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:

	Gross Income Last 6 Months	**Gross Income Last 12 Months**
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