

Services Provided By:

- Waterloo Medical Center
- Waterloo Home Medical Equipment
- Oelwein Medical Center
- Cedar Falls Medical Center
- MercyOne Medical Group–Northeast Iowa

COMMUNITY CARE FINANCIAL APPLICATION

In recognition of MercyOne's policy to provide quality health care to all persons regardless of their financial status, MercyOne's Community Care program provides financial assistance to those in need in a fair, non-discriminatory manner.

Community Care Financial Application Instructions

Submit the following checked (☑) Items:

(Please send copies, originals will not be returned.) All information is needed for both applicant and spouse.

- ☑ Copy of your most recent paycheck stub/voucher.
- ☑ Other Sources of Income; Social Security, Pension, Disability, Rental, Unemployment, Worker's Compensation, Child Support, Alimony.
 1. If one or more of these apply to you, please include the most recent copy of award letter.
 2. If patient is a minor and you do not receive child support, please include second parent's most recent paycheck stub/voucher and current taxes including all schedules.
- ☑ Verification of food stamps, FIP Assistance, heating and housing assistance.
- ☑ Applicants that receive financial help from a family member, school grants or other person for living expenses must include written statement from this person/school.
- ☑ Complete copy of your _____ calendar year signed Federal Tax Return including all schedules. If you have self employment, rental or farm income, please include Schedules C, E and F.
- ☑ If you do not have health insurance
 1. A letter from your employer and/or your spouse's employer, confirming health insurance coverage is not available.
 2. If you declined health insurance offered through your employer and/or your spouse's employer, submit cost of the premiums.
 3. Letter of decision regarding public funded health insurance coverage (Medicaid/Title 19 and/or medically needy spend down program) is required.
- ☑ If you do have health insurance:
 1. Proof of premiums you are paying for health insurance coverage.
 2. Copy of current insurance card/s.

MercyOne will submit a written response to the applicant upon receipt of a completed application and supporting information.

IF YOU HAVE QUESTIONS, PLEASE CALL 1-800-728-0159 OR 319-272-0044.

Mail, email or fax the completed form and other papers to:

MercyOne

Attn: Credit Department

3421 West 9th Street, Waterloo, IA 50702

Email: iafinancialcounsel@mercyhealth.com

Fax: 319-272-5757

Date: _____ Account Number(s): _____

Applicant's Name: _____ **Patient's Name** _____

Applicant's Address: _____ City: _____ St: _____ ZIP: _____

Applicant's Phone No: _____ SSN _____ Date of Birth _____

Marital Status: Single Married Widowed Divorced

Spouse's Name: _____ SSN _____ Date of Birth _____

Dependent's Name _____ Date of Birth _____ / / _____

_____ / / _____

_____ / / _____

_____ / / _____

EMPLOYMENT, INCOME AND INSURANCE INFORMATION (ALL BLOCKS MUST BE COMPLETED):

APPLICANT

Are you presently employed? Yes No Do you file federal tax return? Yes No

Are you self-employed? Yes No Do you have health insurance? Yes No

Hire Date: _____ Monthly amount paid for health insurance: \$ _____

How often are you paid?: Weekly Bi-Weekly Monthly Bi-Monthly Hourly Wage: \$ _____

How many hours are you scheduled each pay period? 20 40 60 80 120 Other _____

Employer: _____ City: _____ State: _____

Monthly Gross Income: _____ Telephone Number: _____

SPOUSE OF APPLICANT

Are you presently employed? Yes No Do you file federal tax return? Yes No

Are you self-employed? Yes No Do you have health insurance? Yes No

Hire Date: _____ Monthly amount paid for health insurance: \$ _____

How often are you paid?: Weekly Bi-Weekly Monthly Bi-Monthly Hourly Wage: \$ _____

How many hours are you scheduled each pay period? 20 40 60 80 120 Other _____

Employer: _____ City: _____ State: _____

Monthly Gross Income: _____ Telephone Number: _____

OTHER SOURCES OF INCOME (check type and list amount):

Income Source Each Month	Gross Monthly Income Amount	Gross Monthly Income Amount for Spouse or Second Parent	Document Requirements
<input type="checkbox"/> Social Security	\$ _____	\$ _____	Award Letter/Bank Statement
<input type="checkbox"/> Pension/Disability <input type="checkbox"/> Rental Income	\$ _____	\$ _____	Pension/Disability Letter Tax Return with Schedules
<input type="checkbox"/> Unemployment <input type="checkbox"/> Worker's Compensation	\$ _____	\$ _____	Unemployment Letter Worker's Compensation Letter
<input type="checkbox"/> Child Support/Alimony	\$ _____	\$ _____	Bank Statement/ Decree

I CERTIFY THAT THE INFORMATION GIVEN IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE AND BELIEF. I authorize the release of information to MercyOne for verification of this financial statement.

Signature of Patient/Applicant

Date 481971 2/10/22 dp