



APPLICATION FOR FINANCIAL ASSISTANCE

Please Print Clearly

Name _____
Last First Middle Initial

Phone (____) _____

Date of Birth: ____/____/____

Gender Female Male

Address _____

City _____

State _____ Zip _____

County _____

Email: _____

Do you have insurance? Yes No Name of Insurance: _____ Care for Yourself Approved

Tax Filing Status- Single or Married Number of Dependent Children: _____

Employer: _____

Combined Family Income: \$ _____ OR \$ _____

MONTHLY

ANNUAL

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.**

Other personal/financial issues explaining need for assistance. _____

How did you hear about the Especially for You Fund? _____

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 Department of Public Health/Care for Yourself Program 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 _____

Card sent _____ Expires _____

Call for Assistance: (319) 221-8889

2024 Version

Referred By: _____
Phone: _____
Immediate Approval? Yes / No
Care for Yourself Referred

Mail Form: Especially for You
701 10th Street SE
Cedar Rapids, IA 52403
Fax Form: (319) 221-8793