Dear Applicant:

Thank you for your interest in Mercyhealth's Community Care Program. Mercyhealth's Community Care is our Traditional Charity Program under Mercyhealth Financial Assistance Policy. Mercyhealth's Community Care is not an insurance policy, or meant to be an alternative to health insurance, or government assistance programs. If you qualify, you may have free or reduced fees for medical services or be eligible for payment plans. Mercyhealth will work out a payment plan based on your ability to pay within the guidelines set in our Financial Assistance Policy.

You may be required to meet with a Mercyhealth Patient Financial Counselor (PFC) or Customer Service Representative (CSR). We will help to determine eligibility for government or other financial resources. Our team can also assist in completing the application and answer any questions you may have.

Community Care approval decisions are based on the household annual gross income. In order to assess your situation you may be asked to complete the application in its entirety, including signature(s). You may be asked to also include most recent income information for all members of the household:

- ☐ Copy of W-2 forms and/or Federal Income Tax Return (1040 or 1099 forms) for the most recent tax year, including all schedules filed with the original return.
- ☐ Copies of the two most recent payroll voucher/check stubs from all jobs held in the current year, showing your year to date income.
- ☐ Documentation of fixed income (Social Security, Veterans, Pensions, Unemployment Compensation, Child Support/Alimony, W2 payments, Disability)
- ☐ Copies of all bank statements for both checking and savings for the last two months, showing all activity.
- ☐ If the household is receiving assistance from family or friends, a statement from the assisting party.
- ☐ If you are unable to work, you must apply for Social Security Disability and provide documentation that the application is being processed.
- ☐ Denial and appeal documentation from any liability insurance if involved in an accident or assault
- ☐ If you are a college student, you must supply documentation of current student status.
- ☐ Verification that you have applied for all medical-related resources:

_____ **Medicaid or other health insurance**

Please apply for Medicaid or Health Insurance through the Marketplace www.healthcare.gov
Or call (800) 318-2596 and send us documentation of the application.

_____ **Additional Medical resources**

Rock County (608) 741-3400; Walworth County (262) 741-3200; McHenry County (815) 338-0234;
Winnebago County (815) 720-4000; Boone County (815) 544-2951; Ogle County (815) 562-6976

Without the above listed items, it could delay the process of the application. If you have questions, please contact Mercyhealth Customer Service at (866) 269-7115 or (800) 987-4170. We look forward to assisting you.

Mercyhealth respects the confidentiality and dignity of its patients and understands that applying for Financial Assistance may be a sensitive issue. All application information is subject to Mercyhealth privacy practices.

For office use only:

Date: ________________________

Patient Account No: ________________________

Mercyhealth Representative: ________________________

COMMUNITY CARE FINANCIAL ASSISTANCE APPLICATION

General Information

PATIENT LAST NAME		PATIENT FIRST NAME	MI	SOCIAL SECURITY NUMBER (not required if uninsured in Illinois)
STREET ADDRESS		CITY STATE ZIP		E-MAIL ADDRESS
DATE OF BIRTH	TELEPHONE – HOME	TELEPHONE – WORK		TELEPHONE - CELL
SPOUSE'S NAME				DATE OF BIRTH

Employment Information

APPLICANT	SPOUSE/PARTNER
EMPLOYMENT STATUS: (CHECK BOX) ☐ FULL TIME ☐ PART TIME ☐ SELF-EMPLOYED ☐ UNEMPLOYED ☐ RETIRED ☐ OTHER: ______	**EMPLOYMENT STATUS: (CHECK BOX)** ☐ FULL TIME ☐ PART TIME ☐ SELF-EMPLOYED ☐ UNEMPLOYED ☐ RETIRED ☐ OTHER: ______
IF EMPLOYED: EMPLOYER NAME: ______ EMPLOYER ADDRESS: ______ EMPLOYER PHONE #: ______ OCCUPATION: ______ DATE HIRED: ______ SALARY $ ______	**IF EMPLOYED**: EMPLOYER NAME: ______ EMPLOYER ADDRESS: ______ EMPLOYER PHONE #: ______ OCCUPATION: ______ DATE HIRED: ______ SALARY $ ______
IS HEALTH INSURANCE AVAILABLE THROUGH EMPLOYER? ☐ YES ☐ NO **IF YES, DO YOU RECEIVE THIS INSURANCE** ☐ YES ☐ NO IF YES, CARRIER: ______ **IF YOU DO NOT RECEIVE THIS INSURANCE, REASON WHY:**	**IS HEALTH INSURANCE AVAILABLE THROUGH EMPLOYER?** ☐ YES ☐ NO **IF YES, DO YOU RECEIVE THIS INSURANCE** ☐ YES ☐ NO IF YES, CARRIER: ______ **IF YOU DO NOT RECEIVE THIS INSURANCE, REASON WHY:**
IF UNEMPLOYED: UNEMPLOYMENT BENEFITS $______/WEEK DATE UNEMPLOYED: ______ REASON FOR UNEMPLOYMENT: ______	**IF UNEMPLOYED:** UNEMPLOYMENT BENEFITS $______/WEEK DATE UNEMPLOYED: ______ REASON FOR UNEMPLOYMENT: ______

