Fax Info:

Date: ______________________

Name of physician office/clinic/ individual:__________________

Phone: (_____)_____________

Immediate approval needed? Y/N

Mail to: *Especially for You*
701 10th Street SE
Cedar Rapids, IA 52403

FAX form to: (319) 221-8793

Call for Assistance: (319) 221-8889

APPLICATION FOR FINANCIAL ASSISTANCE

Please Print Clearly

GENDER ☐ Female ☐ Male

Name ____
Last *First* *Middle Initial*

Address ____ Phone (_______) ____________________

City _________________________ State _______ Zip _______ County __________________________

Date of birth: _____/______/_________ ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Name of doctor: _____________________________________ Email: _____________________________________

Have you ever had a mammogram? ☐ No ☐ Yes (Where: _________________________________)

Combined Family Income: Net household income refers to take home pay or the amount of money earned after payroll withholding such as state and federal income taxes, social security taxes, and pre-tax benefits like health insurance premiums. If enrolled in a flexible spending account to pay for medical costs, the amount withheld from each check is also on a pre-tax basis. **Net Household Income is gross income (minus deductions) of each person living in that household whether or not they are related.**

$ ________________________ **OR** $ ________________________
MONTHLY **ANNUAL**

Number of Dependent Children: ____________

Do you have insurance? ☐ No ☐ Yes (Name of Insurance: _______________________)

Other personal/financial issues explaining need for assistance ____
____
____
____

The above information is true to the best of my knowledge. I understand that the administrative staff of Mercy Women's Center, on behalf of the *Especially for You*® Fund, may find it necessary to call me for further information.

By signing below, I hereby consent to the use and disclosure of my personal health information contained on this form by Mercy Medical Center, Cedar Rapids, Iowa, to carry out treatment, payment and healthcare operations, including submission of this information to Linn County Public Health in order to coordinate breast care and gynecological services as needed. I also understand that I have the right to request Mercy to restrict how my personal health information is used or disclosed to carry out treatment, payment and healthcare operations; however, Mercy is not required to agree to this request (but will be bound by any agreement to do so). I further understand that I have the right to revoke this consent in writing, unless Mercy has already used or disclosed personal health information in reliance upon this consent.

Applicant's Signature ____ Date _________________________

FOR OFFICE USE ONLY

Approved by ____ Date __________________________

March 2018

Card sent _____________ Expires ______________