MERCY FOUNDATION, INC.
2700 Stewart Parkway Roseburg OR 97470
Phone 541-677-4818 Fax 541-677-4891

APPLICATION and FINANCIAL DISCLOSURE
Children's HealthCare Fund

Name of Patient _____ Age _____ Birthdate _____

Parent's / Guardian's Name(s) _____

Mailing Address _____ Home Phone _____

City/State/ZIP _____ Work Phone _____

Email: _____

Number in Household _____ Number of Children _____ Ages _____

Diagnosis _____

Amount Requested $_____ **Purpose:** How will this impact the health of child / children **(attach any supporting information)**:

_____

_____

Other Sources Contacted for Assistance: _____ Outcome $_____

_____ Outcome $_____

Is the Patient on the Oregon Health Plan? YES NO

Is the Patient Eligible for Disability Services? YES NO Does the Family Receive Food Stamps? $_____

Does the Patient go to Doernbecher Hospital? YES NO Caseworker's Name_____

Does the Patient go to OHSU Clinics? YES NO Phone Number_____

Does the Patient go to Shriner's Clinics? YES NO

EMPLOYMENT AND FINANCIAL DATA

Name of Person Employed	Name of Employer	Length of Employment	**Mo. Take-Home**
_____	_____	_____	$_____
_____	_____	_____	$_____

If Unemployed,
Previous Employer _____ Unemployment Amount $_____

How Long Unemployed? _____

Other Income (include TANF, SSI, child support, etc.) Name _____ Source _____ $_____

Name _____ Source _____ $_____

TOTAL MONTHLY INCOME . . . . . **$**_____

(APPLICATION WILL NOT BE PROCESSED WITHOUT A COPY OF PRIOR YEAR'S TAX RETURN ATTACHED)

ASSETS

☐ Checking Account - Bank Name Amount ☐ Savings Account - Bank Name Amount

_____ _____ $_____

Other Assets (list type of stocks, bonds, second home, recreational vehicles, etc.) : Value

_____ $_____

_____ $_____

_____ $_____

TOTAL ASSETS . . . . . **$**_____

MONTHLY EXPENSES **Mo. Payment**

Home: ☐ Own - Mortgage Payment $_____ Property Taxes / month $_____ $_____
(if not included in mortgage payment)

☐ Rent - Paid To: _____ $_____

(APPLICATION WILL NOT BE PROCESSED WITHOUT A COPY OF MORTGAGE PAYMENT COUPON, COPY OF RENT RECEIPT, OR COPY OF CANCELLED CHECK ATTACHED)

Utilities: Gas $_____ Electricity $_____ Water $_____ Phone $_____ $_____

Food & Household Items: Groceries $_____ Household $_____ Repairs $_____ $_____

Auto Expenses: Payment $_____ Gas & Oil $_____ Repairs $_____ $_____

Clothing $_____ Miscellaneous (child care, etc.) _____ $_____ $_____

Insurance (out-of-pocket expenses): Life $_____ Health $_____ Auto $_____ $_____

Drugs & Medical Supplies (out-of-pocket expenses): Patient $_____ Family $_____ $_____

Creditors Name & Address (do not include mortgage payment or auto payment)	Balance Owing	**Mo. Payment**
_____	$_____	$_____
_____	$_____	$_____
_____	$_____	$_____

Medical Creditors Name & Address	Balance Owing	**Mo. Payment**
_____	$_____	$_____
_____	$_____	$_____
_____	$_____	$_____
_____	$_____	$_____

TOTAL MONTHLY EXPENSES . . . . . **$**_____

MEDICAL / INSURANCE INFORMATION

Name of Doctor _____ Phone _____

Insurance Name _____ Group Number _____

Address _____ ID Number _____

Phone _____ Insured's Name _____

Patient's Yearly Deductible $_____ MET NOT MET Office Visit Co-Pay $_____

How Much Do You Pay Per Year in Co-Pays for Patient? $_____ Medication Co-Pay $_____

THE ABOVE INFORMATION IS WARRANTED TO BE TRUE TO THE BEST OF MY KNOWLEDGE. I hereby authorize Mercy Foundation to investigate the references herein listed or statements of other data obtained from me or from any other person pertaining to my credit and financial responsibility, and/or any medical/psychosocial conditions or needs disclosed. I hereby authorize Mercy Foundation to use the name of the patient and/or parent/guardian listed above, and/or pictures of those same persons for the benefit of Mercy Foundation. I understand I may revoke the authorization for the use of the name(s) and/or pictures at any time by notifying Mercy Foundation in writing. **IF YOU DO NOT UNDERSTAND ANY OF THE ABOVE PLEASE CALL 677-4818 FOR FURTHER EXPLANATION.**

_____ Yes, names and/or pictures may be used for the benefit of Mercy Foundation (read the authorization above before checking)

_____ No, names and/or pictures may not be used for the benefit of Mercy Foundation

Signature of Applicant: _____ Date: _____