财务援助申请

感谢您选择 MercyOne 为您的医疗保健服务。为体现 MercyOne 为所有人提供优质医疗服务，无论其经济状况如何的政策，MercyOne 的财务援助计划以公平和非歧视的方式向有需要的人提供财务援助。为了帮助我们确定您是否有资格获得财务援助，请填写并寄回此申请表，连同申请表中要求的文件。

产科患者可能有资格享受爱荷华州的福利。如果您有兴趣获取有关这些计划的信息，请联系财务咨询部。联系信息请参见附件 A。

财务援助申请说明

请发送复印件，原件将不予退还。申请人和配偶均需在 30 天内提供所有信息。

- ☑ 您最近的工资单存根/凭证的副本。
- ☑ 所有银行账户最近两个月的完整银行对账单副本，包括所有页面（定期存款的说明）。
- ☑ 其他收入来源；社会保障、养老金、残疾保险、租金、失业救济金/拒绝信、工伤赔偿、子女抚养费、赡养费、学校补助金、最近的季节性收入的 W2。
  1. 如果其中一项或多项适用于您，请附上最新授予函副本。
  2. 如果患者是未成年人并且您没有收到子女抚养费，请提供第二位家长最近的工资单/凭证和当前报税表（包括所有附表）。
  3. 如果没有收入，请填写申请表的财务支持信部分。
- ☑ 您前一年签署的联邦纳税申报表的完整副本，包括所有附表。如果您有自雇、租赁或农场收入，请附上附表 C、E 和 F。对于自雇/受抚养人，请提供最近三个月的损益表副本。
- ☑ 此文件（财务援助申请书）第三页和第四页的复印件，并附有正确签名。

MercyOne 将在收到完整的申请和支持信息后 30 个工作日内向申请人提供书面回复。

如果您对申请或申请状态有任何疑问，请联系财务咨询部。财务咨询部的联系信息及邮寄地址见附件 A。

保密经济援助申请

[CONFIDENTIAL APPLICATION FOR FINANCIAL ASSISTANCE]

适用于由 Trinity Health 机构和医生提供的医院和专业服务

[For Hospital and Professional services provided by facilities and physicians of Trinity Health]

联系信息

卫生部	将填妥的申请表和其他文件邮寄至：	电话号码	传真号码
Cedar Falls	MercyOne Attention: Financial Counselor 3421 West 9th Street, Waterloo, IA 50702	319-272-0044 或者 1-800-728-0159	319-272-5757
Clinton	MercyOne Clinton Medical Center Attention: Financial Counselor 1410 N. 4th St., Clinton, IA 52732	563-244-5678	563-244-3523
Des Moines / West Des Moines	Patient Business Service Center 20555 Victor Pkwy, Livonia MI, 48152	734-343-3065	313-334-3271
Des Moines Clinic	MercyOne Medical Group 405 SW 5th Street Ste E, Des Moines, IA, 50309	515-643-2519	515-358-7294
Dubuque	MercyOne Dubuque Medical Center Attention: Financial Counselor 250 Mercy Dr, Dubuque, IA 52001	563-589-8913 或者563-589-9066	563-589-9029
Dyersville	MercyOne Dubuque Medical Center Attention: Financial Counselor 250 Mercy Dr, Dubuque, IA 52001	563-589-8913 或者563-589-9066	563-589-9029
Newton	Patient Business Service Center 20555 Victor Pkwy, Livonia MI, 48152	734-343-3065	313-334-3271
New Hampton	MercyOne North Iowa Medical Center Patient Access Attention: Financial Counselor 1000 4th Street SW, Mason City, IA 50401	641-428-3029 或者641-428-7824	641-428-7886
North Iowa (Mason City)	MercyOne North Iowa Medical Center Patient Access Attention: Financial Counselor 1000 4th Street SW, Mason City, IA 50401	641-428-3029 或者641-428-7824	641-428-7886
Oelwein	MercyOne Attention: Financial Counselor 3421 West 9th Street, Waterloo, IA 50702	319-272-0044 或者1-800-728-0159	319-272-5757
Primghar	MercyOne Siouxland Attention: Financial Counselor PO Box 3168, Sioux City, IA 5110	712-957-2300	712-957-0030
Siouxland	MercyOne Siouxland Attention: Financial Counselor PO Box 3168, Sioux City, IA 5110	712-279-2323	712-279-2769
Waterloo	MercyOne Attention: Financial Counselor 3421 West 9th Street, Waterloo, IA 50702	319-272-0044 或者1-800-728-0159	319-272-5757

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请填写并签署申请表，并在 10 天内连同以下材料的复印件一并寄回：
[Please complete and sign application form and return within 10 days including copies of the following:]

所需证明 [Required Verifications]

☐ 过去一个月的总收入证明 [Past One month Proof of Gross Income]

