Genesis Health Group
865 Lincoln Rd, Suite L10
Bettendorf IA 52722
Phone (563) 355-9200
888-700-7842

FINANCIAL ASSISTANCE APPLICATION

I am requesting financial assistance in paying for health care services provided by Genesis Health Group. I understand I must provide certain information for a review and a determination of my eligibility. I further understand completing this form does not guarantee any assistance. *All information must be completed.*

Patient Name:_____ Patient Account Number:_____
Patient Address:_____ Employer Name :_____
_____ Employer Address_____
_____ _____
Patient Phone:_____ Employer Phone:_____
Patient SSN:_____ Patient Date of Birth:_____
Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Responsible Party (guarantor) for payment of bill:

Guarantor Name:_____ Guarantor Employer:_____
Guarantor Address:_____ Employer Address:_____
_____ _____
_____ _____
Guarantor Phone:_____ Employer Phone:_____
Guarantor SSN:_____ Guarantor Date of Birth:_____
Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated
Number of Dependents:_____

Resources (Income/Assets Complete All That Apply)

Wages (Self)	_____
(Spouse)	_____
(Other Person)	_____
Farm or self-employment	_____
Public Assistance	_____
Social Security	_____
Unemployment compensation	_____
Strike Benefits	_____
Alimony	_____
Child Support	_____
Pensions	_____
Other Income (dividends, interest, rent)	_____

Additionally, please provide copies of all of the following documents:

_____Drivers License or Identification Card
_____Last two paycheck stubs or documentation of unemployment
_____Your last filed Federal Income Tax form, completed and signed
_____Proof of any other income received in the last 30days
_____Decision regarding application for Medicaid/Title 19 coverage

ACKNOWLEDGEMENT AND SIGNATURE:

- I declare under penalty of perjury and cancellation of any previous agreements that the answers I have provided are true and correct to the best of my knowledge
- I agree to inform the provider of services, within 10 days, if there are any changes in my (or the persons on whose behalf I am acting) income, property, expenses, or in the persons in the household, or any changes of address.
- I understand and grant permission for Genesis Health Group and its representatives to investigate and verify all information provided within this application. All statements will be subject to verification by contact with my employer, bank, credit bureaus and record searches.
- I understand Genesis is required by law to keep all submitted information confidential
- I further agree, that in consideration for receiving healthcare services as a result of an accident or injury, to reimburse Genesis Health Group from proceeds of any litigation or settlement resulting from such act.
- I understand that if I do not qualify for uncompensated services, I will be personally liable for the charges of the services rendered by Genesis Health Group or I may appeal the decision in writing within 10 days.

_____ _____

Signature Date

For Office Use only:

Additional Account Numbers:_____

Account Balance:_____