TRI-STATE SURGERY CENTER
MEDICAL ASSOCIATES
Mercy

Patient Financial Services

Tri-State Surgery Center

Financial Assistance

FOR OFFICE USE ONLY:

Name: ______________________________

Dept: ______________________________

Date: ______________________________

We are required by law to keep information about you confidential. The information below will only be used for the purpose of confirming your need for financial assistance. Financial assistance is based on Federal Poverty Income Levels.

PLEASE RETURN IN 2 WEEKS

Applicant			**Spouse/Partner**		
Street Address			**Street Address**		
City	**State**	**Zip**	**City**	**State**	**Zip**
Home Phone #	**Cell Phone #**		**Home Phone #**	**Cell Phone #**	

Dependents Under 18

Name (Last, First, MI)	Date of Birth	Relationship to Person Applying	Age

Applicant Employer: ______________________________ Spouse Employer: ______________________________

Household Gross Monthly Income: ________________ (Documentation required: Income tax return & 3 pay stubs)

Other Income	Amount
Child Support / Alimony	
Assistance Programs (i.e. cash, food stamps, etc.)	
Pension / IRA / 403(b), Annuity Cash Out	
Social Security / Social Security Disability (self)	
Social Security / Social Security Disability (spouse)	
Other Income (stocks, bonds, annuities, interest, rental property	
Worker's Comp	
Date Started ______________________________ Number of weeks _____________	
Hospital Bills Outstanding	**Amount**
Hospital	
Doctor	
Pharmacy	

ASSETS/RESOURCES

Assets		Value
Cash on Hand		
Checking Account		
Savings Account		
Investments		
Other Securities		
Retirement Savings		
Life Insurance Cash Value		
Primary Property Value	Balance Owed:	
Other Property Address and Value	Balance Owed:	
Vehicles Owned (cars, trucks, snowmobiles, RVs, etc.	Balance Owed:	
	TOTAL	

Check Programs Applies For in the Past Year: ❒ Title 19 ❒ IowaCare ❒ Social Security/Disability

❒ Other: ____

Was there a member of the household who became unemployed in the past 90 days where health insurance was available? (check one) ❒ No ❒ Yes If yes, company name: ______________________________

****Please provide or attach any information you feel would be helpful in understanding your current situation**** (If unemployed, please note how you are meeting your monthly expenses)

Client Affirmation: I affirm that the statements made herein are a true and correct listing of my assets. I understand that any false statements or misstatements of material fact could result in disqualification for financial assistance. I authorize release of this application and the results to the following providers: Mercy Radiologists, Pathology Associates, and Dubuque Emergency Physicians for their determination of financial assistance.

Patient Signature: ________________________________ **Date:** ________________