



## PATIENT FINANCIAL ASSISTANCE APPLICATION

**In order to determine eligibility in a timely fashion, this completed application and supporting documentation must be returned within 30 days by: (date) \_\_\_\_\_.**

**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**HOUSEHOLD INFORMATION:**

**HOUSEHOLD SIZE** (Attach copy of most recent tax return to support claimed household dependents)

Number of Dependents		
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**HOUSEHOLD INCOME CALCULATION** (Attach copy of two most recent pay stubs or other supporting documentation for each source of household income.)

Salary:	Gross, monthly:	\$	TOTAL ANNUAL INCOME:	\$
	Gross, weekly:	\$		
	Other Income*:	\$	Describe:	
	Other Income*:	\$	Describe:	

**ASSET INFORMATION:**

Do you have any other assets?    No    Yes   (include all values below)

Checking:	\$	TOTAL ASSETS:	\$
Savings:	\$		
Stocks:	\$		
CDs:	\$		

Recreational Vehicle Value:  
(Motorcycles, Boats, ATVs, Trailers, RV's, etc.)      \$

Property other than primary residence	\$	Describe:	
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Other Assets:	\$	Describe:	
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Choose one:    Rent    Own home

**MEDICAL EXPENSES:**      \$      (attach current bills showing portion of balance you owe)

Assessed Valuation:	Home:	\$	Other Property:	\$
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**APPLICATION FOR PUBLIC AID ASSISTANCE:**

Applicants are required to apply for public aid assistance to determine eligibility under the State Medicaid system prior to determining eligibility for the Uninsured Patient Discount and Financial Need Programs. If you need assistance obtaining or completing an application, the Patient Financial Services Department at Mercer County Hospital can assist you. Please call (309) 582-3717 for assistance.

**ATTACHMENTS:**

If you do not have access to a copier, feel free to bring in your original supporting documentation when returning this completed application and we would be happy to make the necessary copies for you.

**ATTACHMENTS CONTINUED:**

- Public aid application/denial. Status of application: \_\_\_\_\_
- Verification of income for each source of household income through previous two paycheck stubs (or) unemployment, workers compensation, pension or annuity checks (or) monthly benefit statement from Social Security.
- Copies of Medical Expense documentation (showing balances applicant owes to other providers).
- Bank account statements for past three (3) months (checking, savings, investments).
- Latest income tax return to support claimed number of dependents.

Notification of approval or request for additional information will be provided to you within two weeks of returning the application with all completed documentation. Any approved financial need expires six (6) months from the approval date. Upon expiration of the approval, applicant will be asked to complete a new application form to update on the current financial status and any changes thereof.

Additional comments you would like to make regarding your financial situation:

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Attach additional page if more room is needed for additional comments.

**PATIENT/GUARANTOR ACKNOWLEDGEMENT:**

I hereby certify that the foregoing statements are true and complete and are made for the sole purpose of determining eligibility for financial assistance. I authorize Mercer County Hospital/Medical Associates Clinic to make inquiries that are deemed necessary to verify the accuracy of the statements including but not limited to, consumer records from consumer reporting agencies and credit information from listed bank and other financial institutions, present and former employers, landlords and creditors. I also authorize any person from the listed creditors and others previously mentioned sources to furnish Mercer County Hospital/Medical Associates Clinic any information that it may have or obtain in response to credit inquiries. I understand that this financial need application can be denied and/or re-evaluated and revoked if it is found that I misrepresented income, assets, expenses or other information.

\_\_\_\_\_  
Signature of Patient/Guarantor

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Director, Patient Financial Services

\_\_\_\_\_  
Date

**\*\*Any approved financial assistance expires six (6) months from the above date.**