

## FINANCIAL ASSISTANCE PROGRAM APPLICATION FORM

BOSTONGENE OFFERS A FINANCIAL ASSISTANCE PROGRAM TO PROVIDE ALL PATIENTS AN OPPORTUNITY TO RECEIVE THE TEST NECESSARY FOR CLINICAL DECISION MAKING AND TO HELP PATIENTS IN NEED TO DECREASE THEIR OUT-OF-POCKET EXPENSES.

WE BELIEVE YOU SHOULD HAVE ACCESS TO MEDICALLY NECESSARY TESTS ORDERED BY YOUR PHYSICIAN.

PLEASE COMPLETE THIS FORM TO APPLY FOR THE BOSTONGENE FINANCIAL ASSISTANCE PROGRAM.

BOSTONGENE WILL CONSIDER THE FINANCIAL APPLICATION TAKING YOUR HOUSEHOLD INCOME AND OTHER LIFE CIRCUMSTANCES INTO ACCOUNT.

\*REQUIRED FIELDS MUST BE FILLED OUT

PATIENT INFORMATION:			
FIRST NAME*		LAST NAME*	
DATE OF BIRTH*		SEX	<input type="checkbox"/> M <input type="checkbox"/> F
PHONE		EMAIL	FAX
STREET ADDRESS		CITY	
STATE	COUNTRY	POSTAL CODE	
HOW WOULD YOU PREFER TO BE NOTIFIED OF THE RESULTS OF THE APPLICATION?			
<input type="checkbox"/> PHONE			
<input type="checkbox"/> EMAIL			
<input type="checkbox"/> FAX			
<input type="checkbox"/> 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):	
<input type="checkbox"/> LOSS OF INCOME DUE TO DIAGNOSIS OR TREATMENT: TEMPORARY OR PERMANENT (PLEASE CIRCLE ONE)	
<input type="checkbox"/> SHORT OR LONG TERM DISABILITY LEAVE	
<input type="checkbox"/> RETIRED (FIXED INCOME)	
<input type="checkbox"/> SIGNIFICANTLY HIGH MEDICAL BILLS	
<input type="checkbox"/> SIGNIFICANT DEBT (E.G. CREDIT CARD) DUE TO DECREASE OF INCOME	
<input type="checkbox"/> NON-LOCAL TRAVEL EXPENSES FOR TREATMENT (E.G. TRANSPORTATION, ACCOMMODATIONS, ETC.)	
<input type="checkbox"/> SUPPORTING FAMILY MEMBERS OUTSIDE OF THE HOUSEHOLD	
<input type="checkbox"/> CHILD SUPPORT/ALIMONY	
<input type="checkbox"/> UNFORSEEN EXPENSES (E.G. HOME OR CAR REPAIR, ETC)	
<input type="checkbox"/> OTHER (PLEASE SPECIFY)	
<input type="checkbox"/> NONE	

ORDERING PHYSICIAN INFORMATION:	
FIRST NAME	LAST NAME
INSTITUTION	
PHONE	EMAIL

PATIENT CONSENT TO APPLICATION:	
ARE YOU A PATIENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	
IF NOT, PLEASE INDICATE YOUR NAME AND RELATIONSHIP TO THE PATIENT	
BY SIGNING THIS FORM, I CERTIFY THAT ALL THE INFORMATION PROVIDED IN THE APPLICATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE. I AUTHORIZE BOSTONGENE TO USE THE INFORMATION PROVIDED IN THIS APPLICATION TO DETERMINE THE ELIGIBILITY FOR THE BOSTONGENE FINANCIAL ASSISTANCE PROGRAM.	
SIGNATURE*	DATE*