MERCY IOWA CITY An affiliate of Mercy Health Network	Patient Name(s):	
	Account No.('s):	
Patient Financial Assistance Application	Extended Payment Arrangements ☐ Financial Assistance ☐	

Responsible Party		**Spouse/Significant Other**	
Name:		Name:	
Date of Birth:		Date of Birth:	
Street Address:		Street Address:	
City/State/Zip		City/State/Zip	
Home Phone:		Home Phone:	
Employer:		Employer:	
Employer Phone:		Employer Phone:	
Number of Dependents:		Number of Dependents:	

	Monthly Income)	**Monthly Income**
Income Type	**Responsible Party**	**Spouse**
Salary/Wages	$	$
Disability/SSI/Work Comp/Unemployment	$	$
Social Security/Pension/Annuity	$	$
Child Support/Alimony	$	$
Food Stamps/ADC	$	$
Rental Property	$	$
Interest income	$	$
Other	**$**	**$**
Total	**$**	**$**

Assets

All checking accts	$	All savings accts	$	Retirement accts	$
LLC or business equity	$	Non Residential Property Equity	$	Rental Property equity	$
Stocks/Bonds/Etc	$	Home Value	$	Mortgage	$

PLEASE NOTE: Incomplete or inaccurate applications will not be approved. Be sure to include most recent tax return, 3 pay stubs, and/or other requested documentation.

☐ I (or my spouse) did not file a Federal Income Tax return in the last 3 years. Please explain:

_____

I acknowledge that the above information, given to Mercy Iowa City is true and correct.
I hereby authorize Mercy Iowa City or their agent to verify any information on this form including employers, banks, or credit reporting. Thank you.

_____ _____

Responsible Party/Applicant Date Spouse /Person Assisting Applicant Date

If you have questions contact Mercy Patient Financial Services at **319-339-3616.**

 Return Application to Mercy Iowa City, P.O. Box 3130, Iowa City, IA 52244 Updated 5/1/18