<b>Gross Income Last 6 Months</b>	<b>Gross Income Last 12 Months</b>
Wages	_____	_____
Public & Emergency Assistance	_____	_____
Social Security	_____	_____
Unemployment Compensation	_____	_____
Worker's Compensation	_____	_____
Farm or Self Employment	_____	_____
Strike Benefits	_____	_____
Alimony	_____	_____
Child Support	_____	_____
Military Family Allotments	_____	_____
Pensions	_____	_____
Income from Dividends, Interest	_____	_____
Rental Property	_____	_____
Other	_____	_____
Total	_____	_____

**Please attach proof of income (copies of check stubs, W-2 forms, Income Tax Return, etc.)**

I hereby request that Mercy Hospital, Inc. make a written determination of my eligibility for financial assistance. I certify the above information is true and correct. I understand that the information I submit concerning my income and family size is subject to verification by Mercy Hospital, Inc. and hereby authorize them to do so. I further authorize the employers/institutions to release such information. I also understand that if the information I submit is determined to be false, such a determination will result in denial of providing financial assistance and that I will be liable for charges of services provided.

\_\_\_\_\_  
 Signature

\_\_\_\_\_  
 Date