BostonGene

Financial assistance program application form

BostonGene offers a financial assistance program to provide eligible patients with access to test(s) to assist their doctors in clinical decision-making and help eligible patients decrease their out-of-pocket expenses. Once you complete this form, BostonGene will be able to determine your eligibility by taking your household income and other life circumstances into account.
We believe you should have access to medically necessary tests ordered by your physician.

***Required fields must be filled out**

PATIENT INFORMATION

First name*	**Last name***	**DOB*** / /
Sex ☐ M ☐ F	Phone/Fax	Email
Street address		City
State	Postal code	Country
Insurance name		

How do you prefer to be notified of the results of the application?

☐ Phone ☐ Email ☐ Fax ☐ Mail to home address

PATIENT BACKGROUND

Patient gross annual household income (estimate)* ____________________

How many family members are in your household?* ____________________

Please indicate any special circumstances (check all that apply):

- ☐ Loss of income due to diagnosis or treatment: temporary or permanent (please circle one)
- ☐ Short or long term disability leave
- ☐ Retired (fixed income)
- ☐ Significantly high medical bills
- ☐ Significant debt (e.g., credit card) due to decrease of income
- ☐ Non-local travel expenses for treatment (e.g., transportation, accommodations)
- ☐ Supporting family members outside of the household
- ☐ Child support/alimony
- ☐ Unforeseen expenses (e.g., home or car repair)
- ☐ Other (please specify) ____________________
- ☐ None

ORDERING PHYSICIAN INFORMATION

First name	Last name
Institution	
Phone	Email

PATIENT CONSENT TO APPLICATION

Are you the patient? ☐ Yes ☐ No If not, please indicate your name and relationship to the patient	By signing this form, I certify that all the information in the application is true and accurate to the best of my knowledge. I authorize BostonGene to use the information in this application to determine eligibility for the BostonGene financial assistance program.
Signature*	**Date*** / /