Iredell Health Foundation

Women's Health Fund Guidelines

GOAL: Offer qualifying women financial support for mammograms and bone density scans.

Qualification for financial support will be based on the following criteria:

1. Completion of the Women's Health Fund application.
2. Stated financial need as described in the application. (2x poverty level, $39,366 single or $53,244 married)
3. Applicants must be seeking funds related to mammography or diagnostic scans.
4. Foundation can offer no more than $1,000 (annual total) to any individual's scans or follow-ups.

The fund will not:

1. Cover co-pays
2. Cover high-deductible plans

(To be completed by applicant)

I have received, read and understand the guidelines for funding _____ (initials)

INTERNAL PROCESS:

1. Women's Health Fund applications are to be completed and returned to the Iredell Health Foundation.
2. Approval status will be communicated within 5 business days of receipt.
3. All approved requests will be submitted to Accounting for payment and communicated to the Women's Health Fund advisor.
4. Invoices and bills for approved funded procedures are to be sent to Iredell Health Foundation and Accounting.

Iredell Health Foundation

Application for Assistance

(To be completed by applicant)

PATIENT INFORMATION: *(all sections to be completed)*

Date: _____

Name: _____ D.O.B. _____

Address: _____

Phone (home/mobile/work): _____

OTHER PERSONAL INFORMATION:

Annual Income (Single): _____ Annual Income (Married): _____

REQUEST FOR SUPPORT:

Type of service: ☐ Mammography ☐ Ultrasound ☐ Diagnostic

Explain the nature of the need and why_____

_____

_ Have you received funds from this source in the past? ☐ YES ☐ NO

If yes, when? _____ *(Due to the volume of requests and limited funding, approval will be granted every other year)*

Are you being referred to Iredell by a free clinic? ☐ YES ☐ NO

If YES, which clinic _____

Applicant's Name by: (print) _____

Applicant's Signature: _____

By signing this application, you (the applicant) attest that the information given on this application for funding from the Iredell Health Foundation is true and correct to the best of your knowledge on the date it was completed. Typing in your name will be recognized by us as a legal and binding signature.

All information given on this application will be kept confidential.

For Foundation Staff Only

DATE RECEIVED: _____ RECEIVED BY: _____

APPLICATION STATUS: _____ DATE: _____

FOUNDATION EXECUTIVE DIRECTOR: _____ (SIGNATURE)

INVOICE RECEIVED: _____ PAYMENT MADE: _____ AMOUNT: _____