APPLICATION FOR FINANCIAL ASSISTANCE

PATIENT INFORMATION					
Patient Name			DOB	Telephone No.	Patient No.
Home Address				Rent ☐ Own ☐	Live with parents? No ☐ Yes ☐
SSN	Marital Status				
Name & Address of employer				Employer Telephone No.	How long employed?
Position/Title				Supervisor's Name	
If unemployed, last date & place of employment				Position/Title	

RESPONSIBLE PARTY INFORMATION				
Name	Relationship to patient		DOB	Telephone No.
Street address, if different from patient				
SSN	Marital Status	Family Size	Names & DOB	
Name & Address of Employer			How long employed?	Employer Telephone No.
Position/Title			Supervisor's Name	
If unemployed, last date & place of employment			Position/Title	
Name of Nearest Relative				Relationship
Address				Telephone No.

SPOUSE INFORMATION				
Name	DOB	SSN		Name of Employer
Employer Address			How long employed?	Employer Telephone No.
Position/Title			Supervisor's Name	
If unemployed, last date & place of employment				Position/Title

HAVE YOU APPLIED FOR MEDICAID OR ANY OTHER COUNTY ASSISTANCE? ☐ NO ☐ YES (DATE/STATE_____)	DID YOU HAVE HEALTH INSURANCE ON THE DATE OF SERVICE? ☐ NO ☐ YES (PROVIDE COPY OF CARD WITH THIS APPLICATION)

MONTHLY INCOME				ASSETS	
ITEM	☐ Patient ☐ Spouse ☐Father ☐ Mother	☐ Patient ☐ Spouse ☐Father ☐ Mother	☐ Patient ☐ Spouse ☐Father ☐ Mother	Checking Account(s) – bank & account number	Balance
Base Income					
Overtime				Savings Account(s) – bank & account number	Balance
Social Security					
Interest/Dividends				Other (bank & account number, money market, CD, IRA)	Balance
Rental Income					
Alimony/Child Support				Life Insurance (company & policy number)	Value
Unemployment					
State Assistance				Stocks, Bonds & Mutual Funds (company)	Value
Food Stamps					
Pension				Automobiles/Trucks (make, model & year)	Value
Disability					
Worker's Compensation					
Other				Other Assets (personal, livestock, machinery, motorcycles, RVs)	Value

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				Real Estate (list and describe)	Present Value
TOTAL				**TOTAL ASSETS**	

PLEASE COMPLETE THE INFORMATION AS THOROUGHLY AS POSSIBLE SO THAT AN ACCURATE ASSESSMENT OF YOUR CURRENT FINANCIAL SITUATION CAN BE DETERMINED. ALONG WITH THE FINANCIAL STATEMENT, AT LEAST TWO OF THE FOLLOWING ITEMS ARE REQUIRED FOR REVIEW. PLEASE PROVIDE THE FOLLOWING ITEMS:

1. **MOST RECENTLY FILED FEDERAL AND STATE INCOME TAX RETURN.**
2. **BANK ACCOUNT STATEMENT (CHECKING AND SAVINGS; LAST THREE MONTHS)**
3. **VERIFICATION OF INCOME (PAYCHECK STUBS, UNEMPLOYMENT CHECK, SOCIAL SECURITY CHECKS, ETC.).**

MONTHLY EXPENSES		**OTHER EXPENSES**	**MONTHLY PAYMENT**	**BALANCE**	**PAYMENT CURRENT?**
ITEM	**MONTHLY PAYMENT**	Charge Accounts			☐ No ☐ Yes
Rent					☐ No ☐ Yes
Mortgage					☐ No ☐ Yes
Electricity					☐ No ☐ Yes
Gas/Propane					☐ No ☐ Yes
Water					☐ No ☐ Yes
Refuse		Personal Loan (name & purpose)			☐ No ☐ Yes
Telephone					☐ No ☐ Yes
Cable TV		Automobile Loan (name)			☐ No ☐ Yes
Food					☐ No ☐ Yes
Clothing		Real Estate Loan (name)			☐ No ☐ Yes
Medicine					☐ No ☐ Yes
Baby Sitter		Cellular Phones/Pager			☐ No ☐ Yes
Transportation					☐ No ☐ Yes
Alimony/Child Support		Miscellaneous (name & purpose)			☐ No ☐ Yes
Auto Insurance					☐ No ☐ Yes
Home Insurance					☐ No ☐ Yes
Life Insurance		**TOTALS**	**TOTAL MONTHLY PAYMENTS**	**TOTAL BALANCE**	
Health Insurance					
Personal Property Tax					
Real Estate Tax		**SUMMARY**			
Sub-total					
		Total Monthly Income $_____			
		Total Monthly Expenses $_____			
		Discretionary Income $_____			
		Monthly Payment Arrangements $_____			

OTHER EXPENSES

Will the patient be unable to work or go to school due to physical impairment? ☐ No ☐ Yes
If yes, what is the disabling condition or diagnosis? _____
How long will the patient be disabled? _____ (Please attach a statement from the doctor.)

COMMENTS

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PATIENT AGREEMENT		
The undersigned applies for financial assistance indicated in this application and represents that all statements made in this application are true and are made for the purpose of obtaining financial assistance. The original or a copy of this application will be retained by the creditor, even if financial assistance is not granted. The undersigned also agrees to allow this facility to contact any or all of the above references for credit verification, including credit bureaus.		
Patient Signature		**Responsible Party or Spouse Signature**
Date	**Facility Representative**	**Department**

Please Mail Completed Application & Support to:
Mercy Health Behavioral Hospital
Attn: Finance
3170 Belmont Ave
Youngstown, OH 44505