☐ 过去两个月所有银行账户的完整银行对账单，包括所有页面（对定期存款的说明） [Past Two months Complete Bank Statements for all bank accounts, with all pages included (explanation for recurring deposits)]

☐ 最近的报税表（1040 表格及附表 C、E 或 F）或三个月的损益表（自营职业者/受抚养人） [Recent Tax Returns (1040 form with Schedule C, E or F) or Three Months Profit and Loss Statements (for self-employed/dependents)]

如适用，请提供以下材料 [Provide the following, If applicable]

☐ 最近的季节性收入 W2 [Recent W2 for Seasonal Income]

☐ 失业救济金/拒绝函 [Unemployment Benefit/ Denial letter]

☐ 儿童抚养收入/赡养费[Child Support Income/Alimony]

☐ 无收入 - 填写申请表中的“资助信”部分 [No Income – Complete Letter of Financial Support portion of the application]

患者信息 [Patient Information]

患者姓名 [Patient Name]		出生日期 [Date of Birth]	
社会保障号/ EIN（可选）[Social Security/EIN Number (optional)]	移动电话 [Mobile Phone]	其他电话 [Other Phone]	
通信地址 [Mailing Address]	城市 [City]	州 [State]	邮政编码 [ZIP code]
电子邮件地址 [Email Address]	您是哪个州的居民？ [Of what state are you a resident?]		
婚姻状况 [Marital status] □ 单身 [Single] □ 已婚 [Married] □ 离异 [Divorced] □ 其他 [Other] _____			
您是否提交联邦报税表？[Do you file a Federal Tax Return?] □ 是 [Yes] □ 否 [No] 如果回答“否”，为什么？[If no, why?]	您能否在其他人的报税表中被列为受抚养人？[Can you be claimed as dependent on someone else's tax return?] □ 是 [Yes] □ 否 [No]		
您或您的受抚养人在接受服务时是否有医疗保险？[Did you or your dependents have health insurance coverage at the time of service?] □ 是 [Yes] □ 否 [No]（请提供保险卡复印件）[(Provide Insurance card copy)]			

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您是有合法证件的美国居民吗？ [Are you a documented resident of the United States?]
□ 是 [Yes] □ 否 [No] □ 不愿回答 [Prefer Not to Answer]

根据您最近的纳税申报表，包括您本人在内的家庭成员 [Household Members, including yourself based on your recent Tax Returns]	出生日期 [Date of Birth]	与患者的关系 [Relationship to Patient]	是否在报税表中申报（是/否） [Claimed on Tax Return (Yes/No)]

所有家庭成员的收入证明 [Income Verification for all household members]

月收入来源 [Monthly Income Source]	由谁领取？ [Who receives this?]	月总收入（税前）[Gross Monthly Income (before taxes)]	月收入来源 [Monthly Income Source]	由谁领取？ [Who receives this?]	月总收入（税前）[Gross Monthly Income (before taxes)]
工资Gōngzī [Wages]			工伤赔偿 [Worker's Compensation]		
社会保障/残疾 [Social Security/Disability]			失业 [Unemployment]		
养老金 [Pension]			子女抚养费/赡养费 [Child Support/Alimony]		
自营职业 [Self-Employment]			地产出租收入 [Rental Land Income]		
公共援助 [Public			其他 [Other]		

资助信 - 仅应由资助者填写 [Letter of Financial Support - Should only be completed by the person providing support]

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☐ 我为患者提供 50% 以上的生活费用，但我无法帮助支付医疗账单。[I provide more than 50% support for the patient's living expenses, but I am unable to help with medical bills.]

☐ 通过签署此信函，本人确认上述声明正确无误，并且本人绝不承担患者的账单费用。如有疑问，请与我联系：_____（电话号码） [By signing this letter, I verify that the above statement is correct and that I will in no way be held liable for the patient's bills. If you have questions, please contact me at _____ (Phone Number)]

资助者姓名 [Name of person providing support]	**与患者的关系 [Relationship to Patient]**
资助者签名 [Signature of person providing support]	**日期 [Date]**

收入和身份核实 [VERIFICATION OF INCOME AND IDENTIFICATION]

我确认，据我所知，本申请表中所列的信息均真实和完整。我理解，提供的信息需要核实。如果上述信息以虚假借口提供，我将负责偿付在 Trinity Health 关联机构提供的任何服务。 [I certify that the information listed in this application is true and complete to the best of my knowledge. I understand that the information provided is subject to verification. I will be responsible for repayment of any services provided at Trinity Health affiliates if the above information is provided under false pretenses.]

患者签名 [Signature of Patient]：_____
日期[Date]：_____

或法定监护人签名（如适用） [Or Signature of Legal Guardian (If Applicable)]：

_____
日期 [Date]：_____

与患者的关系 [Relationship to Patient]：_____
日期 [Date]：_____