*Please add information for additional employment on the back of this page.

Household Information- Please list all people living at your address (even if they are not applying for assistance) *Illinois residents only list dependents shown on your tax return				
HOUSEHOLD MEMBERS	AGE	RELATIONSHIP TO APPLICANT	SOURCE OF INCOME (SSI, SSDI, WORKERS COMPENSATION, CHILD/FAMILY SUPPORT, VETERANS BENEFITS, RENTAL, SUPPORT FROM FRIENDS/FAMILY, OTHER)	MONTHLY AMOUNT

Assets (Attach other if necessary)	Monthly Expenses (Attach other if necessary)	
CHECKING ACCOUNT BALANCE $	MORTGAGE/RENT $	MORTGAGE LOAN BALANCE $
SAVINGS ACCOUNT BALANCE $	AUTO LOAN $	AUTO LOAN BALANCE $
CASH ON HAND (NOT IN BANK) $	GAS $	ELECTRIC $
VALUE OF HOME $	PHONE $	CABLE/SATELLITE $
OTHER REAL ESTATE $	CREDIT CARD (S) $	OTHER LOAN $
STOCKS, BONDS, CDs $	CHILD CARE $	OTHER $
VEHICLE MAKE/TYPE/YEAR	CHILD SUPPORT $	INSURANCE PREMIUM $
OTHER ASSETS $	OTHER COURT ORDERED $	MONTHLY FOOD $

Reason for Application (include any special circumstances, e.g. extraordinary medical expenses that Mercyhealth should consider. If you have no income, please explain your living arrangements. (Attach additional pages if necessary)

If you are **uninsured,** presumptive eligibility criteria may be used to determine if a patient is eligible for hospital financial assistance without further review by the hospital. Please check any of the items listed below that apply to you:

____Homeless

____Medicaid eligible

____Patient is deceased with no estate

____Supplemental Nutrition Assistance Program (SNAP or LINK)

____Temporary Assistance for Needy Families (TANF)

____Patient has a mental incapacitation with no one to act on patients behalf

____Women, Infants, and Children Nutrition Program (WIC)

____Illinois Free Lunch and Breakfast Program

____Low Income Home Energy Assistance Program

____IDHA Rental Housing Support Program

____Receipt of grant assistance for medical services

By signing below, I certify that the information is true and correct to the best of my knowledge. I will apply for any state, federal, or local assistance for which I may be eligible to help pay for this hospital bill. I authorize the Mercyhealth Community Care Program to obtain any financial information held by the Social Security Administration, County Social Services, Credit Bureaus, lending institutions, other financial institutions and/or insurance companies on myself and my family, for the purpose of determining eligibility for Mercyhealth Community Care funding. This authorization is valid for one (1) year from my dated signature. I can revoke it at any time in writing, except to the extent that Mercyhealth has already acted in reliance on it. I understand that a photocopy of this consent is as valid as the original. I understand that if I knowingly provide untrue information in this application, I will be ineligible for financial assistance, any financial assistance granted to me may be reversed, and I will be responsible for the payment of the hospital bill.

Signature of Applicant: ____ Date: ____________________

If signed by a person other than the applicant, complete the following and provide documentation, if necessary.

Signature of legally authorized person: ____________________________________ Date:____________________
Applicant is: ☐ Minor ☐ Disabled ☐ Legal Guardian

You may receive a copy of Mercyhealth's Financial Assistance Policy. You may also receive help with an application Monday through Friday 8 am to 4:30 pm or return a completed application and supporting documents to:

MercyCare Building
580 N. Washington Street-Customer Service Department
PO BOX 5003
Janesville, WI 53547
(608) 741-7630 or toll free (866) 269-7115
E-mail: custserv@mhemaill.org

OR
On our website at www.mercyhealthsystem.org

You may also e-mail completed applications and documents to:
mercycommunitycare@mhemail.org

Revised 8/27/2020