Transplant Genomics | Eurofins Clinical Diagnostics

Eurofins Transplant Genomics - Financial Assistance Application

Patient Name:

Social Security Number: Birth Date Month/Date/Year):

Spouse Name (or Parent(s)/Guardian(s) Name(s) if Patient is a Minor):

Social Security Number: Birth Date (Month/Date/Year):

☐ Employed Employer (Name, Address, and Telephone Number): _____

☐ Unemployed _____

A. Income: Please provide the income for each of the following persons in your household.

☐ Patient is a minor. The income information below is for the patient's parents or guardians.

Patient (or parent) $_____ Hr/ Wk/ Month/Year (circle one)

Spouse (or parent) $_____ Hr/ Wk/ Month/Year (circle one)

Total Yearly Family Income $_____

B. Family Members: Please provide the number of persons in the patient's household). _____
(including the patient)

C. Income Verification: Please provide any of the following types of documentation to support your eligibility:

IRS Form W-2	Paycheck Remittance	Tax Return
Employer Verification	Bank Statements	Non-filing IRS letter
Proof of participation in Government Assistance Programs (WIC, food stamps, housing assistance, Medicaid)	Social Security, Workers' Comp or Unemployment Determination Letter	Physician documentation evidencing determination of financial need, and discount provided by ordering physician practice

If you are unable to provide one of the sources of income documentation listed above, please explain why this information is not available:

_____

_____

D. Other Resources: Please provide the total amount of other resources available to you, including such things as savings accounts, checking accounts, stocks, bonds, etc. $_____

E. Other Extenuating Circumstances: Please explain any other extenuating circumstances.

_____

_____

_____

I understand that I am applying for financial assistance, and I am aware that falsification of information on this Application may result in denial of financial assistance. By signing below, I attest that all information provided is true and factual to the best of my knowledge.

_____ _____
Signature of Patient or Responsible Party Date

_____ _____
Eurofins Employee Signature Date