

Financial assistance program application form

BostonGene offers a financial assistance program to provide eligible patients with access to test(s) that will assist their doctors in clinical decision-making and to 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* <input type="text"/> / <input type="text"/> / <input type="text"/>
Sex <input type="checkbox"/> M <input type="checkbox"/> F	Phone		Email	
Street address			City	
State	Postal code		Country	
Insurance Name				
How do 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"/> Nonlocal travel expenses for treatment (e.g., transportation, accommodations)
<input type="checkbox"/> Short or long term disability leave	<input type="checkbox"/> Supporting family members outside of the household
<input type="checkbox"/> Retired (fixed income)	<input type="checkbox"/> Child support/alimony
<input type="checkbox"/> Significantly high medical bills	<input type="checkbox"/> Unforeseen expenses (e.g., home or car repair)
<input type="checkbox"/> Significant debt (e.g., credit card) due to decrease of income	<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 the patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	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.
If not, please indicate your name and relationship to the patient	
Signature*	Date* <input type="text"/> / <input type="text"/> / <input type="text"/>