MERCY
MEDICAL CENTER

FINANCIAL STATEMENT

F-0417-NS 905 1014

PATIENT NAME & SOCIAL SECURITY NO.	AGE	NO. IN FAMILY	MARITAL STATUS	SPOUSE/PARENT	PHONE

PATIENT ADDRESS	CITY, STATE, ZIP	PATIENT EMPLOYER	HOW LONG

GUARANTOR & SOCIAL SECURITY NO.	GUARANTOR ADDRESS	GUARANTOR EMPLOYER	HOW LONG

WERE YOU AN ACTIVE MEDICAID RECIPIENT AT THE TIME OF YOUR HOSPITAL SERVICE? Y____ N____

IF YES, MEDICAID RECIPIENT NUMBER: _____

WERE YOU AN ACTIVE RECIPIENT OF DISABILITY ASSISTANCE AT THE TIME OF YOUR HOSPITAL SERVICE? Y____ N____

IF YES, ATTACH A COPY OF YOUR DA CARD TO THIS APPLICATION

DID YOU HAVE HEALTH INSURANCE (OTHER THAN MEDICAID) AT THE TIME OF YOUR HOSPITAL SERVICE? Y____ N____

☐ CHECKING ☐ SAVINGS ☐ OTHER ASSETS

BALANCE: BANK:

WERE YOU AN OHIO RESIDENT AT THE TIME OF YOUR HOSPITAL SERVICE? Y____ N____

☐ RENT ☐ BUYING
☐ OWN ☐ C/O RELATIVES

BALANCE	VALUE

GROSS INCOME

*(Please **include copies of income either 3 or 12 months prior** to **date(s) of service**.)*

PATIENT _____

SPOUSE _____

SOC. SEC. _____

UNEMP. _____

PENSION _____

CHILD SUPPORT _____

WORKER'S COMP. _____

OTHER _____

TOTAL INCOME: _____

YEARLY GROSS INCOME: _____

BASIC MONTHLY EXPENSES

*(In the event that you would not qualify for HCAP and would like to be considered for internal charity, please **include copies** of your **monthly expenses**.)*

HOUSING _____

GAS _____

ELECTRIC _____

WATER _____

PHONE _____

FOOD _____

TRANSPORTATION EXPENSE _____

MEDICAL _____

MEDICAL _____

PHARMACY _____

INSURANCE _____

CHILD CARE _____

SUBTOTAL: _____

OTHER EXPENSES

CABLE TV _____

CAR PAYMENT _____

VISA _____

MASTERCARD _____

LOAN _____

LOAN _____

_____

_____

_____

_____

_____

_____

SUBTOTAL: _____

TOTAL EXPENSE: _____

REMARKS: Please use space on back for additional comments.

Dates of Hospital Service

Account number _____ Date of Service From _____ to _____ Balance $_____

Account number _____ Date of Service From _____ to _____ Balance $_____

Account number _____ Date of Service From _____ to _____ Balance $_____

Account number _____ Date of Service From _____ to _____ Balance $_____

SIGNED: _____
MANAGER, PATIENT ACCOUNT SERVICES

_____
DATE

SIGNED: _____
DIRECTOR, PATIENT ACCOUNT SERVICES

THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

SIGNED _____ _____ _____ _____

PATIENT'S SIGNATURE *OR* SIGNATURE OF PERSON COMPLETING FORM RELATIONSHIP DATE

FAMILY MEMBER INFORMATION

Name	Relationship	Birthdate	Soc. Sec. #	Monthly Income

"Family" shall include the PATIENT, THE PATIENT'S SPOUSE, AND ALL OF THE PATIENT'S CHILDREN, natural or adoptive, under the age of eighteen who live in the home. IF THE PATIENT IS UNDER THE AGE OF EIGHTEEN, THE "FAMILY" SHALL INCLUDE THE PATIENT, THE PATIENT'S NATURAL OR ADOPTIVE PARENT(S), AND THE PARENT(S)' CHILDREN, NATURAL OR ADOPTIVE UNDER THE AGE OF EIGHTEEN WHO LIVE IN THE HOME.

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ADDITIONAL COMMENTS