Mercy

Memorial Fund Application-Financial Assistance

Fern & Russell F. de Greeff Hospice House

Mercy Hospice South

As the Sisters of Mercy before us,
we bring to life
the healing ministry of Jesus
through our compassionate care
and exceptional service.

To assist us in determining patient eligibility for financial assistance, please provide ALL information requested in the attached application, in addition to the following:

- A copy of the patient's most recent income tax return, if applicable
- Recent copies of complete statements for any Checking accounts, Savings accounts, Certificates of Deposit, IRAs, 401Ks, etc., and Investment accounts, Stocks, etc.
- Copies of patient's insurance cards

Our financial assistance program is made possible by the generosity of donors throughout the St. Louis regional community.

Revised 06/2021

Mercy

Date of Application_____

Financial Information Request Form

Mercy Hospice South | de Greeff Hospice House

Personal Information (Please Print)

Patient Name_____

Address_____

Primary Phone_____ Sex: F M

Social Security #_____ DOB_____ Marital Status: S M D W

Patient, Spouse or Sig Other_____

Address_____ Primary Phone_____

Durable Power of Attorney for Finances or Financially Responsible Party

Name_____ Relationship to Patient _____

Address_____

Primary Phone_____

Dependents (if applicable)

Name_____ Relationship_____ Age_____

Name_____ Relationship_____ Age_____

Insurance

Primary_____ID_____

Secondary_____ID_____

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Assets

Balance

Checking Accounts:

Bank 1_____ $_____

Bank 2_____ $_____

Savings Accounts and/or Certificates of Deposit:

Bank 1_____ $_____

Bank 2_____ $_____

Investment & Deferred Savings Accounts (Stocks/Bonds, IRAs, Annuities etc.) _____ $_____

_____ $_____

_____ $_____

Other Assets (Life Insurance, etc.)

_____ $_____

_____ $_____

Total Assets: $_____

Debts/Liabilities

Home Mortgage: Yes or No

Loans (Auto, School, Home Equity, Credit Cards, etc.)

_____ $_____

Other (Doctors, Hospitals, Home Repair, etc.)

_____ $_____

Income per Month

PATIENT

Wages..... $_____

Social Security..... $_____

Pension..... $_____

Disability..... $_____

Other..... $_____

SPOUSE

Wages..... $_____

Social Security..... $_____

Pension..... $_____

Disability..... $_____

Other..... $_____

Total Income $_____

Expenses per Month

House Payment/Rent..... $_____

Auto..... $_____

Food..... $_____

Electric..... $_____

Gas..... $_____

Phone..... $_____

Cable/Satellite..... $_____

Trash/Sewer..... $_____

Medications..... $_____

Insurance (Health, Life, Auto)..... $_____

Other..... $_____

Total Expenses $_____

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I certify that the information provided on this application is true and correct to the best of my knowledge. I am aware that I am responsible for reporting any changes to this information as they occur. I understand this information will be utilized solely for the determination of eligibility for financial assistance, and will be kept confidential in accordance with the policies of Mercy South Hospice | de Greeff Hospice House.

Patient Name_____**Date**_____

Signature of Responsible Party_____

Print Name of Signatory_____

Relationship to Patient_____Phone_____

FOR OFFICE USE ONLY:

Reason for request:

_____

_____

_____

Funeral paid for? Yes or No Comments_____

Additional information to be considered:

_____

_____

_____

Recommendation:

_____

_____

_____

Submitted by: _____

Income $_____

Less

Expenses $_____

Available Income $_____

Authorized Determination

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