CMG A DIVISION OF MERCY MEDICAL CENTER

_____ /_____ /_____
(Date)

DEAR PATIENT:

Centennial Medical Group offers a variety of opportunites to assist with non-elective medical treatment, whether it be absorbing part of the cost based on need or helping to identify community or governmental programs to fit your needs. **This program does not cover elective medical services.**

If you wish to apply for financial assistance for your account, please complete the attached application and return it in the envelope provided. Your situation will be evaluated based on the national criteria for **poverty level income**. We will gladly consider you for financial assistance provided the application is completed, signed and returned with the required documents listed below within 30 days of the date of this letter.

You must continue to make payments on the account while this application is being reviewed.

REQUIRED DOCUMENTS:

- MOST RECENT COPY OF ALL INCOME FOR ONE MONTH INCLUDING PAY STUBS, SSI, PENSIONS, UNEMPLOYMENT, CHILD SUPPORT, SPOUSAL SUPPORT, ETC. IF SELF-EMPLOYED, A YEAR-TO-DATE PROFIT AND LOSS STATEMENT.
- A COPY OF YOUR MOST RECENT FEDERAL 1040 TAX RETURN (**ALL FORMS FILED** INCLUDING W-2'S AND/OR ALL SCHEDULES). CALL 1-800-829-1040 OR 1-800-829-0922 IF YOU NEED TO OBTAIN A COPY.
- IF YOU ARE RECEIVING ASSISTANCE FROM DHS, DISABILITY SERVICES, OR ANY OTHER FINANCIAL ASSISTANCE, PLEASE INCLUDE DOCUMENTATION OF YOUR CURRENT BENEFITS.

CHECKLIST

Have you answered all questions? Do not leave anything blank. Attach additional sheets if necessary.
Have you attached the following:

- ☐ Most recent verification of ALL income for one month (paystubs or benefit letters)
- ☐ Year to date profit and loss statement for self employed persons
- ☐ Most recent Federal tax return (all pages filed including W-2)
- ☐ Copy of Medical Savings Account / Flex Account balance
- ☐ Food Stamp acceptance letter
- ☐ Statement explaining any special circumstances

Attachment A to Finance Policy No. 1,
Uninsured/Underinsured Patient Discounts (Charity Care)

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Patient Account Services (541) 677-2307

Financial Disclosure (Please print legibly)

Responsible Party: ______________________ Age: ______ Birth date: ____________ SS# ______________

Spouse: ______________________ Age: ______ Birth date: ____________ SS# ______________

Mailing Address: ______________________ City: ______________ St: ____ Zip: ________ Phone: ____________

Marital Status ☐ Single ☐ Married ☐ Legally Separated (provide copy) ☐ Divorced ☐ Widowed Number in household ______

Dependents (as listed on your taxes):

Name	Date of Birth	Relation	Name	Date of Birth	Relation

Income and Financial Data

	Status (employed / unemployed student / disabled / retired)	Employer Name	Job Title	Hire Date (mm/yy)	Pay Cycle (ex: weekly, monthly)	Monthly **Gross** Wages
Responsible Party:						
Spouse:						

If Unemployed:	Previous Employer	How long Unemployed	If you expect to return, when?	Unemployment Remaining	Monthly Compensation
Responsible Party:					
Spouse:					

Social Security / Disability monthly amount ____________

Pension / IRA monthly amount ____________

TANF grant monthly amount ____________

Child Support monthly amount ____________

School loans or grants ____________

Other income - list source: ______________________ amount ____________

Total Monthly Income ____________

If no income, how are you meeting your basic living needs? Basic living needs are things like food, shelter, clothing. ______________

Do you currently file taxes? ☐ Yes ☐ No If not, please explain why? ______________

Have you filed bankruptcy? ☐ Yes ☐ No ☐ Chapter 7 ☐ Chapter 13 Date filed: __________ Date discharged: __________

1. I, the undersigned, certify that the completed information in this document is true and accurate to the best of my knowledge.
2. I will apply for any and all assistance that may be available to help pay this bill.

Date: ______________ **Signature of Applicant:** X ______________________

Date: ______________ **Signature of Spouse:** X ______________________