

# Patient Financial Assistance Application

Financial Assistance is available to domestic residents of the US.

Please fax to: +1 617.830.0279 Email: [client.services@foundationmedicine.com](mailto:client.services@foundationmedicine.com)

\*Required Information

For more information or to file your application online, visit: [aid.foundationmedicine.com](http://aid.foundationmedicine.com)

Patient Information		*Ordering Physician and Facility Information
*Last Name _____		Office/Practice/Facility Name _____
*First Name _____	MI _____	Ordering Physician _____
*DOB (MM/DD/YYYY) _____	*Sex <input type="checkbox"/> F <input type="checkbox"/> M	Phone _____
*Street Address _____	Apt. # *City _____	Fax _____
*State *Postal Code _____	*Country _____	Email _____
*Phone _____	<input type="checkbox"/> I authorize Foundation Medicine to leave a detailed voicemail at this phone number	
Email _____		

*Total Gross Annual Household Income	Extenuating Circumstances
Estimated Gross Annual Household Income (Current income. Estimated ranges not accepted.) _____	Please advise of any extenuating circumstance that you would like us to consider.
<input type="checkbox"/> Number of family members in household supported by above gross annual household income (including patient) Must be filled out to process form	<input type="checkbox"/> Retired (i.e., fixed income)
	<input type="checkbox"/> Short or long-term disability
	<input type="checkbox"/> Significant credit card debt
	<input type="checkbox"/> Significant medical expenses
	<input type="checkbox"/> Supporting family member(s) outside of household
	<input type="checkbox"/> Alimony and/or child support
	<input type="checkbox"/> Loss of income due to diagnosis or treatment (if both please explain)
	<input type="checkbox"/> Temporary <input type="checkbox"/> Permanent _____
	<input type="checkbox"/> Unforeseen expenses (e.g., home or car repair, etc.)
	<input type="checkbox"/> Non-local travel expenses for treatment (e.g., hotel, airfare, etc.)
	<input type="checkbox"/> College expenses for child/children
	<input type="checkbox"/> Other (Please attach additional detail) _____
	<input type="checkbox"/> None

*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: (select one)
<input type="checkbox"/> Patient	<input type="checkbox"/> Email <input type="checkbox"/> Phone <input type="checkbox"/> Mail
<input type="checkbox"/> Practice	<input type="checkbox"/> Email <input type="checkbox"/> Fax

*I Hereby Acknowledge the Above Information is True and Correct:	
Patient Name OR Representative (Print) _____	Signature (Required) _____
Relationship to Patient _____	Date _____

As a Representative of the patient, or an Ordering Physician completing this application on the patient's behalf, my signature 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. My signature also indicates that, at the time of application, the patient named above was unable to sign this form, and that, should an authorized personal representative have been appointed, no such authorized personal representative was available or willing to sign on the patient's behalf. My signature is not an acceptance of financial responsibility or liability for the services rendered.

Return Signed Form to Attn: Client Services	
Fax: 617.830.0279	Email: <a href="mailto:client.services@foundationmedicine.com">client.services@foundationmedicine.com</a>

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.