

## CONFIDENTIAL APPLICATION FOR FINANCIAL ASSISTANCE

For Hospital and Professional services provided by facilities and physicians of Genesis

**Please complete and sign application form and return within 10 days including copies of the following:**

Required Verifications

- Past One month Proof of Gross Income
- Past Two months Complete Bank Statements for all bank accounts, with all pages included (explanation for recurring deposits)
- Recent Tax Returns (1040 form with Schedule C, E or F) or Three Months Profit and Loss Statements (for self-employed/dependents)

Provide the following, If applicable

- Recent W2 for Seasonal Income     Unemployment Benefit/ Denial letter     Child Support Income/Alimony
- No Income – Complete Letter of Financial Support portion of the application

**Patient Information**

Patient Name		Date of Birth	
Social Security/EIN Number (optional)	Mobile Phone	Other Phone	
Mailing Address	City	State	ZIP code
Email Address	Of what state are you a resident?		
Marital status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Other _____			
Do you file a Federal Tax Return? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, why?	Can you be claimed as dependent on someone else's tax return? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Did you or your dependents have health insurance coverage at the time of service? <input type="checkbox"/> Yes <input type="checkbox"/> No (Provide Insurance card copy)			
Are you a documented resident of the United States? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Prefer Not to Answer			
Household Members, including yourself based on your recent Tax Returns	Date of Birth	Relationship to Patient	Claimed on Tax Return (Yes/No)

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### Income Verification for all household members

Monthly Income Source	Who receives this?	Gross Monthly Income (before taxes)	Monthly Income Source	Who receives this?	Gross Monthly Income (before taxes)
Wages			Worker's Compensation		
Social Security/Disability			Unemployment		
Pension			Child Support/Alimony		
Self-Employment			Rental Land Income		
Public Assistance			Other		

### Letter of Financial Support - Should only be completed by the person providing support

- I provide more than 50% support for the patient's living expenses, but I am unable to help with medical bills.
- By signing this letter, I verify that the above statement is correct and that I will in no way be held liable for the patient's bills. If you have questions, please contact me at \_\_\_\_\_ (Phone Number)

**Name of person providing support**

**Relationship to Patient**

**Signature of person providing support**

**Date**



**CONFIDENTIAL APPLICATION FOR FINANCIAL ASSISTANCE**

For Hospital and Professional services provided by facilities and physicians of MercyOne Genesis

**VERIFICATION OF INCOME AND IDENTIFICATION**

I certify that the information listed in this application is true and complete to the best of my knowledge. I understand that the information provided is subject to verification. I will be responsible for repayment of any services provided at Genesis affiliates if the above information is provided under false pretenses.

Signature of Patient: \_\_\_\_\_ Date: \_\_\_\_\_

Or Signature of Legal Guardian (If Applicable): \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Date: \_\_\_\_\_

**Please mail your application to the address below or fax it to 563-421-3608. If you have any questions, please contact us at 563-421-2233.**

MercyOne Genesis Davenport West Medical Center,  
Patient Financial Services, Suite 2600  
1401 West Central Park Avenue  
Davenport, IA 52803

If your healthcare services were received in the state of Illinois, concerns or complaints with the financial assistance application process or uninsured discount may be reported to: Healthcare Bureau of the Illinois Attorney General at 1-877-305-5145 or <https://illinoisattorneygeneral.gov/consumers/hcform.pdf>.