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 ☐ Single ☐ Married ☐ Divorced ☐ Other _______________

Do you file a Federal Tax Return? ☐ Yes ☐ No
If no, why?

Can you be claimed as dependent on someone else's tax return?
☐ Yes ☐ No

Did you or your dependents have health insurance coverage at the time of service?
☐ Yes ☐ No (Provide Insurance card copy)

Are you a documented resident of the United States? ☐ Yes ☐ No ☐ 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**

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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.

Genesis 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.