Children's Healthcare Fund
Application and Financial Disclosure

CHI Mercy Health
Mercy Foundation

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Roseburg, OR 97471
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Patient Information

Name of Patient ______________________ Age ______ Birthdate ______________

Parent/Guardian's Name(s) ______________________

Mailing Address ______________________ Home Phone ______________

City/State/ZIP ______________________ Work Phone ______________

Email ______________________ Cell Phone ______________

Number in Household __________ Number of Children __________ Ages ______________

Medical Diagnosis ______________________

Purpose *(How will our support impact the health of child/children? Attach any supporting information*

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Amount Requested $ ______________

Income and Financial Information

Does the Patient go to Shriner's Clinics? ☐ Yes ☐ No

Does the Patient go to Doernbecher Hospital? ☐ Yes ☐ No

Does the Patient go to OHSU Clinics? ☐ Yes ☐ No

Is the Patient on the Oregon Health Plan? ☐ Yes ☐ No

Is the Patient Eligible for Disability Services? ☐ Yes ☐ No **Mo. Net Income**

Does the Family Receive Food Stamps? ☐ Yes ☐ No *If yes, provide monthly amount* $__________

Caseworker's Name ______________________ Phone ______________________

Other Income (SSI, TANF, Child Support, Etc.)

Name ______________________ Source ______________________ $__________

Name ______________________ Source ______________________ $__________

Employment *(if self-employed, please add business type)*

Name of Person Employed	Name of Employer	Length of Employment	
__________	______________________	______	$__________
__________	______________________	______	$__________

Total Monthly Income . . . . **$** __________

Required Documentation/Attachments

☐ Documentation supporting medical need

☐ Copy of current paystub

☐ Other: ______________________

Revised 3/2023

Monthly Expenses

Mo. Payment

Do you own or rent your home? ☐ Own ☐ Rent

Lender/Landlord ______________________

Mortgage/Rent $________

Utilities $________

Auto Expenses $________

Patient Out of Pocket Medication & Medical Supplies $________

Other Expenses *(Do not include mortgage payment or auto payment)*

Creditor(s) Name & Address	**Balance Owed**	
______________________	$________	$________
______________________	$________	$________
______________________	$________	$________
______________________	$________	$________

Medical Creditor(s) Name & Address		
______________________	$________	$________
______________________	$________	$________
______________________	$________	$________
______________________	$________	$________

Total Monthly Expenses . . . . **$**________

Provider and Insurance Information

Name of Doctor(s)______________________ Phone ______________________

Insurance Name ______________________ Phone ______________________

Address ______________________

Insurance Subscriber Name ______________________

Office Visit Co-Pay $________ Patient's Yearly Deductible $________ ☐ Met ☐ Not Met

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 information, please call 677-4818 for further assistance.

☐ 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: ______________________

Please Print
Name of Applicant ______________________ Relationship to Patient ______________________

Applications are valid for 6 months from date of approval.
For continuation of services, an updated application is required.

Office Use Only

Received by ______________________ Date: ______________________

☐ Approved on ______________________ for $ ______________________

☐ Denied on ______________________ Reason for Denial ______________________

Notified by ______________________ Date: ______________________

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