BostonGene

Financial assistance program application form

BostonGene offers a financial assistance program to provide all patients the opportunity to receive the necessary test(s) for clinical decision making and help patients in need 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*** MM / DD / YYYY
Biological 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, including you, 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)
- ☐ Significant debt (e.g., credit card) due to decrease of income
- ☐ Nonlocal travel expenses for treatment (e.g., transportation and accommodations)
- ☐ Retired (fixed income)
- ☐ Short or long term disability leave
- ☐ Supporting family members outside of the household
- ☐ Significantly high medical bills
- ☐ Child support/alimony
- ☐ Unforeseen expenses (e.g., home or car repair)
- ☐ Other (please specify) _____
- ☐ None

ORDERING PHYSICIAN INFORMATION

First name	Last name
Institution	
Phone	

PATIENT CONSENT TO APPLICATION

Are you the patient? ☐ Yes ☐ 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*** MM / DD / YYYY