PATIENT FINANCIAL ASSISTANCE APPLICATION

FOUNDATION**ACCESS**

Financial Assistance is available to domestic residents of the US.

Please fax to: +1 (617) 418-2290 **Email:** client.services@foundationmedicine.com

*Required Information

For more information or to file your application online, visit: *access.foundationmedicine.com*

Patient Information

*Last Name

*First Name MI

*DOB (MM/DD/YYYY) *Sex

__ __/ __ __/ __ __ __ __ ☐ F ☐ M

*Street Address *Apt. # *City

*State *Postal Code *Country

*Phone

Email

*Total Gross Annual Household Income

Estimated Gross Annual Household Income

☐ **Number of family members in household supported by above gross annual household income**

Must be filled out to process form

*Who Should We Contact with the Approval Decision?

Ensure contact information for patient and facility is filled in at the top of the form.

Check all that apply:	**Preferred method of contact:**
☐ Patient	☐ Phone ☐ Email ☐ Mail
☐ Practice	☐ Phone ☐ Email ☐ Mail ☐ Fax

Ordering Physician and Facility Information

*Office/Practice/Facility Name

*Ordering Physician

*Phone

*Fax

*Email

Extenuating Circumstances

Please advise of any extenuating circumstance that you would like us to consider.

- ☐ Retired (i.e., fixed income)
- ☐ Short or long-term disability
- ☐ Significant credit card debt
- ☐ Significant medical expenses
- ☐ Supporting family member(s) outside of household
- ☐ Alimony and/or child support
- ☐ Temporary loss of income due to diagnosis or treatment
- ☐ Permanent loss of income due to diagnosis or treatment
- ☐ Unforeseen expenses (e.g., home or car repair, etc.)
- ☐ Non-local travel expenses for treatment (e.g., hotel, airfare, etc.)
- ☐ College expenses for child/children
- ☐ Other (Please attach additional detail if necessary)
- ☐ None

*I Hereby Acknowledge the Above Information is True and Correct:

Patient Name OR Personal Representative *(Print)*

Signature

Relationship to Patient

Date

As a Personal Representative of the patient, or an Ordering Physician completing this application on my patient's behalf, my signature also certifies that I have explained to the patient the nature and purpose of this application and that the patient has consented to my completing the application on his/her behalf.

Return Signed Form to Attn: *Client Services*

Fax: 617.418.2290

Email: client.services@foundationmedicine.com

For patients with health insurance, the insurance provider will be billed first. Your qualified amount for financial assistance will be applied to any unpaid balance remaining after billing insurance.