Mail to: Barb Worley
Especially for You
Mercy Women's Center
701-10th St. SE
Cedar Rapids, IA 52403

FAX FORM TO: 398-6959

APPLICATION FOR FINANCIAL ASSISTANCE

Please Print Clearly

Name _____
Last *First* *Middle Initial*

Address _____ Phone ( ) _____

City, State, Zip _____

Date of birth: ___/___/___ ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Name of doctor: _____

Have you ever had a mammogram? ☐ Yes (where _____) ☐ No

Combined Family Income: $ _____ **OR** $ _____
MONTHLY **ANNUAL**

Number of Dependent Children: _____

Do you have insurance? ☐ Yes ☐ No

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 Healthy Linn Network in order to coordinate breast care services or treatment 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 _____