APPLICATION FOR MAMMOGRAPHY ASSISTANCE PROGRAM

Patient Name: Patient Age

Date of Birth: Phone (8:00 a.m. – 4:30 p.m.):

Address (include city, state, zip):

Employer:

Dates of Service:

Type of Service Requested:
☐ Mammography or Breast Imaging ☐ Lymphedema Treatment

Is the patient covered by?

☐ Insurance ☐ Medicare
☐ Title 19 ☐ Government Programs
☐ Other (specify): ____________________________

NOTE: Persons covered by Medicare or Medicaid (Title 19) do not qualify for this program.

Number of persons in family (see definition of family below):

FAMILY means one or more adults and children, if any, related by blood, or law and residing in the same household. Where adults, other than spouses, reside together, each may be considered a separate family. Emancipated minors and children living under the care of individuals not legally responsible for that care may be considered one-person families. College students, regardless of their residence, who are supported by their parents or others related by birth, marriage, or adoption are considered to be residing with those who support them.

FINANCIAL INFORMATION:
Please list all sources and amount of income. Choose between listing family gross income for prior 12 months, OR total family gross income for the prior 3 months.

Gross income for prior 12 months:

Total gross income for prior 3 months:

Are you unemployed?
☐ Yes ☐ No

If yes, for how long: ______________________________

Other circumstances you feel should be considered during review of this application:

____

____

I certify that the information provided is true and correct.

Signature of applicant: ______________________________ Date: ______________

INCOME refers to total cash receipts before taxes from all sources. It includes money, wages, and salaries before any deductions, but does not include food or rent in lieu of wages. It also includes net income from self-employment from farm and business. It includes regular payments from public assistance, social security, unemployment, and worker's compensation, strike benefits, training stipends, alimony, child support, and military family allotments or other regular support from an absent family member or someone not living in the same household; government employee pensions, private pensions, and regular insurance or annuity payments; and income from dividends, grants, interest, rents, royalties, or income from estates and trusts, as well as student loans.

Jefferson County Health Center Income Guidelines for Mammography Assistance for 2021		
Size of Family Unit	Yearly Income	Monthly Income
1	$33,975	$2,831.25
2	$45,775	$3,814.58
3	$57,575	$4,797.92
4	$69,375	$5,781.25
5	$81,175	$6,764.58
6	$92,975	$7,747.92
7	$104,775	$8,731.25
8	$116,575	$9,714.58
For each additional person add	$11,800	$983.33

NOTE: This guideline is only for mammography or breast imaging assistance and only covers the cost of a mammogram or other breast imaging services at Jefferson County Health Center and the interpretation fees from Radiology Consultants of Iowa, P.L.C.

Questions regarding this program may contact Misti Novak, Financial Counselor at 641-469-4311.

Please return completed applications to:
ATTN: Financial Counselor
Jefferson County Health Center
2000 S. Main St., Fairfield, IA 52556